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A CASE STUDY ABOUT TEENAGE PREGNANCY

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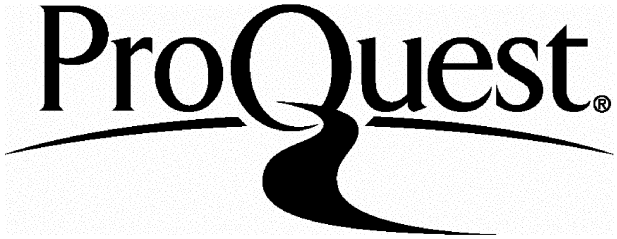

ABSTRACT

Purpose:

Teenage pregnancy is a world-wide problem and a subject of concern in both industrialised and developing countries. It is in fact a growing concern that is very commonly reported in the media. A few studies have considered teenager opinions and have looked at their point of view. This study aims to look at teenagers attitudes to health care services so as to develop better services and thus a better outcome for this group.

Methods:

This is a case study which looked at a specific population, pregnant teenagers and young mothers attending Ashlyns School in Newcastle-upon-Tyne. Different approaches for gathering information were used in this study. A descriptive approach, gaining general information, through observation and documentary evidence was used. A quantitative phase using a self-administered questionnaire was undertaken, and a qualitative phase using focus-group discussions with the young mothers, and semi-structured and unstructured interviews with the key-informants was also undertaken. Participant observation was also an important component of the data collection. These different approaches have enabled us to triangulate our findings.

Results:

Most girls studying in Ashlyns come from a poor background, and seem to repeat a family pattern of early pregnancy. Most pregnant teenagers in the study, seem to seek consistent antenatal care. Also, the majority found antenatal care very important, but they did not like the attitude of the health care providers. They described them as judgmental, patronising, and felt that they treated young mothers differently because of their age. 50% of adolescents would prefer "young mother" clinics, and 25% would like normal clinics with timetables reserved for teenagers. In all, 75% would like something different. The main reason for in delayed antenatal care comes from the late discovery of the pregnancy. 95% of schoolgirls would like to have "young mother" discussion groups. Young mothers, mainly primipara, are keen to understand more about their pregnancy

and would like more information. All the girls at Ashlyns School were successful in gaining their GCSE qualifications.

Conclusion:

The results seem to follow the trends of other studies reported in the literature. There are important differences, however, in the degree to which subjects in this study attended antenatal care and in subjects educational achievements. These positive findings may be the result of the greater degree of support that Ashlyns School provides.

Teenage mothers to be represent an especially vulnerable group at risk of marginalisation by an early pregnancy. Specific models incorporating adapted health care and education can pull this group in from the fringe of society. These young women require self-esteem and confidence to continue productive lives and to be ensure that they are good healthy mothers.

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DEDICATION

"To the young mothers of Ashlyns School"

ABREVIATIONS

C of A:	Certificate of Achievement
EWO:	Education Welfare Officer
GCSE:	General Certificate of Secondary Education
GP:	General Practitioner
MSc:	Master of Science
ONS:	Office for National Statistics
STD:	Sexually Transmitted Disease
UK:	United- Kingdom
UN:	United Nations
UNICEF:	United Nations International Children's Emergency Funds
USA:	United States of America
WHO:	World Health Organisation

P 51 for the table *"Results of the GCSE 1998"*:

Eng. Lang:	English Language
Eng. Litter:	English Literature
Child. Dpt:	Child Development
Cons. St:	Consumer Studies
Food Nutri:	Food and Nutrition
Math:	Mathematics

CHAPTER ONE

INTRODUCTION and LITERATURE REVIEW

I - 1 GENERAL INTRODUCTION

In recent years there has been widespread concern in both Britain and also world-wide about teenage pregnancy. The subject tends to raise emotion and incomprehension, especially in Europe and other industrialised countries. A number of studies have been undertaken in order to try to understand the causes and the consequences of teenage pregnancy, on the mother, her baby, her family and Society. A quote from McRobbie in 1989 sets the scene, "Since the early 1980's there has been a kind of subdued moral panic simmering under the surface about young, unemployed girls becoming pregnant, staying single and taking themselves out of the labour market by opting for full time motherhood" (1).

Different studies have shown that teenagers are more likely than older women to delay their first visit to the doctor, until they are 12, 20 or more weeks' pregnant; and they tend to miss visits (2, 3).

Many authors have indicated that adolescent pregnancy is an "at risk pregnancy" and that good antenatal care is associated with improved pregnancy outcomes. Some strong suppositions stating that antenatal services are not adapted to young mothers have been made, but only a few studies have looked at this aspect, and at the adolescent point of view (4, 5).

Young people are a distinct group with their own and particular needs. It seems then very important to look at their views and desires.

I – 2 AIMS AND OBJECTIVES:

Principal Aim:

To determine the needs of pregnant teenagers with regard to Antenatal care and the reasons why they tend to avoid seeking health care in pregnancy.

Specific Aims:

1 – From Teenagers

To determine the expressed needs of pregnant teenagers about existing Antenatal Care.

2 – From Teenagers

To determine the expressed opinion of pregnant teenagers about existing Antenatal Care.

3 – From Key Informants

To investigate any assumptions about teenage pregnancy that key informants working with teenagers have.

4 – From Key Informants and Observation

To explore the facilities and opportunities that Ashlyns School, a school specialised for young mothers, offers to pregnant teenagers.

LITERATURE REVIEW

I - 3 ADOLESCENT PSYCHOLOGY:

1- Adolescence :

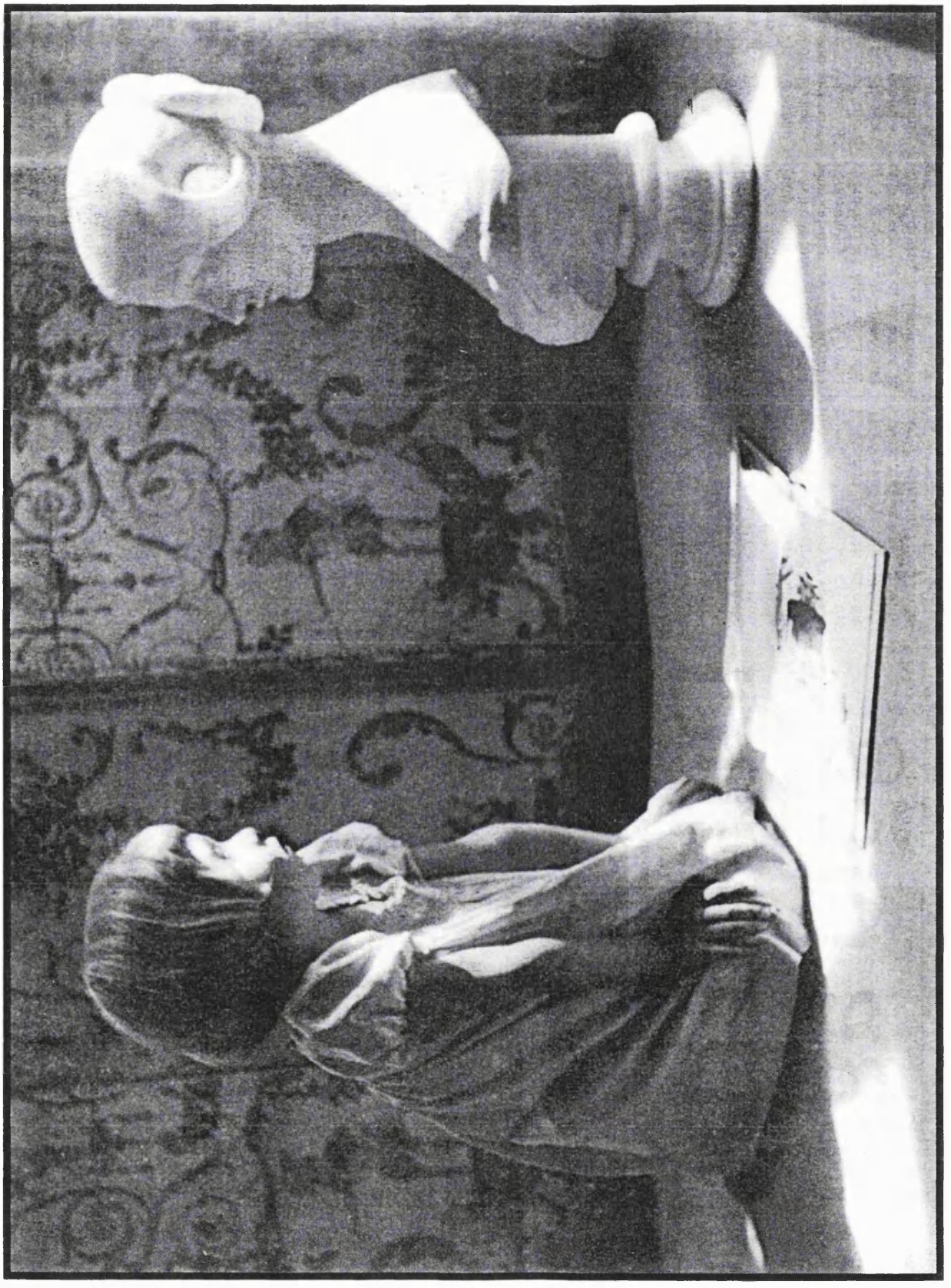
The word "teenage" is used synonymously with the term "adolescence" - which the World Health Organisation (WHO) defines as the period from 10 to 19 years. "Teenagehood covers the period between 13 years and 19 years of age. To talk of teenage pregnancy is to refer to all pregnant women under the age of 20" (6).

Adolescence is an important phase of life; a transitory period between childhood and adulthood. Adolescence is a time of radical psychological change and readjustment. It is a period of dynamic transition, during which many changes occur in the body and mind of teenagers, and when developments in social and sexual relationships take place. The adolescent has to define herself as a person, to find her own personality and to achieve her independence. The struggle for independence usually involves a certain amount of rebellion and rejection of parental values. Rebelliousness can take the form of "antisocial behaviour", like drinking, drug taking or sexual experimentation. We say that teenagers are thus prone to "at risk behaviour".

A very important aspect of adolescent psychological development is the acquisition of a sense of personal worth and the internalisation of a personal "locus of control", the concept which psychologists use to define "who is in Charge" (an assumption of responsibility for one's actions and one's body) (7). During adolescence, there is an evolution in reasoning from concrete viewpoint to abstract thinking, it is in this period that the development of the future time perspective appears. Adolescence is a difficult period, and task, for any adolescent, where a lot of bases for a balanced and stable adulthood are built.

"Growing up is a continuous process and attitudes developed during childhood and youth will influence the whole way of life of future generations" (8).

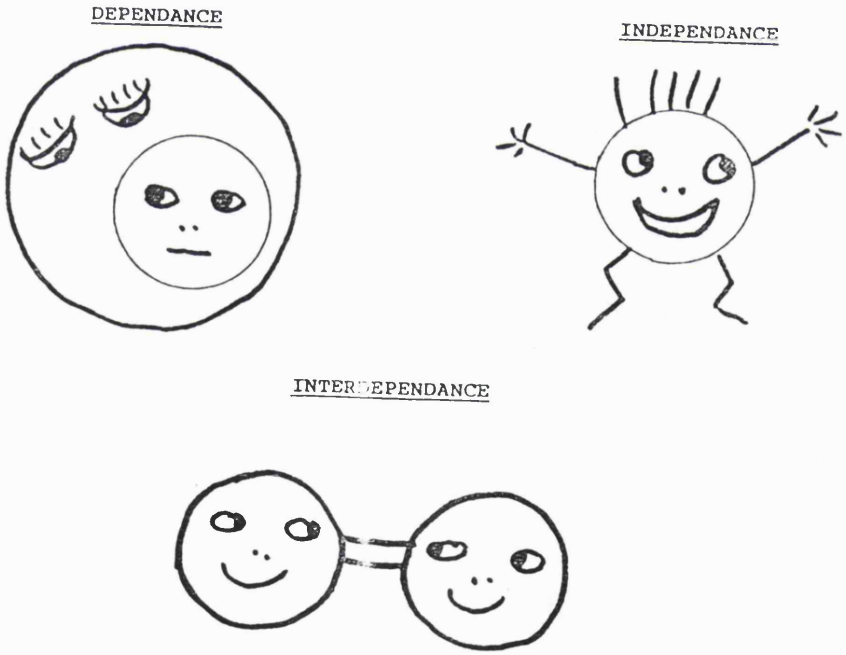
Figure 1: *Growing up*



2- <u>Adolescent Mother</u> :

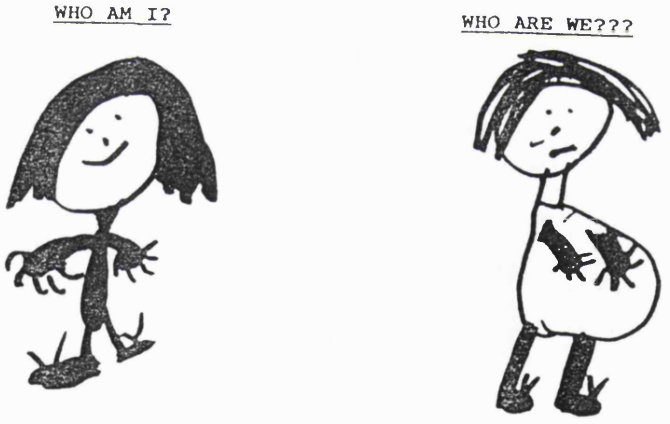
The process of gaining independence has been found to be "out of line" in some girls who become pregnant at an early age. "Establishing a personal identity may be an almost impossible task for the pregnant adolescent, who suddenly finds that her identity is changing beyond her control" (7).

Figure 2: *Dependence, Independence, Interdependence* (7).



Pregnancy pushes a teenager to leave childhood to become "adult" without any transition and time to discover who she is.
The role of mother is thrust upon her before she has established her own identity.

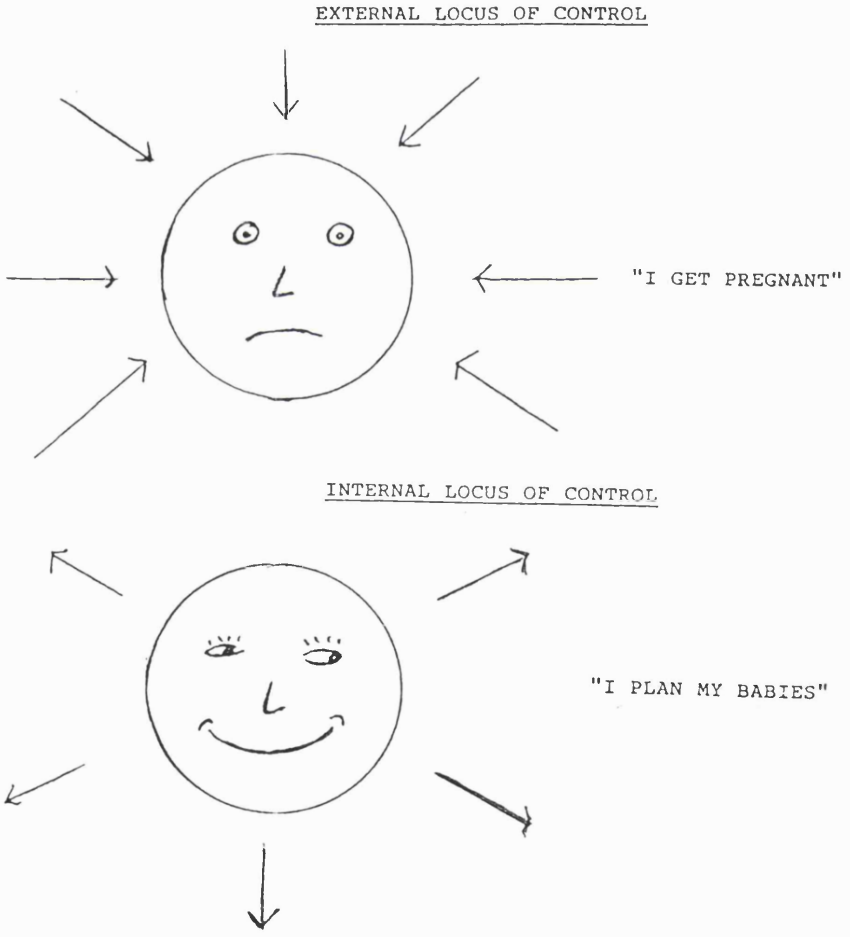
Figure 3: *Who am I? Who are we?* (7).



The fact that a teenage girl becomes pregnant disturbs all the family structure and forces her own mother into the role of grandmother, which can cause problems of communication in the mother daughter relationship.

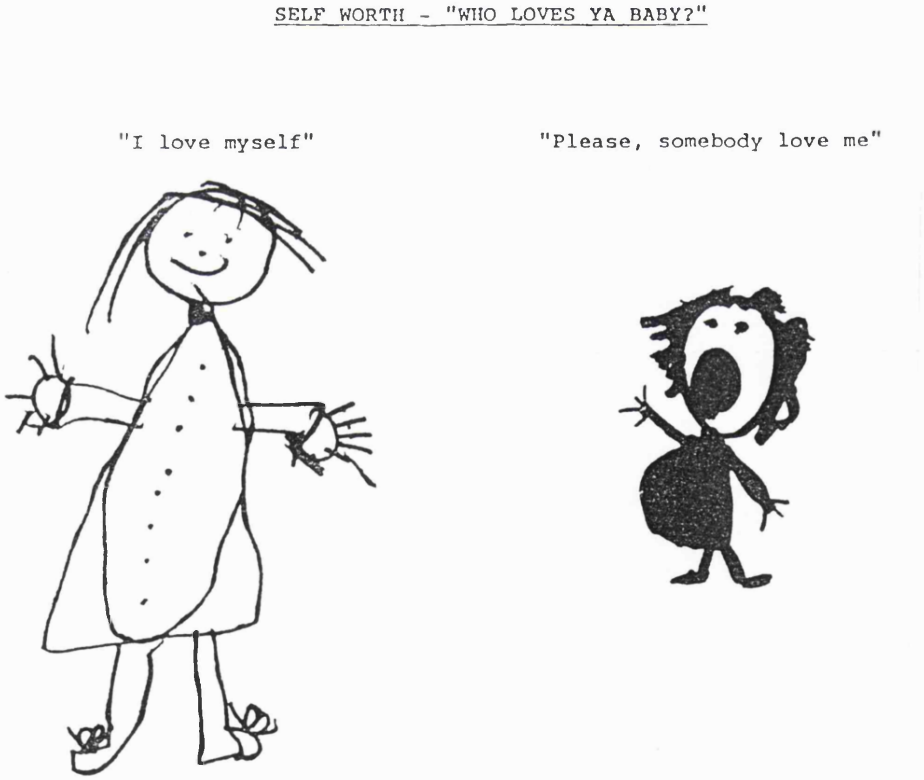
A pregnant girl may have "poor ego control" and may feel a total "loss of control" over her body. Teenagers do not feel responsible for their actions or their body; pregnancy is something that "happens" to them. *"I really believed that it could not happen to me"* (view from a teenage mother) (9).

Figure 4: *External and Internal Locus Control* (7).



It has been said that schoolgirls who become pregnant have difficulty in developing and sustaining interpersonal relationships (family, school...). *"I have lost a lot of friends by being pregnant"* (view from a teenage mother) (9). Their boyfriend might be their only social contact. Teenagers, like every human being, need to be loved, but the regard of others is particularly important at this period of life. Adolescents need to be recognised and loved for who they are: a future adult. *" I love [my baby] but he is exhausting and I do think sometimes I am too young, I need somebody to look after me"* (Carrie, a young adolescent mother of 14 years old) (10).

Figure 5: *Self worth. "Who loves ya baby?"* (7).



Teenagers have a romantic view of love, and might see an occurring pregnancy as a symbol of their love. They have difficulty in realising the consequences of a baby upon their future life. Younger teens still tend to be concrete thinkers, they are more likely to look at short term and immediate results than think about the long-term implication of their actions. "Rational judgement is subject to stress, anxiety, hormonal changes, peer pressures, family conflicts and self ambivalence" (11).

A pregnancy at an early age tends to disrupt the processes of adulthood development. Some authors have spoken of a "child carrying a child" (7), but these young girls do not have the choice to stay a child, they have to become an adult prematurely. Some teenage mothers are often not emotionally mature enough to be a parent. *"I was an immature girl who, because I got pregnant, I was meant to behave like a woman"* (9).

There is empirical evidence that adolescent parents lack the cognitive abilities of childless adolescent of the same age and that many exhibit lower levels of emotional stability, sensitivity to infant needs and social adjustment (12). During adolescence pregnancy impacts the physiological, psychological and sociological health status of women. A pregnancy can have long term physical, psychological, educational and occupational effects on teenagers as they move toward adulthood (13).

I - 4 CULTURE DIFFERENCE :

World-wide, some 15 million babies are born to adolescent mothers (more than 1 in 10 of all births).

"While in some cultures the birth of the first child to a young married women confers status, in others, early pregnancy can completely disrupt their lives" (WHO, 1995) (14).

"Norms" and values are not only based in societies, cultures and religions; they can change over time" (8).

1 - <u>Developing countries</u> :

"Women in most societies have many roles, but their role in reproduction is often the only one recognised, and even in that they can expect little support" (UN, 1995) (15). In the least developed countries, the proportion of births to adolescents is over 17 % of all live births. In the poorest areas like Middle Africa, it is almost 24 %. In many developing countries, marriage also occurs at a very young age.
In urban settings, young mothers are often not married and do not receive any support from their family. Young girls with their babies tend to live in poverty and socio-economic chaos. In this population unwanted pregnancy, unsafe abortion and prostitution are common problems that lead to dramatic situations. These "child mothers" are rejected from society.

In rural areas, the traditional structures and norms prevail in preparing the adolescent for adult life and marriage. In traditional societies, ceremonies of initiation rites occur during early adolescence and mark the passage from childhood to adulthood. Shortly after the ceremonies, girls marry, start sexual intercourse and bear children within marriage. From a very young age, girls perform home responsibilities and are in charge of younger children. In rural Africa, early adolescent pregnancy is regarded as a blessing and increases the status of the girl; young girls have to prove their fertility. In Madagascar, children are regarded as "a gift from the sky"; they are the richness of the country. In the area of Morondave (Southwest coast of Madagascar), families accept and welcome any new baby, even from a young and unmarried woman.
Early marriage has been established to protect young girls from rape and insecurity. Families arrange marriages and young girls do not have anything to say in the matter, even if the man is much older than they are, which is often the case.

From a psychological point of view, these young girls are often more prepared for motherhood than young European girls, because it is part of the culture. However, such early marriages force adolescents to drop out of school and to stop their education. Young mothers may lose out on education and employment opportunities and lose, in that sense, an opportunity for independence and liberty. Early motherhood represents a barrier for women's freedom and empowerment, world-wide.

Risk of teenage Pregnancy:

For the mother:

In all developing countries, teenagers experience greater maternal mortality and morbidity than women over age 20, for a combination of biological and social reasons (16). The adolescent girl who gets pregnant before the age of 18, may be up to 5 times more likely to die than a pregnant woman aged 20-25. Many studies have shown an increased risk related directly to pregnancy such as: Hypertensive disorders, haemorrhage, anaemia, pre-eclampsia, obstructed labour, fistulae and then sepsis (8, 15, 17, 18, 19, 20, 21). In the early adolescent years, a girl is still growing and her pelvis has not reached its full adult size. Some teenagers are not sufficiently physically developed to have a safe pregnancy and delivery.

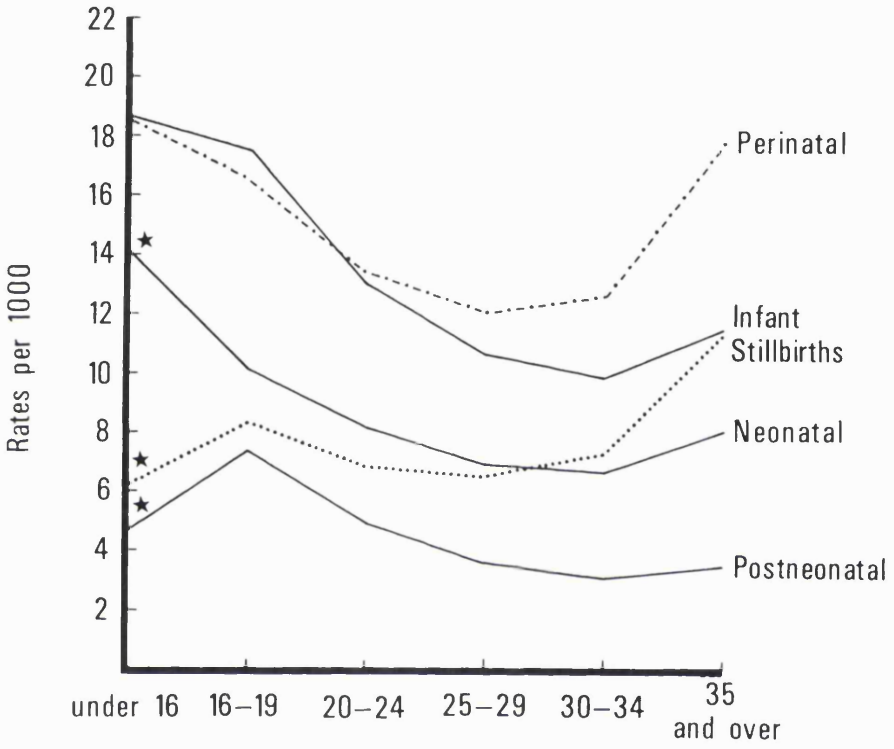
"Pregnancy related complications are the main cause of death for 15-19 year old girls world-wide" (UN, 1995) (15). "Teenagers account for a quarter of the estimated 500,000 women who die each year from causes related to pregnancy and childbirth; 99 % of those deaths occur in the developing world" (UN, 1995) (15).

For the child:

Babies born from adolescent mothers are at increase risk for prematurity, low birth weight, and neurological defects. An increase rate of prenatal and neonatal mortality, in particular "cot death" has also been noticed. (8, 16, 22, 23, 24, 25, 26, 27). Low birth weight is one of the most accurate predictors of future health status. It is an important cause of death in infancy, and equally serious is the effect it may have on the development of the child who survives.

Infants of adolescent mothers have an increased incidence not only of low birth weight and subsequent developmental problems, but also of sudden infant death syndrome, minor acute infections, accidental death and poisoning. The British Cohort found that the children of teenage mothers were significantly less likely to be adequately immunised than were children of older mothers (27).

Figure 6: *Stillbirth and perinatal mortality rates per 1000 total births and noenatal, postnatal and infant mortality rates per 1000 live births, by age of mother, England and Wales, 1980* (27).



Source: O.P.C.S. Monitor DH3 82/3

Note: certain rates for mothers under 16 years (marked ★) are based on 20 or fewer observed events.

Environmental factors also have a more profound effect on babies of adolescent mothers. Poverty, overcrowding, poor sanitation, neglect and absence of father... seem to be factors determining their higher mortality rate.

"A baby born to a teenager 17 or younger has a 60 % greater chance of dying during the first year of life than a baby born to a mother 20 or older" (UN, 1995) (15).

The immaturity of an adolescent mother and their lower level of educational attainment seem to have a profound effect on the child's behavioural development. Adolescents remain a high-risk group because of factors that are more common among them for example biologic immaturity, inadequate prenatal care, poverty, minority status and low pregnancy weight. Also, factors associated with early teenage pregnancy, such as low gynaecologic age, may continue to influence the outcome of subsequent pregnancy (28). Social and care factors are implicated here and are linked with the young mother's age.

Case History: Munni, a young girl married at 13, divorced at 14, remarried at 15, has 3 children, has no formal education and consequently has no real employment opportunities. She is married to a husband who offers her little support. Sadly, Munni represents the situation of millions of adolescent girls in developing countries. (8)

From an obstetrical, educational, social and developmental point of view, the reduction of early marriage and teenage pregnancy is of great importance in promoting the well being of women and of their children and their whole family. The reduction of teenage pregnancy (mostly unwanted), teenage abortions (often unsafe) and teenage STDs, by the year 2000, are part of every International programme and are an important target of WHO and UNICEF.

2 - Industrialised countries :

In developed countries, adolescent pregnancy is a major concern since young unmarried mothers are disadvantaged, as are their children. In Europe and America, teenage pregnant women seem to have a similar socio-economic and family pattern. It has been found that in recent years, pregnant teenagers are more likely to be single and to come from working-class backgrounds. Most come from broken homes with unemployed parents, and come from unusually large families (5, 8, 18, 29).

"For the mothers, who are themselves generally underprivileged in terms of social class and education achievement, there is subsequently a raised likelihood of further reproduction, domestic instability, inadequate support from partners as well as negligible opportunity for social or economic betterment" (27).

An English study undertaken by D. Birch showed that 40% of families of pregnant teenagers were already known to social service agencies, 20% of girls had been in care, and 70% did not live with both parents (65% lived only with their mother). Also, 44% of pregnant schoolgirls lived in unsatisfactory housing conditions, 1/3 had a diet which was grossly deficient in both quantity and quality, and 2/3 were surviving only on state benefits. (30).

It has been found that the mothers of pregnant schoolgirls also started having children very young, while they were still teenagers (31). In a study by Simms (18), one fifth of "Grandmothers" were in their thirties at the time of the interview with their pregnant daughter. It could be argued that these girls were simply repeating a family pattern. Nevertheless, it is interesting to see that most parents continue to give their pregnant daughter financial and emotional support. Even if the parents hoped for something different for their daughter, they understood and stayed confident and supportive in most cases.

Pregnancy results in loss of education, which reduces the chance of finding employment. "A victim of life, her children have to follow in her footsteps" (30). However, 2/3 of teenagers do not follow the same pattern as their mothers who bore them in their teenage years.

Most schoolgirls who get pregnant evince little enthusiasm for school and present a lack of educational achievement, and most studies show that the occurrence of a pregnancy during adolescence is an important barrier for education. Partly as a result of their interrupted education, teenage mothers have more difficulty to find or to remain in stable employment. In consequence, they are more likely to be forced to support themselves and their children on a low income. They often end up living in isolating housing. Teenagers who become mothers are often already socially and economically deprived and early parenthood itself may lead to further deprivation. It is then a vicious "cycle of deprivation" (5, 18, 22, 31, 32). Early pregnancy can thus result in a spiral of social deprivation.

It is not surprising that a substantial number of young mothers get into difficulties, suffer depression and even neglect or abuse their children. Indeed, the rate of postpartum depression and battered children is significantly higher among teenager parents. However, counselling and active support from families, boyfriends and professionals can reduce the severity of these manifestations.

