Exploring teenage mothers’ experiences of support services

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Abstract

The term ‘teenage mother’ conjures up different things for different people, but for many the term is synonymous with a social ‘problem’. A focus on the calamitous outcomes associated with teenage pregnancy means that the voices of teenage parents often go unheard. This research focuses on what teenage mothers have to say.

Over recent years, service cuts and significant changes to how services are delivered, has led to an ever changing service offer for teenage parents. This research investigates teenage mothers’ views of the support they received and what constitutes quality. The hope is that this insight will enable suggestions to be made to improve the support offer.

The mother’s narratives in this research add to qualitative research which gives young mothers a voice. The data highlights mothers’ resilience and determination to be good mothers.

Data revealed that judgement and stigma were experienced by each of the teenage mothers interviewed and the impact of this on their lives and their self was significant. Findings serve to highlight a patchy service offering and experiences which were shared by the participants provide key insights as to how the quality of services could be improved. A positive experience of support impacted on a mother’s view of herself, her confidence as a mother and encouraged ongoing engagement with services. Satisfaction with support led to positive behaviours. This research suggests that negative outcomes associated with teenage pregnancy could be reduced if the quality of services was improved.
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During the writing of the dissertation I bid an emotional goodbye to over 15 years of work in teenage pregnancy. I would like to thank my wonderful Leicestershire TP Team for 11 happy years where we shared passion and beliefs which we converted into energetic delivery. Together we made real change and we left behind a strong legacy that we should be eternally proud of.

Special thanks are due to my supervisor Cathy Herbrand for her patience, support and encouragement. Thanks also to Esmé Hanna for her help with ‘digging deeper’ into what the research data was saying.

Finally, I would like to sincerely thank the mothers who shared their experiences with me. I felt honoured to meet you and listen to your stories – I hope you feel I have done them justice. I dedicate this dissertation to you and to all teenage mothers who have overcome judgement and stigma to become positive role models who your children will be very proud to call ‘Mum’.
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Introduction

Teenage mothers are regularly blamed and shamed in the media. For many, these young women represent everything that is wrong with society today. With the perpetuation of this view, the negative outcomes associated with teenage pregnancy seem inevitable. How can we expect a sector of society presented as the scourge of modern life to seek help and support?

This is an interpretive study exploring teenage mothers’ experiences. Semi-structured interviews explore which services were accessed during pregnancy and on becoming a parent. The research considers mothers’ experience of services and examines from their perspective, what is a quality service.

Teenage pregnancy is not a new research topic. Historically, research has been criticised for domination of quantitative studies presenting a very one-sided, negative view of teenage parenthood. These studies failed ‘to capture the thoughts and feelings of teenage mothers themselves’ (Wilson and Huntington 2005:64).

A challenge with teenage pregnancy explored further in later chapters is that its presentation as a ‘pernicious social problem’ (Duncan 2007:307) can often mean that the views, feelings and experiences of teenage mothers themselves go unheard. For this reason, this research will focus on what teenage mothers themselves say. The research aim is to produce qualitative data on views of support received and what constitutes quality.

The focus of this research is on support rather than the reduction of teenage pregnancy. Support is critical to address the range of outcomes which disproportionately affect teenage mothers (Appendix 1).
Much writing exists on the negative construction of ‘teenage pregnancy’ in policy, the media and wider society. As stated by Brady et al, ‘societal attitudes towards teenage pregnancy often create barriers to accessing health care services’ (2008:579). Barriers can be addressed through the provision of specialist teenage pregnancy services which are evidenced to lead to improved outcomes for teenage mothers and their babies.

Over the last seven years the voices of young parents have become more visible with a ‘growing body of qualitative research being published that describes an alternative and positive view of young motherhood’ (Brand et al 2014:174). The challenge seems to be ensuring that this filters down to influence how we respond to, care for and support young mothers.

What is the experience of the care received by teenage mothers? Does quality mean separate, targeted services or a universal offer that is non-judgemental, encouraging, empowering whilst meeting their particular needs?

Having worked in the field of teenage pregnancy for over 12 years I have seen numerous changes to services. There has been investment and disinvestment, expansion and shrinkage. All of the young mothers I have met have shared examples of where they have felt judged or stereotyped as a teenage mum. In most cases they could also pin-point where an individual or service has provided support that has had a positive impact. Over recent years, service cuts and significant changes to how services are delivered, has led to an ever changing service offer for teenage parents. This research aims to discover what is the experience of support services? And what are the elements of this that would be defined as quality? It is hoped that this insight will enable suggestions to be made to improve the support offer for teenage parents in Leicestershire.
Research Aims and Objectives
Three aims underpin the research question. Firstly, the research aims to understand teenage mothers’ needs and experiences when accessing services in pregnancy, and as new mothers. This insight will be used to develop an empirically-based conceptualisation and analysis of quality from teenage mothers’ perspective of the support services they access. In turn, this will inform suggestions for improving practice to services providing support.

A number of specific research objectives provide a framework for this research project. The research will provide a description of the current policy and context of service provision before exploring the concept of teenage parenthood, how this has been constructed and the meanings attached to this. Next, the research will identify the sources of support teenage mothers received, explore their experience of this and the impact of support on key outcomes. An examination of how teenage mothers themselves define quality in relation to support services will then be considered and contrasted to the concept of ‘service quality’ from a management perspective.

Approach
The term teenage mother is used in the media, in policy and in government reports to describe any woman who becomes a mum before she is 20. The term implies a level of homogeneity. In reality, this group of mothers will include females aged from 14 to 19, married and un-married mothers and women with a wide range of circumstances. For this research, the term teenage mother will be used to describe participants, currently accessing support aged 16-18, with a child age one or under.

A wide range of services provide support to teenage mothers. Some provide a specialist service and others provide support to all mothers. This research will explore support provided by a range of services e.g; maternity, health visiting,
children’s centres and youth services. It will be interesting to see if different service areas are distinguished in the interviews.

Donabedian (1980) writes about quality in healthcare, how judgements of quality are made about those who provide the care and settings where care is provided. This research will explore quality as defined by teenage mothers in reference to care and support received.

Semi-structured, face to face interviews have been chosen for investigating the research question. They will generate data that is descriptive and subjective, each interview being a narrative of one individual’s experience. These accounts will enable the researcher to gain insight into the circumstances and needs of the teenage mothers and explore to what extent services met these.

**Overview of Chapters**

The first chapter sets the scene of work to support teenage mothers. Having outlined key data, the shifting policy context will be explored. An account of service changes that have taken place will be presented alongside a ‘then’ and ‘now’ table of teenage parent support services in Leicestershire. This chapter explains why this research is necessary and what it hopes to achieve.

The second chapter reviews relevant academic literature. It presents a critical review of writing on teenage mothers and explores some of the key themes and topics. This adds to the context of the research whilst informing elements of the research design.

Part one of this chapter looks at how teenage parenthood is constructed as a social problem and how this has led to the absence of teenage mothers’ voices in academic writing and policy making. Part two presents literature exploring
the experience of teenage mothers when accessing support, the impact of support on outcomes and what quality looks like from their perspective. Here, writing on what constitutes quality in the delivery of healthcare is also explored. The chapter concludes by considering the challenge that a positive perspective of teenage parenthood as a choice poses for educational and public health policy.

It will be suggested that the negative construction of teenage parenthood gives rise to stereotyping and judgement. This influences how teenage mothers view themselves, how they engage with support and in some cases impacts directly on the support offered to them. Identification of how teenage mothers define quality services and the impact that such services can have on their lives is important to inform the recommendations borne out of this research.

Chapter three explains how the research was carried out. Having outlined the methodology, the justification for the selection of interviews as the research method will be explained. A description of the research participants will be provided and the interview process will be described. There will then be some discussion about data produced and how this was analysed.

Here, the ethical considerations for the research will be presented as well as how these have been guarded against. An acknowledgement of the researcher’s existing knowledge and opinions is important as well as an explanation of how these will be accounted for. This chapter will discuss the complexities of being a ‘commissioner-researcher’, exploring the challenges of these conflicting roles, and how these were overcome. There will also be some discussion around sharing the research findings.

Ethics in relation to the research participants will also be discussed here. Participant’s vulnerability will be explored in reference to accessing the research
population and recruiting for the research. The concept of informed consent will be considered as an underpinning concept throughout the research to ensure that participants’ needs are accounted for and that data is used ethically and responsibly.

Chapter four outlines and analyses the research results. Themes are examined under four main headings; becoming a young parent, judgement and stigma, sources and experience of support and the impact of support. In each section, data is presented and considered in terms of what the mothers’ voices tell us about society and specifically services. The final section considers what was said about quality and services, how this supports or deviates from definitions of quality in healthcare and what this suggests for future service models.

The concluding chapter summarises key findings and considers what this research contributes to current literature. What is suggested for how services could be improved is presented and the limitations of the research are outlined before some final reflections about what was learnt and the experience of carrying out research. It is hoped that the increased understanding contributes to making services more accessible to young mothers thus reducing the negative health and social outcomes that disproportionately affect them.
These are the apparently inevitable consequences if Britain continues to sweep the uncomfortable issue of teenage pregnancy under the carpet. As reported in the 1999 report into Teenage Pregnancy prepared for the Prime Minister by the Sexual Exclusion Unit (SEU).

This chapter sets the scene of work to support teenage mothers. It starts by outlining the changing policy context since the launch of the Teenage Pregnancy Strategy (TPS) before presenting the data in respect of teenage mothers. An account of service changes that have taken place as policy has shifted is presented before outlining why the research is necessary and what it hopes to achieve.

The TPS was launched in England in 1999 following the findings of the report from the SEU. The ten year strategy had two aims: Firstly, there was a target to reduce the under-18 conception rate. The report refers to England’s high and ‘shameful’ rates of teenage pregnancy. By definition, this presents teenage pregnancy as a problem that needs addressing. The second target which aimed to tackle social exclusion among young parents and their families was to increase their participation in education, employment and training (EET).

The focus on completing their education and keeping in touch with the jobs market led to close monitoring of teenage mothers. From 18 weeks post pregnancy, teenage mothers were tracked to see whether or not they had returned to EET. Unlike older mothers, a choice to be a ‘stay at home mum’ was discouraged. Support was a clear part of the teenage pregnancy strategy, but
the target used to assess this seemed to fail to acknowledge the type and breadth of support being accessed whilst undermining the important role of becoming a mother. Appendix one lists the poor outcomes associated with teenage pregnancy e.g. low birth weight and higher rates of poor mental health. These could be effectively tackled through the provision of support. By using the EET target as the gauge of success, progress against other outcomes was largely ignored and thus, devalued. For example, a teenage mother could have been supported to breastfeed and attend a support group but if she remained NEET (not in employment, education or training) then in terms of the TPS, this was a negative outcome.