It has been found that the baby's fathers were also young. Most of these men had left school early and were in unskilled or semi-skilled work, or even unemployed (18). Most fathers try to contribute financially and to be supportive; however, some others, too young to realise the real consequence of a pregnancy, prefer to run away. Most adolescent fathers are not likely to be ready to shoulder the responsibilities of fatherhood. Young boys need to realise that sex is not only a physical, and pleasurable activity, but also an action that entails responsibilities and concerns that should be shared by both parties (8). In comparison to teenage mothers, very few studies have been undertaken on teenage fathers.

It has been said that for young girls with no dreams of a viable future, having a baby can give them the status and fulfilment that their lives had lacked (22). It gives them "something to do". The majority of teenage mothers are happy with their babies and their new way of life. This can be explained by the fact that they tend to come from deprived backgrounds. For Ann Phoenix (33), most of "the women and their children were mostly doing fine", though their lack of money seems to be the major problem of young mothers. Ann Phoenix also reminds us "that Princess Diana" was not much older than 20 when she had her first child".

Some other authors are much more negative about the consequences of adolescent pregnancy. Arneil (34), underlines the fact that many girls end up neglecting their baby. He said that poverty, overcrowding, unsanitary surroundings, lack of knowledge of child rearing and development, absence of father and so on are serious problems for young girls and their babies and are damaging for the mother, the child and their family. The author notes that children of teenage mothers suffer from developmental delay, behavioural problems and school refusal. (34).

It is important to distinguish pregnancy in young teenagers (<17 years old) from that in older teenagers (17 to 19 years old). Most of the literature refers to "teenage pregnancy" and "adolescent parenthood" without making a distinction between the experiences of the younger and older teenager. As Sacker and Neuhoff (1982) state: "Often we find ourselves comparing apples and pears" (6).

The medical, social, educational and legal problems are quite different in the two groups, before and after 16 years old (35). The problem of teenage pregnancy is much more

important, critical and dangerous in the former group. Young girls of 16 or less, are not socially prepared for motherhood in industrialised societies. "They are not legally allowed to leave full time education, to have sexual intercourse, to marry or enter into certain financial arrangements" (33). Most teenagers may not be sufficiently biologically mature for unproblematic child bearing. The rate of maternal and child mortality and morbidity is higher in this age group. Fewer problems seem to appear in the older group of young mothers.

Some recent American studies have shown a reduction of obstetrical problems among teenage pregnant girls, with a lower incidence of toxaemia and prematurity. They posit that this phenomenon results from an increase of availability of antenatal care, better nutrition and improved socio-economic conditions, in developed countries (6). Hudson and Ineichen (1991) reflect that the medical complications in a teenager's pregnancy are not a result of her age peers, but rather an effect of her lifestyle (36).

"Even if a pregnant adolescent is physically developed, she may lack the social and emotional maturity to cope with the experience of becoming a mother and the changes it means to her life" (PDRH) (37).

I - 5 YOUTH IN BRITAIN :

1 - <u>Adolescent Sexual Behaviour</u> :

" The enormous variation in sexual behaviour within our society, between different societies or groups, and across time can only be explained in terms of learning of cultural and sub-cultural influence" (19), observed Gillham in 1997.

It is interesting to notice that young people are reaching sexual maturity earlier. The age of menarche is now around the age of 12, whereas at the beginning of the century it was around 14. This difference might be due to better nutrition and health; however, it has had an influence upon sexual behaviour in youth. The first experience of intercourse is clearly associated with personal, cultural and social attitudes. Some major changes have been noticed during the past 40 or 50 years : progressive reduction in age at first intercourse, an increase in the number of youths having their first intercourse before the age of legal consent (16 years

old), and equalising in behaviour of men and women. In the United Kingdom, the actual median age for first intercourse is 17, whereas 40 or 50 years ago, it was 21 years old. Around half of 16 year olds and 80 % of 19 year olds are now sexually experienced (38, 39).

This phenomenon can be explained by the formal and informal "liberalisation" of sexual behaviour in 1960's. In France, "May 68" has been named as the "sexual revolution". The advent of improved methods of contraception, particularly "the pill" occurred at this time. In practice, the pill was not available for unmarried women until 1972. Also, abortion became legal in April 1968, and the number of women of all ages having an abortion rose rapidly until 1972.

The earlier onset of maturity may have contributed to the earlier initiation of sexual intercourse. An important reason for the increase in sexual activity in teenagers seems to lie in cultural changes such as: change in attitudes about premarital sex, change in parental behaviour and freedom that they give to their children, rising incidence of marital dissolution, and the reduced influence of religion. The media and advertisements, which give the impression that most teenagers are sexually experienced, have a great influence and power on youth behaviour. They play an important role in attitude changes: sexually inexperienced teenagers appear to be abnormal and consequently are mocked by their peers (22). All these causes are interlinked and have an influence on each other.

Girls with a high degree of risk-prone behaviour or attitudes, girls with problematic life situations and without adequate family support, are more likely to become unintentionally pregnant and to acquire STDs (40). Adolescents need to learn to take responsibility for their own actions regarding sexuality (8). The subject of adolescent sexual behaviour, leading to unwanted pregnancies, is an important concern in the United-Kingdom, and appears regularly in the media.

Figure 7: *Guardian article, May 1998* (41).

May 1998

Daily Mail

COMMENT

Teenage sex and a crisis in the making

EVEN in a nation which resolutely refuses to be shocked by anything, the latest survey on teenage sexual activity should be profoundly disturbing. What the statistics reveal is an almost bottomless well of personal and social tragedy.

Britain now has a higher percentage of unmarried teenage mothers than any other country on earth. Of those who give birth before they are 20, a staggering 87 per cent are unwed. And just as worrying is the evidence that we are at the top of the international league table for young girls having sexual flings.

It isn't just a tut-tutting, Grundyish moralism which recoils from such revelations. It's common sense. And a knowledge that the seeds of a social crisis are being sown.

Thousands of young, unsupported mothers are condemned to years of hardship and perhaps welfare dependency. If their children grow without a male role model, they will certainly be at greater than average risk of emotional, academic and other difficulties.

Predictably, the International Planned Parenthood Federation claims that poverty, lack of education and unemployment are to blame. The Birth Control Trust urges better sex education and easier access to contraception.

But isn't Britain wealthier, more gainfully employed and better educated than most other countries? Isn't contraception as readily available as a packet of Smarties? Hasn't sex education been *de rigueur* for decades?

The problem lies deeper. In tolerant Britain, it sometimes seems that the highest virtue is to be non-judgmental. Responsibility has gone out of fashion, to be replaced by counselling. Self-indulgence no longer attracts automatic censure. The irony is that this apparently kindly attitude can have such bitterly cruel consequences.

For when sex without love is promoted as a universal panacea, when the message is reinforced in films, pop songs, advertisements and teen magazines, youngsters are being cast adrift, without real guidance or moral bearings. No wonder they so often end up wrecked.

Our world record of shame on teenage sex

By EMILY WILSON
Medical Reporter

BRITAIN has the world's highest rate of unmarried teenage mothers, a survey revealed yesterday.

Official statistics show that 87 per cent of girls who give birth in their teens are unmarried, three times as many as in Third World countries such as Rwanda and Colombia.

Britain also has the worst record for young girls having sex outside marriage, with 86 per cent of teenagers having intercourse by the age of 19.

The findings were released as part of the most detailed and comprehensive international study of teenage sexual behaviour ever undertaken. A New York-based charity, the Alan Guttmacher Institute, spent three years collecting and analysing data from 53 countries.

'Time we talked to our daughters'

Figures for Britain, from the Office of Population, Censuses and Surveys revealed that 87 per cent of the 41,000 babies born to girls aged between 15 and 19 last year were born out of wedlock.

The only other country which came close to this was the southern African state of Botswana, with 85 per cent.

After this came France with 78 per cent, followed by another African country, Mali with 75 per cent. Next came the U.S. with 62 per cent and then Germany with 57 per cent.

In Malawi, only four per cent of teenage births were out of wedlock and in Nigeria, six per cent. On sexual activity, 86 per cent of British girls had experience by the age of 19, most outside marriage.

The figures were gleaned from the 1991 National Survey of Sexual Attitudes and Lifestyles commissioned by the Wellcome Trust, the largest survey ever attempted at the time.

Similar surveys – though not always as extensive – showed that in Liberia, 81 per cent of teenage girls had sex outside marriage, followed by 75 per cent in America and 71 per cent in Germany.

In France, 38 per cent had sex outside marriage, and in Poland, 25 per cent.

Cornelia Oddie, of Family and Youth Concern, described the statistics as a 'shameful indictment' on Britain's sex education policy which for 20 years had been based on giving free contraception to young people on demand.

'We need a new type of sex education, more marriage-orientated and more restraint-orientated,' she said.

Jeannie Rosoff, president of the Alan Guttmacher Institute, said: 'In Britain there is this trend for more and more teenage pregnancies. It has the biggest teenage birth rate in the developed world.

'It's something that America went through around five years ago.

'We don't know why it's happening and hope it is a temporary phenomenon, but it's time for people to wake up and see something is going on and maybe it's time we talked to our daughters about it.'

Comment — Page TEN

May 1998

2 - Adolescent and Contraception :

Among sexually active teenagers, the pill remains the commonest contraceptive technique used by about two in five girls, and one in three use condoms. However, about a quarter use no contraception (42, 43). Contraceptive use among teenage girls who become mothers is low and among very young teenage mothers is almost non-existent. The under 16 year old group is particularly vulnerable for pregnancy. Of the girls having intercourse before 16, 50% did not use contraception compared with 33% of girls' aged 18 or older (44).

Teenage sexual behaviour is often sporadic and unplanned; also, many young teenagers do not plan contraceptive methods either. "Indeed, first sex is often experimentation and those involved usually do not prepare for it by obtaining contraceptives, even if they know where to get them" (38). Although there is a general increase in the use of contraception by teenagers, many still do not use contraception during the early months of their relationships.

Some false beliefs like *"I am too young"* or *"It does not occur the first time"*, are reassuring for teenagers, but misleading and dangerous. Clark et al (45), pointed out in their study that 84% of teenage mothers had no intention of becoming pregnant, but were using no contraception when they conceived. Some teenagers do not know where to go for contraceptive advice, they are ashamed and feel embarrassed to see their GP. To obtain the pill, a woman must not only admit to herself that she is sexually active, but she must also admit it to a doctor.

There is also an important problem of the misuse of contraception. A lot of teenagers are not conscientious enough to take the pill every day, and do not realise the real consequences. *"I just didn't bother. Thought if we'd have a child, we'd have It"* (18).

The question of making the morning-after pill widely available for all teenagers (in pharmacies) is an important theme of current debate. The main goal of this suggestion is to reduce unwanted and teenage pregnancies (46,47).

Figure 8: *Times article, June 1998.*

\Y JUNE 12 1998

MPs back move to let chemists sell morning-after pill

BY ALEXANDRA FREAN, SOCIAL AFFAIRS CORRESPONDENT

A CAMPAIGN to make the emergency contraceptive pill available to women without them having to visit a doctor won the backing of dozens of MPs yesterday.

Schering Health Care, the pill's manufacturer, has changed its mind on making the product available without prescription, and is negotiating with the Department of Health to allow women to buy the pill from chemists.

The company's U-turn follows proposals by a government-sponsored committee to allow nurses and pharmacists to prescribe certain drugs under guidelines drawn up by doctors.

Yesterday Jenny Tonge, the Liberal Democrat MP for Richmond Park, who used to practise as a doctor, tabled an early day motion calling for emergency contraception to be available from pharmacists without a prescription. Her motion has been signed by 54 cross-party MPs.

Schering's emergency contraception consists of a course of tablets similar to the normal contraceptive Pill, which must be started within 72 hours of unprotected sex. Young women in particular often found that they could not get a prescription in time, either because their GP discouraged them or because no appointments were available. Dr Tonge said her proposal could prevent up to 70 per cent of abortions and significantly reduce the number of unwanted teenage pregnancies. "We have the highest teenage pregnancy rate in Europe and we need to do something about it. Increasing access to emergency contraception could make a real difference," she said.

Dr Tonge said that 30 years as a family planning doctor had taught her the importance of making emergency contraception more widely available. At present it is available only on prescription from GPs, family planning clinics and some hospital accident and emergency departments.

Dr Tonge dismissed claims that the drug could be harmful to women. "What we are talking about is a drug that is less dangerous than aspirin and paracetamol, which are available from petrol stations," she said.

David Paintin, chairman of the Birth Control Trust, said that the great advantage of emergency contraception was that it could be used after intercourse in the "cold light of the next day". "Anyone can have a contraceptive accident ... providing emergency contraception in pharmacies would be a sensible and effective means of reducing the upset caused by unplanned pregnancies," he said.

Roger Odd of the Royal Pharmaceutical Society said surveys had shown that about 70 per cent of pharmacists would be happy to dispense emergency contraception, providing there were strict guidelines.

Ruth Real, secretary of the Association of Catholic Women, criticised the campaign, saying that emergency contraception was a form of early abortion. "I would think it would encourage exactly the sort of irresponsibility that ministers themselves have criticised," she said.

There is some evidence that teenagers may be increasingly willing to use effective contraception at an early stage in their sexual relationships. Sex education and reproductive health programmes provide hope for the future, and could hopefully eliminate misconceptions or conflicting messages created by the media, peers or family (8). Reproductive health care programmes can take several steps to increase male involvement, including education, encouraging better communication between partners, and making services more "male friendly" (15).

3 - <u>Abortion among teenagers</u> :

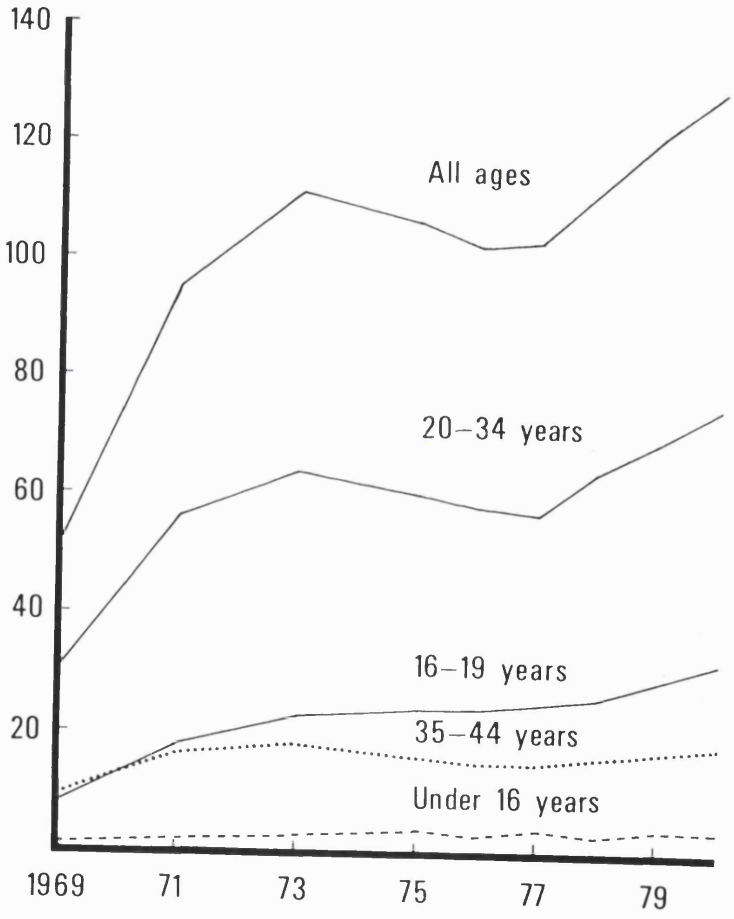
In the decade between 1970 and 1980, some 83 to 104 thousand teenage girls became pregnant each year in England and Wales. But whereas in 1970, 81,000 had babies and only 15,000 had abortions, by 1980, only 61,000 had babies while 36,000 had abortions. Medical terminations have been the most frequent outcome for girls under the age of 16 since the 1970's. Some recent figures suggest that around half of the conceptions to this age group result in abortions, compared to around a third in those aged 16 to 19 (48). Teenage abortions have risen during the last twenty years. Rates of conception leading to abortion rose from 14.3 conceptions per 1000 teenage women in 1971, to 24.6 by 1990 (49). Two-thirds of all abortions are for unmarried woman, and only a quarter is for teenagers.

Teenagers are less likely than older women to have abortions in the earlier months of their pregnancy. Lots of teenagers hide their pregnancy from others and even from themselves. By the time they realise that they are really pregnant, it is too late for a termination. At this age, girls can be easily influenced and often follow the desire of their parents, boyfriends, or close friends. Peer, parental and partner's attitudes toward abortion have an important impact, as do religious beliefs.

The majority of teenagers do not take any decision about their pregnancy, they do not want to think, they just *"wait and see"*; it is part of their immaturity not to plan for the future. They become attached to their baby growing in them. Young women may develop an attachment to their baby and suffer feelings of loss and regret after an abortion, even more strongly than older mothers. Young women in the most affluent groups, with higher education, socio-

economic background and occupational ambitions, are two or three times more likely to obtain a termination (19).

Figure 9: *Legal abortions performed in England and Wales 1969-80 by age of female involved, thousands* (27).



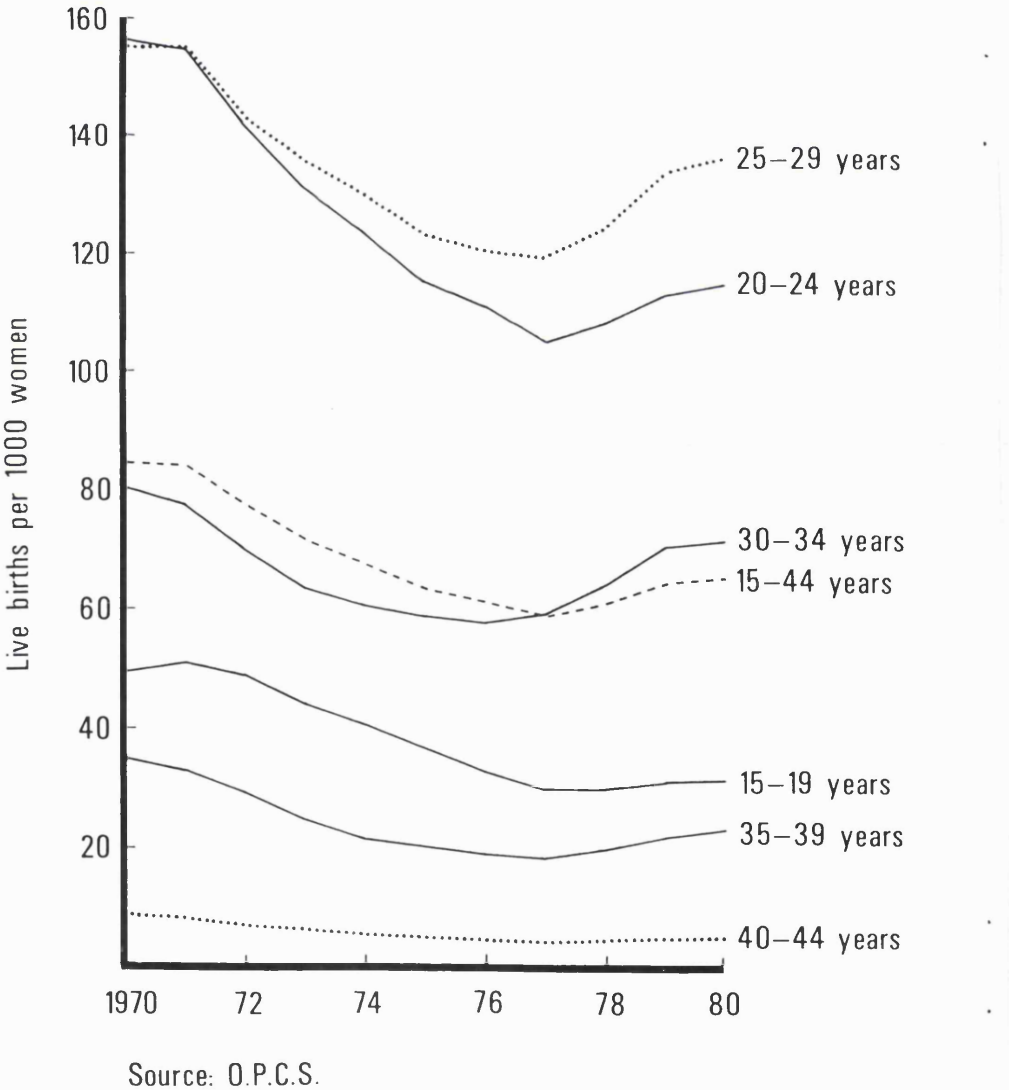
Source: Social Trends

I - 6 TEENAGE PREGNANCY:

1 -Teenage pregnancy :

The United-Kingdom has one of the highest rates of births to young women in the Western World, exceeded only by the United-States. In England and Wales, for the first half of the century, the number of pregnancies in young teenagers remained low and remarkably constant. However, in the late 1950's the number began to rise steadily, and with it, the number of abortions (35). Births to teenagers were at their peak at the end of 1960's.

Figure 10: *Live births by age of mother, England and Wales, 1970-80, rates per 1000 women* (27).



The number of conceptions to younger teenagers has been increasing. The conception rate for all teenagers rose from 56 conceptions per 1000 women in 1983, to 69 per 1000 in 1990 (and 65.1 per 1000 in 1991) (49). In 1993, some 41,900 teenagers in England and Wales had a baby which represented about 6.8% of all births (48). In 1991, 9.3 of every 1000 13 to 15 year old girls became pregnant and 65.1 of every 1000 15 to 19 year old girls (50).

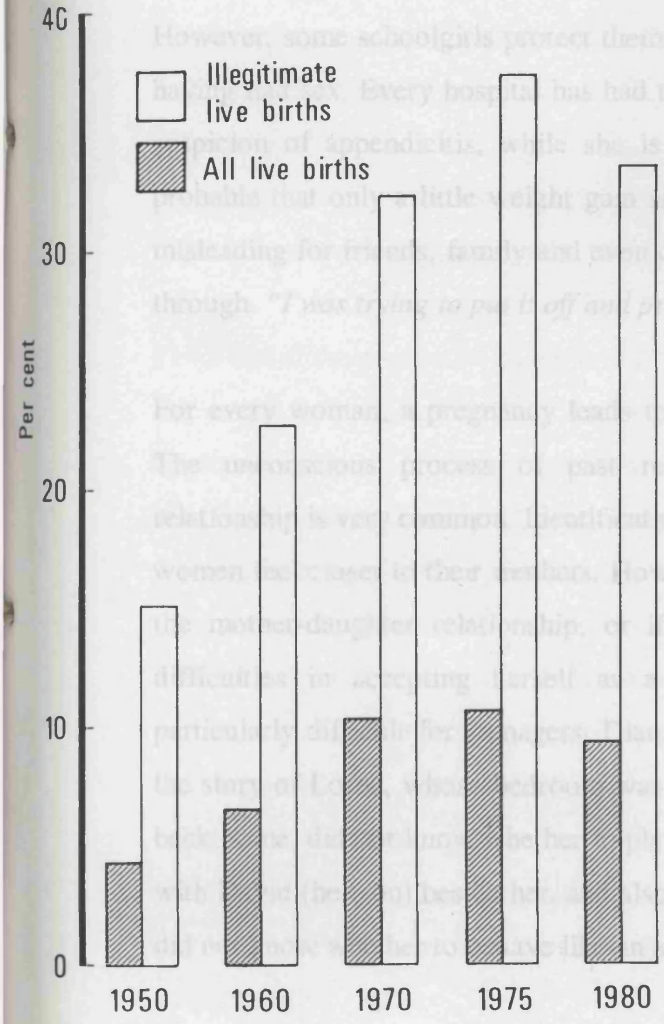
There are many lessons to be learnt from countries such as the Netherlands that have the lowest rate of teenage pregnancy in the world (and one of the lowest rates of abortion too). In the Netherlands attitudes towards sex education, contraception and sexuality are in general much more open and progressive, questions of sexual behaviour and contraception are commonly discussed at home among family members. A generous approach to sex education is undertaken in the school curriculum and contraceptive services are widely available to young people (51, 52, 53, 54).

2 - <u>Attitudes towards pregnancy and motherhood</u> :

There is a general impression that teenage pregnancies are unplanned and mostly unwanted. "For many women who are determined on a career, pregnancy before their late twenties would be seen as personal and professional disaster" (19). Clearly many of the women who have had unprotected intercourse did not intend to become pregnant. However, there is a significant amount of evidence that many teenagers are happy to find themselves pregnant. Even if the pregnancy is unplanned and unwanted in the beginning, at the time of the delivery, most babies are wanted and expected. In a 1986 HMSO report (18), 23% had been initially pleased about the pregnancy: "*I thought it was great, I was over the moon*". 39% had mixed feeling: "*I was a bit worried, I suppose it was a bit of a shock, I didn't think it would happen to me*". And 68% said they were upset to very upset: "*Shocked, I wasn't ready for that kind of thing you know, I went hysterical*".

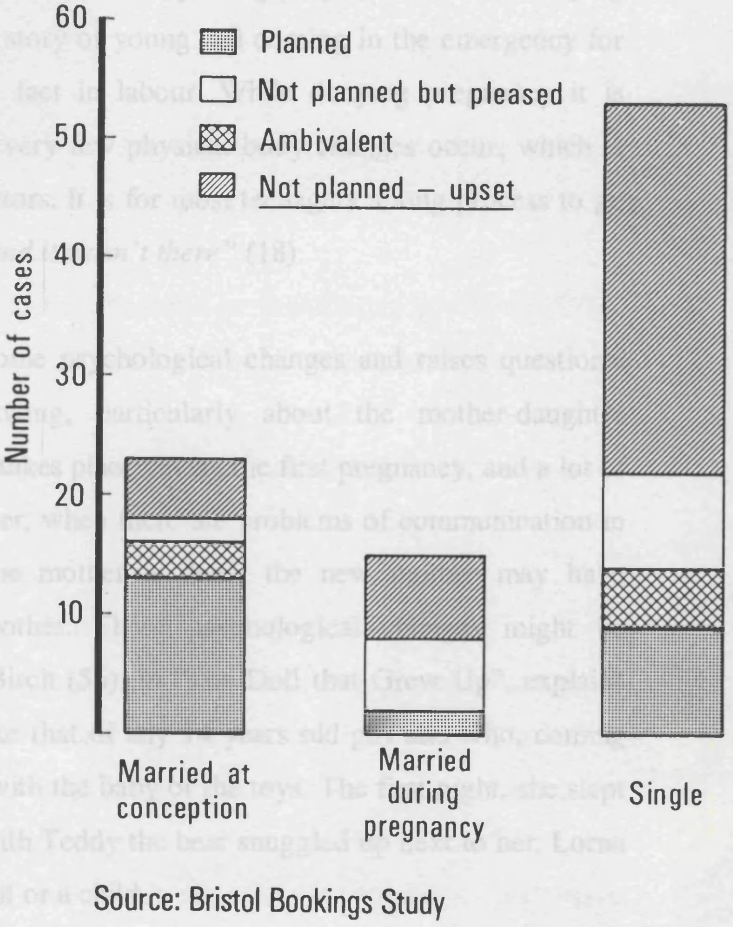
From another English study, 28% had planned the pregnancy, 10% were ambivalent, 16% had not planned it but were pleased at the news and 46% had neither planned the pregnancy nor were pleased at the news (37). In a study undertaken by Macklin (55), the following comments from young girls were obtained: *"It's Hard, because of the response of family and friends"*, *"loss of contact with friends"*, *"loss of activities"*, *"it is difficult physically and emotionally"*, *"it's hard to be a mother"*, *"it is scary"*, *"it is too soon"*.

Figure 11: *Percentage of (a) all live births (b) all illegitimate live births attributable To mothers aged 15-19 years, England And Wales, 1950-8.* (27).



Source: O.P.C.S.

Figure 12: *Attitude to pregnancy by marital status in the Bristol study.*



Source: Bristol Bookings Study

Often, young girls do not immediately realise that they are pregnant. A lot of adolescents do not realise the significance of missing periods until they have missed at least three. Also, feeling ill, tired or putting on weight is not associated with the idea of pregnancy for one fifth of schoolgirls, until others (mother, sister or boyfriend) realise it for them. "For many girls, realisation of pregnancy is a crisis point, they may not be able to cope with this realisation

and deny it to themselves, they may conceal their pregnancy in fear of discovery by their parents" (7). Young girls need time to face the reality of their pregnancy, and time to make decisions regarding the baby. When a girl suspects she is pregnant, her mind is in turmoil of indecision, guilt and fear. Often, she finds it difficult to tell her parents; many prefer to tell their boyfriend first.

However, some schoolgirls protect themselves by denying being pregnant and even denying having had sex. Every hospital has had the story of young girl coming in the emergency for suspicion of appendicitis, while she is in fact in labour. While denying pregnancy it is probable that only a little weight gain and very few physical body changes occur, which is misleading for friends, family and even doctors. It is for most teenagers a long process to go through. *"I was trying to put it off and pretend it wasn't there"* (18).

For every woman, a pregnancy leads to some psychological changes and raises questions. The unconscious process of past reviewing, particularly about the mother-daughter relationship is very common. Identification takes place during the first pregnancy, and a lot of women feel closer to their mothers. However, when there are problems of communication in the mother-daughter relationship, or if the mother is dead, the new mother may have difficulties in accepting herself as a mother. These psychological changes might be particularly difficult for teenagers. Diana Birch (56), in "The Doll that Grew Up", explains the story of Lorna, whose bedroom was like that of any 14 years old girl and who, coming back home, did not know whether to play with the baby or the toys. The first night, she slept with David (her son) beside her, and also with Teddy the bear snuggled up next to her. Lorna did not know whether to behave like an adult or a child.

Bury (22) in a study showed that nearly 90% of teenage mothers were pleased to have had their baby when they did. "Despite, or perhaps even because they tended to come from rather deprived backgrounds and to have had rather restricted lives, the majority of teenage mothers were delighted with their babies and their way of life and would not have it otherwise" (19). From the work of Phoenix (33), teenage mothers were shown to love their child and held their child's needs as their priority, often sacrificing their own food and clothing.

For teenagers who receive support, pregnancy may provide a growth experience, enabling the young girl to increase her self-esteem and thus to better mother her infant (22). But other

unmarried young girls may feel stigmatised by becoming pregnant at such a young age (26). The psychological impact of pregnancy on a young adolescent can be detrimental to her health (8).