Between 1999 and 2010, the government’s TPS required Local Authorities to have a local plan and a designated Lead in post whose role was to coordinate local action. The national directive was clear; there was an expectation for all services involved in local Teenage Pregnancy Partnerships to prioritise activity to engage teenage mums and enable progression into EET.

From 2000 to 2010, monitoring of Local Authorities’ progress to the TP targets was scrutinised at a national level. Regional Leads were appointed in Government Offices. Annual visits to local areas would highlight performance against national targets and where action was required. Where areas were struggling, a National Support Team (NST) of experts would be drafted in to inspect local systems and mobilise activity.

In 1998 (baseline year), there were 41,089 conceptions to young women under-18. 42% of these were terminated which equates to 23,831 births to teenage mothers. In 2014 there were 21,282 conceptions to young women under-18, 1

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1 This was the professional role delivered by the researcher. In Leicestershire, teenage pregnancy work sits within Public Health and the researcher maintains a lead for this alongside other Public Health work-streams.
51% of these were terminated leading to 10,620 births. This represents a 48% reduction in the under-18 conception rate for England (ONS: 2014).

When labour lost power in 2010, the TPS and supporting ring-fenced budget was lost. Whilst the under-18 conception target is maintained in the Public Health Outcomes framework within the ‘Health Improvement’ Domain (Great Britain: 2013), the EET target for teenage mothers has been lost. Since 2010, Local Authorities’ performance against these targets has not been scrutinised.

In 2010, Leicestershire’s EET levels for young mothers were just under 60%. At the time of writing they were around 50% and in recent years have been below 40%. This suggests that fewer teenage mothers are in EET now than in 2010.

In Leicestershire, activity to reduce teenage pregnancy rates and support teenage mothers has continued. However, service cuts and changes to service delivery have led to an ever changing offer. This has been linked to a reduction in the number of EET teenage mothers but has this led to a decline in the quality of service provision?

To summarise changes in services from 2010 to 2016, two diagrams with supporting tables have been developed (Appendix Two). The diagrams highlight the overlapping relationships between the different service areas; Health Services, Emotional Health and Well-being Support and Education, Employment and Training support. The accompanying tables detail the providers of the services and key features of the models.

In 2010 there was a much stronger emphasis on having dedicated, targeted support for teenage mothers in line with the directive from the TPS. This commenced with Teenage Pregnancy Specialist Midwives who case-loaded the majority of teenage mums-to-be. Support continued post-natally where a
number of services had dedicated TP posts. The needs of teenage mothers were addressed through interventions developed for this specific cohort, be that groups or targeted short-courses. There was some overlap between services but referrals tended to be between single agencies and even, specific staff members. This meant little consistency across the county. Where data sharing took place, this was between single agencies. For example, the Specialist Midwives referred all of their young mothers to Connexions (a service who would offer support advice around education and employment options) but data was not consistently shared with other services. Pathways of support were fairly linear with referrals taking place to a relatively fixed formula. Some parents remained engaged with one service well into their 20s. Another feature of the model in 2010 was that support was not holistic. Services tended to provide support based on their organisation’s remit e.g. the youth service would address issues of isolation and peer support but have no requirement to address parenting issues.

In 2016 there is less dedicated support. For many services, teenage mothers are now one of a number of cohorts of parents who are targeted and supported due to their vulnerability. This follows national guidance outlined in the Healthy Child Programme (HCP) which was launched in 2009 (Great Britain: 2009). This support starts in pregnancy and offers support until young people are 19 years old but there is a strong focus on 0-5s. The programme aims to ensure that families receive support appropriate for their needs – with the most vulnerable families receiving intensive interventions and co-ordinated support packages. The HCP is about integrating ways of working, e.g. health visitors working more closely with children’s centres to meet a range of familial needs. Young parenthood is one of a number of predictors of vulnerability used to target interventions. Some services and interventions are only available to parents who have identified vulnerabilities. This is true of the Early Start Health Visitors
and targeted ante-natal programme delivered through the children’s centre programme.

What is reflected in 2016 is better coordination between all service areas. This change has been led by national policy like the HCP but has been facilitated at a local level by the development of TBAG Forums. These are multi-agency meetings which take place in each locality every 6-8 weeks. Representatives attend from all existing support services. Typically attendance includes a Health Visitor, Youth Worker, Family Outreach Worker (Children’s Centre Programme), Parents-Under 20 (commissioned provider) and any locality-specific delivery agencies e.g. Homestart. There is a spreadsheet which details all of the young parents/parents-to-be in the locality (permission to share their data has been provided), their current activity and needs. Information on individuals translates to provide an estimation of needs. For example, social isolation has been identified as an issue across the young parent cohort. The TBAG model is consistent across Leicestershire and forums generate an ethos of information sharing and facilitation of wider referral pathways. It has been observed that this approach has led to increased accountability across services and has been successful in widening practitioners’ aspirations for young mothers.

Leicestershire’s service offer for teenage mothers increasingly forms part of a wider offer. The model in 2016 appears to facilitate better integration, communication and data sharing. There has been a shift from targeted provision, requiring mainstream services to take account of the needs of teenage mothers alongside other vulnerable groups. However, TP EET levels remain lower than in 2010 and it is unclear if provision in 2016 is genuinely meeting the cohort’s needs. From the perspective of those delivering services, it appears that agencies are working more closely together with the TBAG forums ensuring early engagement thus facilitating access of support. But what do teenage mothers think?
This research aims to gain insight from teenage mothers about their experience of services. Does the current support offer meet their needs? How would they define quality and how closely did their experience reflect this?
Methodology

The purpose of this study is to explore teenage mothers’ experience of support services. A methodology that provided insight and understanding was required. This study lent itself to a qualitative research methodology which aims to aid understanding of the social world. The origins of qualitative research are in the interpretivist paradigm which explores meanings, motives, actions and feelings and how these are constructed.

Research Design

The research process reflects the methodological approach. By its nature, qualitative research focuses on people and employs a more flexible approach. But as with all research this still requires a systematic research process.

The concept of reflexivity is important as it describes the process of accounting for the subjectivity of the researcher and of the researched and critical reflection on data produced (Braun and Clarke 2013). The researcher kept a reflexive research journal throughout the research. Writing in the diary facilitated reflection on the research, the process of data collection, and the researcher’s subjectivity. In doing so, this helped to guard against the researcher’s own bias (Rajendran 2001).

Research Method

A research method which allowed insight to be gained from teenage mothers was required. A survey would have allowed data to be collected from a large sample but as this is at the cost of only collecting a small amount of information from each respondent (Gomm et al 2000), this method was not chosen. Focus groups were considered but the logistics of bringing groups of mothers together was likely to make this more difficult and it was felt that a group situation might affect accounts given. Interviewing was the method decided upon. This offered
an ideal setting to allow a detailed and coherent picture of each mother’s views and experiences to emerge but in a confidential, safe environment (Dodds et al 1996). Interviews could be organised with each individual thus fitting in with their lives and minimising potential anxiety for participants.

Semi-structured interviews involve a number of open questions with prompts to enable wide discussion of the topic in question. The researcher made a list of questions/themes as an interview guide (Appendix 3). All of the questions in the interview guide would be covered in every interview but each interview could develop slightly differently taking the lead from the interviewee (Bryman 2012).

Sample and inclusion criteria

Non-probability sampling known as purposive sampling was used to identify participants. Participants were selected in a strategic way to ensure relevance to the research question (Bryman 2012).

The research population were young women living in Leicestershire who became parents aged under-18. Further criteria required current access of support. Over the last 5 years the service landscape has changed significantly. Current access therefore ensured a review of existing services. The aim was to carry out interviews with up to 7 participants from a sampling frame of between 7 and 14.

Recruitment

Anderson and Hatton’s (2000) writing on accessing vulnerable populations for research provided some guiding ideas to recruit participants. The approach termed as ‘opportunistic’ recruitment was done via young parent groups.

In each of Leicestershire’s seven districts, the Children’s Centre programme run weekly young parent groups or pathway groups which young mothers attend as
target parents. The researcher contacted practitioners who run groups with information about the research to request a slot at a forthcoming session. The aim was to visit a group in each district to recruit mothers from different parts of the county with differing experiences. This would mean that findings could be summarised about services rather than risking identification of practitioners if research was undertaken in one district. Offering the research in all districts ensured equal access thus complying with the LCC Equal Opportunities Policy. Due to timetables of groups and the Easter break, groups were only visited in six districts.

Practitioners were told that visits to groups were as a researcher (practitioners knew the researcher in her professional role). Where a slot running into an informal break time was not possible popping in at the end of the group was requested. Prior to attendance, an advertising poster (Appendix 4) was provided to give advance information about the research.

The researcher attended 7 groups in total (2 young parent groups and 5 pathway groups) and spoke to mothers who expressed an interest in participating in the study. Contact details were given to other potential participants in case they preferred to contact the researcher later. Subsequently, no-one made contact in this way.

A number of reasons led to this choice of recruitment. Firstly, groups provided relatively easy access to a research population who by their nature are difficult to identify. Secondly, by attending existing groups herself, the researcher could ensure that information about the research was presented consistently. Thirdly, this approach allowed parents to make their own decision about involvement in the research and enabled a rapport to be built before the formal research process commenced. Fourthly, the groups will provide forums to take research findings back to.
Participants who came forward were asked to provide basic personal information via the Participant Response Slip (PRS) (Appendix 5). It was hoped that from each visit one or two mothers would complete a PRS. This was only the case at 3 groups. At this stage a participant information sheet (PIS) (Appendix 6) was sent out. The PIS gave more information about the research, clarified the confidential nature of the interview, as well as the need to participate voluntarily and to sign a consent form. Participants were then contacted by phone. Interviews were organised to take place at a mutually agreed time and location. A consent form (Appendix 7) was completed at the beginning of the interview.

The research sample

Amy\(^1\) – Age 17 – Living with Mum – 9 month old baby
Becky – Age 17 – Living with Partner – 8 week old baby
Chloe – Age 18 – Living with Partner – 18 week old baby
Dana – Age 17 – Living on her own – 9 month old baby

Four young mothers took part in the research. Amy, Becky and Dana expressed an interest in the research when the researcher visited their groups. Chloe became aware of the research through a support worker and expressed interest in taking part. Mothers came from four of seven Leicestershire Districts. All participants had given birth in the last year and were currently aged 17 or 18. Three of the interviews took place in the mother’s home, one in a Children’s Centre.

The sample frame was eight. Four mothers who completed participation information sheets decided against taking part. As an interpretive study, the

\(^1\) Pseudonyms have been used to protect the identity of the mothers
research aim was not to present a representation but to provide an in-depth understanding of a social process (Faugier and Sargeant 1997). Whilst smaller than planned, data does achieve this. The researcher sought to present as complete account of the data as possible (Guba and Lincoln 1989) to ensure faithful witness to accounts within the data (Thompson 1999).