I - 7 ANTENATAL CARE :

1- Health Services:

A young person's right of access to health related services, and to express opinions about them is enshrined in the United Nations Convention on the Rights of the Child (1991) (57).

Peers and siblings seem to be the preferred source of advice for relationship problems (52%), due to the perception they have had a similar experience. Confidentiality and their doctor's approachability are important issues for adolescents.
In a study undertaken by Oppong-Odiseng and Heycok, on "adolescent health services – through their eyes"(58), a third of girls felt embarrassed, shy, scared or nervous about seeing their general practitioner, for any medical reason.
The majority (85%) felt that there should be health-related services, specifically for young people, with specialists who are able to understand young people. Various suggestions about health issues have been raised by adolescent, such as condom machines in school toilets, mobile clinics to go round the schools, or use of school drama huts for group discussion. Adolescents seen to have clear views regarding the nature of services they would like to see provided. They need information about local services available to them, and more confidentiality.

2- Antenatal care:

"The purpose of antenatal care is to maintain the pregnancy, to recognise difficulties when they occur and to teach the woman and her partner about pregnancy and childbirth to dispel fear and ignorance" (7). "Good quality of antenatal care seems to reduce dramatically the risks of pregnancy for both mother and baby" (8).

Teenage mothers are looked upon as a high-risk group for whom attendance to antenatal care seems very important. A number of studies have demonstrated that adequate antenatal care is associated with improved outcomes for teenagers and their babies as well as for older women (34, 59, 60).

Yet studies have shown that a teenage mother's use of antenatal services differs from that of older women in a number of respects. Girls who become pregnant in their teenage period are less likely to seek antenatal care, they may enrol in antenatal visits late in pregnancy, and they make fewer visits (also the rate of missed appointments is high among this age group). (2, 3, 27, 60, 61, 62, 63). Non-attendance rates ranged between 0.2% for France and 1% for the United States. Non-attendance for the first trimester varied between 4% for France, 8% for Denmark, 13% for Belgium, 21% for the United States and 70% for Jamaica (64).

A 1986 study undertaken in the United Kingdom, reported by HMSO (18), showed that 42% of teenage mothers first consulted a doctor for their pregnancy within two months of conceiving. 31% waited until the third month, and 27% were three or more months pregnant before they consulted a doctor. It is interesting to see that 45% did not deliberately delay their first visit, because they did not realise that they were pregnant.

Among the late antenatal care attendance, 16% mentioned fear and or embarrassment about consulting a doctor; while 14% could not bring themselves to tell their parents about the pregnancy, and therefore did not feel able to consult a doctor. 13% did not perceive the need to go earlier, 4% feared they would be directed to have an abortion, and some others were afraid that the doctor would tell their parents. In an American study, 5.6% of pregnant women under the age of 15 did not receive antenatal care; nearly 50% began antenatal care at 4 or 6 months; and 14.2% began in the third trimester of pregnancy (65).

In a study in the United Kingdom, 27% of young pregnant women did not consult their doctor until the second trimester (66). In another British study (18), more than one quarter of the teenage mothers consulted their doctor for the first time when they were more than 3 months pregnant, and one fifth did not arrive for their Antenatal visits until they were more than 5 months pregnant.

A cohort study based on the British Survey found that young mothers were significantly less likely to attend for their first antenatal visit in the first trimester of pregnancy when compared with older mothers, and significantly more likely to time their initial attendance during the

third trimester. They are also less likely to attend for mothercraft advice than were other older primiparous women (27).

Figure 13: *Proportion of British Births Survey cohort attending for the first time at antenatal clinics at different stages of Pregnancy, by maternal age* (27).

When a young pregnant woman delays her entry into medical care, due to ambivalence about the pregnancy or a reluctance to face motherhood, this delays and disorganises her future antenatal care. Late attendance has been found to be more important amongst single mothers, unsupported teenagers and working class women.

An interesting study looked at the under-use of antenatal care, and undertook a comparison of non-attenders and late attenders for antenatal care, with early attenders. The non-attenders were more likely to be teenagers, unmarried, in union of very short duration, smokers, and women who felt that friends and relatives were not supportive (7, 64, 67, 68).

Non-attenders were usually teenagers in unstable relationships and from a depressed environment. Also, the more advanced the age of the first intercourse, the older the girl was when she first conceived, and the better was her attendance to antenatal care. Mc Kinlay found that under-users of antenatal care were appearing to sustain a crisis existence (67).

In developing countries, pregnancy is viewed as a natural process that does no need visits. Women coming from low socio-economic status spend their time trying to find the necessities for survival and do not have time to go to the clinic. Antenatal visits are a secondary task, in comparison to the daily life emergencies associated with seeking shelter and food. "The pregnancy is just one more event that is "happening to them"" (8). Omuga and Ojwang's study (69), undertaken in Nairobi, shows a different range of reasons for non-attendance at antenatal care. Explanations given by adolescents were*: "Didn't think of a clinic"*, *"feared the doctor"*, *"felt shame"*, *"no time"*, *"afraid of parents finding out about the pregnancy"*, *"didn't know she was pregnant"*. However, 31% anticipated starting antenatal visits, and 24% did not have any reason. Some teenagers are also frightened to see their GP. *"Just scared to go to a doctor because my doctor might have started going on at me. Telling me that I was stupid and should have done something about it"* (18).

Many reasons have been cited to explain the under use of antenatal care by teenagers: the adolescent's cognitive immaturity, ambivalence about the pregnancy, and the fear of pregnancy discovery. Also, some girls find it difficult and sometimes humiliating to attend antenatal clinics and classes with older women.

Many other general factors including, psychological issues such as levels of self-esteem; level of education; poverty; ethnicity and social support system; are thought to play an important role in health related aspects of teenage behaviour.

Lack of information and knowledge as to the need, where and how to access these facilities, sheer immaturity, as well as fear of parents, teachers, or being ostracised by society may all contribute to young women delaying, or not using, antenatal care services (4). Young girls often do not really appreciate the necessity of antenatal appointments, they often have to wait

a long time and tend to have a low tolerance of frustration. They attend clinic irregularly so their medical supervision is poor throughout pregnancy (7). *"I was always alright. I didn't see the point of going"* (18).

"A pregnant woman is in a vulnerable state emotionally, she is worried about her body, about the pregnancy and whether the baby will be OK. She requires reassurance and explanations. This applies even more to teenage and particularly schoolgirl mothers" (7).

I – 8 PROPOSITIONS FOR THE FUTURE:

Grace Darkwah (4), in her 1997 review of the literature proposed ways to break down the barriers between teenagers and Health care providers, and to design services that would be more "youth friendly":

- The services need to be well advertised, easy to access outside school hours, informal and confidential (especial for under 16 year old).
- The staff must be trained to work with young people.
- Prices should be affordable in areas where user charges apply.
- It seems a good idea to organise specific youth clinics, or at least reserve timetables for adolescents. Specialised Antenatal care programmes for pregnant teenagers, involving health care, social services and material and psychological support appear to be important for young mothers, and promising for the future.

Communication strategies should be aimed at building rapport with teenagers, using techniques such as maintaining confidentiality, avoiding judgmental sentences and gearing communication to cognitive immaturity (70). Specific changes in the health care system are needed to make prenatal visits more accessible for pregnant teenagers. These changes would include enhancing community awareness, establishing links between prenatal clinics and the school health system, and scheduling prenatal clinics at times more convenient for teenagers (71). It is also important to help pregnant teenagers to care for themselves, i.e "self-care practices"; because they have a tendency not to take care of their physical and psychological health (72).

Teenage mothers represent a particular population: between childhood and adulthood, and, they therefore need particular attention. "Adolescents need to be treated in a more

sympathetic and non-judgmental way as this is often a high-risk pregnancy" (64). C. Dennison (53), in her work has underlined the importance of the support of the adolescent mother's mother, for a good development of the adolescent mother and her child. For Diana Birch (30), it is important to improve the self esteem of teenagers, so that "girls do not have to feel that their reproductive ability is their only "raison d'être"".

A study undertaken in Los Angeles (73) investigating services provided for pregnant teenagers showed improvements over the last years: "services to pregnant teens have become increasingly more sophisticated", they try to combine their agency services into networks to meet the needs for medical, educational, financial and social support systems for pregnant teenagers, their families and the teenage father. This new positive approach to pregnant teenagers is promising for the future (73, 74, 76).

Some school intervention strategies may be helpful for pregnant schoolgirls, such as the provision of flexible school schedules to enable teenage mothers to continue their education while they assume the role as parents, and the creation of opportunity for discussions which address teenage pregnancy and parenting issues (76).

Late or non-attendance of antenatal care by adolescents cannot be seen simply as a form of deviant or irresponsible behaviour, but arise also from cultural norms and personal circumstances (8). "Teenage pregnancy cannot be treated as an isolated problem – it is part of the culture of poverty" (30).

To ensure good health-seeking behaviour, all groups: pregnant teenagers, parents and the child's father, must be involved. It seems important to listen to pregnant teenagers, to listen to what they have to say and what they need. Indeed, they are in the centre of the debate and are the only ones involved in the incredible experience which is a pregnancy. It is important to enable teenagers to use their own "voice" to describe their experiences and ideas regarding antenatal care.

"We *have been slow to give adolescence the same concentrated care that has gone into the study of the baby and the young child". "If as a society we are to understand our adolescents instead of being estranged from them, we have to catch up fast on our ignorance of what life means to adolescents today, and what the world looks like though their eyes"* (77).

CHAPTER TWO

METHODOLOGY

II – 1 AIMS AND OBJECTIVES

1 –PRINCIPAL AIM:

To determine the needs of pregnant teenagers and young mothers with regard to Antenatal care and the reasons why they tend to avoid seeking health care in pregnancy.

2 –SPECIFIC AIMS:

1 – From teenagers

To determine the expressed needs of pregnant teenagers about existing Antenatal Care.

2 – From teenagers

To determine the expressed opinion of pregnant teenagers about existing Antenatal Care.

3 – From Key Informants

To investigate any assumptions about teenage pregnancy that key informants working with teenagers have.

4 – From Key Informants and Observation

To explore the facilities and opportunities that Ashlyns School offers to young mothers.

II – 2 MATERIALS AND METHODS

This study aimed to investigate the expressed needs and opinions of pregnant teenagers and teenage mothers concerning antenatal care, and the factors that motivate them from not seeking health care. A group of young mothers aged 13 to 17 years, from Ashlyns School, Newcastle upon Tyne, were observed and interviewed. The study also examined the view of adults working with these teenagers (i.e. teachers and health professionals).

This chapter outlines the location of the study, describes the study, the study population, the sample selection, and then the data management undertaken. Ethical considerations and possible approaches of disseminating the information also are presented.

1 –LOCATION OF STUDY POPULATION:

This descriptive study, looking at opinions and views of and about, teenage mothers from the North East of England, was conducted in Ashlyns School, Newcastle upon Tyne. Ashlyns is a specialised educational establishment for young mothers, where all schoolgirls who discover that they are pregnant can go, in order to continue their education. The school is also organised to receive young mothers with their babies, for the preparation of the GCSE.

2 –TYPE OF STUDY:

This is a descriptive study, looking at the opinions and views of teenage mothers, using both a quantitative and a qualitative approach. This study can also be described as a Case Study.
A variety of methods were used to obtain the descriptive and quantitative data and to address the problem of bias. These included:

1 – Descriptive phase:

Examining documents. A descriptive study was undertaken, using general information and documentary evidence ("a priori" information).

2 – Quantitative phase:

Designing and administering a questionnaire to survey opinion about the issues being explored.

3 - Qualitative phase:

Using a combination of focus group discussions, semi-structured interviews and observation. Qualitative research describes in words rather than numbers the qualities of social phenomena; and it aims to study people in their natural social settings and to collect naturally occurring data. (78)

"Qualitative methods are characterised by an open procedure, trying to determine "what exists" and "why it exists" rather than "how much of it is there". Through allowing the people to voice their opinion, views and experiences the way they want to, qualitative methods aim at understanding reality as it is defined by the group to be studied". (79)

4 – Validity, Reliability, Representativeness:

"In qualitative inquiry, the researcher is the instrument. Validity in qualitative methods, therefore, hinges to a great extent on the person doing the field work". (80)

The three different ways of collecting the study data (i.e.: the descriptive, quantitative, and qualitative method) has enabled us to triangulate our findings; which is an important method of cross checking and strengthens a study design. (80)

"There needs to be more recognition of the value of visiting triangulated methods in order to enhance the validity of quantitative and qualitative research". (81)

5 – Case Study:

"A case study is a research method which focuses on the circumstances, dynamics and complexity of a single case, or a small number of cases. The numbers are necessarily small as the cases are intensively explored in depth, retrospectively, currently and sometimes over

time, through, for example, detailed observations, interviews and information from records. Multiple research methods are usually employed in order to investigate fully complex situations and to validate the findings. It is a valuable method for the study of complex social settings." (78)

"*Case studies are particularly useful where one needs to understand some special people, particular problem, or unique situation in great depth, and where one can identify cases rich in information – rich in the sense that a great deal can be learned from a few examples of the phenomenon in question*". (80)
"Good case studies can provide more valid portrayals, better bases for personal understanding of what is going on and solid grounds for considering action". (82)

3 - STUDY POPULATION AND SAMPLE SELECTION:

1 - Study Population:

Our study population was mainly composed by 19 teenage mothers aged between 13 and 17 years old, studying in Ashlyns School during the study period. The study also included key-informants working in the school. We met three educational professionals, and three health professionals. The educational professionals included the head teacher, the other main teacher, and the Educational Welfare Officer. The health professionals included the attached school Midwife, the Health Visitor, and the Senior Clinical Medical Officer. All participants lived or worked in the city of Newcastle upon Tyne.

2 – Sample selection:

All the staff working regularly in Ashlyns School were interviewed. For the focus groups, all the students were invited to participate, (they were free to refuse to participate).

Inclusion criteria:
It was planned to include every student going to Ashlyns School, during the period studied (from the 4th of July until the12 th of July, and from the 9th of September until the 28th of

September). Only schoolgirls up to 19 years old were included, that represented 100 % of the school population.

Exclusion criteria:

Only those girls who refused to participate would have been excluded. (All the teenagers agreed to answer the questionnaire, and only one young girl refused to take part in the focus group).

Age range:

The World Health Organisation (WHO) defines adolescents or teenagers as those aged from 10 to 19 years. We then decided employ this accepted definition for our teenage pregnancy sample at Ashlyns School.

Table 1: **Summary of sample size**

	July	**September**
Questionnaire (teenagers)	16	3
Focus Group (teenagers)	3	0
Semi-structured interview	1 head teacher 1 teacher	1 Health Visitor 1 Education Welfare Officer 1 Midwife
Unstructured interview		1 head teacher and 1 teacher 1 Senior Medical Officer

3 – Changes in the Methodology, during the study:

Initially, the study was designed to take place partly in Ashlyns School, and partly in Luton and Dunstable Hospital. The initial proposal was to send a questionnaire to teenagers who had delivered in the 6 month period immediately preceding the research, to give more depth to the study. It was known that the maternity department at Luton and Dunstable regularly used a postal survey and commonly received an 80% response rate (Midwifery Manager of Luton and Dunstable Hospital). It was proposed to organise focus-groups during the antenatal classes which were specifically ran for pregnant teenagers in Luton and Dunstable. To

complete the study, semi-structured interviews were planned, to take place with health practitioners (i.e. obstetricians and midwives).

The component of the study based in Luton and Dunstable Hospital was planned with Jenny Amery, consultant in Public Health, and the Midwifery manager. However, when the study was presented to the Clinical Director, administrative problems arose. The Clinical Director was not happy with the time frame of the study, and felt that it should be discussed in depth at the obstetrical committee, which was not scheduled to meet until the 15th September 1998, far too late for this thesis. For this reason, the Luton and Dunstable component of the study, unfortunately had to be dropped.

To full this study gap, we decided to find other schools functioning like Ashlyns, in order to perform a comparison across the United Kingdom. After contacting the main Education Authority of London, and a few other Education and Health Authorities, we realised however, that Education Authorities appear not to be informed about the existence of specific schools for teenage mothers. "*I am sorry, but this kind of school does not exist in the United-Kingdom, we have only a referral unit of home tutoring*" was one of the comments, and coming from the UK Health education Authority was amazing. We were surprised by this lack of knowledge and communication which exists amongst the Education Authority services. This pushed us to investigate more deeply the case of Ashlyns School, as a single school case study.

II – 4 DATA COLLECTION METHOD:

A review of Ashlyns School was conducted by personally visiting the school and observing the area.

Self-administered structured questionnaire:

A structured interview was undertaken and a questionnaire was administered to the schoolgirls while they were attending school. The questionnaire was introduced by the researcher, and the teenagers filled in the questionnaire on their own. The researcher was at that time available to answer questions and to clarify any doubtful points. A consent form was offered for signature to the schoolgirls, but the majority of teenagers gave oral consent and

did not want to sign the form. It is assumed that they did not want to have their name written somewhere, not understanding the real purpose of a consent form. This was a snowball reaction, a phenomenon commonly encountered amongst adolescents.

Focus-Group:

Three focus groups were undertaken with in the school, with between 4 to 6 teenagers taking part in each group. The students were invited to take part in the focus groups while undertaken their personal individual study work. Those who agreed, took part in discussions around a table in an area of the classroom. Each focus group took between 1 to 2 hours. The presentation phase of the focus-group took a small amount of time, the researcher having been presented at the beginning of the week; and the schoolgirls knowing each other quite well, having spent many months together. A tape recorder was used after obtaining agreement of the schoolgirls. Unfortunately, because of the children playing around or crying, the quality of the recording was poor; but it gave a good idea of the real conditions of teaching in Ashlyns School.

Semi-structured interview with key informants:

Key informants, working in Ashlyns School, were chosen. One of the main key informants was Barbara Peacock, the head and founder of the school. Barbara Peacock has a great deal of experience of working with pregnant teenage girls, and is willing to learn and understand more about adolescence in order to maximise her help to them. Margaret Glynn, the other principal teacher, was also another important key informant. The other key informants chosen were the midwife, the Education Welfare Officer, the health visitor, and the doctor attached to Ashlyns School.

All the key informants chosen are closely associated with the daily life of Ashlyns School for young mothers (pregnant teenagers and adolescent mothers).

A tape recorder was used with the agreement of the different key informants.

Systematic observation:

A systematic observation was undertaken by the researcher, by taking time in Ashlyns School, during the classes attendance. The facilities offered by the school, the course progress, as well as the schoolgirls attitudes and relationships were looked at. The attitudes of the teenagers toward their teachers, their babies and other children were also examined.

Problems identified during data collection:

Questionnaire:

The questionnaire was first reviewed and corrected by two research specialists and two health workers, and suggested changes and adaptations were made. When it was presented to Ashlyns'students, however, a few of the students asked for explanation of words such as "Partner", or "Occupation" or again the meaning of the sign "<", "less than". The researcher answered these questions directly, and the questionnaire was then updated on the basis of these questions and remarks from students, and some questions were added for the September session.

Focus-Group and Semi-structured interview:

Due to financial limitations, the interviews were conducted by the researcher only. All interviews and focus groups were tape-recorded after agreement of the interviewees. Immediately after each interview a preliminary transcription was done. This was later compared and completed with the aid of the recorded interview.

Unfortunately, as mentioned earlier, for the focus-groups, the quality of the recorded interviews was adversely affected by the laughs and cries of children and babies, playing around. It is also important to mention that the focus-groups were difficult to run, because the young mothers frequently had their attention disturbed, by the activity taking place around them. However, the focus-group took place in real teaching conditions, which gave the researcher a true picture of Ashlyns School daily duty and activities.

5 - ETHICAL APPROVAL AND PERMISSION TO CONDUCT THE STUDY:

Permission for undertaking the study was sought from the Ethical Committee of the Institute of Child Health as well as from the Ashlyns School director.

For the qualitative study, young mothers were asked whether they agreed to participate in the study and that the interview was recorded. Explaining to the teenagers that only the interviewer was allowed to listen to the recorder and to read the transcriptions ensured confidentiality. The identification of the adolescent was eliminated in the final report.

It is interesting to see that even with this confidentiality ensured, most teenagers preferred to give their agreement orally rather than by signing a consent form.

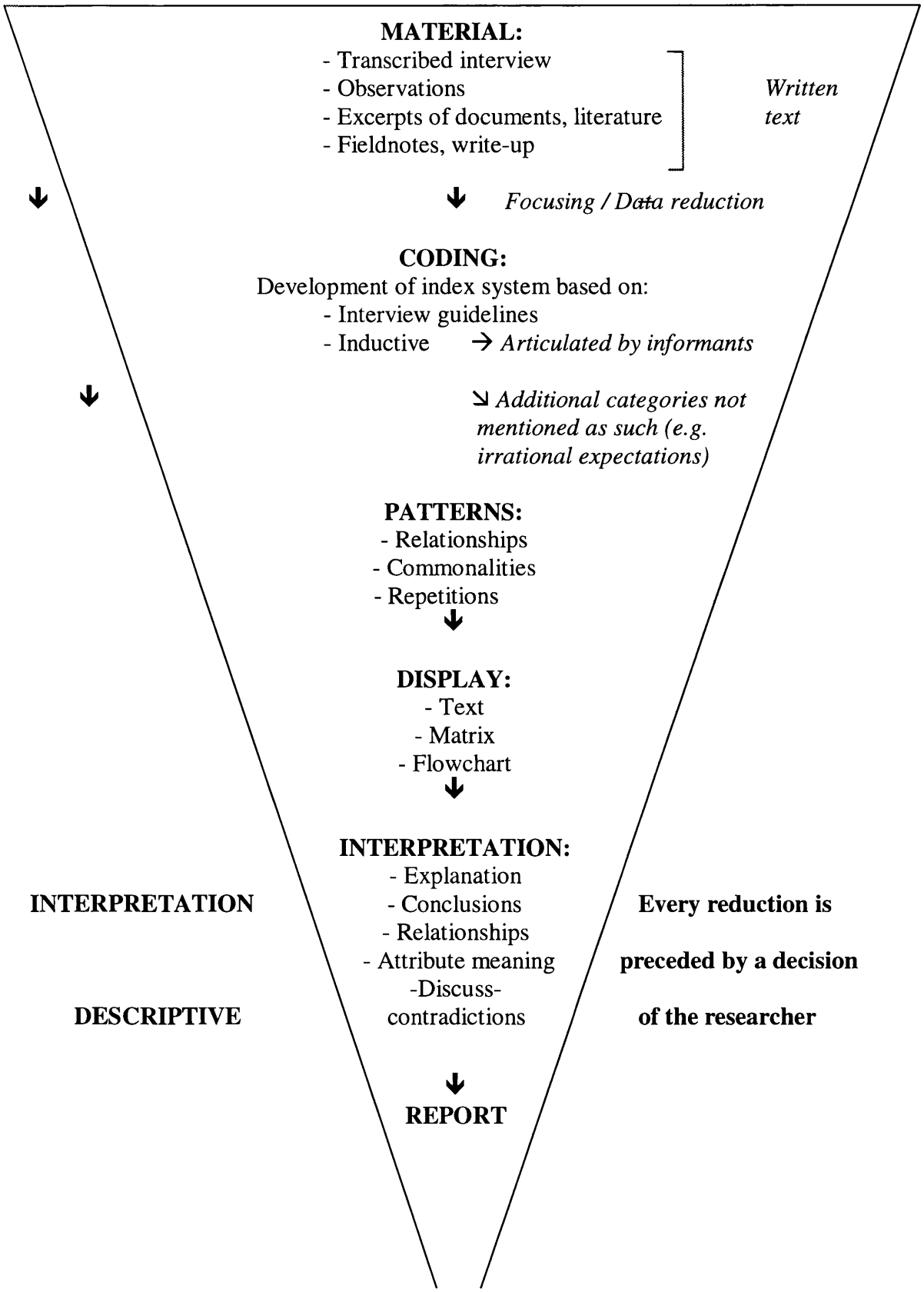
6 - DATA ENTRY AND ANALYSIS:

All data was entered into and analysed on the Epi-info statistics package, using a CICH computer, to analyse the quantitative data of the study. (Some variables were cross-tabulated, in order to find any underlying relationship. Chi-squared tests were carried out to determine the degree of association between the factors of interest.)

The qualitative part of the study was analysed by hand, using a traditional thematic approach and the construction of a coding scheme (Figure 14).
The triangulation of the data provides a mean of testing one source of information against the other source.

Figure 14:

CODING, ANALYSIS & INFORMATION



7 - LIMITATION OF THE STUDY:

- The fact that school holidays occurred in the middle of the study, was a limitation. When the researcher first went to Ashlyns School, the students who had taken the GCSE were already on holidays. The students left school the 10th of July, and came back only the 7th of September. On one hand, schoolgirls were more relaxed in the beginning and in the end of the academic year (after the exams); on the other hand, fewer students were present at school.

- The language might have been a limitation, particularly with the strong accent that exists in Newcastle amongst lower social classes, the Geordie. The poor quality of the recording did not help this first weakness, and some expressions might have been missed during the interviews. However, the technique of rephrasing sentences has been tried to reduce the bias linked to the language.

- In a way the problem of Luton access was a limitation, because it would have given another perspective of teenage pregnancy; but on the other hand, because of the limited time of an MSc project, it was interesting to study only one area in depth.

8 - DISSEMINATION OF THE RESULT:

The feedback information on the research will be communicated to the participants themselves, through the school director, in a letter of appreciation thanking them for their participation, and co-operation and explaining how the information is being used. Similarly, information will be fed to the school director, Barbara Peacock, and to the authorities of the research area. Some feedback might be given to the National Education Authority. The thesis will be presented to the CICH committee, and will stay in the ICH library. A copy will also be sent to Barbara Peacock.

CHAPTER THREE

RESULTS

Note: All quotes in the Results section which are in italics are direct quotes from the various people interviewed. They have been transcribed word for word.

III - 1- DESCRIPTIVE PHASE:

1 - GENERAL INFORMATION

1 - 1 Facilities in the United-Kingdom to enable teenage pregnant girls to pursue their Education:

From a book compiled by Sophie Robinson et Al (1998) (83): "The Really Helpful Direction, Services for Pregnant Teenagers & Young Parents", it appears that there are in the U.K around 30 "schools" reserved for pregnant schoolgirls. However, most places provide only a few hours per week, and seem more a support for education rather than an actual school. Only a few of these prepare students for the GCSE. The great majority of places provide a crèche, and Ashlyns seems to be the only school which welcomes mothers and babies together. Some few institutions were funded in the early 70s, a few more followed in the 80s, most of them opened in the 90s. Otherwise, in most other parts of the U.K, they still use home tuition, for young mothers under 16.

1 - 2 Introduction of "Ashlyns" (83)

Aims of the service: To provide education and support to pregnant schoolgirls and schoolgirl mothers in a relaxed, friendly environment.

Target group: Pregnant schoolgirls and schoolgirl mothers up to 17 years of age.

Users: Pregnant young women and young mothers of school age. Average age 14 to 15. A young woman is no longer eligible for the service after school leaving age. Ashlyns School works with those who live at home, in care and those who are homeless. Ethnic mix variable.

The majority of students (99%) are from local authority area, although the service will consider extra-district pupils, dependent on funding.

Referrals: Referrals from Social Services, Education Health Professionals, Self-referrals accepted.

Service: Educational facilities. Academic course work leading to GCSE qualification in a variety of subjects including: Maths, English language / Literature, nutrition, Child Development, Science, French, Sociology. Also work towards qualifications in NPRA, AEB basic tests, Certificate of Achievement. Information and advice are offered on a range of subjects including: benefits, education, training opportunities, assertiveness / self-awareness, sexuality / contraception, personal health, relationships, childcare and housing.

Can accommodate up to 50 young women in the service. On an average, young woman will use the service for two years.

Facilities: Transport provided. No crèche, but the mothers can come with their babies.

Staff: two full-time teachers, one part-time Education Welfare Officer, an Auxiliary, a Health Visitor and a Midwife.

French and German also spoken.

History: Funded by City of Newcastle upon Tyne Department of Education. Established in September 1984.

1 - 3 Information on "The Big Apple", supportive institution for teenage mothers also located in the West End of Newcastle (83):

Aims of the service: To provide support and information on all aspects of health, pregnancy, rights and benefits to pregnant women aged 13–19 years and provide postnatal support and advice.

Target group: Pregnant young women from the West End of Newcastle.

Users: Accept all pregnant teenage young women and their family and friends. Average age of users is 17, average number of users is 4, could accommodate up to 18.

Referrals: From Social services, Education and Health Departments, Youth workers and local community groups. Self-referrals accepted.

Service: Drop-in centre offering antenatal and postnatal support and information and advice on maternal and child health, childcare, contraception, benefits and housing. Also offer aquanatal classes and have visits from an aromatherapist, dietician and dental nurse. Staff: Three full-time. History: Established in 1996. Temporary funding for 2 years from the Local Health Trust.

At the start of this year, Ashlyns had some problems with admission. The Education Authority suddenly decided that the structure of the school could not accommodate more than 20-25 girls. Therefore, they believe that, only teenagers after the 24th week of pregnancy should be admitted in to the school. If the head of the school enforces this new idea, they would not be able to prepare pupils for the GCSE. Adolescents, who discover that they are pregnant, need time to realise it and time to feel confident in a new environment and a new school. Also, it is during the last trimester of pregnancy that a pregnant woman has most antenatal visits, then her level of attendance is consequently low. In addition, if the teenagers do not have the time to get to know each other, they would not give each other so much support, and they would not have the motivation to come back after the delivery.

> *"You cannot do the same job in 6 months that you did in 12 months, and it is just unfair for the young girls who are waiting to come"*. (a staff member).

For Ashlyns staff, it would be easier to have less students, but it is felt that this is just not right for the pupils.

> *"And this school has been built for them in the first place, for their benefit"*.

This admission problem had not been resolved by the end of my project.

2 - THE SCHOOL:

2 -1 INTRODUCTION:

"Ashlyns, Pregnant... and still at school? We can help!!"