_Circumstances_

For Amy, Becky and Dana, pregnancy was not planned. All three were at a transitional point in their education. Amy had ‘...not long left school’, Becky was part way through exams and about to leave school, and Dana was applying for college. In Dana’s case, advice when having her contraceptive implant removed led to pregnancy – Dana had understood that she was safe with no form of contraception for a year.

_The interview process_

Interviews were organised to take place during the day. The researcher shared the interview schedule with her Line Manager so that someone was aware of her whereabouts and timings of the interviews. After each interview had taken place, and the researcher had left the interviewee’s home, the researcher returned to work and notified her Manager that she was safe. Childcare was not necessary for any of the interviews. Children were present and either slept through or were kept entertained during the interview.

A set of open questions (Appendix 3) with prompts was used. These were informed by ‘theory, previous research and intuition (notions that the interviewer has in mind from his/her own experience)’ (Grbich 1999; 93). The opening question; ‘Tell me about when you found out you were pregnant’ was informed by Whitley and Kirmayer (2008) who used similarly broad questions in their research. This worked well to commence the interview. Question five
explored the extent to which services communicate and work together. Fragmentation of services was an issue highlighted in the literature review.

Questions seven and eight explore the concept of quality. Mothers were asked to ‘score’ the services that they accessed from ‘poor’ to ‘excellent’ based on criteria from ‘You’re Welcome’ and explain their scores. They were then asked what services would look like if they were designing services for young mothers.

Interviews lasted between 30 minutes and an hour and were recorded.

The interview guide ensured a standard format to the interviews. All questions were covered in roughly the same order. The recording commenced at the start of the interview and was turned off once all questions had been answered. Even where there was dialogue after the interview had finished this was not recorded and was not included in the data.

**Credibility of the data**

The research aimed to investigate individual’s experiences of accessing services. The nature of interpretivist studies with small research samples means that criteria used to assess the credibility of data are inappropriate. In the application of reliability in qualitative research it is important to consider to what extent data generated is ‘trustworthy’ and methods used are ‘dependable’ (Braun and Clarke 2013:279). This relies on the researcher to present a coherent and complete exploration of the topic under investigation.

Validity in qualitative research lies in the reader being convinced that the researcher has accessed and accurately represented the social world being studied (Grbrich 1999). Are findings well founded? Was the field work, analysis and interpretation of the data high quality? Thompson (1999) suggests that rigour in data can be assured by the researcher ensuring faithful witness to participant’s accounts. This was done through careful interpretation and analysis of the interview data.
Data analysis

Analysis started with transcribing the interviews. Transcription was done as soon as possible after interviews took place to ensure the interview experience was fresh in mind and important detail was not lost. Transcription was ‘verbatim’, noting what was said and by whom as close a rendering of the actual interview as possible. The researcher made note of any significant nuances which were felt to add meaning to what was said.

Having transcribed the interviews there was a stage of immersion (Braun and Clarke 2013) in the data. The researcher read and familiarised herself with the data, starting to consider what it said. Braun and Clarke (2013), outline the analysis of data using different qualitative methods. Thematic Analysis was chosen for this study. This is a flexible method which enables the identification of themes and patterns of meaning across a data set. Themes can be identified from the data itself and/or can be applied from theoretical ideas which data is tested against.

The researcher prepared a list of themes prior to data collection (Appendix 8). This list was added to once analysis commenced and summarised the experiences and feelings described. Each transcript was read line by line, themes were highlighted as they arose in the data. At the end of each interview transcript, a summary of the main themes were noted. These were transferred to a grid (Appendix 9).

The next stage of analysis looked for themes across the whole data set. Completion of a second grid aided this process. The researcher considered recurring themes across the data. Where did mothers place emphasis? Was what was said different to what was meant? How did judgement manifest? Was there a shared view of what constitutes quality in service provision? This process of ‘mapping’ is identified by Braun and Clarke (2013) and is an
important stage to bring together themes from across the transcripts. Once themes were defined, anonymised quotes from interviews were selected to explain and qualify findings.

**Ethical Considerations**

Teenage pregnancy is an emotive issue. When researching sensitive topics there is a need to account for this from the outset (Lee 1993). A number of ethical issues needed to be considered: the vulnerability of research participants; their feeling of stigmatisation and the professional role of the researcher. These are considered in turn below.

**Access to participants and ethical approval**

The research topic and nature of access meant that permission to carry out the research was sought from both DMU and Leicestershire County Council. Copies of completed Ethics forms can be found in the Appendix (Appendices 10 and 11).

**Young people aged under-18**

Those individuals that make up the research sample are vulnerable in terms of age and circumstances. While in law, people under 18 are recognised as children, in the case of interview participants who are under 18, the Gillick\(^2\) competency framework was used to assess suitability. Since the original Gillick case, guidelines have been more widely used to assess whether a child has maturity to make decisions and to understand their implications. Participants were aged 17-18. As part of the recruitment process, the researcher conversed with participants to ensure they had read the PIS (Appendix 6) and explain what

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\(^2\) Victoria Gillick is a British campaigner best known for the eponymous 1985 UK House of Lords ruling that considered whether contraception could be prescribed to under-16s without parental consent or knowledge. The ruling established the term ‘Gillick Competence’ to describe whether a minor (below the age of 16) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.
the research would entail. Participants were asked if they had questions about the research and their role in it. This enabled the researcher to feel confident that participants had sufficient maturity to know what was involved and were therefore ‘Gillick competent’. The consent form was a further step to ensure participants understood what taking part entailed.

Dodds et al (1996) describe a number of practical steps in reference to their research with disabled parents that were useful to consider. Time was built in for the interviews to be set up. The researcher also considered accessibility of venues and ensuring that interviews took place at convenient times of the day for participants.

*Informed consent*

Having decided to take part, participant’s consent was obtained through the completion and signing of a consent form (Appendix 7). This required participants to confirm they had read and understood what the research was about and what taking part involved. These measures ensured that participation was voluntary and that participants were giving ‘informed consent’.

*Confidentiality, anonymity and data storage*

The selected interview venues provided privacy and confidentiality. Participants were informed that interviews would be recorded and transcribed but that any quotes used would be anonymised. The identity of interviewees would not be shared.

Participants were told that if anything was shared during the interview that suggested harm to them or their child the researcher would be duty bound to share this. This confidentiality policy did not seem to be off-putting for participants. It was assumed that this was because participants were familiar with the policy from their dealings with services.
Data was stored in accordance with DMU’s storage policy in a locked cupboard, electronic copies of data are password protected. As stipulated in the DMU Policy, data will be stored for at least five years after completion of the project.

*Right to withdraw*

The PIS explained that participants can withdraw from the research at any time without having to explain their decision.

*Participant distress*

The researcher tried to ensure that interviewees were comfortable throughout their interview. Participants were told that they did not have to answer any questions that made them uncomfortable or talk about anything upsetting in an attempt to minimise distress that could be caused by sharing experiences. Dana did get upset during her interview. She was given a drink and tissue. Once Dana composed herself and spoke more about the situation which had upset her, the researcher advised that she raise the issue with her support worker.

*Self-respect and dignity*

Interviews were held in venues selected by the mother to make it easy for them.

Participants were thanked for their contribution in person after the interview and by text later that day. Research findings will be shared with individual participants and young parent groups. A summary research report will be taken to the groups visited and sent to each of the research participants.

Participants will be informed that the research report and suggestions for how practice can be improved will be shared with the Sexual Health Strategy Board which now oversees teenage pregnancy work.
**Being a Commissioner/Researcher**

According to Bell and Nutt (2002) it is important to note and account for the researcher’s professional role in the field being researched due to inevitable challenge and potential tension between roles. There is also a responsibility to colleagues and service users in terms of how the research is undertaken, how findings are shared and used.

**Accessing young parent groups**

Having gained ethical approval, the researcher took a report about the research to the Teenage Pregnancy Leadership Board to make Managers of local support services aware that the research was taking place. Managers were asked to inform staff who run young parent/pathway groups, to expect contact from the researcher.

In her professional role, the researcher is known to practitioners. When making contact to visit groups it was important to reassure practitioners that the researcher’s role was to gain knowledge on teenage mothers’ views, not to pass judgment on the setting being visited (Rajendran 2001). Research data about specific services is written up in a generalised way with no references to individual staff. The researcher was not present for all group sessions thus avoiding potential for wider observation. Having presented the research to the group, the researcher stayed for a short while to give interested parties the opportunity to ask questions, then left.

It is hoped the research will provide evidence to inform future commissioning decisions about young parent support. It was important to share this broader aim with practitioners whilst being realistic about what is possible from a small scale study. This is important as part of the researchers responsibility to colleagues. As Anderson and Hatton (2000) note, staff who work with
vulnerable populations often feel overwhelmed by the magnitude of their needs. Research findings will be used to make suggestions for improving service delivery but will not be a basis for making the case for new investment or service redesign.

By presenting the research to potential participants herself, the researcher was able to explain the Commissioner/Researcher relationship. What could not be guarded against was how this relationship was explained by practitioners to groups when the researcher had left. The researcher did provide research participants with a simple explanation of the researcher/commissioner role. As described in Bell and Nutt’s research (Mauthner 2002) this involved a playing down of the day to day work role to focus on the research and research aims.

The challenge that the researcher/commissioner role posed for the researcher is worthy of note. When the interviewees revealed issues with services, the researcher felt frustration that services weren’t providing the support that they should and she was unable to do more about this. It was important for the researcher to de-brief with her Supervisor about this to retain a realistic perspective on what could be achieved through the research.

**Research Feedback and follow-up**

*Considering research participants*

A key aspect of ethical research and respecting the vulnerable population who have shared their stories is ‘valuing the stories told’ (Anderson and Hatton 2000:247). This was done by ensuring that interviews were transcribed carefully and that data was analysed thoroughly to identify key themes.

Exploration of quality in terms of teenage mothers experience is interesting and provides feedback on which to base suggestions for improving practice. As Hall et al (2014) note, listening and responding to the voices of marginalised clients
is an important dimension to ensuring ethical practice. Research findings will be taken back to those who took part in the research (via the young parent groups) and to Practitioners and Managers.

**Considering colleagues**

An ethical consideration which links to responsibility to colleagues is ensuring that points raised about services in research data are generalised and do not reference specific practitioners.

In order to ‘make their research’ count, Brady et al (2008) describe how they shared research findings with professionals by delivering training in collaboration with young mothers. Anderson and Hatton (2002) describe how they provided workshops to staff who supported their research. Offering a briefing on the research findings to interested practitioners is something that the researcher plans to do, using the research to inform practice.

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Since the research was undertaken, new Governance arrangements have led to the Teenage Pregnancy Board being replaced by an overarching Sexual Health Strategy Board which has oversight of teenage pregnancy work as part of Leicestershire’s Sexual Health Strategy.
Literature Review

Literature concerning teenage pregnancy has grown significantly since the launch of the TPS and growing political interest in this issue. This chapter explores a number of themes from academic literature. It aims to provide further context, guiding the research question and informing elements of the study by exploring central concepts. By examining existing literature it will be possible to identify gaps in writing thus providing a rationale for how this study contributes to the body of literature.