Figure 15: *Ashlyns School brochure.*

YOU CAN CONTACT

1. BARBARA/HEAD OF ASHLYNS ON 2280517

OR

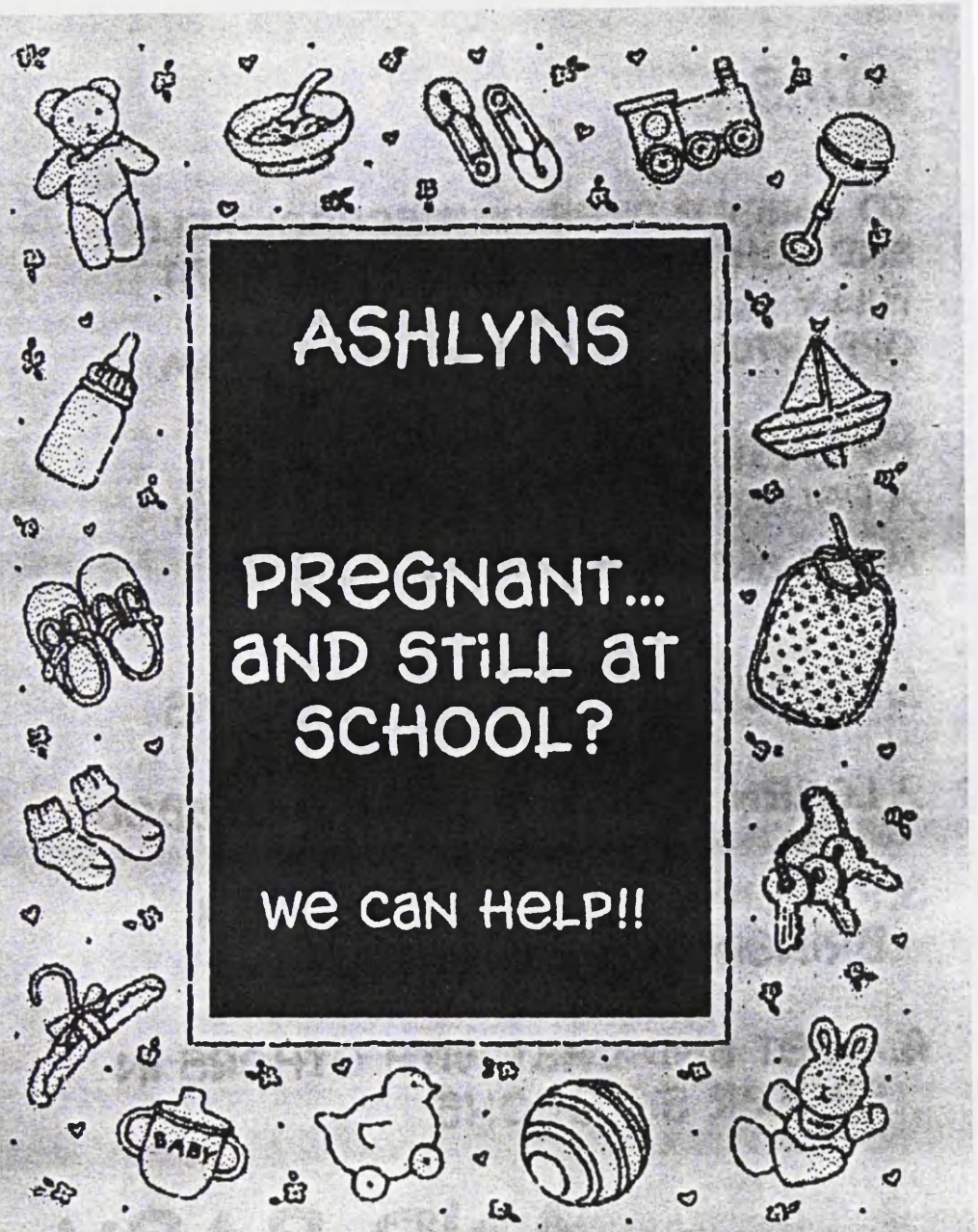
2. HELEN/EDUCATION WELFARE OFFICER ON 2740911

OR

3. YOUR YEAR TUTOR, SCHOOL NURSE OR EDUCATION WELFARE OFFICER

City of Newcastle upon Tyne

Education Service
• Leading Learning •



ASHLYNS

AIMS:

TO ENABLE PREGNANT SCHOOLGIRLS AND SCHOOLGIRL MUMS TO BENEFIT FULLY FROM THE EDUCATIONAL OPPORTUNITIES AVAILABLE TO THEM.

PROVIDES:

A RELAXED SETTING WHERE YOUNG MUMS AND MUMS TO BE CAN:

1. STUDY FOR THEIR GCSE EXAMS
2. LEARN ABOUT PREGNANCY+LABOUR
3. RECEIVE PRACTICAL HELP ON BRINGING UP A BABY
4. MEET AND CHAT WITH OTHERS IN SIMILAR SITUATIONS

HELPS WITH:

- ADVICE ON WELFARE BENEFITS
- SOCIAL/FAMILY PROBLEMS
- EDUCATIONAL PROBLEMS
- PRACTICAL WORRIES
- GENERAL SUPPORT

AND BABY COMES TOO!

Ashlyns, is a school situated in Newcastle (Northern England) reserved for teenagers who are pregnant or who already have their baby. The aim of the school is to enable pregnant schoolgirls and schoolgirl mums to benefit fully from the educational opportunities available to them.

Ashlyns was started in 1984 by the Newcastle Education Committee, and Barbara Peacock (Head of the Unit) was invited to run it. In the area, there was home tutoring organised for teenagers who became pregnant or had a baby, but it was very expensive and it was recognised that the young mothers were very isolated. It was decided to create a school to enable pregnant teenagers to continue their education in a friendly atmosphere. It appears important that pregnant teenagers, isolated by their unusual situation, could meet other young mothers like them, and share experiences together. The mutual support of the schoolgirls is very important. They see that they are not on their own in this situation of early pregnancy; they are at the same level and have similar problems.

Two choices were offered to Barbara. First of all, to create a crèche close to the school, open at the same hours as the teaching course, and free of charge; to enable young mothers to leave their children while attending school. The other option was

> *"to take mothers and babies together and attach the education around them".*

In other words, to allow teenagers to attend class, with their children playing or sleeping around them in the same room. The idea was to avoid separating the young child from his or her mother.

> *"It is important for a young baby to stay with his or her mother".*

For Ashlyns, Barbara Peacock chose the latter option, less formal, more original, but more challenging. The school is financed by the Newcastle department of education. Barbara Peacock explained that most of the girls who get pregnant have problems with traditional education and do not like mainstream school. Formal classroom teaching would not have been accepted by them.

Indeed, I witnessed a discussion between 3 schoolgirls with Barbara and Margaret. The 3 girls expressed that they did not like their previous school, and that they were constantly inventing excuses for not going. They admitted having a very low school attendance. They expressed too, that they felt pressured, and were treated like children.

"In other schools, they treat you like children, but we are not children any more, but here you take us more as adults"

Margaret explained that it was different here, because they were mothers.

"We cannot treat you as children, you are mothers now"

The teenagers said that since they are in Ashlyns, they like to go to school, and they are happy to learn new things.

"We actually like the school with you; we feel comfortable"

Barbara laughed and answered,

"We are probably too nice with you; there must be something wrong with us, if you begin to like school!"

In Ashlyns, a very broad-based view of Education is given to include teaching on moral values and social skills alongside the more academic subjects. For Barbara Peacock, these young mothers need to continue their education, need to understand about their pregnancy, about labour and delivery, and how to bring up a baby.

2 - 2 SCHOOL STAFF

Full Time Staff:

- Barbara Peacock is at the heart of the school. She is the head teacher and is responsible for the school administration. She is also one of the main two teachers. Her background is in economics, with a degree in Economics, and experience of teaching in a special school and home tutoring in the Newcastle area, and recently a Law degree.

- Margaret Glynn, is the other main teacher and head teacher assistant. Her background is in teacher training, experience of teaching in a special school, head of a specialised education department, and home tutoring in the Newcastle area (mainly with hospitalised children and later one with difficult children).

- Joan Connolly, is an auxiliary nurse. Joan represents a "grandmother" figure, she is there to help look after a baby when a girl is stressed or needs a break.

Part Time Staff:

- Education Welfare Officer: The Education Welfare Officer deals with all the referrals. She visits each new family and sorts out with the family what is the best educational programme for the girl. She then brings the young girl with her parents on a visit to Ashlyns and she arranges with Barbara when the girl is to start at the school. The Education Welfare Officer also deals with any social problems the girls may have, particularly those which affect her school attendance and her performance in school. She chases up truants and, with Barbara, establishes a programme to improve their attendance.

- Midwife: She visits Ashlyns once a week to give antenatal advice to prepare youngsters and post-natal advice to those who have recently delivered.

- Health Visitor: The Health Visitor comes once a week to the school, to follow any new-born babies and any children. She organises in Ashlyns a baby clinic, where any young mother can have her baby weighed and checked. It is a time where worries may be expressed and questions answered.

- Senior Clinical Medical Officer: The Clinical Medical Officer talks over any medical problems a girl may have and makes sure she is well enough to attend school. Ashlyns School also consults her if they have any medical concerns over a girl or if there is something they need to query about a pregnancy or about the health of any of the babies.

2 - 3 ASHLYNS SCHOOL OBJECTIVES AND GOALS

In the school brochure it is stated:

"Ashlyns provides a relaxed setting where young mums and mums to be can:

1. Study for their GCSE exams.
2. Learn about pregnancy + labour.
3. Receive practical help on bringing up a baby.
4. Meet and chat with others in similar situations.

...and babies can come too!"

Barbara Peacock explained that she believes that most of these girls did not reach their full potential at school; most of them were in the bottom of the class and were left behind. In Ashlyns, in an informal school system, they are given a second chance to learn and to look forward.

> *"Even if they do not reach their full potential here, with babies running around, they still have opportunities they would not have had elsewhere".*

Ashlyns prepares most pupils for GCSE exams, with less able girls opting for the certificate of achievement in maths and English. Each year, 40 to 50 teenagers, who are between 13 to 17 years old (exceptionally 12 years old) go to Ashlyns school.

Table 2: *Number of Pupils in Ashlyns School:*

Years	1995-1996	1996-1997	1997-1998	1998-1999
Number of Students	54	49	46	25 until now

The results of the GCSE exams are very good; 100 % success; which is very encouraging, particularly as many of those girls would not have achieved any success in mainstream school. This year, 17 girls sat GCSE, and 5, the certificate of achievement. (It is the first year that the certificate of achievement has been set up).

Table 3: *Number of Pupils who sat GCSE*:

Years	1994-1995	1995-1996	1996-1997	1997-1998
Total number of candidates	20	16	17	17
Number of subjects taken	51	47	59	61
Number of subject passed	51	47	59	61

For the GCSE, pupils have 10 subjects to present. Some of the girls, who have their delivery during the year, or who are late in their work, present only 5 subjects the first year, and the other 5 subjects, the following year. Thus, although some of the pupils may take two years to obtain their GCSE, they do obtain it. After GCSE, teenagers are offered work experience.

Table 4: Results of the GCSE 1998:

Marks→ Subjects↓	**A**	**B**	**C**	**D**	**E**	**F**	**G**
Art		1	2	2			
Eng. Lang			1	6	4		
Eng. Litter			5	4	2		
Child Dpt			2	2	1	1	
Cons. St					1		
Food Nutri			2				
Math			2	5	6	3	
Science				1	3	4	1

2 - 4 SCHOOL PROGRESS

Girls are referred to Ashlyns school by: their previous school, GPs, Midwives, Health Workers, Friends, Parents or even themselves, when they discover that they are pregnant. Some of the girls come after having dropped out of school in some cases for as much as 2 years.

"Some of them can hardly read".

The first visit to the school is arranged by the Education Welfare Officer for the young girl and her mother.

"Some parents think that they will find a school for prostitutes (they do not know what to expect), and they are very surprised to see normal young girls, like their own daughter!".

During this visit, it is important to explain the school rules and objectives. Also, as in any school, the parents are responsible for their daughters' behaviour (but the schoolgirl only, and

not her baby). It is important to speak with the schoolgirl's mother, to tell her in a nice way, that she has a very important role, but that it is the role of grandmother of the future baby only. The support of parents is very important, but they have to keep the place of grandparents.

> *"Too many girls find their mother too invasive, which can push them to leave home!".*

Students are of different ages; different levels of achievement and arrive at different times; therefore each girl must be treated individually.

> *"It is sometimes difficult to teach at different rhythms, with babies and young children playing around; but it is important for the mother and the baby to be together; so it is worth doing it. When we succeed it is encouraging for us too".*

All schoolgirls have their own individual timetable and see with their tutors and teachers (Barbara and Margaret) what they have done and what they have to do.

A school bus collects Ashlyns students (with or without their baby), like any other college. Pregnant teenagers or young mothers come along together with their babies. They have lessons given by Barbara, Margaret or outside people from the community and each has her own personal work to do. Every girl works at her own pace. A lunch is provided for all girls, but they have to bring food for their child, if he or she eats special baby food.

Everybody, pregnant teenagers, young mothers and babies learn, chat, play, and live together. It is a school for education as well as a school of life.

2 - 5 SCHOOL PROGRAM

<u>To prepare for the GCSE</u>:

- Science and Art (lessons by outsider teacher)
- Mathematics
- English language and literature
- Child development
- Food and nutrition

- Consumer studies
- Law
- Religious Education
- Art (lessons by outsider teacher)

Only Science and Art are taught by outsider teachers, but all the other subjects are taught by Barbara and Margaret.

Figure 16: *Drawing by a teenage mother.*

Other lessons:

- Health education:

Every week, a midwife comes along to speak about pregnancy (Antenatal classes), delivery and contraception. She is available to answer questions or worries that the young mothers may have. The school organises some visits to the delivery suite in order to help reduce the stress of delivery.

> *"It is mostly the unknown which is frightening."* (Barbara)

The midwife follows each pregnant girl and checks that each one is keeping her antenatal appointments.

> "*It is important that* we (Barbara, Margaret, The midwife and all the other schoolgirls) *look interested in each visit, each scan; it pushes pregnant girls to seek care."*

The school organises some practical exercises with babies like: safe baby bath or baby massage. Some discussions around contraception and sex education are part of the programme. Also, condoms are available.

> *"When a girl tells me that she will have sex tonight and that she has not planned any method of contraception, I offer her a condom. This is not to push them to have a sexual relationships, but it is to protect them".*

- Religious education (different religions and spirituality).

It is important to speak about moral subjects.

> *"I would like to teach my students how to have self-respect and some values of life." "Tolerance of other people is something that I would like to pass on to the students ".*

Many of these young girls do not take care of themselves, they sleep with more than one partner. One week for a relationship is a long time at this age! Most teenagers are intolerant and often racist, but they do not accept that other people could be intolerant towards them. Some discussions are organised around these subjects, or around broader subjects like life and death.

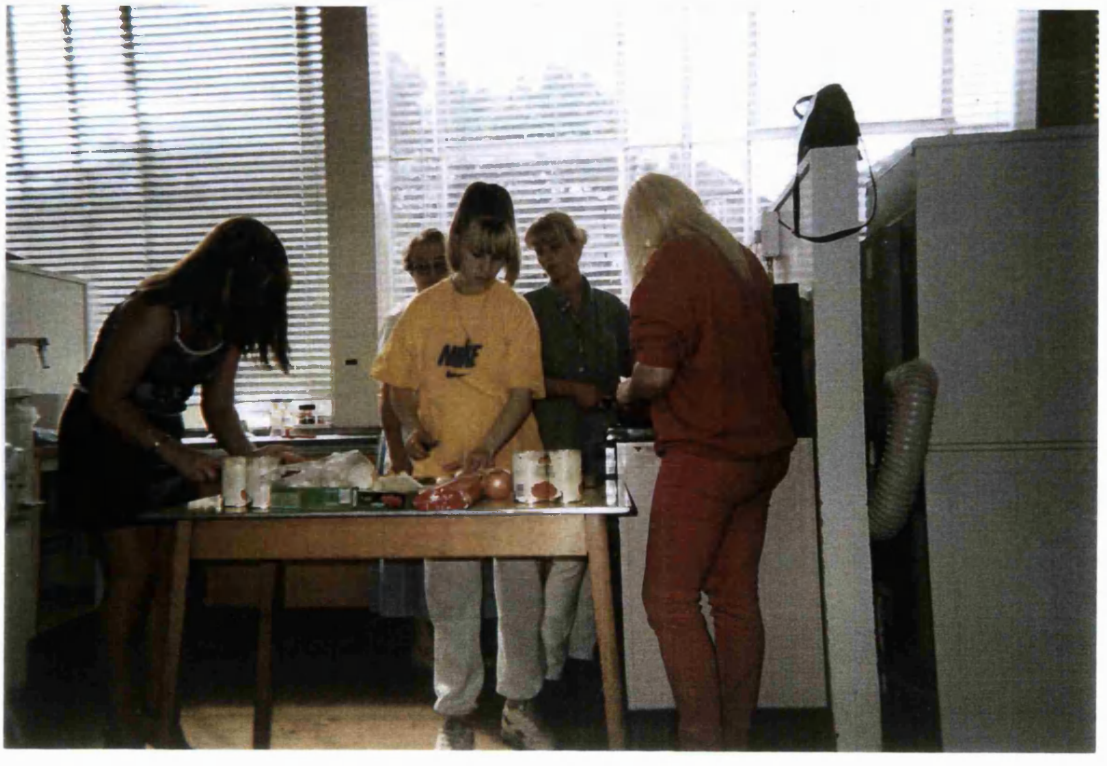
- Law: The girls who chose Law have a particular interest in the subject. Indeed, between the 3 schoolgirls who have chosen law, 2 of them had a brother who went in court, and spent a

small period in jail.

"We realise that Law is really part of the daily life".

- Other lectures are organised, like cooking sessions (how to make simple and cheap dishes for the mother and the baby), talks about rights, social benefits and English Law in general.

Figure 17: *Cooking session*



Remarks about the English law:

Girls under 16 do not qualify for income support. They only receive child benefit, which starts at £17 a week. The Law does not allow girls under 16 to have sex, so their rights cannot be recognised as single mothers. Teenagers above 16 with a baby automatically qualify for income support. When a sexual relationship occurs under the age of 16, the Law condemns the man and not the girl. For boys, it is a criminal offence to have sex with a girl under 16 years old. However, most partners are teenagers too, and there is no gain from condemning them. They are as willing as the girls to have intercourse,

"*it is an experience for both of them*".

When the relationship is stable, there is no point in disrupting it. The police tend to prosecute older men (aged 24 years or above) or when there is evidence of rape, which is difficult to prove. There are some cases of incest, but the problem is much more difficult and complex.

> *"We have had cases of incest in our school, but it is a complicated situation. Most of the time they do not speak about it, but you feel it. They often are too silent, too introvert!"*

However, for most of the girls I met during the course of this study, their first intercourse seemed to have been a shared experience.

2 - 6 SCHOOL STAFF ATTITUDE

The school is not responsible for babies. It is the mother herself who is responsible for her child and who is in charge of her baby. However, there is an auxiliary nurse present every day in the school, who takes care of some children when the mother has lessons with that mother's permission.

The role of the school is not to teach "*how to be a good mother*" even if in many ways it helps. Therefore, said Barbara:

> *"I cannot say what is right or wrong, I have to pay attention".*
> *" It is not my role to say: "do this or do not do that with your baby", because if I offend them, they will not come back!" "It is sometimes surprising to see them giving tea, Coca-Cola or mars bar to a baby, but I cannot really say anything".*

Most girls come from poor backgrounds and repeat things they have seen at home. If you criticise, they will not understand, and their families might react strongly. Also, if you say too many things, they will not take into consideration the important items.

"You have to stay quiet!"

But when they do something dangerous or harmful for the baby, then it is our role to tell them that is wrong. Most of the time, they are very responsive, and do not repeat a dangerous thing, provided that it has been well explained why it was harmful.

"It is really that we cannot change a person's culture, and it would not be right for us to do so".

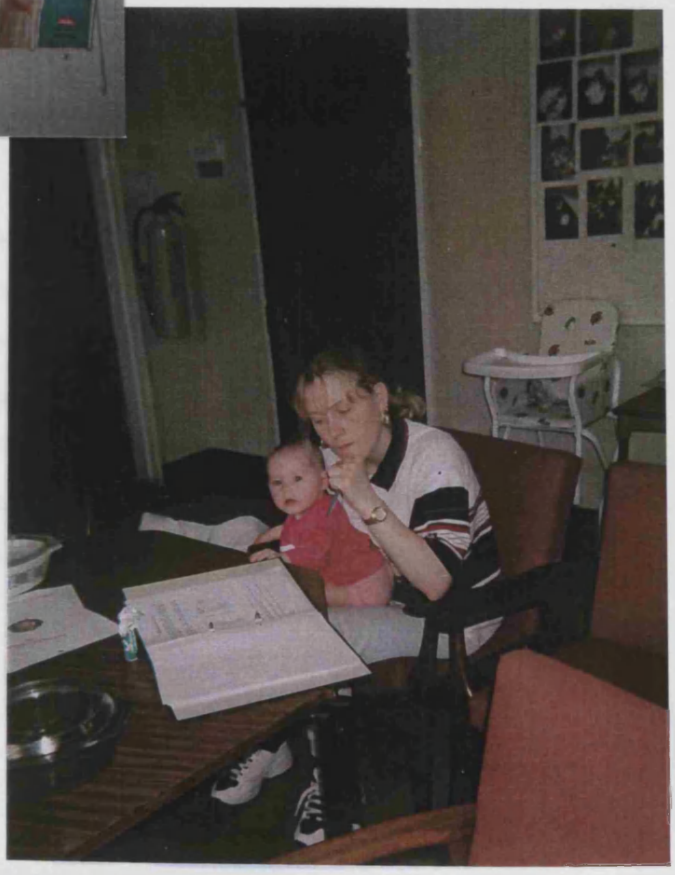
It is important to use the language and the vocabulary that the girls themselves use, and to guide them while staying informal. At this age, it is important not to put their back up, otherwise you lose their confidence and they run away; and the opportunities to help is lost.

"We are not their mothers, we are their teachers, their guide and their spokesman". "We would have had a totally different attitude if they were our own children!"

1 - 7 SCHOOL PLAN:

The school consists of two big classrooms, separated by Barbara Peacock's office. Each classroom contains a small open kitchen, some desks, some children's cots, some toys, nappy changing tables, and some baby chairs. In one of the rooms, there is a small health laboratory, which also contains a hospital bed (reserved for the midwife). A lot of health advertisements or brochures about pregnancy, and nutrition adorn the walls.


pregnancy
Ultrasound
Positions
Children
pregnant
FROM MILK TO MIXED FEEDING



III - 2 QUALITATIVE PHASE:

1 - MAIN RESULTS FROM THE HEAD OF THE SCHOOL

From one unstructured interview with Barbara Peacock in May 1998, and one semi-structured interview with Barbara Peacock and Margaret Glynn in July 1998.

1 -1 SCHOOLGIRLS FAMILY BACKGROUND

The majority of these teenagers come from the poorest social class; only a couple were from a higher family background. Most of the parents live on social security benefits and are unemployed. The occurrence of teenage pregnancy seems to be highly correlated with poverty. Typical family characteristics are: large families with 5 or 6 children, divorced couples or single mothers, and often - as previously noted - the mother herself had got children at a very young age too; it is a cycle. One of the girls came from a "*moving family*". They came recently from Scotland, and nobody seemed to know where exactly they do come from, nor what do they exactly do.

> *"It is the kind of family, where you go one day at their home but they have disappeared".*

The girl is quiet and lonely and has difficulty in getting to know other girls (who know each other from previous school). One day, she might not come back to school, and nobody would know where she and her family have gone.

> *"Before the end of the year, she might have disappeared".*

It seems that higher social classes opt more for termination. They actually expect more from life; they would like a better education and a better life. They have career expectations.

> *"Most of the girls here, aspire to have a baby".*

To be a mother gives them some status in society and gives them a role in life. Most of the girls not only have the problem of pregnancy at a young age, but also have difficult lives with serious family problems.

1 -2 BABY'S FATHER OR BOYFRIEND

The baby's fathers are very young too, most of them are schoolboys. The majority of pregnant teenagers do not have any steady partner; if they have a boyfriend, it is rarely the father of their baby. At this age, they seem to change partners frequently; boys just go from one girl to another.

A few years ago, Ashlyns tried to organise one morning per week with the baby's father or the girls' boyfriend. They stopped this idea, because they encountered many difficulties with relationships. Indeed, some boys came only with the goal of finding another girlfriend, which created many tensions. Or sometimes, one of the boys was the father of two babies... Therefore, the presence of young fathers was more disruptive than beneficial!
However, for some girls, the support of their boyfriend or the baby's father seems very important and helpful.

1 -3 TEENAGE SEXUAL BEHAVIOUR

Most girls do know about contraception. They often do not relate their menstrual cycle with any safe period. Young girls believe in strange things, which are unfortunately often false, like:

> *"you cannot become pregnant the first time", "If you stand up when you have sex, you cannot become pregnant"*, or again *"If you take a bath just after the intercourse, it will wash everything away". "Unfortunately, we have the result here, and it does not work!"*

A lot of adults deny that young girls are sexually active at 14 or 15 years old; but they are, and they can become pregnant.

> *" I say to them: "I cannot stop you having sex, but I can help you not to have another baby". They laugh and answer: "No you cannot stop us having sex" ".*

The pregnancy does not stop their behaviour, they continue to take the same amount of risks. Many have intercourse soon after the delivery, without taking any precautions. They

sometimes come to ask for a pregnancy test or the morning after pill a few weeks after their delivery. They are too afraid to go to a health centre, where they might be chided with:

"You again, you are totally stupid".

It is difficult to make them understand the real risks of sexual intercourse. One girl is expecting her second baby, and she is only 17 years old. When she left the school in June of this year, she was already 7 months pregnant, and nobody (including: the school staff, other teenagers, parents, friends...) had noticed it. The mother of this schoolgirl found out about the pregnancy at the end of June, when she was already 7 months pregnant. She gave birth to a small girl at the end of August 1998. She is moving to her boyfriend's house (the father of the second baby). But her mother is at the moment taking care of her first baby!

"Do they really realise the consequences?!"

1 -4 THE REASONS WHY YOUNG GIRLS BECOME PREGNANT

They know about contraception, most of the time, but it is often their boyfriends who do not want to use condoms. Some teenagers would like to try sexual intercourse as a new experience. The idea of not becoming pregnant the first time or *"when it hurts"*, is a commonly held belief. Often, their mothers were pregnant when they themselves were teenagers; there are grandmothers of only 30 years old. Teenagers have the image of their mother sleeping with different men, and they think that is a normal picture. The majority of girls come from deprived families, and have no hope of a job or for their life in general. A baby gives them some importance, a social status and a goal in life. Pregnant teenagers are often quite happy with the idea of the pregnancy, (even if it was a shock when they discovered it). The concept is often well accepted by families and friends.

"Having a baby does not seem to be a trauma for the teenager,
they cope well with it".

They are most of the time *"good mothers"*.

Girls get support from the school, from their parents and from each other. Young girls find it difficult to imagine that their life will be changed by the arrival of a *"small baby"*. They think that everything will remain the same. They only understand the difference when the baby is born. At that time, they realise that they cannot go out with friends as before; they have to plan ahead and think of a baby sitter. It is all over. They often move away from their former

friends, who do not really understand the new situation. They become very lonely facing a new life, which is "*imposed*" on them, with a baby. It is sometimes hard to cope with this new future. Therefore, the support of the other girls at the school is very important, because they have been through the same life experience.

1 - 5 USE OF ANTENATAL CARE

Most of the teenagers, in Ashlyns, attend antenatal care. However, a lot of girls do not ask any questions during antenatal visits, they prefer to wait and ask the midwife at the school. They are afraid of being judged by health staff. If they ask too many questions, the staff will say that it is because of their age that they do not understand; but if they do not ask enough questions, they will be accused of being *"too young"*. Therefore, they are blocked in a scheme of

"too young to be pregnant" "*too young to be a mother"*.

They feel blamed for *"being too young"*. It is the same thing with health visitors. Teenagers do not want to ask questions, and answer all the time that "*everything is fine*". They are afraid that health workers will feel they are not able to bring up a baby, and therefore take their baby away from them.

Most teenage girls have fixed ideas about doctors, such as:

"I do not like male doctors", "I do not like old doctors" or *"I do not want to see a black doctor"*.

Teenagers can be very racist and intolerant; and if they do not like something, they just run away. They do not come back to other appointments; and they have the same attitude at school.

Schoolgirls are often not satisfied by the way health staff treats them. Health Staff talk down to them, using medical words that they do not understand, and which health staff do not take the time to explain. Being lost and feeling stupid at not understanding medical words is a common feeling that women expecting their first baby have experienced. However, when you are older and more mature, you feel more comfortable about asking questions, and in expressing what you want. When you are younger, you do not feel confident enough to interrupt adults for explanations. Teenage mothers need even more support. Often, Ashlyns'

students bring their medical notes to school and ask the staff to explain what all the medical vocabulary means.

Sometimes the staff in hospitals forget who is the real mother of the new-born baby. They direct their talk to the grandmother, rather than to the teenage mother.

> *"I think that it is a wrong attitude, the mother is the teenager and they have to consider her as such".*

GPs are often not very tolerant, especially with very young girls. Young teenagers are afraid that Doctors will force them to have a termination; therefore, they prefer not to consult them, or not to consult them too soon. Some GPs refuse to give contraception to young girls who ask for it, and who already have a baby. Teenagers do not feel understood by their GPs and are afraid of their reaction.

Specialised antenatal visits, and classes for young mothers, appear to be a very good idea. Teenagers need the support of each other; they feel more confident with other girls of their age.

> *"It is in a way, the same idea at our school".*

Indeed, schoolgirls feel ashamed to seek antenatal classes with older women; they have the impression that everybody is looking at them, because they are "*so young*".

> *"I really do not know why some teenagers never seek antenatal care".*

We have had some cases of girls who kept their pregnancy secret until the delivery, they then arrive at the school after the delivery.

> *"It seems incredible that such young girls could keep such a heavy secret for so long: 9 months".*

We have had 3 recent cases: one delivered in the family bathroom on her own, another went to hospital for an appendicitis crisis but delivered a nice baby a few hours later, and another did some trampolining two days before the delivery.

> *"I think that they think that by ignoring the baby, they will take it away from their life!"*

In the school, we encourage students to seek antenatal care; to ask questions, to ask to see the scan pictures. Teenagers motivate each other. When you see that people around you are

interested, it pushes you to go further, because you do not want to disappoint them. However, some girls do not seek antenatal care regularly, but they are happy to see the midwife at the school. Teenage girls know that antenatal care is important on paper, but they do not realise that it is important for them. Some teenagers have difficulty getting into a routine of keeping appointments; the habit is not part of their life. They forget an appointment or they decide not to go because they have other more important things to do. It is the same with school!

However, antenatal care has improved. The Health Authority is trying to develop community-based care, and attempting to keep the same midwife for each pregnant woman. Teenagers can phone their own midwife and feel more confident with them. Midwives often have good contact with teenagers.

Remarks about English Law:

If a young girl does not go to school regularly or does not seek antenatal visits or postnatal visits regularly, social services are able to say that the young girl is immature and not responsible enough to bring up a child. They can use this argument to take the baby away from her. The teenagers know this and act accordingly. Most of the young mothers are afraid that somebody (health workers, social workers...) might be able to take her baby away from her.

1 - 6 CHANGES IN RECENT YEARS

Things have been changing in the last 10 years. There now tend to be younger pregnant girls in the school. Before, pregnant pupils occurred in year 11 (15 years old), and now we are seeing more in year 10 (14 years old). Also we have begun to see teenagers coming for their second pregnancy.

"This is a new phenomenon, a change of climate".

These changes can be explained by the change of society itself. Nowadays, people seem to accept single mothers, unmarried mothers, or even young mothers more. Also, teenagers tend to prefer to have children close in age. And sometimes, a new partner means a new baby. This phenomenon is in a way interesting, but is also frightening!

1 - 7 FUTURE OF THESE SCHOOLGIRLS

Some girls go to college and continue their education. They tend to go for travel and tourism, business administration, hair dressing or health and social work. It is difficult to assess the number of girls in each field, because there is no follow up after the school, and it is not possible to know the direction of every girl. Some just stop their education after the GCSE and take care of their child. Some others wait until their child goes to school and continue their education at that time. For quite a few, to have a baby pushes them to go further in their education. Having a baby can give them a goal to find a job and to earn money for a decent life.

Most girls keep contact between each other and continue to come back to Ashlyns, to give news. Some get married after having 1 or 2 children, more often to a man who is not the father of their child.

2 - MAIN RESULTS FROM THE TEENAGERS THEMSELVES

2 -1 FOCUS GROUPS:

From 3 focus-groups, organised in Ashlyns school, in July 1998. The first focus-groups were run with 4 teenagers, the second one with 6 teenagers, and the third one with 5 teenagers.

The focus-groups were quite difficult to run, because the babies and the young children were playing around and trying to catch their mother's attention. However, it gave me a good idea of the daily teaching conditions of Ashlyns School.

When did you discover that you were pregnant?

A significant proportion of teenagers discovered that they were pregnant during the first or the second trimester of their pregnancy. A couple of adolescents realised that they were expecting a baby, only during the last trimester of their pregnancy. The reason for this late diagnosis was explained by one girl, by the presence of periods during the first months of her

pregnancy. The other girl expressed that even with her missed periods, she could not believed that she was pregnant.

"It was something impossible, I could not believe it".

One of the girls explained that it was hard for her to believe that she was pregnant. She had had sexual intercourse only once in her life and in the beginning she had even lied to her parents, her friends, the school, (and herself) claiming that she never had any sexual relationship!

How did you discover that you were pregnant?

The majority of teenagers had been alarmed by their missed periods. Some girls had then decided to undertake a pregnancy test to confirm their worries. Some girls mentioned other symptoms like feeling sick, feeling tired or having a growing belly. Also, one teenager explained that it was her mother who discovered the pregnancy, and pushed her to do a pregnancy test. Few girls expressed their doubts when faced with their missing periods, they thought that it was a mistake and they were sure that their periods would come back in the following months. It took them a few months (and a few more missing periods) to realise that they were pregnant.

"I thought that my periods would arrive the next day, then the next week, or finally the next month".

What were your first reactions?

The main thing, which comes out, was crying. In 2 of the focus-groups they said all together in a common voice "Crying". One even said:

"When I discovered that I was pregnant, I cried for 3 days, I could not believe it!"

Only one girl said that she was so surprised, that she laughed! The other comments of the first reaction were: surprised, shocked, upset, and an important proportion of teenagers were afraid of their parents' reaction. One girl explained that she did not tell her mother that she was pregnant until the 7th month.

"I was so afraid that I couldn't, I just couldn't".

The family, boyfriend or friends reaction:

Most schoolgirls first told their partner that they were pregnant. The boy friend's reactions seemed to vary between "*He laughed*", "*He was happy*", and "*He did not care*". The parents' reactions look more homogenous; they were shocked and angry.

"My parents were upset, very upset".

Nevertheless, most mothers appear to become rapidly supportive. Some girls who were late telling their parents that they were pregnant, explained that their mother had already felt it, and in a way, knew it. A few teenagers observed that they felt closer to their mother since the beginning of the pregnancy. However, some fathers reacted strongly to the announcement of their daughters' pregnancy. One father refused to speak to his daughter for three weeks. Several of the young mothers did not seem close to their father, and quite a few did not live with him any more. One teenager did not tell her father she was pregnant, until the delivery; and he has seen his grandson only once since then (4 months of age).

Some adolescents said that the mother of their boyfriend knew about their pregnancy before their own mother. It was sometimes a difference of only a few days or weeks, but after reflection, they found it quite strange; especially when they do not have any contact with their boy friend anymore. Some girls explained that their friends did not really understand what had happened to them, and they have lost some of them.

The first visit:

The majority of teenage pregnant girls had their first antenatal visit in the second trimester of their pregnancy (3 to 5 months). When asked why they did not go earlier, they explained that because they did not know where to go, they did not feel confident enough to go anywhere on their own, or they were fearful and ashamed of the medical staff's likely reaction. Some adolescents simply did not want to think about the pregnancy, and not seeking antenatal visits was a way to forget about it. In most situations, it is the teenager's mother who brings her daughter to see the GP, when she realises that she is pregnant.

"I told my mum, and she took me to the Doctor".

What young mothers think of the Health staff:

GPs

A majority of adolescents did not like their GP's attitude, and they did not feel comfortable with them. They have strong opinions about not wanting to see a male doctor, especially an old male doctor, and some of them refuse categorically to see a black doctor. They expressed that they feel uncomfortable to speak about contraception or sexuality with adult men, and the barriers are even stronger when they are a certain age.

> *"When my doctor asked me when was the last time I had sex, I could not answer, I was too ashamed; I cannot speak about these kind of things with an old man".*

Also a few girls said that they found men abrupt when they examine them.

> *"When he pushed my belly, it was painful, men do not understand".*

One of the teenagers described her first visit with the GP, and explained why she did not want to go back ever.

> *"When I first saw my GP for the pregnancy, he told me that "I was disgusting", and at my age I needed to have an abortion. I did not want an abortion, then I just left and never went back!"*

A few adolescents agreed that their GPs offered them an abortion, and they were afraid that health staff could force them to have one. Many teenagers do not want to see their GP too early for fear that they would push them to have an abortion. Some girls explained that their GP refused to give them the pill, even after their first delivery.

> *"He told me that I was too young and too disgusting!" "I do not like doctors, I feel uncomfortable and ashamed". "I do not want my doctor to laugh at me!".*

However, a couple of the girls said that they saw their family GP, and they felt confidence in him and were reassured by their doctor, even if he was a man.

Midwives

The adolescent opinions about midwives were mixed. Some felt confident with their midwives, while other found them rude and intolerant.

> *"The midwife I saw was very rude to me, therefore I did not go back. I saw the midwife at the school, she is very good and we*

can say every thing to her, she understands us".

It appears that the teenagers who saw different midwives during their pregnancy, did not feel comfortable with them; while the girls who had the same midwife each time felt much more confident. Some adolescents had their midwife's telephone number and could phone her if needed; which is very reassuring for young mothers. In the second case, they spoke about "*my midwife*" or more exactly "*me midwife*". All schoolgirls seem to like the midwife who comes to Ashlyns once a week. They know her well, they are confident with her, and do not feel ashamed to ask any kind of questions. They know that she will understand them without judging them. It appeared very important for pregnant teenagers, that the school midwife was able to visit them at the hospital, during and after labour. One of the girls due in the following week said to the midwife:

> *"If I call you, would you come to the Hospital to see me, would you come straight away...Do you promise me?...Are you sure?".*

And when the midwife reassured her, the young girl appeared happy and much more relaxed. The school midwife appears to be the teenagers advocate and the person to refer to for any problems related to the pregnancy.

Hospital staff:

Most teenagers were not happy with the hospital staff. They had the impression that the staff treated them differently because they were young.

> *"They did not treat me as an adult, but like a silly girl!".*

A few stories were mentioned, showing that the staff did not treat them as normal mothers because of their age.

> *"They did not let me breastfeed, they said that I was too young, and that I would not do it well". "They took my baby away to the nursery without telling me; when I said that I was worried, they replied that he was better here". "They refused to give me more painkillers, and when I asked why, they answered that I was too young to understand". "One day the doctor came with all his students to show me like an object; I was so ashamed".*

It seems that most teenage mothers did not feel comfortable during their days in hospital, they had the impression that everybody looked at them and treated them differently, because of their age (both staff and other mothers in the ward). They would like more information from

the staff, more respect and less judgement.

"They must respect us as young mothers, and not judge us".

"They really treat us badly, because we are young".

However, a couple of girls, had been happy with the attitudes of the staff. Every teenager went to the hospital with her mother, and felt reassured by her presence.

Antenatal care:

All adolescents recognised the importance of antenatal care. They did not think of their health, but of the baby's health. No teenager seemed to know that a pregnancy could also represent a risk for the mother's health; or they ignored it. No girl mentioned that antenatal care was good for her health, they only mentioned the baby's health. Teenagers are very concerned about the health and well being of their baby.

"Antenatal visits are important to control the health of the baby, and see if he is growing well". "It is the only way to see if the baby is fine".

Also, a young mother said that antenatal visits had helped her to get out of stress. She was anxious that her baby might have been abnormal. Antenatal care was something important for all teenage mothers.

When asked what they liked or did not like during antenatal visits, they mostly underlined technical aspects. The two things that teenagers mostly like during antenatal visits were scans and to listen to the babies heartbeat.

"It is when you have your first scan, that you realise that you are really pregnant".

However, they did not like blood tests, injections, blood pressure and internal examinations.

Antenatal care for young mothers:

Teenagers expressed that they do not have specific needs as young mothers, they have the needs of all pregnant women; and they want to be considered as normal pregnant women.

"It is not because we are young, that we are different".

They all agreed with the idea of having special antenatal classes for teenagers, where they could learn things about the pregnancy and the delivery, without the intensive look and

questions of older pregnant women.

> *"The other older women looked at me because I was the youngest, I felt ashamed and embarrassed and I could not say anything".*

For this same reason, a lot of teenagers did not go to antenatal classes. They all said that if they had been with mothers of their own age, they would have felt more comfortable to go.

The majority of adolescents would have liked more information about the pregnancy and the delivery, from the health staff. When asked if they would like specific clinics for young mothers, their opinions were divided. Some girls would liked to have "young mothers clinics", and they thought that it could help teenagers to seek care earlier and more often. However, some other girls underlined the fact that they were like any other pregnant patients, and there was in that case no reason to take them separately. Nevertheless, they would all like some staff who could understand them and respect them as young mothers.

Generals comments:

Most girls seemed happy with the antenatal care given, and could not find any criticism. And when asked why some teenagers do not seek antenatal care, their only answer was

> *"Because they do not know that they are pregnant".*

However, when we asked more precise questions that probed more deeply into this subject, some schoolgirls expressed that teenagers might feel uncomfortable with the staff, might suffer from a lack of respect because of their age and from non-recognition as a pregnant women. They also underline the judgmental attitude of the staff and other patients.

> *"They said that I was too young!"*

Also, there is a desire from teenagers to improve sex education at school.

> *"Sex education is important at school, it can be done in a better way, in a more intelligent way".*

3 SOME MORE RESULTS: THE VIEW OF THE STAFF

3 -1 HEALTH VISITOR

From a semi-structured interview with the Health Visitor, in September 1998.

The health visitor comes to the school once a week. She is working in primary care (Community and Development) and is attached to a group of GPs, in the West End of Newcastle. Her main role is to look at the babies' general health, to give advice, and to support each girl in the baby's developmental follow up. She weighs children regularly and gives information about nutrition. She is here also to answer any worries the young mothers have about any health or feeding problem.

"It is in a way like a baby clinic, but I go to see them".

However, all girls have their own GP and Health Visitor, therefore you have to pay attention and direct them to their GP or Health Visitor if there is a problem.

"When I ask them to see their GP, they usually do so; they are very conscientious".

"I have good relationship with the girls, they know me, and know what they can ask me".

[Observation: Indeed, during my time spent in Ashlyns, I observed that the schoolgirls were very confident to speak with the Health Visitor, and came to ask about a lot of different worries and concerns like a spot or a rush, which were most of the time not serious problems, but they had the opportunity to question and then to be reassured.]

When asked if teenage mothers have any specific characteristics, the Health Visitor answered: Teenage pregnant girls come from all backgrounds,

"they are young and vulnerable".

However, they have an awful lot to give to their children, they are committed and dedicated. They are very good and concerned about their babies,

"they want the best for their children".

Teenage mothers seem to ask more questions than older mothers; they want to be sure that they are doing well. They need a lot of encouragement and reassurance about what they do.

Teenage mothers seem to seek less antenatal care than older mothers, this can be explained by the fact that adolescents are scared of hospitals, and its procedures in general. Some of them have heard horrible stories about deliveries, and they fear the unknown. Also they do not want to meet people they might know (neighbours or a friend of their mother), and there is also a lack of motivation and basically a lack of self-esteem. There are a lot of aspects of body image going on at that age. Most girls are scared of the delivery, but when they understand what will happen to them, it gets better. The schoolgirls who are in Ashlyns are privileged because they obtain a lot of support from the school environment.

> *"The midwife takes time to explain them the pregnancy and the delivery, which reduces a lot of stress and panic".*

The grandmothers go through a stage of shock and anger, but after this, the majority become very supportive.

> *"Granny is the dominant influence in the life of the mother and her baby".*

Most of the teenagers do not breastfeed. Their living environment does not encourage them to breastfeed.

> *"It is more difficult to give the breast in front of your father or your brother, than in front of your partner".*

Some young mothers have tried to breastfeed, but if they cannot succeed immediately, they give up. Adolescents do not wait for the adaptation period. Thus very few girls end up breastfeeding.

To break the circle of teenage pregnancy, children need to be taught appropriately at an early age (3 years old). In their education they need to have more information about sexuality, contraception and pregnancy (health visitor).

> *"Sex education has to be done by the right person, at the right time".*

A teacher is probably not the right person to give this kind of information. Also, you have to start before the girls can become pregnant.

> *"We have to start at the bottom in our approach, and even if it does not stop teenage pregnancy occurring, it might have an impact".*

Teenagers need to know where to go to get the proper information and where to go to have a pregnancy test. There are some places organised for teenagers, but it is not easy to make them come.

"Because of their vulnerability, teenagers find it difficult to go to places they do not know". "But I think that places designed for young people is a very good idea".

There is a new organisation that will open its doors in few months time, which is dedicated to adolescent use only. This will provide a combination of health education and community workers, with health and social workers for health and sexual education, as well as job orientation. This new complex will be attached to a family planning clinic. This place will be reserved for young people, less than 25 years old. The idea is to provide a place for young people, where they would be confident and happy to go:

"it is for them, and must be run by them".

It is important to have a place where different appropriate services are provided; a place that they think and feel as theirs.

The ***Big Apple,*** another facility reserved for pregnant teenagers, open once a week from 11a.m to 1 p.m. It is run by a midwife (working in Ashlyns too), a health visitor and a social worker. It was open for two years, as a friendly place to talk and get advice. There are 2 to 7 girls each week, but it is up to the teenagers to go or not! The Big Apple is advertised in schools, clinics, libraries, and hospitals.

It is important to provide supportive community centres for young mothers and their babies. The baby needs care, and the mother also needs care and support. It is a very good idea to create antenatal care for the teenager, if you can get them to attend.

"They have got to want to come".

For this reason, it might be a good idea to attach the antenatal clinic to the youth centre; in this way everything would be provided in the same place.

The environment of Ashlyns School is very good; it is a learning environment, teenagers are together and receive a great support from each other and from the staff. Therefore, they are more motivated to seek care and to go to new places together. They are encouraged by the staff and they motivate each other.

"It is not because you have a baby at a young age that you have

to stop your education or stop your life".

A baby is something unexpected in an adolescent's life, an obstacle that occurs, but teenagers have to continue their education, continue their life, and it is important that they get the support to do so.

> *"They are very young and their life continues, they still have many possibilities if they are able to take them; and it is your role to help them to take theses opportunities".*

3 - 2 EDUCATION WELFARE OFFICER

From a semi-structured interview with the Education Welfare Officer, September 1998:

The Education Welfare Officer has the responsibility in the city for special schools, and she started this job only last term and in Ashlyns, last April. She is undertaking at the moment, a diploma in Social Work. The initial referrals come from the previous schools, GPs, Midwives or Social Workers. There are some self-referrals also. When a teenage girl is discovered to be pregnant, the Education Welfare Officer is informed, either directly or, more often, via Barbara Peacock.

The Education Welfare Officer is responsible for the first contact with the future student, and will organise a home visit. The goal of this visit is to obtain information about the young girl, her family and the boyfriend. A plan for future possibilities of studying is decided upon with the schoolgirl and her mother. Pregnant girls are encouraged to go to Ashlyns, but they have the choice to stay in their previous school. There is no pressure on them, we try to find together the best to way to accommodate studies, pregnancy and social life. They come from every school in the city.

During this first visit, problems in the school, attendance regularity and level of achievement are taking into consideration. Later, the agreed plan must be signed by the young girl, her parents, the Education Welfare Officer and the Head of Ashlyns (see Annexes). The mother in most cases is happy to follow the wishes of her daughter. The Education Welfare Officer organises a visit to the school with the schoolgirl and her mother. She also brings the new student for her first day in the school. Some girls have never heard of Ashlyns before, and do

not know what to expect. Adolescents and their parents have from time to time strange ideas about the school.

The EWO is also available for any problem of attendance or any family problem that might interfere with the girl's presence at school. After consecutive absences the EWO will visit the teenager at home to find out the reason for missing school.

> *"It is my role to motivate them to go to school, and to show them that education is obligatory and very important for them".*

Most of the girls were poor attenders at their previous school. Two or tree families were very close to going to court because of this truancy, when they discovered that their daughters were pregnant. There seems to be a link between poor attendance, poor achievement and the occurrence of a pregnancy. This can manifest itself in different ways. Often, the same motives and reasons emerge for non-attendance at school. They do not like school, they think that they would never have a job, they are unmotivated. It seems to be a family cycle. Indeed, we often discover that the parents had a poor achievement. Education is therefore not a priority at home.

> *"Les chiens ne font pas des chats".*

I think that I have a good relationship with most of the students. Because of their situation, we do not take the parents into court. We allow them more missing hours, it is a more flexible school. In a school like Ashlyns, 65 % attendance is a very good rate; because they have their antenatal visits, antenatal classes, post natal visits and appointments for their babies. In a mainstream school they do not like having less than 95 % attendance. Because of these percentages, schools in Newcastle are quite happy to transfer pregnant schoolgirls to us, to improve their own annual attendance percentage record. I try to be friendly with the girls, and find out what motivates them not to attend, in order to resolve the situation with them. Our approach is less formal than in other schools.

> *"As an example, they call us by our first names, which would have been forbidden in a mainstream school". "However, I belong to an institution, therefore it is important to be friendly but not to be over friendly; you cannot be too informal".*

I cannot say about the particularities of teenage pregnant girls, I have not worked long enough with them to say. I do not deal with the boyfriend usually: if they are not living with the teenager, then I rarely meet them.

Parents are most of the time very supportive. They often know about Ashlyns before the pregnancy occurs, and they are very happy to see special provision for young pregnant girls. For the majority, they found it very important that their daughter continues her Education. But,

"I am more here for the girls than for their parents".

When there are important family problems, I refer the case to the Social Services of their area. I always keep in mind the problem of child protection, and if I have any doubt I might have to open a proper case file.

I think that Ashlyns is by far the best way to learn, for girls who will become mothers. They are in a better environment, where nobody will laugh at them because they are pregnant. It is a safe and secure place for them and their baby to be. They can learn parenting skills as well as English literature and math. When they are pregnant, they can become used to the bottle and nappies, by watching the others. The girls know each other and feel secure. It is a safe and helpful environment for a mother and her baby. Barbara and Margaret use any opportunities to give information about parenting skills, antenatal care or postnatal care. They receive informal advice and definite support. The staff knows the young mothers, and they can tell if something is going wrong, and act to put it right. We know that adolescent mothers are more at risk of postnatal depression.

"It is a great way to monitor the mothers who are not coping with the pregnancy or the new born baby".

I am glad that this kind of school exists, and I think that the girls realise it too.

3 - 3 MIDWIFE

From a semi-structured interview with the Midwife, September 1998:

The midwife comes once a week to Ashlyns. Her role is to provide some midwifery knowledge and to answer questions about the pregnancy, the labour, and the delivery. She

tries to demythify the delivery by visiting a delivery room, looking at a delivery pack and a midwife dress. She organises "parent craft" courses, relaxation exercises, and some aquanatal classes. The midwife tries to see every pregnant girl separately to get an idea of her follow-up. If a girl already has her own midwife then the school's midwife uses her mothering skills more, rather than her midwifery skills; she does not want to interfere with the normal follow-up. However, if she finds out that a girl does not seek care, she takes the opportunity to see her at school, and informs the community midwife.

I asked the girls who have already delivered to give me some advice on the antenatal classes for this year. I asked them in what subjects they may have needed more information. They felt they needed more information about delivery, pain and the length of pain. They would have liked to learn how to breathe and how to push, and how to diagnose the signs of labour. Teenagers would have appreciated an understanding of the different stages of the pregnancy and of child development. They would have liked to have more explanation about the blood taken and the monitoring of the baby. They also stinted that nobody explained to them about the "after delivery", the bleeding, the pain, the care of a new-born baby. And now that their babies are born, they would be happy to have information about babies' sleeping habits, feeding habits, bottle preparation, and what to do when a baby cries. They also felt that it would be a good idea for her to leave a suggestion box for them to use. They expressed the need for enquiries to be anonymous, because of the peer pressure going on. Even between themselves, they are afraid of the comments of others.

I got the impression that the schoolgirls like me. They seem to feel confident with me, you can see that through their attitude and their body language.

"They know that I am a mother, a health worker and a midwife; and only by chatting with them, you can pick up a lot of things".

There are a lot of tips you can give as a mother to a mother, and you can pass a long a lot of messages about child care issues.

"I try to give advice of daily life as a mother, a mother like they are".

Teenagers represent a particular population with particular needs. Adolescence is a transition period; there is:

"a long way to go from being a girl to a woman".

Pregnant teenagers have to learn parenting skills at the same time as learning to behave as adults. The majority of teenagers are very impatient, they want things immediately when they think of it. When you work with teenagers you have to be prepared for a high level of noise, and to answer questions as they come up from every corner of the room. And if you are not quick enough, they get bored.

"They call you, without paying attention to what you are doing, they do not wait for the end of a conversation to ask something. An adult would have the maturity to wait their turn".

Immaturity and impatience are everyday things you have to deal with, when working with teenagers.

Adolescent mothers do not have much time to be a mother, they are not in charge of their domestic role and often not in charge of their baby at home. The grandmother takes over the baby. The only time the teenager herself is intermittently in control of her baby is when she is at school. The grandmother is in control; she decides what the baby will wear or eat.

"The granny is often here to play with the baby, but when the baby cries during the night, it is no more her business; it is her daughter's responsibility".

The young mother cannot complain, because she does not have any choice. Nevertheless, it is fortunately the case that most of the grandmothers are a great support for their adolescent daughter-mothers.

The young father is often not present. The few boys who stay with the girls do not seem very supportive from a baby caring point of view, but when they give a present to the baby, the young girl is proud to show it.

"It is coming from his or her father, what a lucky boy or girl!"

Most of the girls are physically mature enough for pregnancy, and they do not have particular problems. The main trouble comes from hormonal changes and adolescent psychological immaturity. For a teenager, the pregnancy represents a lot of changes, to take all at once.

As a midwife, I try to make visits more fun for young mothers; I use their language and I stay simple.

"I try not to be a typical middle class midwife. And it is worth it, because they come back, and I can follow their pregnancy".

I have heard from the girls a lot of complaints about health staff's attitudes. Lots of health professionals look down to them, are paternalizing or patronising, and judgmental towards pregnant teenage girls.

"Naughty little girl, you are pregnant, at your age!"

There are a lot of bad feelings and attitudes toward teenage pregnant girls, and some professionals show it openly. Most of the teenagers met are not happy with the antenatal care provided, and this is mostly due to the staffs approach.

"Their attitude puts the kids off".

Most young girls are frightened to ask questions; they are ashamed not to use the right vocabulary or not to understand the answer.

In my experience teenage girls use antenatal care as much as other mothers. I think that the problem of attendance is more linked with the problem of area, access and family regard of health services. Some families do not use health services and therefore would not help and support their daughter to do so.

To have a clinic only for adolescents seems a great idea, but the staff has to be trained to work with teenagers. It is important that they have the right manner in speaking with young people, and do not make them feel lower than they already feel. It would be a good idea to establish a general centre for adolescents, known as the young peoples' place, where you could mix social, health, counselling and computer skills. I would also like to include an antenatal care unit to make it more complete.

We set up the Big Apple two years ago, to provide support and information on all aspects of health, pregnancy, rights and benefits to pregnant women and to provide postnatal support and advice. The Big Apple is situated in the West End of Newcastle, and tries to target the population of this area; especially girls after 16 years old when they finished school, as a continuing support.

Ashlyns is a great chance for Newcastles pregnant teenage girls, they have more support, more follow up, and more opportunities than other pregnant adolescents. However, it would be good for the school to have more space and to have more modern equipment. It would be interesting too to have one or two full-time nursery nurses, who could provide an example and give daily small messages. But this is all a question of money.

3 - 4 SENIOR CLINICAL MEDICAL OFFICER

Unstructured interview with the Senior Clinical Medical Officer, July and September 1998:

The Doctor comes once a week to Ashlyns. She comes to see any new pupil, and spends time with her to get some general medical information. The Doctor intervenes at any time that the head of the school thinks a schoolgirl might have a medical problem.
The Senior Clinical Medical Officer does not spend a lot of time with the adolescents, so they do not get to know her very well, and do not choose to take opportunities to ask for advice.

> *"It is rare that a young girl spontaneously comes to see me to talk about problems for her or her child".*

Some years ago, the doctor undertook a follow-up study on the children of teenage mothers in Ashlyns. In this, the children were observed for 2 years, and it was found that the development and care given (medical follow up, immunisation) to children of teenagers at school in Ashlyns did not differ from the general population (all age matched). With the help of another colleague, she wants to undertake a new study, with a follow-up period of 5 years, and hopes to find the same positive results. This study would be particularly interesting, the results being in contradiction with many published studies about babies of teenage mothers (Clinical Medical Officer).

3 - 5 MORE INFORMATION

Some more information, collected through the daily life in Ashlyns (<u>Observation</u> and informal and unstructured interviews):

In the morning, the girls arrive by bus or taxi to the school. They are very organised and bring all the material they need for the baby for the day. They chat a lot together and are not very strict with their hours of school work. From time to time they use their baby as an excuse for not working. Some schoolgirls obviously come more to the school for the social aspect rather than to work. However, some others, are very keen to learn and come before the others or stay after wards, to have the opportunity for a quiet time with Margaret or Barbara, to have some explanation or more work to do.

They seem very good mothers, very practical and resourceful. They act very quickly in any situation. They give a lot of affection and attention to their child and interact often with them. They speak to them and often use the terms: *"lovely baby", "sexy boy, or girl"*. They sometimes have conversations with their child, as if the child was able to understand everything. However, they tend to be as impatient as their child. They can suddenly say very loudly:

"Get out of here now, I have work to do, go and play on your own".

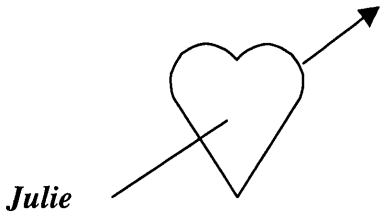
They lose their temper very quickly, and the child has to adapt his or her behaviour accordingly.

"Get down from this chair now, or I will smack you".

However, if the child laughs or makes fun of him or herself, all the teenagers laugh at him or her. They change their attitude all the time.

In a lot of ways these young mothers are still teenagers. They chat about their ex-boyfriends and their new boyfriends who was the ex-boyfriend of their best friend.

Their exercise books are covered of symbols like:



I love you
You love me.
For Ever
I love you

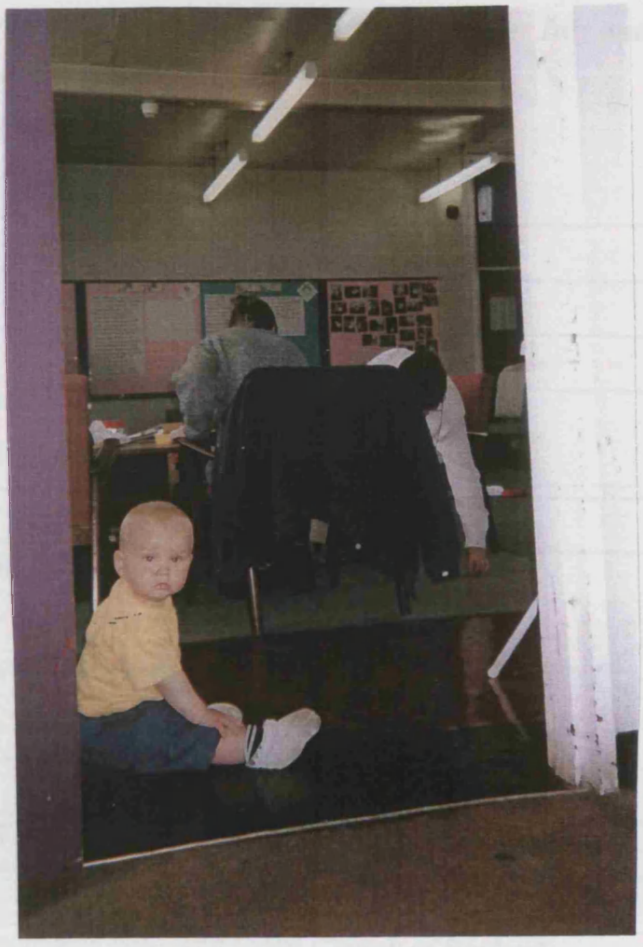
However, on the other hand, they can be very mature and responsible, especially with their babies. One day, a small child smacked his head against a table. He was very tired and felt asleep soon after wards. One of the girls, sitting close to him, took the responsibility, after the mother gave permission, to check him every 20 minutes, to be sure that he was all right.