The first part of this chapter looks at the construction of teenage parenthood as a social problem. This leads into part two, an exploration of current research on teenage parenthood and gaps within this. This helps to contextualise a study which aims to add to the body of qualitative research, describing young mothers’ experiences in their own words. The third part of the chapter looks at the concept of quality in healthcare before moving to explore young mothers’ experiences of services. What constitutes quality from a young mothers’ perspective will be considered as well as the impact that provision of a ‘quality service’ can have. This section will be used as a base on which to produce an empirically-based conceptualisation and analysis of quality from teenage mothers’ perspective and to inform the interview themes.

The literature review concludes by considering the challenge that a positive perspective of teenage parenthood poses for educational and public health policy. This is important because the research aims to make suggestions for improving practice. An understanding of the potential barriers to this are therefore critical, to ensure that recommendations made are feasible and clearly argued.
Construction of the term

The term ‘teenage pregnancy’ is used in a variety of ways with a wide range of meanings. Here the focus is on the use, and construction of the term within academic literature.

Over 30 years ago, Murcott (1980) wrote about the construction of this term and explored the ideologies which she believed led to the assumption that teenage pregnancy was problematic. She proposed that the negative construction was borne out of the challenge teenage pregnancy posed to two significant ideologies; reproduction and childhood. Teenage pregnancy is an uncomfortable fit, firstly for being pre-marital and secondly because it challenges one of the fundamental ways that adults and children are distinguished – it is adults who bear children. According to Murcott (1980) this is why teenage pregnancy is viewed as ‘social pollution’ (1980:1), it threatens an orderly view of the world.

A number of academics have explored the construction of the term in policy and medical discourse (Wilson and Huntington: 2005, Duncan: 2007 and Breheny and Stephens: 2010). ‘Teenage mothers are vilified’ (Wilson and Huntington 2005:59) and presented as a drain on society whilst early motherhood itself is viewed as a ‘disease requiring surveillance and intervention’ (Breheny and Stephens 2010:307). These authors share the view that the traditional presentation of teenage pregnancy is intrinsically negative, ‘a calamity for individual young women and a severe problem for society’ (Duncan 2007:307).

In this respect, Hacking’s (1999) work provides an interesting perspective on how concepts are socially constructed. He explains how the process of social construction can be liberating, it reminds us that the meanings of words are not fixed, they evolve as a result of historical events and changes in ideology. Motherhood is used as an example of a concept where its meaning has evolved
due to changes in family norms and structures. Mothers today understand that their behaviour and emotions are not predetermined by biology and that they can therefore make their own decisions on parenting. However, Hacking acknowledges that there are times when the social construction of a concept is not liberating and offers few benefits to those labelled with it. Teenage mother is such a term. Whilst in most situations – motherhood is seen as a positive, normal, inevitable role for women, this is not the case in this context. The term ‘Teenage mother’ is used to distinguish ‘a certain class of person’ (Breheny and Stephens 2010:307), a group of women who become mothers at an age and time at odds with the normal and assumed life trajectory for women in today’s society (Wilson and Huntingdon 2005).

This construction leads to the presentation of these mothers as a homogenous group with no distinction of age or circumstances (Murcott 1980). Teenage pregnancy is linked to outcomes of poverty, lack of employment and poor health (Great Britain: 1999). In reality however, Duncan (2007) argues that it is pre-pregnancy social disadvantage not the circumstance of becoming a teen parent that holds the impact.

The domination of quantitative research on teenage pregnancy has been criticised (Wilson and Huntington 2005, Duncan 2007 and Arai 2009). These authors argue that this approach to research presents an unjustified, negative view of pregnancy which fails to show how teenage parents themselves experience pregnancy and parenthood. Breheny and Stephens (2010) explored discussion in medical and nursing journals. They identified a number of discourses within journals and argued that teenage mothers are portrayed as financially dependent, often from ethnic minority groups and psychologically, physically and educationally unprepared for parenthood.
It was Quantitative data that informed and directed the national ‘Teenage Pregnancy Strategy’ (TPS) (Great Britain: 1999). This had the provision of better support for teenage parents as a key aim. However, researchers like Kidger (2004) and Arai (2009) argue that the TPS itself with its focus on reducing the UK’s ‘shameful’ (Great Britain: 1999) levels of teenage pregnancy compounded the negative construction and reinforced its depiction as a social problem.

Research on Teenage Pregnancy

Having explored the construction of teenage pregnancy, it is now important to look at how research has added to our understanding of this concept and further influenced the term’s construction.

Graham and McDermott (2006) use teenage motherhood as a case study to explore conclusions drawn from quantitative reviews and highlight the juxtaposition which comes from comparing this to qualitative accounts from teenage mothers. They explore how teenage pregnancy has been accounted going back to the 1960’s and explain the negative framing of teenage parents as heading for social exclusion as being a result of how young people’s transition to adulthood and the domestic transitions of marriage and parenthood have changed (Graham and McDermott 2006).

Wilson and Huntington (2006) echo the view that quantitative studies present only one side of the story, this presentation is ‘one-dimensional’ (2006:64) and ‘bleak’ (2006:65). Daley et al (2013) explore how clinicians could better meet the unique needs of adolescent parents. However, their focus on scientific data and discussion of the risks which adolescent parents are more likely to face, undermines their perspective.

Since the launch of the TPS, the body of qualitative research on teenage pregnancy has grown. Not only does this challenge the assumption that early
childbearing is problematic it goes further to provide a narrative that teenage motherhood can be experienced positively (Arai 2009). What this qualitative research tells us will now be explored in greater detail.

**A positive view of motherhood**

From a small-scale qualitative study, Arai (2009) noted that whilst the occurrence of teenage pregnancy might initially be a shock to a mum-to-be and her family, neither viewed this as a disaster. Reviews of research literature undertaken by Duncan (2007) and Brand et al (2014) support this. Many mothers describe the positive effects of motherhood, making them ‘feel stronger, more competent, more connected to family, and more responsible’ (Duncan 2007:316). In contrast to the previously explored constructed view of teenage parenthood, for teen mums, this is an identity to be valued.

Smithbattle (2007) outlined how for the mums in her study, teenage pregnancy prompted a re-evaluation of priorities and a return to education. This was confirmed by Newby et al (2011) who describe renewed aspiration in mothers in their research.

**Teenage motherhood and Stigma**

Numerous articles explore how teenage mothers are viewed differently (Kidger 2004, Duncan, 2007, Arai, 2009 and Robb et al 2013). Unlike other mothers, there seems to be ‘no room for an acceptance of full-time mothering as a valid choice’ (Kidger 2004:296) – teenage mothers are discouraged from staying at home with their baby. Here, the ‘surveillance’ described by (Breheny and Stephens (2007) and Price and Mitchell (2004)) is visible in the monitoring of teenage mothers who are EET (in education, employment or training).

Another common theme across the qualitative research is young mothers’ experience of stigma, feeling like ‘a disgrace’ (Smith and Roberts 2009:63). In
qualitative studies which explore the experience of teenage parenthood, mothers report ‘comments and stares’ (Higginbottom et al. 2006:144), and feeling as though ‘...everyone is looking down on me’ (Price and Mitchell 2004:3).

It is hard to establish to what extent this is real or imagined, but the necessity to manage a ‘stigmatised identity’ is one of the headings that Graham and McDermott (2006:28) identify across all of the studies looked at in their systematic review. This will be a key concept to explore in the interviews.

Access to support and care
Price and Mitchell (2004) explore teenage mothers’ experience of maternity services and highlight the impact stigma has on willingness to ask for help. Brady et al (2008) make recommendations for how services can better meet the needs of young mothers. In their view, societal attitudes create barriers to accessing services. Brand et al (2014) reiterate this and report that the stigmatising of young mothers makes them reluctant to ask for help. These findings suggest the internalising of negative stereotypes of teenage pregnancy. In turn, this leads to reluctance to access services, ‘fearing they will be judged negatively and that their status as mothers will not be taken seriously’ (Brady et al. 2008:579).

This is a stark contrast to the pride in their identity which teenage mothers have. Brady et al explain this by suggesting that negative stereotyping of teenage mothers impacts on practitioners who support them. This leads to misjudgement and labelling. The complexities of communication between mothers and practitioners (particularly if other family partners are involved) can leave young mothers feeling ‘left out’ and ‘disempowered’ argue Brady et al (2008:579).
This suggests that whilst the growing body of qualitative research gives teen parents a voice and provides a positive view of teenage parenthood, this is yet to filter down to care provided. Services continue to be delivered by practitioners who stereotype and stigmatise young mothers.

Here, the theme of ‘quality’ in care is introduced. From their review of literature, Brand et al (2014) state that to improve service provision, practitioners need to reflect on their personal assumptions and values to allow them to take account of the lived experiences of young mothers and deliver care appropriately.

Brady et al (2008) make suggestions for how professionals can improve the service they provide. They encourage practitioners to not lose sight of the individual needs of young parents.

**Quality in service delivery**

The concept of ‘Quality’ in service delivery is now explored further before returning to explore teenage mothers’ experiences.

The exploration and definition of quality in healthcare has evolved. Quality in healthcare is often assessed in reference to outcomes, this has been criticised. In 1966, Donabedian, founder of the study of quality in healthcare, proposed that despite being easy to measure, outcomes alone were not appropriate measures on which to assess quality, ‘patient attitudes and satisfactions’ (1966:693) were also important criteria to consider.

This view is echoed in the 2008 Department of Health document ‘High Quality Care for all’ which encourages service providers to look at quality from the patient’s perspective (Great Britain:2008). Here, quality in healthcare incorporates; patient safety, patient experience and the effectiveness of care
and performance, in delivering; outcomes, service improvements and costs savings.

But what is it that patients value? How do they define quality when they are unable to judge the technical quality of services? Donabedian (1966), Kenagy et al (1999) and Naidu (2009) all acknowledge that patients assess quality on a range of characteristics. These include accessibility, communication with and their relationship with the medical practitioner, changes in their condition and staff demeanour.

Within this qualitative study, quality should be considered in broader terms, in reference to the meanings and experiences of individuals. In considering services for young mothers, not all services are health care services. When comparing the regulatory frameworks of the Care Quality Commission (CQC) who monitor health care services and Ofsted, whose role is to assess Schools, Local Authorities and their internal services, there was significant overlap in principles around compliance, public/patient involvement and raising standards of care/services.

So then, patients’ assessment of quality is based on their overall experience but this is influenced by a range of factors. Newby et al (2011) identified that when accessing support, young people did not identify the organisation the person works for, simply an adult who could help. These are all significant points when considering the interview questions which explore quality of services accessed.