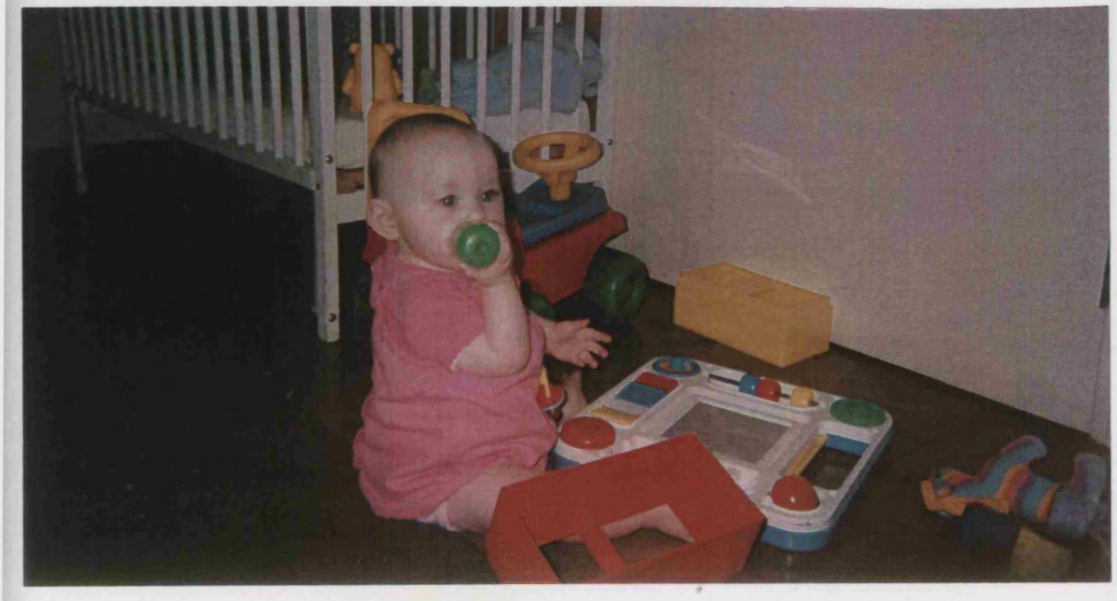
"You know, you have to check a child every 20 minutes, when he has smacked his head. The doctor told me that".

The girls look after each other children, they check that they are not in danger. But if one of the children begins to cry, they immediately call the mother.

"Quick, Sophie, Peter is crying"

The main picture I will keep from Ashlyns, is of a 15 years old teenager, sitting at a table working; with her baby on her knee, her exercise books, pencils and a can of *Coca Cola* in front of her, a *Mars bar* in her hand, and a *Dummy* in her mouth.





III - 3 – QUANTITATIVE PHASE:

1 - QUESTIONNAIRE:

From the 19 questionnaires from Ashlyns School, Newcastle. July and September 1998.

1-1 -CLOSED QUESTIONS

Sample size:	- 19 teenagers under 19 years old.	
Age:	- 13 girls were less than 16 years old	68 5 %
	- 6 were between 16 and 19 years old	31.5%
Pregnant or having delivered:		
	- 5 girls were pregnant	26%
	- 14 had already their baby	74%
	- For all of them, it was their first pregnancy	100%
Ethnic group:	There were all British, and 100 % were white.	100%
Religion:	- 9 teenagers belonged to the Church of England	47%
	- 7 were Catholic	37%
	- 3 did not have any Religion	16%
Education:	- 1 had already taken her GCSE exam.	5.5%
	- 10 had taken the first part of the GCSE exam	52.5%
	- 8 were preparing for the GCSE exam.	42%
Marital status:	- 14 were single	74%
	- 5 were living in stable union	26%
	- No one was married.	

Their father's occupation: (Using the HMSO, Standard Occupational Classification, (1991) based on professional activity) (84)	
- 2 were Grade II	15%
- 4 were Grade IV	31%
- 7 were Grade V (Unemployed)	54%
- 1 father was dead.	
- 5 girls did not know what their father's job was...	
⇒ 85 % of fathers have a professional activity of Grade IV to V.	
Place of residence before the pregnancy:	
- 16 with their parents	84.25%
- 1 with her partner	5.25%
- 1 with relatives	5.25%
- 1 in care	5.25%
Place of residence during and after the pregnancy:	
- 13 with their parents	63%
- 3 with their partner	16%
- 1 with their parents and their partner	5.25%
- 1 with a friend	5.25%
- 2 other: with foster parents or Catholic care	10.5%
Sibling: - 1 girl had no sibling	5.5%
- 6 girls had 1or 2 sisters and / or brothers*	31.5%
- 12 girls had more than 3 sisters or/and brothers	63%
* One of the girls who said that she has 2 siblings added that she also has a few step brothers and step sisters.	
Age of the baby's father: - 5 were less than 16 years old	26.25%
- 7 were between 16 and 19 years old	37%
- 5 were between 20 and 25 years old	26.25%
- 2 were more than 25 years old	10.5%
⇒ 63 % of baby's father were less than 19 years old.	

Baby's father's occupation: *(Using the HMSO, Standard Occupational Classification, (1991) based on professional activity) (83)* - 4 were students - 1 was Grade II - 2 were Grade III - 3 were Grade IV - 2 were Grade V - 7 girls did not give any information. ⇒ 59 % of baby's fathers have a professional activity of Grade III to V.	 33% 8% 17% 25% 17%
How often do they see their baby's father? - 6 girls said: *All the time* } Often to All the time - 3 girls said: *Often* } 50 % - No girl said: *From time to time.* - 5 girls said: *Rarely* } Rarely to Never - 5 girls said: *Never* } 50 %	 31.5% 16% 26.25% 26.25%
Contraception: *The question was not precise as to whether it was before or after conception, or delivery...(Which type of contraception did you normally use?). Some girls used more than one method of contraception* - 9 girls did not use any contraception - 1 girl "normally" used the safe period - 5 girls "normally" used condoms - 3 girls "normally" used pills - 5 girls "normally" used injection - 2 girl "normally" used the morning after pill	 47.5% 5.3% 26.5% 16% 26.5% 10.5%
Number of modes of contraception used: - None: 8 girls - 1: 5 girls - ≥ 2: 6 girls	42% 26% 32%

Origin of contraception information:		
- From their parents	(10 girls)	55.5%
- From the GP	(4 girls)	22%
- From Youth Centre	(1 girl)	5.5%
- From the School	(7 girls)	39%
- From friends	(7 girls)	39%
- From books	(8 girls)	44.5%
- From the Radio	(3 girls)	17%
- 39 % of girls received information from 1 source	(7 girls)	39%
- 61 % of girls received information from more than 1 sources	(11 girls)	61%
- 1 girl did not answer.		
Plan for pregnancy: - 1 girl planned her pregnancy		5%
- 18 girls did not plan their pregnancy		95%
Duration of pregnancy before discovery:		
- 1-2 months:	8 girls	42%
- 3-4 months:	9 girls	47.5%
- > 5 months:	2 girls	10.5%
Teenagers reaction to the pregnancy:		
- Happy:	2 girls	10.5%
- Surprised:	5 girls	26.5%
- Afraid of parent's reaction:	7 girls	37%
- Upset:	8 girls	42%
- Shocked:	8 girls	42%
- Did not realise:	2 girls	10.5%
Pregnancy confirmation by:		
- GP / Community clinic:	12 girls	70.5%
- Hospital:	3 girls	17.5%
- Family planning:	1 girl	6%

- Youth Centre:	1 girl	6%
- 2 girls did not answer.		
Whom did the teenager tell first that she was pregnant:		
- Partner:	12 girls	63%
- Parents:	4 girls	21%
- Sister or Brother:	1 girl	5.5%
- Friends:	2 girls	10.5%
When was the first antenatal visit?		
- Less than 3 months:	5 girls	29.5%
- 3-5 months:	11 girls	63.5%
- 6-8 months:	1 girl	6%
- 2 girls did not answer.		
When was the first antenatal visit?		
- Less than 3 months:	5 girls	29.5%
- 3-5 months:	11 girls	64.5%
- 6-8 months:	1 girl	6%
- 2 girls did not answer.		
Where were their antenatal visits?		
- Hospital:	3 girls	17.5%
- GP / Community clinic:	10 girls	59%
- Both:	4 girls	23.5%
- 2 girls did not answer.		
How many antenatal visits did they attend?		
- All of them:	16 girls	84%
- Most of them:	3 girls	16%
- No girl said: Some of them or none of them!		

What did antenatal visits represent for the teenagers studied?		
Girls answered to on or more questions		
- Something you had to attend (obligation):	11 girls said Yes	58%
- Something you were happy to go to:	14 girls said Yes	74%
- Something you were interested to go to:	11 girls said Yes	58%
- Somewhere you did not like to go to:	2 girl said Yes	10.5%
The importance of antenatal visits for the teenagers studied:		
- Very important:	16 girls	89%
- Important:	2 girls	11%
- No girl said: Slightly important to Not important!		
- 1 girl did not answer.		
Feeling of teenagers, during antenatal visits:		
- Very comfortable:	7 girls	37%
- Comfortable:	9 girls	47%
- Moderately comfortable:	3 girls	16%
- No girl said: Moderately comfortable to Uncomfortable!		
Could young mothers ask questions they wanted to ask, during antenatal visits:		
- All the time:	14 girls	73.5%
- Most of the time:	2 girls	10.5%
- Some of the time:	3 girls	16%
- No girl said: Rarely to Never!		
When asked if they were satisfied with the information given:		
- Very satisfied:	6 girls	31.5%
- Satisfied:	8 girls	42%
- Moderately satisfied	5 girls	26.5%
No girls said: Dissatisfied to Strongly dissatisfied!		

When asked if they were satisfied with the care given:		
- Very satisfied:	7 girls	37%
- Satisfied:	11 girls	58%
- Moderately satisfied	1 girl	5%
- No girls said: Dissatisfied to Strongly dissatisfied!		
With whom do teenagers feel more confident to speak about the pregnancy:		
- Their GP:	2 girls	11%
- A midwife:	5 girls	28%
- Their mother:	12 girls	66.5%
- Their partner:	8 girls	44.5%
- Relatives:	3 girls	16.5%
- Friends:	3 girls	16.5%
- No girl mentioned Hospital Doctor, Youth Centre or School nurse!		
- 50 % of girls were confident with only one person	(9 girls)	50%
- 50 % of girls were confident with more than one person	(9 girls)	50%
- 1 girl did not answer the question.		
When asked if they think that antenatal visits are adapted to young mothers needs:		
- 67 % answered Yes	(12 girls)	67%
- 33 % answered No	(6 girls)	33%
- 1 girl did not answer.		
Teenagers preference for antenatal clinics:		
- Hospital:	4 girls	21%
- GP / Community clinic:	13 girls	68%
- Youth clinic:	1 girl	5.25%
- Others: Home:	1 girl	5.25%

- **47.5 %** would prefer a special "Young mothers" clinic	(9 girls)	**47.5%**
- **26.25 %** would prefer an ordinary clinic with special hours reserved for teenager	(5 girls)	**26.25%**
- 26.25 % prefers an ordinary clinic	(5 girls)	26.5%
When asked if they would like some "Young mothers" discussions:		
- **95 %** of girls answered Yes	(18 girls)	**95%**
- 5 % of girls answered No	(1 girl)	5%
How schoolgirls found out about Ashlyns school:		
- Parents:	3 girls	16.5%
- Previous School:	7 girls	39%
- Health Professional:	8 girls	44.5%
- 1 girl did not answer.		
When asked: Do you think that the idea of putting young mothers together to continue their education is a good idea?		
- Strongly agree:	13 girls	68.5%
- Agree:	6 girls	31.5%
- No girl said: Moderately agree to strongly disagree!		
When asked: Do you find it important to receive information about pregnancy at school (Ashlyns)?		
- Very important:	17 girls	89.5%
- Important:	2 girls	10.5%
- No girl said: Moderately important to Not important at all!		
Satisfaction with information about pregnancy, given at school (Ashlyns):		
- 47.5 % would like more information	(9girls)	47.5%
- 52.5 % is happy with the amount of information	(10 girls)	52.5%
- Nobody would like less information		

1 - 2-OPEN ENDED QUESTIONS

Table 5:

How did they discover that they were pregnant:

Missed periods *"I never had a period".*	7 girls
Morning sickness and tiredness *"Tired and being sick".*	2 girls
Pregnancy test *"I got a pregnancy test from the chemist"* *"I took a home pregnancy test then I went to the doctors"*	4 girls did it at home and 2 in a Health centre ⇒ 6 girls
Confirmation by a doctor *"I already knew about the pregnancy, but it was the doctor who confirmed it".* *"Went to the doctors and he told me".*	4 girls
Mother *"My mum, I told her I slept with someone".*	1 girl

Table 6:

Which aspect of antenatal visits did you mostly like:

Listening to the baby's heartbeat. *"I like to listen to the baby's heart beat"* *"The baby's heart beat, knowing she was OK"*	12 girls
Scan *"I liked to see the baby when I went for my scan".*	6 girls
Other *"They care for your child".* *"Just to talk to someone that knew more than me"* *"All of them"*	3 girls

Table 7:

Which aspect of antenatal visits did you mostly dislike:

Blood test *"Getting blood taken".*	11 girls
Being weighed *"Getting weighed".*	2 girls
Answering questions *"Answering questions".*	1 girl
Internal examination *"All the prodding around to see if the baby's head was engaged"*	1 girl
None	1 girl

Table 8:

What can be done to improve antenatal visits, and to improve young mother's attendance:

Make antenatal visits more comfortable *"Make it more comfortable"*	2 girls
Organise groups for young mothers *"Their own place for under 16".* *"Maybe a separate group for teenage mums".* *"Have a group run for just young mothers".* *"There should be a special place for young mothers as some feel out of place because everyone's older"*	6 girls
Home visits by midwives *"The midwife should visit more often".*	2 girls
Change in attitude of the staff toward young mothers *"Talking to them more".* *"Doctors, midwives etc...should not have on attitude towards us".* *"They could be more nice to young people".*	3 girls
More advice, more help *"Get more advice". "More help".*	2 girls
Be treated like others *"to be treated like others"*	1 girl

Table 9:

Which subjects should be discussed in "Young Mothers" group discussions:

Labour *"What to expect, going through the birth".*	5 girls
Pregnancy	3 girls
Contraception	3 girls
After birth *"What happens when you have the baby, the care and attention you give"* *"How you feel about having a baby is a Big commitment".* *"Sex, contraception and how to cope"*	5 girls
Benefits housing *"Benefits housing, what is going after the births".*	1 girl
Sex *"Sex"*	1 girl

Table 10:

Why do you think that the United Kingdom has the highest rate of teenage pregnancy in Europe?

Not enough sex education (at school) *"Not enough sex education in schools".* *"Because there is not enough talk about contraception in school".* *"Because they don't learn us enough".* *"Because people don't get told enough in school about pregnancy"*	6 girls
Group influence *"Young teenagers want to copy others".*	1 girl
Other *"Because they like more sex!".*	2 girls

General comments about the school:

All the comments are positive, teenagers seem to like their school:

The adjectives met are: good; supportive; helpful; relaxed; great idea; brilliant.

Also: I love the school; you learn more here; good to be with your baby.

"Ashlyns is very good and supportive".

"Very informative and helpful, relaxed".

"I think Ashlyns is a good idea".

"It is very good".

"Its very good to get information and good to learn with your baby".

"I love the school, it's a great idea".

"Yes, it is Brilliant, and you learn more here".

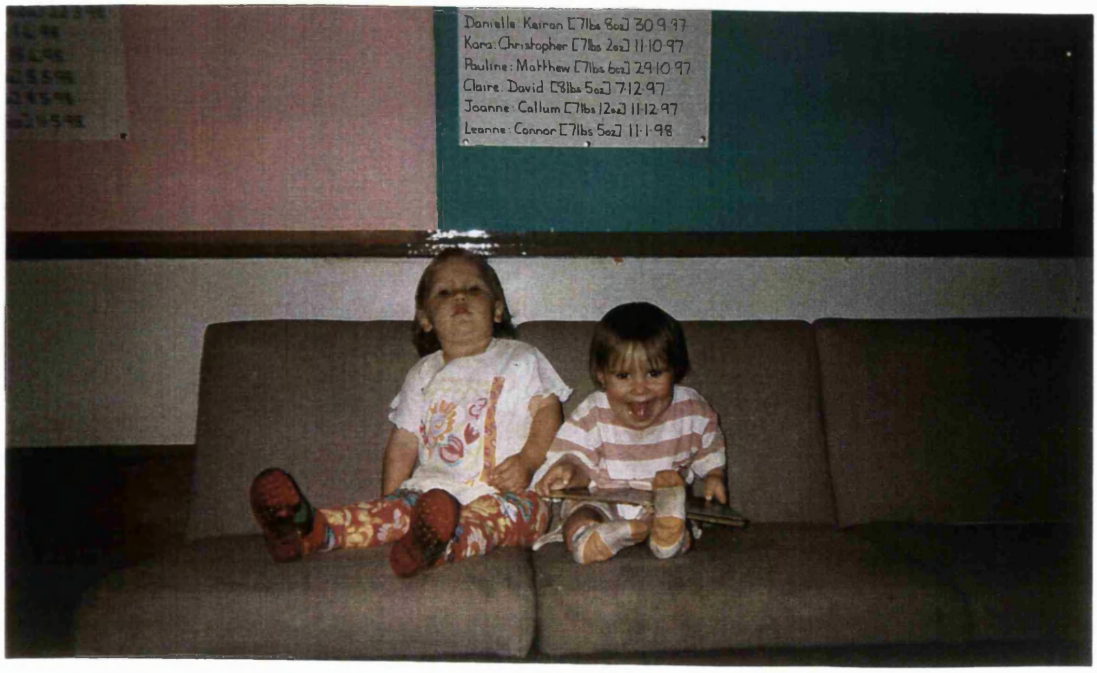
Only one girl wanted to make a remark, but she did not finished her sentence:

"It's a good school, but it needs...".

Table 11:

General information about antenatal care:

More scans *"There should be more scans".*	1 girl
More informative	1 girl
Young mothers clinic	1 girl
Important and a good thing *"I think it's very important that everybody goes to antenatal visits to see if the baby was alright".*	2 girls
Change of staff attitude *"The doctors shouldn't look down on us and be the same with people older than us".*	1 girl



CHAPTER FOUR

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

IV – 1 DISCUSSION

1 – Most teenagers do not realise that a baby might change their lives:

Adolescence is a transitory period between childhood and adulthood. Teenagers tend to be concrete thinkers and are more likely to look at short term and immediate results rather than about the long-term implications of their action. (11). Barbara Peacock pointed out that often teenagers do not realise the consequences of a baby. They do not imagine that such a small thing might change their life. This inability to plan and project themselves in the future, is one of the causes of teenagers' "risk behaviour".

An article in the Daily News (a South African Newspaper), described an experiment in the United States, using robot dolls as a tool in the battle against teenage pregnancy. These dolls are programmed to cry every 2 hours, the crying stopping only after 10 minutes of hugging the doll. The aim is to show young girls that motherhood demands much time, energy and personal investment. The Doll experiment was a success. Before handling the dolls, almost half the teenagers said they felt mature enough for parenthood; afterwards, none said that they felt ready to be a parent.

Article: Daily News, September 1998 (85).

Figure 19: *Daily News article, September 1998 (85).*

DAILY NEWS, FRIDAY, SEPTEMBER 25, 1998

Hard truth about child-rearing

Not my baby love

"Baby Think it Over" is helping in the United States' battle to cut down on teenage pregnancies, writes ***UTE EBERLE*** *for Sapa.*

LIVING DOLL: Aged just nine, Brazilian Maria Mascarenha became the world's youngest mother when she gave birth to h daughter Dianane. In an effort tc educate teenagers on the proble of underage motherhood, American authorities have come with a novel campaign which giv girls an insight into the responsibilities of being a parent.

THE cute little doll has a snub nose, sleepy eyes and dimples in its chin and countless kids at schools in the United States are only too delighted when the teacher allows them to take the toy home for a couple of days.

However, the euphoria doesn't usually last long and at least one child was moved to write in her diary: "How much longer before I can give the thing back?" Another child was reported to be so desperate to return hers that she threw the doll at her teacher.

No wonder. This is no ordinary doll. Behind the sweet exterior lurks an effective tool in the battle against teenage pregnancy in the country.

The doll, christened "Baby Think It Over", is in effect a type of robot and is being employed to show young children exactly what it would be like to have to care for a real baby.

The computerised plastic toy is programmed to start crying every two hours, interrupting homework or a telephone call to a friend, in the cinema or even in the middle of the night. "Mum" or "dad" then has to drop everything else and press an electronic switch on the doll's body for up to half an hour to quieten their charge.

The key needed for this operation is fixed to the teenager's wrist for the test period, which usually lasts several days. The whole exercise is to simulate how much time would actually be required to feed, change and carry about a real child.

"This makes the responsibility much more realistic than a film or a book," says Carol Lambert, a spokeswoman for the manufacturers of the doll in Eau Claire, Wisconsin.

Sachas Mays, for example, was woken up by "baby" four times in one night. "After the first day I was ready to give it back," admits the teenager. "It is a lot of responsibility and prevents you from doing other things you want to do."

Along with Sachas, almost a million other teenagers in the US have been spending many restless days and sleepless nights having to look after their dolls, according to the manufacturer's estimates.

The doll, which was invented some five years ago by a Californian aircraft engineer, has since won several awards.

Each doll costs between $250 and $290 and comes, politically correct, in differing skin colours. There is even a "crack doll" on offer which displays the effects of drug withdrawal, crying for care almost incessantly.

In no other industrialised nation do more teenagers suffer unwanted pregnancies than in the US, almost a million every year, according to the National Campaign for the Prevention of Teenage Pregnancies.

Although numbers have been dropping sharply, an unplanned family still means leaving school prematurely, bleak job prospects and subsequent social problems.

Although no comprehensive study results are available, teachers and staff at schools are reporting an astonishing change of attitude.

"Before the courses with the dolls almost half the kids said they felt mature enough for parenthood. Afterwards: none," says Aimee Bollinger Smith, head of a social programme being carried out in Baltimore County, Maryland.

At the same time, according to Ms Bollinger Smith, there has been a dramatic increase in the willingness to use contraceptives.

Above all it is schools and social institutions which greatly value the three kilo, lifelike doll. Previously the care needed by babies was demonstrated in schools by letting the teenagers carry about self-made baby dummies, made from little sacks filled with flour and raw eggs.

The plastic dolls, in comparison, not only possess impressive lung power, but also do not let themselves be ignored.

A built-in microchip registers if the doll is being neglected or treated roughly, which in turn will mean a visit by the teenager to the teacher to explain, or a drop in grades, or what for some is the worst of all, being kept in to look after the doll.

2 - Contraception

Just as teenagers do not think of the consequences of motherhood, they tend not to plan contraception. Many teenagers live "au jour le jour". Welling et al (38) explains that the first sexual intercourse is often experimentation, and those involved usually do not prepare for it by obtaining contraceptives, even if they know what to use and where to get them. The head teacher at Ashlyns School, underlined the fact that despite teenagers knowing about contraception, they rarely plan for it. She also added that often a pregnancy does not change a young girl risky behaviour. However, it is interesting to see that the teenagers interviewed insisted that they would have liked more sex education and information about pregnancy. The majority found that at their previous school, they received a poor level of sex education; *"it was useless"* said one of them.

Despite all the information given (school, parents, media, reviews, etc...), a great proportion of teenagers still do not use contraception. In our study, more than 40% of the girls did not use any kind of contraception. Condoms seem to be the most used way of contraception amongst teenagers, however, young girls seem to have problem in imposing their will when the partner refuses. Reproductive health care programmes have to increase male involvement, encouraging better communication between partners, and making services more "male friendly" (15).

The pill seems to be a form of contraception wanted by adolescents; it is easy to use and does not need the co-operation of the partner. Birch (7) reports that teenagers may have problems with the routines required for compliance. Also, it appears that some GPs refuse to prescribe the pill to young women, and are judgmental of the teenage patients; *"My GP said that I was disgusting"*. Clark (45) underlines that adolescents were ashamed to ask for contraception. In our case study, few girls asked for the pill, but the GP refused to prescribe it; one of the teenagers questioned reported that her GP refused to give her the pill, even after her first pregnancy, saying "she was too young". GP's have the right to strike patients off their list. Barbara Peacock explained the belief that if teenagers' parents complain about the Doctors' attitude, all the family might be struck off from the list. The easiest solution for teenagers is to refuse to see their GP. The head of the school also describe that when teenagers are not happy with a situation, and do not have the power to change it, "*they just run away*". It is the same thing for education or health care.

Figure 20: *The Sunday Times article, November 1998 (86).*

THE SUNDAY TIMES

GPs drop patients who ask questions

by Chris Dignan

AS MANY as 1 in 10 patients struck off from GPs' lists is removed because he or she asks too many questions about medical treatment. Doctors' groups and the health service ombudsman admit there is a problem and GPs have been told to be less "trigger-happy".

The number of patients removed from doctors' registers across Britain has risen by almost 8% between 1993 and 1996 to 85,700 a year. This does not include those struck off for being violent.

The Department of Health, which refuses to intervene in disputes, emphasised that the majority were struck off because they had changed addresses. However, new research by the Patients' Association (PA) and the Association of Community Health Councils for England and Wales (ACHCEW) shows that thousands — up to 1 in 10 — are struck off for minor reasons.

Joyce Robins is a council member of the Patients' Association which is launching a campaign to lobby the government to force GPs to give reasons and set up a right of appeal or arbitration. "It just shows how arrogant GPs can be if you don't do what they tell you to do," she said.

"Most of the patients struck off who contact us are perfectly reasonable people — and mostly women. Some disagree with a doctor or refuse treatment they do not want, and others seem to be people who simply ask too many questions.

"Many patients subsequently found themselves rejected by other surgeries and had to travel long distances to find another."

One GP, who wished to remain anonymous, said wealthy and well-educated people often asked too many questions and did not accept the answers.

"You can't say to the patient that you think they are a complete idiot, that you are fed up with them and that you can't argue for half an hour because you have 27 other patients waiting to see you," he said.

"So you slip a quick entry on the computer saying 'goodbye' and the patient gets a letter from the health authority a few days later saying they have been struck off."

Sue Moore, 50, from Sussex, asked if she could have a second opinion about her diagnosis and even offered to pay. "My GP then said to me, 'You make me sick — you always want to see the best.' I was horrified. I received a letter a fortnight later telling me I had been struck off," she said.

GPs are not legally obliged to give a reason, except to say there has been a breakdown in the doctor-patient relationship, and patients do not have a right of appeal.

Sarah Hales, 42, was struck off after asking questions about a routine test that her doctor wanted her to have during pregnancy. She knew the test carried a risk of miscarriage and refused it.

"I said no and explained why and wanted to know what my GP thought about the risks," she said.

"He shook my hand and showed me the door. I received a letter a week later saying I should look elsewhere for a GP. He also threw my husband off the register although he had had nothing to do with it."

Michael Buckley, the health service ombudsman, criticised GPs earlier this year for striking off patients too readily. He cited a grandmother in the Wigan area who complained to her GP about his advice to her daughter about breast-feeding. Three households were struck off as a result — the grandmother, her daughter and her son, even though the son had not been involved.

The ombudsman, however, has no power to change a GP's decision. The General Medical Council, the doctors' disciplinary body, the British Medical Association, the doctors' professional body, and the Royal College of GPs (RCGP), the clinical watchdog, have all issued guidelines urging GPs to give their reasons but all are opposed to making it a contractual obligation.

Dr Catti Moss, a GP and medical vice-chairman of the RCGP's patients liaison group, said GPs struck off more people after the introduction of the Patients' Charter and other reforms in the early 1990s led to more paperwork.

"GPs felt more frustrated with these changes and there was a backlash. Some doctors were abusing the system and threw patients off the list for quite minor disagreements," she said.

1 November 1998

Despite information, adolescents continue to have false beliefs like "*I am too young*" or "*It does not occur the first time*" (14). The head of the school pointed out a number of false ideas held by the students such as: *"If you stand up, you cannot become pregnant", "You cannot become pregnant when its hurts"* or again *"If you take a bath just after intercourse, it will wash everything away"*. Theses ideas circulate between young people or have been heard by a parent, a relative, or read in a magazine. We do not know exactly where they come from, but they are present in teenagers' minds, which can be dangerous and misleading. Also, adolescents find it easier to excuse their "at risk" behaviour, or to convince themselves, they won't fall pregnant.

In our study, over half the teenagers principal source of contraceptive advice came from parents, which shows that parents (principally mothers) are aware of their daughter's sexual behaviour. Some parents are not ignoring the sexual freedom of the late 20th century, and want to protect their daughter from an unwanted pregnancy. Also, 45% of girls got information about contraception from books and magazines, 40% from school or friends, but only 20% from health staff. A positive step might be to "train" parents to speak about sex education to their children, or at least to prepare parents to answer questions about sex and contraception. However, some children have difficulty speaking frankly with their parents, or are uncomfortable talking about sex related subjects; therefore schools remain an important source of information. We should bear in mind the example of the Netherlands, where sex education is commonly discussed at home. Many authors (51, 52 54) quote the Netherlands as having both lowest rate of teenage pregnancy in Europe and the lowest abortion rate.

Teenagers seem willing to learn more about sex education and pregnancy, and are very concerned about it. The health visitor working at Ashlyns believes that good sex education at school is very important and may be a key point in reducing teenage pregnancy. She insisted that sex education should only be undertaken by qualified people. She added that teachers are probably not qualified enough. The Oppong-Odisen study (58) underlines the fact that teenagers know what they want and what they would like to see provided; but they need proper information and need to be listened to. In Grace Darkwah's literature review (4), one of the main points to "change the future", was to have trained staff to work with young people.

3 - Influence of the Media:

Teenagers are very sensitive to many influences, and are at a stage when the opinions of others are very important, peer pressure is constant, and the media have great impact. Adolescents also need idols to identify with (7). Society is changing, and currently single and unmarried mothers are increasingly accepted. Women of the 20th century have much greater power and independence that they have ever had in industrialised countries. The media gives us the picture of "super women", who have a career, keep a nice house and have children on their own. A famous French song from Golman "Elle a fait un bébé toute seule" illustrates this point well ("She had a baby on her own"). The media have an important power and influence on people and particularly on adolescents. Health professionals are concerned about the impact that the "Spice Girls" may have over teenage pregnancy rates now that two of them are pregnant. Some articles about the Spice Girls like: "Don't wait, have a baby now", are very punchy (*The Times, August 1998 (87)).* However, this particular influence has to be studied in the months to come. When I spoke with the Ashlyns pupils about the subject, no one seemed particularly concerned about the Spice Girls' pregnancies. Since writing this, "Ginger Spice" has put herself forward to highlight the problems of teenage pregnancy, especially in the underdeveloped world!

Figure 21: *The Times article, August 1998.*

AUGUST 1998

Don't wait, have a baby *now*

Pregnancy is a normal and natural state — even for a Spice Girl, says **India Knight**

Call me naive, but I tend to spend much of my time genuinely believing that, in certain obvious respects, we live in a reasonably evolved post-feminist society. And then I am brought down to earth with a spectacular bump. Evolved societies do not equate pregnancy with illness or disability. This is because — I'll write in simple words, so everyone can understand, even the dim men — being pregnant is a normal, natural state. It is not debilitating. It does not stop you from being able to work. It is a nice thing. It is good.

Not that you'd know it. The Spice Girls' record company, Virgin, is reportedly "furious" at two of its artists' pregnancies, feeling that the "meticulously planned promotional campaign" timed to coincide with the band's Christmas single has been thrown into disarray.

Honestly! One does wonder, sometimes, whether anyone, anywhere has a brainlet in their head. There are, presumably, women executives at Virgin, some of whom must have had children, who must — surely? — be aware of the fact that pregnancy isn't a disease. The Spice Girls sing songs and prance around a bit. Having a fat stomach does not preclude one from either of these activities (as so ably demonstrated by the Spice Girls' rivals, All Saints, one of whose number is heavily pregnant, looks fabulous and is still performing happily).

Apart from the fact that I find it perfectly extraordinary that, in this day and age, people still equate pregnancy with "confinement" (this seems particularly odd coming from a supposedly enlightened company such as Virgin), having tantrums because one of your employees gets pregnant strikes me as really depressingly asinine and pusillanimous.

> Virgin should realise pregnancy isn't a disease

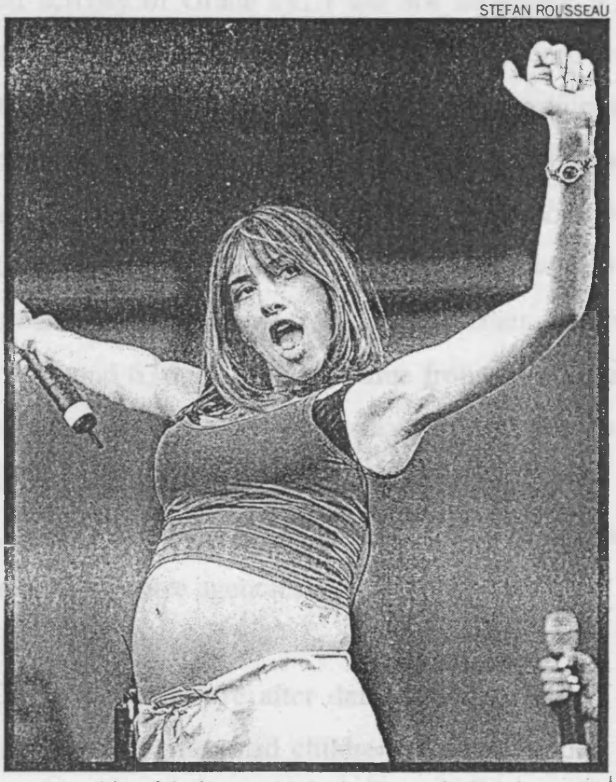
"It's the wrong time," such people always bleat. "She should have waited." To which one can only ask, what on earth for? The entire point about pregnancy is that there is no such thing as "the right time".

Misguided notions about waiting for "the right time" are why you can't walk down the street without bumping into at least 12 women wailing about "having left it too late". The right time doesn't exist. This is an uncomplicated notion to grasp, and one does wish people would get to grips with it.

Tomorrow, as some wise old proverb-maker so sensibly pointed out, never comes. You are more than likely to be happier, more "settled", richer, stronger than you are now at some stage over the next 20 years. There may well be a time in your life when you are earning more money than you do now. Chances are that you will move into a bigger house at some stage in the future. But so what? Babies are very small, and really don't mind not having a 20ft playroom or their own en-suite bathroom.

So why wait? Quite apart, of course, from the sad fact that, by the time they are living in their lavishly appointed mansion counting their hard-earned cash, those stragglers might very well find that they have left things too late to conceive easily. I know it's an annoying fact, but the actual business of getting pregnant does get harder as you grow older. Risks to the baby's health do rise in direct proportion to the mother's age. And quite apart from that, despite what that tabloid-friendly gaggle of mad 60-year-old mamas tell us, finding the energy to get up four times a night is much easier in your twenties or thirties than it is later.

STEFAN ROUSSEAU



Looking fabulous — Melanie Blatt, of All Saints

The other truth is that it is far easier to abandon one's career for a few years if one is in one's twenties than it is at, say, 38. I had my first child when I was 26 and my second at 29, during which time I more or less retired and stayed at home with the children. The minute amount of work I did do was at the kitchen table, on a laptop.

Female former colleagues, busily climbing the greasy pole, frequently told me I was either mad or pathologically old-fashioned. "It's not the right time," they said. "You should have waited." But children aren't desirable Conran sofas that might be cheaper in the sale, or properties in up-and-coming areas that would be a good investment in a year's time. I wanted my children in my twenties, and was fortunate enough to have them then. There simply was no point in waiting.

Even though the Spice Girls make me feel ill, I feel more nauseated still by the idea of men in suits telling them what they can and can't do with their reproductive systems. I am going to buy their next single in the spirit of outraged sisterhood. Now there's a phrase I didn't think I'd use much in England in 1998.

4 - Family background:

The majority of girls in Ashlyns come from a low social background, with 55% of fathers unemployed and 30% with a professional activity of Grade IV. I did not undertake a full investigation about mothers or step-fathers occupations, but according to the school staff, only a couple of pregnant mothers come from a slightly higher social class. The questionnaire did not ask whether parents were living together or not, but from the discussions I had with the girls, it appears that most of them come from single parent backgrounds or a recomposed family. It is interesting to see that 5 girls did not know the occupation of their own father! Other researchers have found teenage mothers frequently come from large families, divorced couples or single mothers. In our study, we found 63% of the girls came from families with more than 3 children. A view from the key-informants underlined that teenage pregnancy seems to be correlated with poverty and poor family achievement. This confirms the information found in the literature (5, 8, 18, 29). Birch (7) showed that 40% of families of pregnant teenagers were already known to social service agencies.

In our study, one girl was in care before the pregnancy and in a foster family after the delivery, and another girl went into a Catholic care centre after delivery. The head of the school explained that mothers of pregnant teenagers often had children at a very young age themselves. A girl said to me: *"My mother had me when she was 15, so she could not say anything to me, when I had my son."*

Simms and Seamark's study(31) confirms our findings, quoting one fifth of grand-mothers were in their thirties at the time of the interview with their daughter. It appears then, that teenage pregnancy might be part of a cycle, part of a social and family pattern. By helping pregnant teenagers, by giving them confidence through education the vicious circle of teenage pregnancy may be arrested. Most adolescents in our study were single (74%), did not have a stable relationship, and were living with their parents (84% before pregnancy and 63% after). After a period of anger and shock, most parents appeared supportive. *"My father refused to speak with me for 3 weeks". "My parents were upset, very upset".* From the Dennison et Al (53) study, mothers play a very important role when their daughter gets pregnant. Dennison also added that the grandmothers to be need help and support.

5 – Baby's father or current partner:

The baby's fathers were very young, most of them still schoolboys. Indeed, 63% were less

than 19 years old. Four girls said that the baby's father was a student and 7 did not say anything about the child's father. Among the few fathers who were working, the majority had a job of grade IV to V (a couple of them were unemployed). This portrait of baby's father agrees with that given in the literature review (18).

In our study, 50% of the girls said that they see the baby's father "*often*" to "*all the time*". The other 50% said they saw the baby's father "*rarely*" to "*never*". Even if they did not see the baby's father often, the teenage mothers were proud to say that they saw him, especially if he gave presents to the baby. It is interesting to note that 63% of the girls first broke the news of their pregnancy to their partner. (For a couple, the boyfriend's mother knew about the pregnancy before the girl's mother). 45% of teenagers said that the person they were most confident in speaking to about the pregnancy was their partner (second person after their mother). All these statements show that the baby's father is very important for the young mothers, and his presence appears to be very supportive. Birch (7) underlines that teenagers have a romantic view of love, and might see pregnancy as a symbol of love. Also, the partner might be the only social contact that a young teenage mother has, having lost most of her friends through becoming pregnant.

Boys appear much more immature faced with their parental responsibilities. Indeed, 50% seem to leave the girl in an attempt to escape the situation. The other 50% have problems in coping with their new status. Barbara explained that when the school organised weekly visits from the baby's father or partner, some boys tried to charm other girls, which created tensions. Some of the partners had fathered the children of more than one girl! Therefore, in some cases the presence of young fathers was more disruptive than beneficial.

Young mothers change even against their wills, their body changes, their psychology changes and they go through a certain maturity during their pregnancy. Young boys do not undergo such changes, especially when they do not see the pregnant girl very often. Therefore, they do not appreciate that the child might change their life until its birth. They do not feel much responsibility for the new baby. Morgan (8) said that young boys have to realise that sex is not only a physical and pleasurable activity, but also an action that entails responsibility and concerns that should be shared by both parties. Most of the work and prevention of teenage pregnancy has been undertaken with young girls, and only a few projects have focused on young boys.

On the whole, teenage mothers cope alone, for their pregnancy, their delivery, and the care for their baby; however, in most of cases, they are "*good mothers*".

Figure 22: *Daily Mail, November 1998* (88).

Daily Mail, Wednesday, November 4, 1998

Teenage mothers who cope alone

ALMOST half the teenage mothers in a research study had split up with their baby's father by the time the child was a year old, it emerged yesterday.

While all the married mothers stayed with their husbands, half of those who were living with their boyfriends and two thirds of those in a 'steady relationship' had broken up with them.

All but a handful of the teenage mothers were on social security and half were entirely dependent on state benefits, the study said.

A third were living in council houses or flats – and another third had put their names on the waiting list for local authority homes.

The study from the Policy Studies Institute think-tank paints a bleak picture of the lives of girls who become mothers while teenagers – of whom more than 17 out of 20 across England and Wales are unmarried. In 1975 more than two thirds had husbands.

Overall, one in five children is now brought up in by a lone parent.

Professor Isobel Allen, co-author of the report, said: 'Teenage mothers are not all lone mothers living on benefits in council housing. But our research shows this does happen to a substantial number of them and there is certainly a need for better education in sex and personal relationships to help dispel romantic views of life as a teenage mother.'

She added: 'Young men need to share the responsibility for teenage pregnancy and motherhood.'

Among the 84 girls in the study group, all nine who were married stayed with their husbands – and six more married their boyfriends in the year after they had their baby.

That contrasted with the 50 per cent break-up rate among those cohabiting with the father when they became pregnant.

Of the two thirds of those who had been in 'steady relationships', the split was equally likely to come during pregnancy or in the months after the birth. A total of 41 out of the 84 were no longer with the father.

The study, based on the stories of girls in Hackney in East London, Leeds and Solihull, also showed that half had been daughters of teenage mothers, and only just over a half had parents who were still married to each other.

Despite Professor Allen's call for more sex education, the study found that two thirds of the teenage mothers had educational qualifications, mainly GCSEs. A third were unemployed when they became pregnant. A quarter had been on income support when they became pregnant, compared with more than four out of five by the time the baby was a year old.

By STEVE DOUGHTY
Social Affairs Correspondent

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Two's company: A reality for many young mothers

Picture posed by models

6 - Discovery of the pregnancy:

In our study, the pregnancy was unplanned for almost all of the girls (95%). Only one said that she wanted a baby, but it was apparently not planned with her partner. In Hudson and Ineichen's study (36), only 62% did not plan the pregnancy. It is interesting to see that the study population of Hudson and Ineichen's study were girls under 19 years old; whereas in our study, the girls were younger, under 17years old (68% were under 16 years old).

Teenage pregnancy is often associated with unwanted pregnancy, but by the time of the delivery, most of the children are wanted and expected. Gillham (19) said that for many women, who are determined on a career, pregnancy before their late twenties is as a personal and professional disaster. While for young girls who do not have any expectation, a child might be the only thing that can give them some status, something to do, to care for, or to live for. From the work of Phoenix (33), teenage mothers were shown to love their child and held their child's need as a priority, often sacrificing their own food and clothing.

When we looked at a teenagers' reaction to the discovery of the pregnancy, we found that most of the girls describe their reaction as *"upset"* (42%), *"shocked"* (42%) and *"afraid of parent's reaction"* (37%). Some of them said that they were *"surprised"* (26%), and only a couple answered that they *"did not realise"* or *"were happy"*. During the focus-group, the adolescents all admitted that crying was their first reaction to the pregnancy.

One girl even said that she cried for days, because it was such a shock. In Simms and Smith study (18), 28% had been *"initially pleased about the pregnancy", 39% had "mixed feeling",* and 68% said that they were *"upset to very upset". "Shocked, I wasn't ready for that kind of thing you know, I went hysterical".* We found similar reactions in our case study. However, adolescent mothers at Ashlyns expressed less happiness than teenagers examined in the Simms and Smith study. This difference can also be explained by the difference of age of the two study populations; and as we saw earlier, most of the pregnancies in our sample were unplanned.

In our case study, 47% of the girls discovered their pregnancy at 3 to 4 months, 42% were aware of their pregnancy before the 3rd month, and 10% only after 5 months of pregnancy. Teenagers explained that even with their missing period, they could not believe that they

were pregnant. They were waiting for their periods to come, the next day, the next week or the next month. We find here, the same degree of denial as cited by Birch (17).
Birch also described girls even going as far as denying having had sex. In Ashlyns, one teenager denied ever having sex for the first 7 months of her pregnancy. Even with the evidence of her growing belly, she still refused to admit to having had sex to her parents, the school or her friends. It took her more that 7 months to digest what had happened, and to admit the consequences of her first sexual intercourse. The Ashlyns head noted: *"It can definitely happen the first time!"*

The head of the school explained other cases of pregnancy discovered at the time of the delivery; or again recently, of a girl pregnant for the second time, to whom the pregnancy appeared hidden until the 7th month. Her mother discovered the pregnancy during the summer holidays. It is very interesting to see that a pregnancy can be totally hidden when the pregnancy is unwanted. This is particularly true amongst pregnant teenagers. It is surprising to see that a woman who is very happy and proud of being pregnant, will carry her baby on the "outside", at a very early stage, her pregnancy cannot be missed. Whereas, a woman who refuses her pregnancy, will carry her baby on the "inside" and will remain "normal" as long as possible. In that case, nobody will notice the pregnancy, even people living closely to that person. There are cases of men living with their partners, and having sex with them, without realising that they were pregnant, until the 7th, 8th, or even 9th month.

7 - First consultation for the pregnancy:

In our study, 65% of the girls had their first antenatal visit at 3 to 5 months of pregnancy, 30% saw their GP before the 3rd month, and one girl had her first visit after the 5th month of pregnancy. The reason why this girl sought antenatal care late, is because she discovered her pregnancy at this stage. In the Simms and Smith study (18), 42% of teenage mothers first consulted a doctor about their pregnancy within two months of conceiving, 31% waited the third month, and 27% were three or more months pregnant before they consulted a doctor. In an American study, 5.6% of pregnant women under the age of 15 did not receive antenatal care, nearly 50% began antenatal care at 4 to 6 months, and 14.2% sought care at 7 to 9 months of pregnancy (65). In a study in the United Kingdom, 27% of young pregnant women did not consult their doctor until the second trimester (66). In another British study (18), more than 25% of the teenage mothers consulted their doctor for the first time when they were

more than 3 months pregnant and 20% did not arrive for their antenatal visits until they were more than 5 months pregnant. The time of the first antenatal visit among girls at Ashlyns seems more delayed than in the other three British studies, but less delayed than the American one. It is important to note that the American study looked at teenagers under the age of 15, whereas the population for the UK studies was under the age of 19. Ashlyns population included girls aged 17 years old, but most of them were under 16 years old. The age of schoolgirls might explain these differences. The differences between the UK and American studies might also be explained by the differing antenatal care approaches of the two countries.

In our study, when we looked at the timing of the first medical consultation, we see that 47% of girls had delayed visits only because they did not know that they were pregnant. Only 10% knew that they were pregnant, but did not see their GP. In the focus-groups, it appeared that many girls were frightened to tell their parents about the pregnancy. Also, they did not feel confident enough to see their doctor on their own. *"I could not imagine myself going on my own"*. Most girls took time to tell their parents and went to see the GP with their mother. *"I told my mum, and she took me to the GP"*. A few teenagers expressed that were frightened to see a Doctor, because they thought that the GP could force them to have an abortion against their will. None of the girls admitted thinking about a termination when they discovered their pregnancy, but some of them were afraid that adults might push them to have a termination. In the literature, we found that very young girls, especially when they came from a poor socio-economic background, did not think of termination. Teenagers are less likely than older women to have abortion in the earlier months of pregnancy.

Delay in care seeking among adolescents:

- Failure to realise they are pregnant, or refuse to realise it (immaturity).
- Fear of parental reaction.
- Not enough confidence to consult a Doctor on their own.
- Afraid of somebody imposing a termination upon them.

8 - Antenatal care seeking:

When asked how regularly they attended antenatal visits, 84% answered that they went to *"all of them"*, and 16% replied *"most of them"*. It is possible that some of them might have answered the way that they thought I wanted them to answer. I know from the midwife and head of the school that some girls did not seek care as regularly as they said, but they saw the midwife at Ashlyns, where they finally sought care regularly. The staff in Ashlyns agreed that the majority of girls sought antenatal care (and health care in general), regularly and seriously. This differs from other authors reporting that pregnant teenage girls under use health services. The pregnant teenage girls in this study seem to use antenatal care as much as other older mothers. The key informants interviewed suggested that this good attendance was due to the help and effective support that these particular girls get at school. One of the informants remarked, *"When you ask for news about their pregnancy or to look at their photo scans, when people show interest in their pregnancy, that motivates them to seek care. Also, when you give them confidence and show them their responsibilities, they do not want to disappoint you. Teenagers get important support from each other, which is another important source of motivation"*. At Ashlyns, adolescents get more information and support than the majority of pregnant girls. I quickly noticed that with the support of the staff and with the support shown between the teenage mothers, girls acquired confidence and self esteem.

In McCow Bimms et al study (64) comparing early attenders and non-attenders of antenatal care, the non-attenders seem more likely to be teenagers, unmarried, in unions of very short duration, smokers and women who felt their friends and relatives were not supportive. The pupils of Ashlyns fall into many of these categories, they are teenagers, the majority are unmarried and in an unstable union, and some of them smoke. However, the majority get important support from school staff, and from their classmates and friends. Support seems to be an important factor for seeking health care. The midwife interviewed, reported that attendance to clinics was associated with proximity of clinics, access to care, and the family's regard of the health services, rather than the clients' age.

Ashlyns schoolgirls seem to seek as much antenatal care as older women, and this might be due to the support they receive in the school.

When the teenagers were asked what antenatal visits represented for them, 58% felt obliged to go, 74% were happy to go, 58% were interested to go and only 10% did not like going. It is interesting to see that 100% of teenage girls said that antenatal care was "*important*" to "*very important*". Most girls seem very concerned about the health of their baby, and found it important to seek care and to monitor the well being of their baby. *"Antenatal visits are very important to control the health of the baby, and see if he is growing well". "It is the only way to see if the baby is fine".*

Margaret Glynns said that from adolescents often appreciate what is important, and why it is important, in health care for example, but they do not necessarily relate it to themselves. They know that all women have to use contraception to avoid a pregnancy, they are aware of the different types of contraceptives, but they do not use it themselves. Attendance of antenatal care is similar to this, services are generally underused by this group. Birch (7) stated that young girls often do not really appreciate the necessity of antenatal appointments. However, on the other hand, she said that a pregnant woman is in a vulnerable state emotionally, worried about her body, about the pregnancy and whether the baby will be OK. Teenage mothers require more reassurance and more detailed explanations of pregnancy related events. From the girls I met, most of them were very concerned about their baby's wellbeing and wanted a lot of information and explanation about what was happening to them. The young mothers interviewed seemed unconcerned about their own health, but only about the baby's. I got the impression that they were unaware that a pregnancy could be dangerous for the mother. As the health visitor stated, there may be a problem with low self-esteem, or perhaps naïveté could provide an explanation.

The key-informants tried to give more explanation about the problems that teenage girls might encounter during their antenatal care, and that this might lead them to non-attendance.
Difficulty of keeping routine appointments; a habit that is not part of adolescents' life.
They are frightened of the unknown, scared of hospitals and procedures. Some girls have heard horrible stories about deliveries, and are frighten by it, like any woman expecting their first baby. Adolescents, like any primipara, need information and reassurance in order to build their confidence (visiting the hospital and the delivery room can help).

They can have a lack of motivation due to a problem of low self-esteem and a poor body image.

Health workers may appear to be intolerant with pregnant teenagers or young mothers on occasion. The midwife said that: *"I know that some of my colleagues are judgmental and patronising of adolescents"*.

The head of the school also said that if a young mother consulted health workers too often or not enough, health workers will say that it is because of their age, they are too young and immature to take proper decisions. Adolescent mothers cannot win, as for they are to blame for *"being too young to be mother"*.

Health providers unconsciously use medical jargon that teenagers do not understand. It is true that the girls at Ashlyns have poor general knowledge, and health care professionals need to adapt their language. Most of the time, adolescents do not understand medical terms (like other patients), and are too ashamed to ask for the meaning, believing that asking makes them appear ignorant. "Teenagers are frightened to ask questions, they think that they won't use the right vocabulary or not understand the answer", said the midwife. Teenagers often ask questions about medical consultations and terms in the safe environment of the school. When asked if they could ask the questions they wanted to ask during antenatal visits, 75% of teenagers answered *"all the time"*, 6% *"most of the time"* and only 19% *"from time to time"*. It appears then that the difference between our findings may be due to: 1) Ashlyns'staff have the wrong impression about teenagers feelings; 2) the girls not wanting to admit their difficulties in asking questions, which may appears as a weakness; or again, 3) having had their baby, the frustration of not understanding medical jargon has lost its importance. The two last comments seem the more appropriate, when we look at the other sources of information i.e. Focus-groups and the semi-structured interviews.

Health staff has a tendency to address their speech to the grandmother, the pregnant teenager's mother, as if it was her who was pregnant and the future mother. Most teenagers complain about this attitude of health providers. Adolescents have the impression that they are judged and treated differently because of their age. They fear the view of adults, particularly the regard of older pregnant women. The majority of teenagers do not go to antenatal classes, or parent craft courses, as they feel that they are different and out of place. *"They were all looking at me because I was young, I felt embarrassed, and I decided not to come back"*.

During the focus-groups, adolescents expressed their shame at seeing male Doctors, or old Doctors, especially when they ask questions about sex.

The midwife also said that is not always easy to work with adolescents, because they are very impatient, demand great deal of attention, expect immediate answers to their questions. They can also be very intolerant and racist. *"I do not like male Doctors, I do not want to see an old male Doctor, and I hate black Doctors"*.

Therefore, it is important to learn how to work with teenagers, how to "handle" them in order to create confidence and a positive dialogue. It is important to use a simple vocabulary, and to speak their colloquial language.

Barriers for seeking care:

- Difficulties sticking to routine.
- Fear of the unknown.
- Lack of self-esteem.
- Attitudes of health professionals, seen as judgmental, patronising, intolerant and not respectful of the teenagers' status as mothers.

Ideas to change this situation:

- Train health professional to work with teenagers, and young mothers.
- Encourage positive interactions between health professionals and teenagers.
- Support for young mothers.

9 - View of Antenatal care:

The teenagers interviewed had mixed feelings about their satisfaction with the information given during antenatal care, 25% were *"very satisfied"*, 44% *"satisfied"* and 31% *"moderately satisfied"*. Whereas for the care given, 31.5% were *"very satisfied"*, 62.5% *"satisfied"*, and only 6% *"moderately satisfied"*. Adolescents are generally pleased with the medical aspects of antenatal care, and were confident with the medical care received.

However, they are slightly less satisfied by the information given. It was interesting to see that teenage girls never chose negative statements to describe antenatal care. This could be explained in two ways: they are really satisfied with antenatal care; or they are afraid to say what they really think. In our study, we found that 40% of teenagers expressed that antenatal visits were not adapted to young mothers needs. However, when asked in the focus-groups if young mothers have particular needs, most of the girls said that they have the needs of all pregnant women, and they insisted in saying that they wanted to be treated as normal pregnant women. *"It is not because we are young, that we are different".*

Teenagers seem to be caught between two feelings, being treated as any other pregnant women and needing more information and attention. Adolescent mothers are really between two stages, a child and an adult. The health visitor underlined that *"Teenagers are young and vulnerable",* which puts them in "an at risk" population. They want protection and attention, but do not want to admit it, because they want to be accepted as proper and responsible mothers.

All key-informants agreed that specific antenatal care for teenage mothers is a very good idea, and could be a great help for young mothers. When asking Ashlyns pupils their views about the best place for antenatal care, 44% said that they would prefer a specific *"young mothers"* clinic, 31% would prefer an ordinary clinic with special hours reserved for teenagers, and only 25% were happy with an ordinary clinic. Which means that 75% of teenagers in the study, would prefer a place or a time reserved for young mothers. These results confirm the suggestions proposed by Grace Darkwah (4), in the conclusion of her in depth literature review, saying that it would be an excellent idea to organise specific youth clinics or at least reserve timetables for adolescents. She also added that it would be interesting to involve health care, social services, material and psychological support.

It would be also interesting to organise parent craft courses only for teenagers. In the Luton and Dunstable Hospital, they have adopted this formula with great success (Personal communication with Izabel Dodd, Midwifery manager, the Luton and Dunstable Maternity Unit). The adolescents in the study, expressed their need to have *"Young mothers"* discussions (94%), in order to share experiences with other young mothers and to be able to ask the questions that worry them. The subjects they would like to talk about are contraception, sex education, development of the pregnancy, delivery, the post-partum

period, child development and young child behaviour. Teenagers are willing to receive information, to learn more and understand what will happened to them; they want to be sure they are *"Good Mothers"*. They need a dialogue and explanation expressed at their level. Bulestein and Starling (70) suggested that communication strategies should be aimed at building rapport with teenagers, using techniques such as maintaining confidentiality, avoiding judgmental sentences and gearing communication to cognitive immaturity. We come back to a point we saw earlier, it would be important to have places reserved for teenagers and young mothers, with a specialised staff, trained to work with teenagers.

Clinics specialised for teenagers, or with timetables reserved for them appear to be an important step for the future; using a specialised and trained staff, able to cope with adolescent cognitive immaturity and needs.

A proposed project in Newcastle has been developed with these points in mind. The idea is to create a place for teenagers, run by them, where they could find information and counselling about family planning, sex education, job orientation and social problems. They did not plan to have antenatal care for teenage mothers, but it might be a good idea to use this structure to promote "youth clinic".

Making antenatal visits more comfortable, organising groups for young mothers, home visits by midwives, having a named midwife, changing the attitude of the staff toward young mothers, get more advice and help, be treated like other mothers, and have a youth clinic.

10 - Ashlyns School:

Ashlyns School appears to be unique in England, and probably in Europe, providing a very broad-based view of education, including teaching on moral values and social skills, alongside the more academic subjects. It is one of the only schools which welcomes mothers

with their babies. *"The idea is to take mothers and babies together, and attach the education around them".*

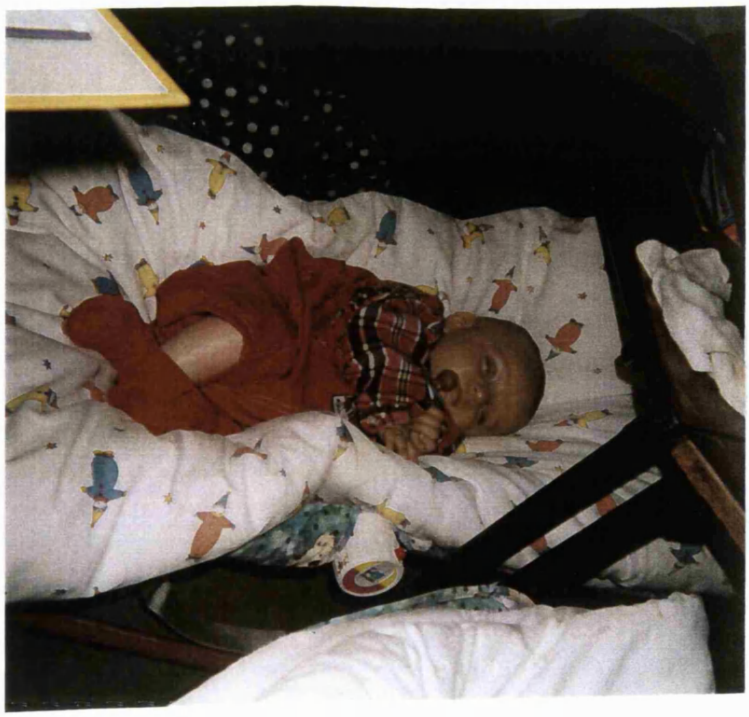
The midwife explained that for some of the girls, the school is the only place where the teenager is totally in charge of her baby, escaping of the constant control of the grandmother. All around the world, early pregnancy is a barrier for education. In our society, no education means no training, few marketable skills and often unemployment; which forms a vicious circle. In many countries, the lack of education is also associated with a lack of female empowerment. This is an important message coming from most of the International Organisations, aiming to reduce teenage pregnancy, and to increase Women's education and power in society. However, as the head of Ashlyns observed, having a baby can motivate young women to study, and find a job, as they have new responsibilities and something to care for. To give mothers the opportunity for education and to take care of their child at the same time, is a unique and interesting challenge, and might be a way to break the vicious cycle.

Ashlyns is not only a place which prepare pupils for the GCSE exams, it is also "une école de la vie", which prepares teenagers for their adult life. The aim of Barbara and Margaret is to give young mothers moral values, confidence and self-esteem. To help them to find their responsibilities as mothers, to push them to seek care and to respect their health. Cartwright et al (71) underlined the importance of prenatal clinics and a school health system. Birch (7) insisted that it is important to improve the self-esteem of teenagers in an environment where girls do not have to feel that their reproductive ability is their only "raison d'être". It is also important to say that all the teenage mothers leave Ashlyns with GCSE qualifications, an impressive feat.