An existing set of quality principles developed by the Department of Health in 2011 is the ‘You’re Welcome’ Criteria (Great Britain: 2011). This 9 point-criteria aims to make health services more young people friendly. Many of the principles have relevance for all services;
• **Accessibility - Is the service accessible?**
• **Confidentiality - is confidentiality explicit?**
• **The service environment - what is the venue like where the service is delivered? Is the waiting area comfortable?**
• **Are staff trained and approachable?**
• **Do staff link up with and know about other services?**
• **Are young people actively involved in the monitoring and evaluation of the service?**

These criteria aim to ensure that health workers respond to adolescents effectively, appropriately and with sensitivity. It is widely used as a benchmark to assess how friendly services are.

These principles seemed valuable to use for this study but firstly it was important to assess the relevance of these principles across a range of services.

Parallels can be drawn between the principles of ‘You’re Welcome’ and recommendations made for schools in Vincent’s (2012) book about teenage pregnancy and education. In the final chapter of the book, Psychologist Vincent, makes recommendations about how education providers could be more inclusive of school age mothers. These include; schools being accessible and flexible with regard to uniform and part-time attendance; training and support for teachers and ensuring that appropriate policies exist and are complied with.

Assuming that for young mothers like all patients there is a ‘myriad of characteristics which shape their experience of care’ (Kenagy et al 1999:661), using the ‘You’re Welcome’ principles as a framework to examine quality seems appropriate.
Another dimension to explore in reference to quality is how patient satisfaction influences behaviour. Naidu (2009) examines the benefits of patient satisfaction and the favourable action this prompts in patients. Behaviours explored are loyalty and compliance. Satisfied patients return to services and follow advice given. This idea will be explored within the interviews.

The concept of quality will be kept in mind as teenage mothers’ experience of services is considered.

**Teenage Mothers’ experience of services**

A range of services are accessed during pregnancy and on becoming parents. This section explores experiences of three key service areas; maternity and health services, schools and education and employment/financial advice services.

*Maternity and health services*

A search on EBSCO of the terms ‘teenage pregnancy’ and ‘antenatal’ brought up a number of articles exploring experiences of maternity services.

Common themes linked these articles. One of these was lack of information being provided by midwives (Price and Mitchell: 2004, Higginbottom et al: 2006 and Hunter: 2008). This impacted on teenage mothers in a variety of ways. Higginbottom et al (2006) highlight inadequate information provided in relation to labour and childbirth. Price and Mitchell (2004) found this led to young women feeling ‘overwhelmed and disempowered’ (2004:1). Hunter (2008), a Practice Development Midwife, undertook research exploring teenager’s experience of breastfeeding support. The majority of women spoken to wanted more help and support. Interviewees referred to not knowing or being told how to feed, bathe and care for their babies and being made to feel uncomfortable if they asked for help. Smith and Roberts (2009) suggest that poor experiences of
care ante-natally led to poor attendance at post-natal sessions. Young women felt scared, lacked confidence or simply did not know that support was available as they had not been told.

Brand, Morrison and Down (2014) explore how health professionals support young mothers. They argue that the surveillance exercised by some services leads to distrust of health and social care services due to fear of being judged or their abilities doubted.

Schools and Education

Vincent’s (2012) research considers the experience of school age mums during their pregnancy and beyond. There are accounts from 12 women of statutory school age. Schools response to the news of a pregnancy differed greatly. At worst this led to unofficial exclusion or ignoring a pupil and her circumstances, at best, support and acceptance was immediate.

Differing responses from education providers was also highlighted in Dench et al’s 2007 qualitative study. Over half of the sample reported disruptions to their education or employment due to pregnancy. Reasons for leaving education in this study varied: health and safety risks, not being allowed to use a disabled lift despite health issues and lack of on-site childcare provision. What comes across is that many barriers could have been overcome if help and support had been proactive and provided with empathy.

Employment/Financial advice

Hall et al (2014) explore the implementation of welfare reforms in a locality in Australia, and specifically the engagement between social workers and young parents. Fifteen parents were spoken to, all of whom were in receipt of social security benefits. Most of these individuals had worked and felt embarrassed and humiliated to be receiving benefits. Similarly to studies exploring maternity
care, Hall et al reported that there was scope ‘to better inform and connect young parents’ (2014:262) and that parents struggled to ‘assume responsibility’ (2014:262) due to feeling undermined. Those interviewed understood the need to consider future options of work/education and were keen to do so but highlighted that interview appointments and other processes were challenging when you have small children.

These studies suggest that whilst becoming financially independent might be an aspiration, how systems work makes that difficult. An account from a young parent in the book ‘dear me: letters to my pregnant self’ (2010), adds weight to this:

‘...went to the Jobcentre to ask about going back to part-time work and returning to university; the lone parent advisor did the sums and told you that it wasn’t possible.’ (2010:72).

These accounts of teenage mothers accessing a range of services present a negative picture where information and support is poor, feelings of disempowerment and stigmatisation are common and where quality is largely absent.

The impact of targeted support
It is important to examine examples of targeted support for young mothers to ascertain whether or not this makes a difference to the quality and experience of care. A search on ‘Cinahl’ of the terms ‘pregnancy in adolescence’ and ‘experience of care’ brought up a range of academic articles exploring or evaluating services targeting teenage mothers. The review of literature that follows will assist the researcher in considering themes to explore in the interviews.

A key feature of services which target young mothers seems to be their understanding of, and response to, the specific needs of the cohort.
Austerberry and Wiggins (2007) evaluate the Sure Start Plus programme, this was an initiative to support pregnant and parenting teenagers and formed part of the TPS. They describe how participants valued the appreciation of their ‘dual role’ as mothers and young people and how the programme addressed issues that were important to them. In Pilon’s (2011) exploration of a targeted antenatal programme for teenage mothers, a number of components are described which aim to meet the specific needs of the cohort, like providing after school sessions. Flexibility in provision was also described in Thompson’s (2010) article about a teenage pregnancy antenatal clinic where young women were given flexible appointments.

Another feature of specialist support was an informal approach and providing a range of assistance— from emotional support to practical help like taking mothers shopping. This integrated model is described by Malin and Morrow (2009) in their evaluation of the Surestart Plus Advisor. Here, workers providing the service are seen as advocates, who don’t judge, can be trusted and whose support makes things better. This enables teenage mothers to feel more confident and better able to do things.

Regular and easy communication between mothers and workers was something that Pilon (2011) and Austerberry and Wiggins (2007) note as significant and that mothers themselves acknowledge ‘The midwife that dealt with the teenage clinic, she was brilliant. I had her mobile number in case anything happened’ (Austerberry and Wiggins 2007:10).

It seems that when support is targeted and accessible, young mothers are more likely to engage with it. This will be a key theme to draw out in the interviews, distinguishing between universal and targeted models of support and finding out which models were preferred and reasons for this.
It is clear that targeted services are well received but how do they impact? In their article reviewing a dedicated antenatal programme, Das et al (2007) report that attendance at the clinic for adolescent women was 42% higher when compared to other antenatal clinics. This in turn led to higher breastfeeding rates and access of post birth contraception. This supports Naidu’s (2009) view that satisfaction results in positive behaviour.

When considering the earlier notion of ‘quality’ in service provision – to what extent do the models of specialist provision outlined adopt the ‘You’re Welcome’ principles? Accessibility is a strong theme; broad appointment slots, sessions run at times that are convenient and staff who understand their needs. The attitude and approach of staff was also really important and associated with increased confidence and competence. These targeted services have young mothers as their focus and involve them in informing how services are delivered. The ‘You’re Welcome’ principles therefore seem to be a good fit for assessing the quality of support that young mother’s access.

The challenge providing specialist support for teenage mothers presents

When the evidence of what works to engage and improve the outcomes of young mothers is strong, why have targeted models of care not been widely implemented?

Since 2010, the focus on teenage pregnancy and in particular supporting young parents has become less of a policy priority. Funding for targeted young people’s services has reduced significantly and a number of recent changes to taxes will hit young families hardest (The Guardian: 2015). So, is the lack of dedicated services for young parents down to lack of funding or is there more to it than that?
Despite the reduced funding and shift in policy priorities, teenage pregnancy rates have continued to fall, whilst conceptions to women over 30 have increased (ONS: 2014). This has been explained as a result of ‘increased participation in higher education, increased female participation in the labour force, the increasing importance of a career, the rising opportunity costs of childbearing, labour market uncertainty, housing factors and instability of partnerships’ (BBC: 2014). This statement indirectly devalues teenage parenthood which by its nature challenges such values. Might this explain why the current government has not developed specific policies in relation to teenage pregnancy? The overriding priority for the current administration is austerity measures and reducing welfare costs. Support of young parents would not fit well here.

Newby et al (2011) and Vincent (2012) argue that recognition that teenage pregnancy can lead to positive outcomes poses a challenge to educational and public health agendas. Austerberry and Wiggins (2007) support this view. They highlight the prescriptive policies aimed at young mothers, which expect them to return to work or education whilst policies for older mothers are far more flexible and extended maternity leave is totally acceptable. They argue that the Government should adopt a broader approach to the tackling of social exclusion and within this, afford equal rights and opportunities to all mothers.

An understanding of current policy framework and the limitations of services is important when developing suggestions to improve practice from this research. Young mothers might present with slightly different needs, but their difference should be recognised and responded to without stigmatising. This approach, argues Vincent (2012) is the only way to ensure inclusive and affirming provision for teenage mothers.

1 EBSCO– Database for accessing journal articles
2 Cinahl – Database for accessing journal articles
Results and Analysis

This chapter outlines and analyses the research findings\(^1\). Results and the accompanying discussion are presented under four main headings which reflect the key themes from the interviews; becoming a young parent, judgement and stigma, sources and experience of support and the impact of support. In each section, data is presented and discussed in terms of what mothers’ voices tell us, and what this contributes to what we already know. The final section considers what was said about quality, how this supports or deviates from definitions of quality in healthcare and what this suggests for future service models.

Becoming a young parent

Pregnancy

Confirmation of pregnancy prompted a range of feelings. For Dana it felt positive, ‘I couldn’t wait – I just wanted to do it all’. Becky’s response was more mixed; ‘It was a shock. It was a lovely shock’. For Amy, fear of breaking the news to family resulted in her feeling very anxious. In Arai’s (2015) research, young women did not always react well to the news of their pregnancy and more than one contemplated abortion. Despite pregnancies being unplanned for Amy, Becky and Dana, abortion was not considered even though others suggested this.

Chloe and her partner had been trying for a baby. When the pregnancy was confirmed Chloe stated she was ‘on cloud nine’, she explained ‘I lost my Mum at the age of 9 and ever since then I’ve wanted to be a Mum’.

\(^1\) See Appendix 9 for Data Analysis Table
Chloe’s planned pregnancy supports Arai’s (2015) research, where motherhood was linked to adversity. Here, Chloe makes an explicit link between losing her Mum and wanting to become a mother herself.

**Sharing the news**

Amy and Chloe’s Partners initially suggested an abortion. Amy was adamant this was morally wrong. She didn’t see why ‘the baby should have to suffer because I made a wrong decision’. Amy described how she knew she wanted to keep her baby despite knowing her relationship wouldn’t last. Amy was steadfast in sticking with a decision she would not regret. Dana described her partner’s fear ‘I told him that, as long as we’ve got our, both of our families supporting us then we’ll keep the baby’.

The decision to proceed with the pregnancy was made by the mothers. In research by Sharpe et al (2015), young men felt that it was the woman’s right to make the decision on pregnancy outcome. It is unclear in this case how fathers felt when their views were ignored. Dana and Amy’s use of the word ‘baby’ suggests they see the foetus as a baby even at a very early stage of pregnancy.

For Chloe, joy about her pregnancy was short-lived, ‘I was so happy and then the second I told me other half it all just fell down (sigh laughs)’. Her partner’s reaction was not what she expected;

> ‘he really really, got, really scared and then he, after a week or so of arguing, him saying that we can’t keep it because, it wouldn’t work and he’s not ready to be a Dad. I think he just completely freaked out.’
This period of stress and upset continued. Despite Chloe wanting her baby, her partner’s mother booked an abortion. This attempt to control the situation by the paternal grandmother is extreme – could this perhaps be explained by the absence of Chloe’s own Mother? On the morning of the termination Chloe told her partner she would not go and he ‘flipped’. In the end he accepted that Chloe was keeping her baby and things calmed down.

These accounts are interesting in terms of the lack of influence of fathers. Duncan states that in policy, ‘young fathers are seen more as feckless and possibly immoral perpetrators’ (Duncan 2008:309). For Amy, Chloe and Dana, it appears their partners had little part in the decision about whether or not they would become fathers. This suggests the notion of ‘maternal gatekeeping’ (Allen and Hawkin 1999), written about in terms of how women can shape fathers’ involvement in childcare, can come into play prior to a child being born, with women making the decision about whether or not men will become a father. Lack of choice about fatherhood could explain why in some cases relationships breakdown and why fathers go on to have little involvement in childrearing.

**Impact on self**

For Amy, the prospect of becoming a ‘teenage mum’ overshadows everything. Amy is applying for a job when she discovers she is pregnant. Amy doesn’t tell the employer she is pregnant ‘I’d rather them thought that I didn’t want the job than think that I was going to be, a teenage parent’. This comment indicates just how negatively she perceives her pregnancy will be viewed. Amy makes numerous references to anxious
feelings during her pregnancy. These feelings are compounded by misinformation which reinforces a negative view of teenage motherhood;

‘...I had heard from other people before, that erm, teenagers, teenage parents are more likely to lose the baby. Erm, so obviously I was like, well then, if I’ve lost the baby, then erm, like what am I supposed to do? And then obviously I would feel bad because like that was my fault that the baby didn’t have a chance, in life.’

Amy doesn’t share her concerns with anyone. Robb et al (2013) suggest that young mothers are reluctant to ask questions and ask for help because of their internalised stigmatisation. Internalised stigma provides an introduction to the concepts of judgement and stigma which were strong themes throughout the interviews, this will now be explored.

Judgement and stigma

Family stigma

Negative views of teenage parenthood became apparent in the descriptions of sharing pregnancy news with family. This is highlighted in quotes from Amy ‘his Mum also told me that I wasn’t going to be a good Mother because I was young’, and Dana ‘...she didn’t really like it when she found out I was pregnant because how old I was’. Chloe described the very strong reaction of her partner’s mother;

‘She, then, was like, going crazy at us both. We’ve ruined her life. What have we done? We’re not old enough to have kids.’

These reactions to pregnancy relate to the women’s age. Similar reactions from family were reported by Arai (2015), parents were initially angry and upset. However, once parents had accepted their daughter’s pregnancy,
their support was considerable. In this research that was not necessarily the case. Amy had some support from her Mum who she lived with, and Becky, support from her grandmother but in the case of Chloe and Dana, family support was limited. In Smithbattle’s (2007) longitudinal study with teenage mothers it was found that teens’ parents did not have the social or economic capital to support their daughters because of their own familial/financial responsibilities. It is unclear to what extent this was a factor here.

Where there were negative reactions to their news, this impacted heavily on the mums-to-be as their pregnancy progressed. Amy described how angry her mother was when she found out about the pregnancy. Even once she accepted it, Amy’s anxiety continued. Here she describes her feelings on route to her first scan;

‘I started getting very anxious because I was like, what about if I go in and there is no baby there, and it’s, it’s like, it’s not survived and stuff.’

This supports Rubertsson et al’s research (2014) where mothers under 25 were found to experience the highest levels of anxiety in pregnancy.

External stigma

Each of the mothers interviewed were aware of, and acknowledged the widely held negative view of young mothers and described feeling judged or stigmatised. The young women’s awareness of the stigma associated with teenage parenthood concurs with other literature (Kidger 2004, Duncan, 2007, Arai, 2009 and Robb et al 2013). Kidger (2004) and Duncan (2007) explore how teenage parenthood is constructed and presented as a
social problem in policy and academic literature. This assumes negative outcomes for teenage parents and their children and leads to stigmatisation and judgement by professionals, friends and strangers in the street (Kidger 2004). Arai (2009) and Robb et al (2013) explore teenage mother’s experience of stigma through interviews. As in this research, stigma manifests in a range of direct and indirect ways. Dana comments that her mum could not judge her as she was a teenage mother herself. This implies that judgement would otherwise have been inevitable.

For Amy and Chloe judgement manifested early when their boyfriends’ mothers told them they wouldn’t be good mothers because of their age. Chloe talks quite matter-of-factly about the ‘society based’ view of young mothers with multiple children who are on the dole and references the depiction of ‘Vicky Pollard’ on the TV show ‘Little Britain’.

This observation of the caricature of teenage parents is interesting and another issue discussed in the literature. Duncan (2007) discusses how the term ‘teenage mother’ is used by politicians and the media. This ‘invokes a particular categorial representation of a type of person. Teenage mother is seen to stand for a priori, unitary, fixed, coherent and inherent set of attributes and characteristics’ (Duncan 2007:327) in turn, this becomes a negative stereotype.

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2 Little Britain is a British character-based comedy TV sketch show. The show comprised sketches involving exaggerated parodies of British people from all walks of life in various situations. One of the infamous characters was Vicky Pollard, a teenage mother.
At various points during her interview Amy highlights negative views of young mothers as ‘bad mothers’. She observes; ‘Some people just, don’t seem to value us as much as everyone else’. The weight of the teenage parent label is heavy. Amy refers to looks and comments from people in the street. Robb et al (2013) discuss young mothers’ fear of being stigmatised in their research and how this can lead to mothers viewing themselves differently and negatively, they ‘self-stigmatisate’. An example of this is where Amy commented that people assume Surestart is for ‘rough people’ and a place where ‘freeloaders go’. In some ways this seems to be a remark about herself.

‘...if people er, ask her how old I am she’ll say I’m 18, she won’t tell them that I’m 17. Erm. That kind of hurts a little bit because right, well obviously, she obviously doesn’t feel like that she can be proud of me which is a little bit sad.’

This quote from Amy about her mother suggests that the stigma of teenage parenthood can transfer to family members too. This self-stigmatisation, or the expectation of judgement impacts on what mothers do. In Amy’s case, feeling judged and looked down on makes her reluctant to go out by herself.

The extent of internalised stigmatisation can be perceived in the fact that Chloe and Becky are pleasantly surprised when mothers at groups they attend don’t judge them. Chloe comments;

‘everyone seemed really accepting. Cos I was a bit apprehensive if everyone would look at me, a bit like, she’s young enough to be our daughter’. 
The impact of stigma

Whilst it was not always clear if judgement was real or imagined, the impact of this was significant. How this impacts on mothers’ engagement with support is examined below but firstly, it is important to acknowledge mothers’ resilience in the face of stigma.

Young Mother’s Resilience

‘I love being a Mum and it’s really good but, sometimes it’s just really hard’

Here, Dana summarises perfectly the challenge that young mothers face. In each case, mothers were excited about becoming mothers and they wanted their babies but they felt judged by virtue of being young. What is then required is to find resilience in the face of stigma and to construct a positive maternal identity which challenges the dominant negative discourse which presents them as the problem. For Amy, Becky, Chloe and Dana, in the face of judgement and stigma from family, society and services they stand firm and find resilience to overcome huge challenges. Dana describes a battle with her GP when she feels they are not taking her son’s illness seriously. Despite being sent away she returns the following day demanding attention. This is a clear example of how ‘commitment to their maternal identity provides a buffer against potential threats to self-esteem’ (Graham and McDermott (2005:29). This strength and resilience cannot be maintained all of the time. There are a number of examples of where the internalised stigma of teenage parenthood prevents mothers from seeking help or asking questions.
Reluctance to ask for help

Chloe describes a situation where she visits her Health Visitor for weaning advice but feels judged. Chloe ignores advice given and instead turns to Facebook for further help. Johnson (2015) explores the changing nature of support and information-seeking practices for new mothers in the context of increased digitalisation. Chloe’s access of a peer led group on Facebook is a really good example of how ‘intimate mothering publics’ (Johnson 2015) (ie online, faceless public forums facilitate the discussion of what would historically have been seen as sensitive, private topics) enable women to seek advice and gather practical tips from other parents. This model of seeking and gathering information is seen to be a strategic choice, especially for mothers who sit outside the norm of mothering discourse. Teenage mothers are one such group.

Both Dana and Amy refer specifically to Social Services and fears over what their intervention would mean. During Dana’s interview, she cried talking about being depressed and feeling pressured. Dana described recent intervention from social services which left her feeling unfairly treated. Having battled with depression, she is reluctant to seek help for fear of further intervention. Amy too talked about feeling watched in the hospital and being scared that social services would take her baby away.

The distrust of social care is echoed by Brand et al (2014) and Robb et al (2013). Views expressed by Dana and Amy support Robb et al’s suggestion that Social Services are not perceived as being there to offer support. Where social services intervene or their intervention is threatened, this
causes anxiety and in some cases hinders mothers from being honest about support required. Sources and experience of support will now be examined further.

**Sources and experience of support**

*Experience vs expectation*

Mothers described a positive experience of services. However, this overriding view seemed in part to arise from low expectations and relief when that did not transpire. In her interview, Becky compliments the Sure-start centre she attends and describes how different it is to what she expected ‘...you think it’s going to be horrible and full of people who want to be muscling in.’ Becky expected unwanted and intrusive intervention because she was a young Mum. Chloe too had expectations about the support she would receive as a young mum ‘...the impression that I get given as a teenage mum is that everyone frowns upon you, you don’t get any support.’ In both cases, presumptions about support were not realised but fear and expectation of a particular response from services because of their age was very real. This anticipated judgement and perception of being treated differently because of age is discussed by Robb et al (2013) and is said to form part of the self-stigmatisation process. The following quote from Amy supports this. She describes how she will be almost 18 by the time her son is 1, this is a year closer to being an adult thus legitimising her as a parent;

‘Although I was 17 at the time. I had just turned 17 erm, before he was born. So I was kind, that kind of made me feel a bit better. Erm, that I wasn’t like 16. I was closer to 18. Closer to being an adult. So they couldn’t really try and say anything ‘cos err I’d be an adult before he was 1.’
Referral pathways

A range of services were accessed during pregnancy and in the early stages of motherhood. There was some commonality in services seen but the different experience of the four women suggests inconsistent delivery despite the introduction of TBAG3 Forums. Referral pathways between some services were very clear – in other cases, support was found by the proactive approach of the Mums themselves or workers they were involved with. Amy described how she and her mother went to their local children’s centre to seek out support.