The teenagers in this study all agreed that putting young mothers together to continue their education was a good idea (75% *"strongly agree"* and 25% *"agree"*). They also felt that it is important to receive information about pregnancy at school (87.5% said *"very important"* and 12.5% *"important"*). The girls themselves expressed their satisfaction about the school. *"Ashlyns is very good and supportive". "Very informative and helpful, relaxed". "It's very good to get information and good to learn with your baby". "I love the school, it's a great idea". "Yes, it is Brilliant, and you learn more here".*

During my time in the school, I did not receive any negative feed-back about the school. The only comment close to this was that they would like to have even more information about pregnancy. The students were all very pleased about the informal teaching atmosphere that the school provides. The majority of them were not happy in mainstream education, they found it difficult to deal with authorities, and invented different ways of avoiding school. Harris-Jacob (76) showed the importance of providing a flexible school schedule to enable teenage mothers to continue their education while they assume the role of parents, and creating opportunities for discussions which address the teenage pregnancy and parenting issue.

Adolescents have specific needs and teenage mothers especially so. From what I saw and understood, they want to be respected and treated as adult mothers, yet needed the attention, patience and care a child requires. Teenage mothers need to be seen as good and capable mothers, but they also need attention and support.



IV – 2 CONCLUSION

Adolescent pregnancy is a world-wide problem and represents a major concern in the Northern as well as in the Southern hemispheres. Many programs aim to help teenagers to avoid an unwanted pregnancy. However, when a pregnancy occurs at a young age, it is our duty to help adolescents as best as we can. A pregnancy must not be a reason for a break in education or social marginalisation. The literature has pointed out that pregnant teenagers tend to avoid seeking health care in pregnancy; also, antenatal care seems poorly adapted to the needs of young mothers. The objectives of the study were to understand the teenagers' point of view about existing antenatal care, and to determine their expressed needs.

Our study is a case study about a particular school, specialised for young mothers, where all girls who discover that they are pregnant can go in order to continue their education. The school welcomes schoolgirls with their babies, which is a unique approach in England. When studying this particular group of young mothers, it appears that most schoolgirls come from poor backgrounds, with unemployed parents with a poor educational achievement. The main point of our findings was that most pupils studying in Ashlyns seem to seek consistent antenatal care; which is something new in comparison with the literature review. Also, the majority of the girls found antenatal care very important, but did not like the attitudes of the health care providers. The teenagers described health care providers as judgmental and patronising, suggesting providers treated young mothers differently because of their age. 75% of adolescents would prefer "young mother" clinics, or a normal clinic with timetables reserved for teenagers. The great majority of the schoolgirls met would have like to have "young mother" discussion groups, where they could speak about contraception, sex education, pregnancy, delivery, the post partum period, child development and child care in general. The adolescents met expressed their need for more information and their willingness to be treated and respected as "normal" mothers. It is also interesting to see that Ashlyns pupils expressed their happiness at being in that specific school. They had strongly positive comments about the informal approach of the school.

This is a case study which looked at a specific population. The results seem to follow the trends of other studies reported in the literature. There are important differences, however, in the degree to which subjects in this study attended antenatal care and in their educational achievement. These positive findings may be the result of the greater degree of support that

this specific school provides. However, more investigation of this is needed. Adolescents are a particular group, characterised by immaturity and vulnerability, yet need to be respected as future adults and as potentially responsible mothers. These young mothers need, however, more attention, comprehension and support.

IV 3 – RECOMMENDATIONS:

- Ashlyns School appears to be a unique example of a facility providing education for pregnant teenagers. This school provides a broad-based view of education, including moral values and social skills, alongside the usual academic subjects. The fact that health and educational providers work together appears to be a new and positive approach. Ashlyns might become an example for young mother educational facilities all over England and indeed Europe. Education is one of the keys for Women's freedom and empowerment. Also, because teenage pregnancy occurs mostly among the educationally disadvantaged and poorest families, the Ashlyns model may offer a way out of a vicious cycle.

- In order to encourage young people to use the health services, it seems important to design services which are more "youth friendly". Specialised antenatal care programmes for pregnant teenagers including "Young mother" clinics or timetables reserved for teenagers appear to be promising methods for bringing the young to seek health care. These services targeted at young people need to be run by trained staff, experienced in working with adolescents, using an informal approach and respecting confidentiality. The health professionals need to be sensitive towards the pregnant teenagers specific needs and demands. These new services have to look at teenage pregnancy as a global problem, incorporating personal, educational, social and family support.

- A link between specialised education and health care might be an answer to help break the cycle of teenage pregnancy. It is our duty to give young mothers the opportunity to continue their lives and to give them hope for the future.

- It would be interesting to undertake more research into the Ashlyns'method, and comparison of Ashlyns with another school, or group of young mothers might be considered. The benefits of all approaches could thus be incorporated.

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APPENDICES

QUESTIONNAIRE

Health Seeking Behaviour by Pregnant Teenagers:

Interview number: - - - -

Date of interview: - - - - -

Thank you for agreeing to answer this questionnaire.
Please, fill in the questionnaire as required:
For each question, fill in only one box.
You will be able to fill in more than one box for some of the questions, but only when it will be specify: (fill in one or more boxes).

Are you actually pregnant? Yes ☐ No ☐
If Yes, what is your term of pregnancy? (Number of months) - - - - - - - - -

Do you already have your baby? Yes ☐ No ☐
If Yes, how old is he or she?- - - - - - - - - - -

I- Personal Information :

1 - Age: less than 16 ☐ 16-17 ☐ 18-19 ☐ more than 19 ☐

2 - Ethnic Origin:
British ☐
Other European Countries ☐
Asian ☐
African ☐
Other - please specify: - - - - - - - - - - - -

3 - Religion:
Church of England ☐
Catholic ☐
Muslim ☐
Hindu ☐
None ☐
Other - please specify: - - - - - - - - - - - -

4 - Educational attainment:

Certificate of achievement ☐
GCSE ☐
A level ☐
Other - please specify: - - - - - - - - - - - - -

5 - Professional activity:

Student ☐
Unemployed ☐
Employed ☐

6 - What job were you doing when you became pregnant:- - - - - - - - - - - - - - - - - -

7 - Marital status:

Single ☐ Living with Partner ☐ Married ☐ Divorced ☐

8 a – Father's occupation (Your dad's job)**: -**

Employed: Yes ☐ No ☐

8 b – Mother's occupation (Your mother's job): -

Employed: Yes ☐ No ☐

9 – Where were you living before you were pregnant ?

With

Parents ☐
Partner (boyfriend) ☐
Friends ☐
Relatives ☐
Alone ☐
Other - please specify: - - - - - - - - - - - - - -

10 – Where do you live now ?

With

Parents ☐
Partner (boyfriend) ☐
Friends ☐
Relatives ☐
Alone ☐
Other - please specify: - - - - - - - - - - - - - -

11 - How many brothers and sisters do you have ? -

II- <u>Information about baby's father</u> :

12- His Age: less than 16 ☐ 16-19 ☐ 20-25 ☐ more than 25 ☐

13 – The baby's father occupation (job)**: -**

14- Do you still sees your baby's father ? All the time ☐
Often ☐
From time to time ☐
Rarely ☐
Never ☐
Other- please specifies: - - - - - - - - - - - -

- -

III - <u>Past Medical History</u> :

15 - Is this your first pregnancy ? Yes ☐ No ☐

16 - How many times have you been pregnant in the past ? - - - - - -

17 - How many children do you already have ? - - - - - - -

18 - Which type of contraception did you normally use ? (Before the pregnancy)
(fill in one or more boxes)

None ☐
Safe period ☐
Condom ☐
Pill ☐
I.U.D ☐
Cervical cap ☐
Spermicides ☐
Morning after pill ☐
Injection ☐
Other - please specify: - - - - - - - - - - - - - - - - - -

19 - Where did you find information about contraception?
(fill in one or more boxes)

Parents ☐
GP (General practitioner) ☐
Youth Advisory centre ☐
Education at school ☐
Friends ☐
Books and magazines ☐
Radio and television ☐

III - <u>About the Actual Pregnancy:</u>

20- Was the pregnancy planned ? Yes ☐ No ☐

21 - When did you discover you were pregnant ?

(Month of Pregnancy)
- Less than 1 month ☐
- 1-2 months ☐
- 3-4 months ☐
- 5-6 months ☐
- More than 6 months ☐

22 - How did you discover you were pregnant ? -

- -

- -

23 - What was your first reaction ?

(fill in one or more boxes)
- Happy ☐
- Surprised ☐
- Afraid of parent's reaction ☐
- Upset ☐
- Shocked ☐
- Did not realise ☐
- Other - please specify: - - - - - - -

- -

24 - Where did you go to confirm you were pregnant ?

- GP / Community Clinic ☐
- Hospital ☐
- Family Planning ☐
- No pregnancy confirmation ☐
- Other - please specify: - - - - - - - - - - - -

25 - Who did you first tell you were pregnant ?

- Partner(Boyfriend) ☐
- Parents ☐
- Sister or Brother ☐
- Friend ☐
- Nobody ☐
- Other – please specify: - - - - - - - - - - - -

26 - When was your first Antenatal visit ?

(Month of Pregnancy)
- Less than 3 months ☐
- 3-5 months ☐
- 6-8 months ☐
- More than 8 months ☐
- No visit ☐

27 a – With who do you attend antenatal visits ?

Hospital Doctor ☐
GP ☐
Midwives ☐
Other – please specify: - - - - - - - - - - - -

27 b - How regularly do/did you attend antenatal visits ?
Did you attend

All of antenatal visits ☐
Most of the visits ☐
Some of the visits ☐
None of the visits ☐

27 c - If you did not attend at all the antenatal visits, what are/were the main reasons ? *(fill in one or more boxes)*

Financial problems ☐
Transportation problems ☐
Finding time to go ☐
Finding a place to go ☐
Knowledge of available prenatal care ☐
Other - please specify: - - - - - - - - - - - - - - - -

- -

28 - What do/did Antenatal visits represent for you ?

(For each question tick yes or no)

Something you had to go to (obligation):	Yes	☐	No	☐
Something you were happy to go to:	Yes	☐	No	☐
Something you were interested to go:	Yes	☐	No	☐
Somewhere you did not like to go:	Yes	☐	No	☐

29 - For you, Antenatal visits are/were:

Very important ☐
Important ☐
Moderately important ☐
Slightly important ☐
Not important ☐

30 a - How did you feel during Antenatal visits ?

Very comfortable ☐
Comfortable ☐
Moderately comfortable ☐
Uncomfortable ☐
Very uncomfortable ☐

30 b - If you felt uncomfortable, what were the reasons ? - - - - - - - - - - - - - - -

- -

- -

31 - Could you ask the questions you wanted to ask ?

All the time ☐
Most of the time ☐
Some of the time ☐
Rarely ☐
Never ☐

32 – Were you satisfied with the information you were given ?

Very satisfied ☐
Satisfied ☐
Moderately satisfied ☐
Dissatisfied ☐
Strongly dissatisfied ☐

33 – Were you satisfied with the care given ?

Very satisfied ☐
Satisfied ☐
Moderately satisfied ☐
Dissatisfied ☐
Strongly dissatisfied ☐

34 - Which aspect of antenatal visits did you mostly like ? - - - - - - - - - - - - - - -

- -

35 - Which aspect of antenatal visits did you mostly dislike ? - - - - - - - - - - - - -

- -

36 - If you have/had any doubts or anxiety about your pregnancy, with whom do you feel/felt more confident to speak about it ? *(fill in one or more boxes)*

GP (General practitioner) ☐
Hospital doctor ☐
Community Midwife ☐
Youth advisory centre ☐
School nurse ☐
Mother ☐
Partner ☐
Other relatives ☐
Friends ☐
Other - please specify: - - - - - - - - - - - -

37 a - Do you think that the Antenatal visits are adapted to young mothers needs? Yes ☐ No ☐

37 b - If not, what can be done to improve them ? -

- -

- -

38- What can be done to improve young mother's attendance at Antenatal visits?

- -

- -

39 a - Where would you prefer to have Antenatal visits ?

Hospital ☐
GP practice/ Community clinic ☐
Youth Centre ☐
School nursery ☐
Other – please specify: - - - - - - - - - - - -

- -

39 b - Would you prefer to go:

To a special "Young Mother" clinics ☐
An ordinary clinic, but with special hours reserved for you age group ☐
An ordinary clinic ☐

- -

40 a - Do you think that "Young Mothers" discussion would be helpful ?
"Young Mothers" discussion : Enable young mothers to speak together and ask questions to a professional.

Yes ☐ No ☐

40 b - Which subjects do you think should be discussed ? - - - - - - - - - - - - - - - -

- -

41 - Why do you think that United Kingdom have the highest rate of teenage pregnancy in Europe ?

- -

- -

42 – How did you find out about Ashlyns School ?

Friend ☐
Parents ☐
Your previous school ☐
Health professional ☐
Advertisement ☐

Other – please specify: - -

- -

43 – Do you think that the idea to put young mothers together to continue their education is a good idea ?

Strongly agree ☐
Agree ☐
Moderately agree ☐
Disagree ☐
Strongly disagree ☐

44 – Do you find it important to receive information about pregnancy at school ?

Very important ☐
Important ☐
Moderately important ☐
Not really important ☐
Not important at all ☐

45 – From the school, would you like :
(about the pregnancy)

More information ☐
Less information ☐
About the same ☐

46 – Do you have any comments about the school ? -

- -

47 - Do you have any comments about Antenatal visits in general ?

- -

- -

- -

- -

- -

Thank you for your time and your Co-operation.

CONSENT FORM

Dear Participants,

A study on teenage pregnancy is to be conducted. It is hoped that this study will enable Health Services to understand and adapt to the needs of young mothers.
It is hoped that the information obtained by this study will help to design services which are more "Youth Friendly".
The questions asked will be treated in confidence and anonymously.
We would be happy if you agreed to help this study by fill-in a questionnaire.
However, if for any reason you do not want to participate at this study, you are free to refuse the questionnaire.
A summary of the results will be sent to Ashlyns School in the end of December, and you are welcome to ask for feedback to Barbara Peacock.
Yours answers will by used in order to support future young mothers.
Thank you for your help.
Your sincerely,
Claire Rozette

- - - - - - - - - - - -

If you agree to participate in the study, please complete the following form:
I accept to take part in the study on teenage pregnancy, and will be happy to respond to the questionnaire.

Date:
Name:
Signature:

CHECK-LIST OF QUESTIONS FOR FOCUS-GROUP

Introduction
Presentation of the interviewer and all the participants.
Confidentiality

I am not part of the British Medical care. You can be as honest as you wish. Your answers would be confidential.

There is no right or wrong answer, it is your view, your ideas, your opinion.
You may have different opinions, which is normal, and which is even more interesting for debate or discussions.

1- Remind me your name?

2- When did you find out, that you were pregnant?

3- How did you find out, that you were pregnant?

4- What was your first reaction?

5- What did you do, when you realised you were pregnant?

6- How did your family react?
The baby's father?
Your friends?

7- When did you attend your first antenatal visit?

8- What could have help you to consult earlier?

9- Where did you attend your first visit? With who?

10- How did you feel during the first visit?

11- With whom did you go for your first Antenatal visit?

12- How did you find the staff: doctors, midwives, (social workers).....?

13- Do you think that the staff have different attitude with young and older patients?

14- What does antenatal care represent for you?

15- Do you think that antenatal care is useful or important?
Can you specify?

16- What do you think is the main objective of Antenatal care?

17- Do you think that it is important for the mother too? Why?

18- What did you mostly like in antenatal visits?

19- What did you mostly dislike?

20- Would you prefer home visit? Why or why not?

21- What would you like to find in health care that you do not have? (about pregnancy)

22- Do you think that young mothers have specific needs?
If yes, which are they?

23- Do you think that you got enough information about the pregnancy and the delivery?

24- Could you ask the information you wanted, during visits? If not why?

25- Did you feel more comfortable to ask questions to the midwife in the clinic or to the midwife at school? Can you explain why?

26- Where would you like to find information about the pregnancy, the delivery and the new-born baby?

27- Some teenagers would like to see some specific clinics for teenagers, or specific times reserved for adolescent (or specific antenatal classes).
What do you think of the idea?

28- Do you think that fathers are involved enough in the actual system? What do you think might to be done?

29- Do you know that a majority of young mothers do not seek antenatal care.
What do you think the reasons are?

30- What is the main advice you can give to a young mother like you, who just discover that she is pregnant?

31- Do you have any suggestions to improve antenatal care services for young mothers?
Give me 10 points for a good or ideal Antenatal clinic.

32- What do you think out about Ashlyns school?
In which way do you think this particular school help you?

33- Positive points of Ashlyns school?

34- Negative points of Ashlyns school?

35- Do you have other general comments?

If more time.

- What do you think of the pregnant spice Girl article: "Don't wait, have a baby now"?

- Draw a picture of you in 5 years.
- Draw a picture of an ideal antenatal clinic.

Summary
Ask for any questions
Thank participants for their assistance

SEMI-STRUCTURED INTERVIEW

Presentation of the interviewer
Presentation of the subject
Confidentiality

Ask the person to present him or herself
His or her role in the school
How do they interfere with students?

Head of school, teacher:

1- When did the school begin?

2- How did the school begin?

3- What was the purpose of the school?

4- What are the objectives of the school?

5- How many students do you have at the moment?

6- Do you think that the number is increasing?

7- What is the programme on a year?

8- What are the lectures or activities related to pregnancy?

9- What are the main characteristics of teenagers coming to your school?

10- How do you think pregnant teenagers know about the school?

11- How do you find the young mother family support?

12- What are the characteristics of the fathers?

13- Which role do they play?

14- Some research has shown that teenage pregnant women under use antenatal services, in comparison to older women.
What do you think can be the reasons?

15- Do you think that it is true among your students?

16- Do you think that pregnant teenagers have specific needs?

17- If yes, what specific needs do they have?

18- From what you have learnt from your students, do you think that they are satisfied with the antenatal visits?

19-Can you be specific?

20- Have you heard any complaints or problems they face during antenatal visits?

21- What do you think can be done to improve young mother's health seeking behaviour?

22- To improve antenatal services?

23- To help young mothers in general?

24- Do you think that schools (in general) have a role to play in youth health seeking behaviour? And your school in particular?

25- Do you have general comments about teenage pregnant women?
about antenatal care?

Think for time and co-operation

SEMI-STRUCTURED INTERVIEW

Presentation of the interviewer
Presentation of the subject
Confidentiality

Ask the person to present him or herself
His or her role in the school
How do they interfere with students?

Midwife, Social worker, EWO:

1- Which role do you have in Ashlyns school?

2- How do you think students consider you?

3- Which relationship do you have with them?

4- What are the main characteristics of teenage pregnant girls, if any?

5- What are the characteristics of the fathers?

6- Which role do they play?

7- How do you qualify the role of the parents?

8- How do you find their support?

9- Do you think that teenage pregnant girls are particularly at risk?

10- Do you think that teenagers seek as much care as older women?

11- Some research has shown that teenage pregnant women under use antenatal services, in comparison to older women.
What do you think can be the reasons?

12- Do you think that pregnant teenagers have specific needs?

13- If yes, what specific needs do they have?

14- From what you have learnt from Ashlyns students, do you think that they are satisfied with the antenatal visits? Can you be specific?

15- Have you heard any complaints or problems they face during antenatal visits?

16- What do you think can be done to improve young mother's health seeking behaviour?

17- To improve antenatal services?

18- To help young mothers in general?

19- Do you think that schools (in general) have a role to play in youth health seeking behaviour? And Ashlyns school in particular?

20- Do you have general comments about teenage pregnant women?
about antenatal care?

Think for time and co-operation

City of Newcastle-upon-Tyne Education Committee

EDUCATION WELFARE SERVICE

Confidential Report

Education Welfare Service
Pendower Hall EDC
West Road
Newcastle-upon-Tyne
NE15 6PP
(From: Mrs L Price, EWO
Tel: 2740911)
(Refhwdc50)

To: A. Senior Clinical Medical Officer
B. B Peacock, Ashlyns

Name:_____ D.O.B:_____

Address:_____ Tel No:_____

School:_____ Eligible to leave:_____

Expected Date of Confinement:_____ Consultant:_____

G.P.Details:_____

Midwife:_____ Health Visitor:_____

Date of First Visit:_____

Recommendation:_____

Other Agencies
involved:_____

Additional Information:_____

_____

_____

Date:_____
Signed:_____

Actual Date of Confinement	Sex	Weight	Name	Date left Ashlyns

Date referred to S.C.M.O._____

INDIVIDUAL ACTION PLAN - PREGNANT SCHOOL GIRL

SECTION 1 **PERSONAL DETAILS**

Name of pupil _____ DOB _____

Address _____

_____

Name(s) of parent(s)/carer(s) _____

SECTION 2 **BACKGROUND**

School at which pupil is registered _____

Date of last attendance _____

Background information on pupil:
(include attence, educational performance, difficulties in school life, achievements).

SECTION 3 **INDIVIDUAL PLAN & TIMESCALE**

Signed _____ LEA

_____ Ashlyns

_____ Parent

_____ Pupil

Date _____

Are we condoning the over counter abortions?

AVAILABLE AT CHEMISTS

LIBERAL DEMOCRAT MP Dr Jenny Tonge was backed by 54 cross-party MPs yesterday when she tabled a Commons motion to make the so-called morning after pill available from pharmacists. At present the pill — a dose of oestrogen ten times more powerful than the contraceptive pill — is available only when prescribed by a doctor.
Some say emergency contraception — effectively an early abortion — could cut Britain's high teenage pregnancy rate. But what are the social and health risks? Femail spoke to a scientist who has studied the effects of hormones, to a woman who has used the morning after pill, and to a concerned mother.

DR ELLEN GRANT, 63, is a research consultant who has studied the effects of hormones on the body for more than 30 years. She is against emergency contraception being made available over the counter. She says:

BACK in 1961 I was involved in trials to test the effects of a range of hormones such as those used in emergency contraception. We wanted to find out the lowest safe dose to stop ovulation and pregnancy.

In 1969 doctors were warned not to prescribe pills with any more than 50 microgrammes of oestrogen because of the high risk of thrombosis.

The current morning after pill involves four tablets each containing 50 microgrammes of oestrogen. The first two tablets are taken within 72 hours of unprotected sex then 12 hours later the further two pills are taken.

Dr Grant: Health danger

This means the total amount of oestrogen administered is 200 microgrammes which I believe has too many risks of side-effects.

Each pill contains two steroids — a progesterone-like steroid and an oestrogen-like steroid.

The best known side-effect is thrombosis. Blood clots in the leg can spread to the lungs and be fatal and five in every 100 women are at high risk.

One problem with emergency contraception is that some of the girls it is prescribed to will be young. Even if they are susceptible to thrombosis, high blood pressure or strokes, they are unlikely to have already suffered from these so they will not yet have a medical history. They may not be asked about family medical history if they do not have to see a doctor.

The pill can cause a clotting disorder which can last for life. When they later want a baby they would be more likely to have miscarriages.

The cell and immune changes mean women who take hormones are more susceptible to infections which can cause infertility or wart viral infections which cause cervical cancers.

Exposure to this pill could set off a chain of events which leads to breast cancer up to 40 years later.

There can also be the problem of headaches and migraines. One woman I saw at a clinic had migraines for two years after taking only one pill.

If someone takes the emergency contraception and they are unknowingly already a few weeks' pregnant the hormones can affect the baby. Hormones can upset brain development and cause multiple abnormalities such as heart defects.

Progesterone and low-dosage oestrogen can cause depression. The highest rate of attempted suicides is in girls aged 15 to 19. There is also the psychological effect of dealing with the thought that you are destroying the embryo with pills.

It is for these reasons that I think emergency hormone contraception should not be available over the counter without prescription.

Amanda Callaghan: Many women can't get this help

I was unlucky and needed help

by JULIE COHEN

AMANDA CALLAGHAN, 34, a parliamentary officer who lives in North-West London, took emergency contraception two years ago. She is single. She says:

THERE must be many women who have found themselves in my situation. I wasn't being irresponsible — I was simply unlucky. I was 32, I had a partner at the time but I decided I wasn't ready to have children.

I had been on the Pill for years but a bad case of food poisoning made it ineffective. So my partner and I decided to use condoms for a few weeks to make sure it was safe.

One weekend the condom split. I didn't panic, my partner and I discussed the options and decided we didn't want to take any risks so I would take the morning after pill.

The doctor's surgery was closed except for real emergencies, so knowing I had 72 hours to take it, I decided to wait until Monday morning and phone them then.

I got up early and phoned the surgery first thing, before going to work. I explained the problem but the receptionist refused to give me an appointment before the following day. That would have been too late and I patiently explained this to the receptionist. Her response was that there was nothing she could do because it wasn't a 'real' emergency and my only other option was to go to Accident and Emergency at a local hospital.

I started to panic. Not all hospital A&E wards were willing to prescribe emergency contraception. The woman said I should phone local A&E wards to see where I could get help.

I'm very fortunate in that I've got understanding bosses who would never make a fuss about me taking a few hours off work in an emergency, but there are many women who just couldn't drop everything and go. There would definitely be the temptation to say: 'Leave it, I probably wouldn't be pregnant.'

I was lucky enough to know about a good family planning clinic just five minutes away from where I work. I phoned them up straight away and explained the situation and the receptionist said they weren't too busy to see me. I had to wait only ten minutes before I saw the doctor. They took my blood pressure and went through a series of questions about whether either I or my family had a history of migraines, thrombosis, high or low blood pressure etc.

They explained the possible side-effects of the emergency contraception and gave me the pills. They also gave me pills to stop nausea which is one of the most common side-effects.

I had no nasty symptoms, I just felt complete relief. I was also angry that many women faced with my dilemma wouldn't have known about other forms of help other than the doctor or the A&E wards and would have risked the possibility of pregnancy.

It really would have been an accident. It wasn't as if I took a risk, I was just very unlucky.

ALL WOMEN have the right to choose whether or not they want to use protection. If an accident happens, the morning after pill should be available to them.

The parliamentary motion is for a pharmacist to issue it which would mean going to speak to the pharmacist and he or she would ask relevant questions about your health and explain possible side-effects.

This would make things a lot easier for the many women who are faced with this stressful situation.

It would make girls more vulnerable

JOANNA MOORHEAD, 35, from South London, is a writer specialising in pregnancy and parenting. She is the author of New Generations: 40 Years Of Birth In Britain, and is a wife and mother of two daughters, aged six and four.

SOBERING it may be for a mother such as me to think it, but in ten years' time my own daughters could be buying an abortion pill in the chemist's.

However much I hope I'll be able to trust my children, and however much I hope to give them open and honest advice about sex in general and about sensible, before-the-event contraception, the thought that an abortion-inducing drug could be so easily available sends a shiver down my spine.

The problem, of course, is that the morning after pill removes the last line of defence for teenage girls. At the moment, if a girl wants to go on the Pill she must first go to her doctor to discuss it, and she will have to think about this beforehand. This means she must talk to at least one responsible adult about her plans, and one can hope that the doctor will ask her whether she has thought through the consequences.

Teenage girls suffer greatly from peer pressure which can make them easy prey for aggressive older boys and men.

At the moment they at least have the defence of saying 'I'm not on the Pill'. With the morning after pill even that excuse has gone, for the predatory male will simply tell her to fix it the next day.

Protecting our children should be the priority in our society — and making a drug like this one easily available is making them more vulnerable, not more protected.

What will be the implications for teenagers' views on sex, if ruling out the possibility of a pregnancy is as straightforward as popping a pill you buy at the corner shop?

If the aim of a mother like me is to instill in our children the idea that sex and responsibility go hand in hand, society is hardly helping to back up the message.

'No-strings sex' seems to be the subtext of making a pill like this so widely available. And the truth is that so-called emergency contraception doesn't come without strings attached. The trouble is it can very easily look as though it does when you're a young person starting out in life. Young people are, notoriously, unfettered by worries about the long-term effects of their actions.

It is unrealistic and unfair to expect them to be aware of the far-reaching damage they could do, both to their physical and emotional well-being, by using abortion pills.

When the morning after pill was first introduced in Britain a few years ago, some of us feared it would be no time at all before the drug would be freely available over the counter.

NOT A CHANCE, we were told by those who supported its bid to be licensed for prescription. Everyone, it seemed, agreed: the morning after pill was simply too dangerous a cocktail of hormones to be dispensed without a doctor's say-so.

Today, we're sliding down the slippery slope.

Making it freely available opens up the possibility of women — possibly young girls — returning time and again to the chemist's.

And take it repeatedly, of course, some women will. Proponents of the move to over-the-counter sales try to dismiss the risks of this by claiming that any pharmacist who sells the morning after pill will have to advise a girl buying the drug to see her GP as soon as possible to discuss long-term contraception.

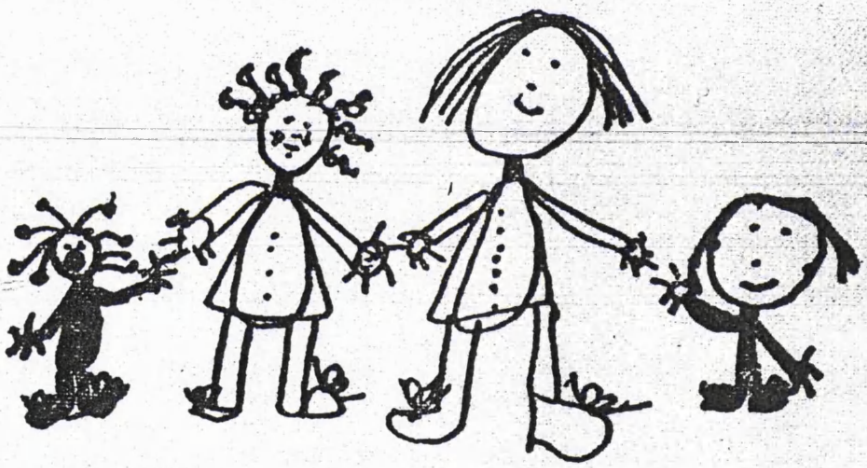
It is, of course, pie in the sky — most of them will simply take the drug, breathe a sigh of relief, and continue to follow the pattern of behaviour that got them into their fix in the first place.

For a few women, the effects of emergency contraception could be even more damaging. Post-abortion syndrome, in which women become seriously depressed as the result of terminating a pregnancy, is well-known: and some women who take the morning after pill are affected by a particularly tormenting type of post-abortion syndrome, since they are haunted by the fact that they don't know whether or not they have had a very early abortion.

For these girls, what looks at first sight like an easy way out of a difficult situation could prove to be very different.

Joanna Moorhead: Worried mum

"Are you my sister Mummy?"



DIANA M. L. BIRCH


AUREVOIR!

To clare

we are all
going to miss
you!
Aurevoir