When asked about services knowing about each other and linking support up, responses indicated that this often relied upon relationships between individual workers as highlighted here; ‘I know my midwife did speak to my health visitor’ ‘My midwife knew a lot of the Surestart staff’. This suggests that services work differently from one locality to another and referrals between services still rely on heavily on relationships between practitioners.

Some roles were clearly identified by the mothers, this tended to be GP, midwife, health visitor – roles that are more commonly known. Contact with other services like the Children’s Centre was often associated with one named worker. There did not seem to be a clear understanding of where the role and remit of different services started and ended and links to centralised services like the hospital. Dana explained, ‘I don’t think the hospital, doctors and that talk to each other but the baby group places,

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3 Multi-agency forums which meet in localities every 6-8 weeks. Attendance from all agencies who support young parents facilitates data sharing and allocation of support based on individual’s needs.
they, I think they do’. Again, this suggests lack of coordination across the system.

Specialist versus universal services

All of the mothers interviewed were 18 or under which should mean a direct referral for assessment to the teenage pregnancy specialist midwife. Depending on the outcome of this assessment, mothers might be case-held by the specialist midwife (if they present a range of vulnerabilities) or they would be referred to the community midwifery team. Only Amy had contact with a specialist midwife. This highlights that the initial referral and assessment process is not happening consistently.

The baby box is a project in Leicestershire where all Mums aged under-20 should receive a home visit and baby box ante-natally. The aim of this visit is to provide some useful items that both mum and new baby need but also to share information about local support services and facilitate access of these. Only one Mum specifically mentioned having received a baby box, another indication that referral routes are more robust in some localities than others.

All of the mothers accessed their Children’s Centre Programme (CCP) ante-natally. The CCP delivers support pathways for groups of vulnerable mums and their babies from pregnancy until children are 2. Amy, Becky and Dana continued with their pathway post-natally and viewed this positively;
‘It’s been nice to, erm, meet up with the mums again and it’s nice for the little ones to bond with each other as well and. Because they’ve got someone to grow up with. I think we stay on with them until they are 2. So. It’s quite a good, It’s a good thing’.

In Chloe’s case, she missed a number of the post-natal sessions at the Children’s Centre. When she enquired about returning to the group, she was put off doing so ‘...it was just like there’s no point coming cos you’re going to miss 4 weeks of it. So, I never went. (laughs) It’s a shame. I would have liked to have gone’. Chloe’s experience highlights lack of flexibility which means that she misses out on support, ‘Because somebody who feels quite lonely and not very confident that could be their last hope at finding friends and support’.

All of the mothers talked about their Health Visitor and in two cases, ante-natal contact with their Health Visitor was mentioned. This visit forms part of the Healthy Child Programme (Great Britain: 2009) and aims to improve the transition from midwives to health visitors. For Amy, the ante-natal visit had led to further anxiety due to misinformation ‘...some people had said that they hadn’t had a health visitor during pregnancy and they were just sending them out to young mums’. This highlights the importance of explaining how services work and what the ‘offer’ is, to avoid misinterpretation which can lead to further stigmatisation.
Experiences based on the ‘You’re Welcome’ Framework

Interview participants were asked to score services based on their experience. The results are summarised below using some of the principles from the ‘You’re Welcome’ framework (Great Britain: 2011).

Accessible services

Accessibility was a theme across all of the interviews. Services were scored highly when they were easy to access. For Amy, accessibility was talked about in terms of where the service took place and her proximity to this. Becky and Chloe talked about a phone line the hospital offered and a text service – these services facilitated access to advice and support at a distance, without others knowing about it. For Becky accessibility meant being treated kindly and being involved in activities, for Chloe it was regular sessions that she could dip in and out of without worrying if she missed one.

Confidentiality

Confidentiality came up in interviews with Becky and Chloe. The confidential nature of the text service was highlighted, as was the importance of one-to-one time with workers to allow you to raise issues in confidence.

The service environment

Where services took place was important to interview participants. Positive comments about service environments included ‘it’s a colourful place’, ‘it’s warming’ and ‘lovely environment’.
Clear, consistent information

The importance of clear, consistent information was apparent with high scores awarded to practitioners who explained things clearly. Becky explained the impact of information on how she felt;

‘It was just reassuring. It was about the breastfeeding and bottle feeding. You know, explained that breastfeeding is best for your baby but if you’d prefer to bottle feed. Explaining how to make the bottles and. Like baby bathing as well. Pain-relief. So she explained everything all in general really.’

Negative experiences

In the interviews, particularly with Amy and Dana, there were several examples of poor care. Dana described a traumatic experience when her baby became ill and was hospitalised. It later transpired that he could have died. It seemed evident that there was an initial misdiagnosis of his condition which led to the deterioration of his condition. Dana described repeated visits to the doctors before they recognised how poorly her son was. Brady et al (2008) refer to lack of control that young mothers can feel and how this is heightened by imbalance of power in their relationships with practitioners. In another part of the interview Dana talked about advice from healthcare staff. She described her reaction at the time ‘I was just like, ‘oh, ok’ and just left them to it’. This indicates Dana felt powerless and as a result she disengaged. Disengagement with services as a result of bad experiences is something that Smith and Roberts (2009) observe in their research, young mothers stopped attending appointments after bad experiences with health care practitioners.
There was also an issue about mothers’ expectations of services. Dana commented that she had ‘never seen the same midwife so it was just being told different things all of the time. So it was just a load of old rubbish really.’ In reality, women may see different midwives during their pregnancy. Whilst one would hope that advice would be consistent, the same midwife throughout pregnancy cannot be guaranteed. This highlights a need for clarity on what to expect from services.

The importance of information and communication
For Becky, one of the key positives of support is the information she receives. This helps her to feel reassured and understand what is happening throughout her pregnancy. Not all of the mums received comprehensive information. When Chloe receives inadequate advice on weaning from a Health Visitor, she seeks advice from a Facebook group. This is a good example of ‘resilient mothering practices’ as described by Graham and McDermott (2005). Resilient mothering practices describe where young mothers ‘seek out the resources - emotional, practical and material – they need to succeed as a mother’ (Graham and McDermott 2005:29). Chloe is committed to her child’s needs but having been made to feel like ‘the worst mum in the world’, she opts for a faceless, modern mode of communication as a buffer against the potential further threat to her self-esteem, which advice from a practitioner may have caused.

There were other references to ‘faceless’ advice: Becky talked about a maternity phone line and Chloe really valued support provided via a confidential text service in the early stages of her pregnancy. Comments about advice and support via these more anonymous routes are
interesting. The following quote from Chloe confirms that avoidance of judgement was a key selling point of the text service;

‘...with texts it’s a lot more confidential and you feel that they don’t know as much about you. They literally know what you are telling them. They can’t hear your voice, they can’t judge you’.

External factors
Amy and Dana mentioned their geographical distance from the hospital and how this caused issues when attending appointments. For Dana this was compounded when her son had a hospital stay. On two occasions Dana was discharged from hospital late at night and had to negotiate trains to get home, ‘I’m walking the street, in the pitch black with my son ‘cos the hospital wants to discharge me at 9 o’clock at night. It’s like what good’s that’. Due to their age and circumstances, young mothers are likely to have more barriers in terms of transport. This example highlights the importance of professionals relating to young parents as individuals and considering their needs when providing support.

The impact of support on teenage mothers’ outcomes
This section outlines the range of impact and benefits that resulted from support received.

The significance of ‘Congratulations!’
One of the most significant impacts of support was simply how what someone said made the mum feel. The following quote from Amy highlights how notable her midwife’s positive response to her pregnancy was;
‘...when I first met the midwife, she was the first, like the only person to say congratulations to me. So that made me feel happy, happier as a person to know that some, some people are happy that I’m pregnant even though she didn’t know me.’

Becky too mentioned an occasion when she had been offered congratulations by her teacher. Reflecting on familial reactions and the widespread judgement that the mothers experienced provides some context as to why a positive reaction and ‘congratulations’ was so significant.

The importance of individual practitioners
Service experience was largely down to individual practitioners, their nature, approach and support they offered. As stated by Newby et al (2011), mothers recognised someone who would help them rather than a particular organisation. Becky, Chloe and Dana all referenced individual staff who in their view, had gone the extra mile to provide support. These workers were talked about by their first name with little reference to their professional role. For Dana it was the persistence of her Family Outreach Worker who didn’t give up on her. For Chloe, it was the ongoing contact offered by the worker who ran the text service, ‘... she’d follow up the next day..... It just felt like a guardian angel guiding me’. For Becky it was the way her Family Outreach Worker responded to her needs ‘She’ll come out if I need her’. The importance of support from practitioners who are friendly, offer consistent contact and who the mothers know they can rely on was evident in all of the interviews. Malin and Morrow’s (2009) paper evaluating the Surestart Plus Advisor highlights how these advocates

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4 Sure Start Plus was a pilot programme of support for pregnant teenagers and teenage parents which was launched in 2001 with 20 pilot areas. This formed part of the Teenage Pregnancy Strategy.
were reported to have increased mothers self-esteem and altered their perceptions of themselves. It was clear from the interviews that individual practitioners gave the mothers confidence by being there and responding to their needs.

Additional outcomes of this support were sometimes physical e.g. practical things like food or white goods for their home. It was the action and approach of individuals that seemed to hold the highest value as Chloe explained ‘They didn’t just leave it there, d’ya know what I mean – they reached out’. This endorses the recommendation from Brand et al (2014) that support for teenage mothers should foster meaningful relationships.

Support from other mothers
All of the mothers talked about the positive impact of contact with other mothers. Becky referred to how supportive the mums were in the group she attended and both Becky and Chloe described the benefits of contact with people experiencing the same things as you. The initial reaction of other mums at groups was important;

‘..when I met them all they were all really, really nice and treated me just like a normal person that’s having a baby which made me feel a lot better about myself and felt like that I could do this and be a good mum’.

This quote from Amy suggests that the positive reaction of the mothers boosts her self-esteem and renewed self confidence in her own abilities.
The impact of poor care on health outcomes

Amy was not supported to breastfeed. Her baby had a tongue tie which made feeding difficult but there was little intervention to assist with this. This impacted on how Amy felt; ‘So after a while my milk just dried up because obviously he wasn’t getting enough. Erm, So that kind of made me feel a bit, a bit bad.’ The impact here is twofold. Firstly, Amy feels guilty and as though she has somehow failed her baby. Because her milk dries up Amy stops breastfeeding which saddens her. This outcome was also found by Hunter (2008). Women Hunter spoke to wanted to breastfeed but gave up because of a lack of knowledge and support. The health benefits of breastfeeding are well documented as are lower rates of breastfeeding amongst young mothers. Amy’s experience would support Hunter’s (2008) recommendation that to succeed with breastfeeding, young mothers need targeted support which needs to start in hospital but continue post-natally once mum and baby go home.

The impact of motherhood on aspirations

‘…at the age of 17, with a house, and a baby. I think I’ve done like, really good for myself’

Here, Dana highlights her view of her own achievements, against the odds. All of the mothers interviewed had babies that were just weeks or months old. Because the focus was on their past experiences, there weren’t explicit opportunities to talk about future plans for college or work. That said, both Amy and Chloe did note future employment plans. All of the mothers talked aspirationally during their interviews. Amy, Chloe and Dana talked about wanting nice places to live ‘I wanted him to have a permanent place where he could call home’. There were also references to
the value of training, Amy referred to a parenting course and Dana first aid training. Whilst for three of the women, parenthood was not planned, it was clear that they viewed it positively and their primary focus was ensuring the best for their baby. As Smithbattle (2007) found, becoming a mother can foster new meanings and educational goals which can lead to rethinking educational and employment journeys. This does not however, mean a loss of aspiration, aspirations may just become shorter-term and more incremental.

**Quality services according to teenage mothers**

Mothers were asked what quality services would look like if they were in charge. In the main, descriptions focused on groups in centres rather than on ‘universal’ services like midwives and health visitors. It was clear that views of quality had been shaped by mothers’ own experiences of services, good and bad.

*Advertising, accessibility and the importance of a warm welcome*

Amy and Chloe talked about the need to advertise services better, implying that the visibility of services could be improved.

All of the mothers talked about the importance of a warm welcome from staff. Comments about venues where services are delivered highlighted the importance of provision being close-by and allowing you to walk-in without an appointment.

Amy and Dana wanted more frequent groups/activities to attend. During their interviews both of these individuals expressed loneliness and isolation. It would appear that groups provided some respite from this.
Amy suggested that the venue for the group she attended should have a cafe attached to enable mums to have lunch together before the session. At another group attended to recruit interview participants, all of the mothers turned up early for the session with lunch. This suggests that mothers value time with each other and will find ways of extending this where they can.

What activities and support should be provided?
There were numerous suggestions about activities. Ideas included parenting courses, life skills (e.g. cooking) as well as wanting practical support (like accessing goods for your house). This mirrors elements of existing service provision, indicating these are valued. Amy and Dana had suggestions about groups running day trips; ‘Days out with the babies, like going to see the animals, something like that. Go see the fish, go feed the ducks or have a picnic in the park’, this implies a keenness to escape their immediate surroundings and/or have people to do things with.

One mum suggested utilising groups to sell on unwanted baby stuff and share tips with other mums. When discussing ideas it appeared that this was the first time mothers had been asked how they thought services could be improved. All of the Mums felt that being able to provide feedback on services was important, to improve services, ensure they benefitted others and, in one case, there were ideas for cutting costs.


**Specialist vs universal support**

When asked if there should be dedicated provision for teenage mothers or if support should be open to all, Becky, Chloe and Dana thought services should be for everyone. As Becky explained ‘..it’s not really about age, it’s about how you are as a Mum’. Here, an acknowledgement that mothers have support needs, whatever their age.

**External factors**

Dana talked about a need for action in her community to address drug use in the parks where she lived. This anti-social behaviour was limiting her access and highlights a responsibility for the police and community safety teams, services who would not traditionally be seen as having a key role to play in supporting young mothers.

Dana also had some very specific thoughts on quality informed by her poor experience. One important point was the need for services to take account of people’s circumstances and vulnerabilities;

’Yeh because it’s like safety as well really because. Like – what if something happens to me – walking home, at 9 o’clock at night from the hospital. Like my son can’t fight for himself’.

**Comparing the management concept of ‘quality’ to the view held by teenage mothers**

This final section explores to what extent mothers’ definition of quality aligns with writing on quality and healthcare. The impact of quality on patient behaviours will then be considered before looking at what the research data means for services.
Quality in healthcare

This research supports Donabedian’s (1966) assertion that quality of care is a difficult notion to define. Donabedian goes on to explore the use of outcomes as an assessment of quality in healthcare. Whilst outcomes may be a useful measure of quality in scientific terms, for patients, outcomes are not necessarily clearly defined. For example, complications with a simple operation might be viewed by a patient as a poor outcome but if the risk of more significant harm was avoided, this is a positive outcome.

Patients generally assess health care on elements that they personally value (Kenagy et al 1999). Chloe’s discussion about the baby box provides a good example of this. Chloe had appreciated the box and its contents but for her, the proactive approach and visit meant more than the box itself ‘...it’s just the fact that somebody is coming to your door, going out of their way to help me. It was more the action than the actual thing.’ Later in her interview, Chloe made suggestions on how the baby box could be pared down to make it cheaper so more women could have one. This reiterated how much she valued this.

Judgements of quality of healthcare by patients are based on a ‘myriad of characteristics’ (Kenagy 1999:661) that shape the whole experience of care. For this reason, the quality principles of ‘You’re Welcome’ criteria provided a useful framework. Feedback on services highlighted the importance of accessibility, publicity, confidentiality, the service environment and how staff responded.
It was clear that opinions of practitioners were made quickly. In cases where practitioners were felt to be judgemental or their care inadequate, mothers disengaged from support. The importance of a friendly and non-judgemental first impression was very significant. Where practitioners engaged well with mothers, the value of their support and intervention was considerable. Chloe went as far as describing it as like having a ‘guardian angel’.

Quality and patient behaviours
For consumers, if a service is deemed as unsatisfactory or lacking quality, then a customer can take their business elsewhere. In a health care situation this is more difficult. Patients may not have a choice.

Naidu (2009) writes about patient satisfaction and healthcare and draws parallels between customer satisfaction and patient behaviours: ‘satisfied customers are more likely to exhibit favourable behaviour intentions’ (Naidu 2009:367). This implies that when a patient is satisfied with care received they are more likely to follow advice given. Research data supports this idea. In Becky and Chloe’s interviews, they described their dissatisfaction when advice was given in a manner that made them feel inferior. In Chloe’s case, she was urged not to wean her baby yet as it was felt that she was too young. In both cases, advice was ignored and mothers went ahead with what they felt was right for their babies. In medical terms these are not favourable behaviours.

Amy talked about struggling to breastfeed and lack of support received. As a result, Amy’s milk dried up and she was unable to breastfeed. As a key
public health target, it is surprising that more wasn’t done to support Amy. This illustrates poor quality not only influenced a patient’s behaviour but also impacted on health outcomes.

It is noteworthy that in each interview, mothers had experienced disappointing or poor care but none of the mothers made a complaint or raised their concerns. It would be interesting to explore whether this links back to fear of judgement and not being taken seriously or if this is typical of all mothers and in fact all patients.

**Implications for services**

Mother’s views on whether or not there should be specialist support for teenage mothers was interesting. Becky, Chloe and Dana felt that providing groups for all mothers was a better model. Amy saw the value of the young parent group she attended but felt that the age for this should be raised to 25. There was an acknowledgement that being young didn’t necessarily mean you had more problems than older mothers as Chloe explained;

‘...there’s probably 35 year old women finding out they’re pregnant and people, their partner’s or husband’s saying ‘I’m not ready for a child or’ ‘I don’t want another child’ and they are probably going through the exact same thing that I went through’.

There is clear evidence of the value of specialist support for pregnant teenagers and young mothers. Thompson (2010) and Das et al (2007) make the case for tailored midwifery support for pregnant teenagers. Brand et al (2014) highlight how non-standard models of care increased engagement by young mothers. But does this have to mean separate
specialist services? If universal services were more accessible for young parents would the need for separate specialist provision disappear?

Brady et al (2008) summarise their findings from a number of research projects exploring how services can better meet the needs of young mothers. The observation that pregnant teenagers and young mothers ‘internalise negative stereotypes of teenage pregnancy’ (Brady et al 2008:579) is borne out in this research. Brady et al highlight the importance of supportive, non-judgemental staff and of making services accessible to young parents.

Leicestershire still has a service offer for teenage mothers, but increasingly this forms part of a wider offer for vulnerable parents. The positive experience of accessing provision alongside older mothers that Amy, Becky, Chloe and Dana described, suggests that providing support in this way can work. What is most important is ensuring that support is proactive, non-judgemental and accounts for individuals’ needs.

The age of young mothers can set them apart in terms of circumstances. This was emphasised in Dana’s description of being discharged from hospital late at night and not having the means to get home. Sadly there are always going to be examples of poor care, but is it possible that lack of information described in the interviews was linked to the mothers’ ages? Do some professionals make assumptions about the capability of young mothers to understand advice? Are there times when young mothers are not taken seriously as parents due to their age?
It is not possible to answer these questions but accounts of poor care outlined would support the recommendation from Brady et al (2008) and Robb et al (2013) that training for practitioners should be put in place to ensure the particular needs of young mothers are accounted for in the provision of services. Training should highlight that young mothers aspire to be good mothers but due to their age and their own expectations about judgement and stigma, support should be provided with this in mind.

Whilst the overall experience of the mothers was good, in the descriptions it was clear that the reality was patchy and inconsistent. Frequently, support received reinforced the mothers’ sense of being different due to their age. When asked how services could be improved all of the mothers had ideas. By consistently asking about the experience of services, we could improve things further for future young mothers.
Conclusion

This chapter summarises the key findings before considering what this research contributes to current literature. Suggestions for how services could be improved are presented and limitations of the research outlined before some final reflections about what was learnt and the experience of undertaking research.

Summary of findings

Four women aged 17/18 were interviewed. In three cases pregnancy was not planned. Participants presented a range of circumstances prior to pregnancy, in terms of their living arrangements and work/education. A range of emotions were experienced when pregnancy was confirmed but each of the women was excited about becoming a mum. They wanted their babies, enjoyed motherhood and aspired to be good mothers but felt ‘othered’ due to their age.

A range of services were accessed prior to pregnancy and on becoming a mother. Despite provision being patchy and referral pathways inconsistent, the mothers overall descriptions present a positive account. It seems likely that this was in part a relieved response when low expectations of services were not realised.

A positive experience of support impacted on a mother’s view of herself, her confidence as a mother and encouraged ongoing engagement with services.

There were numerous examples of where services ‘failed’ the mothers. This failure manifested in a range of ways; a poor welcome; lack of adequate provision of information or support; feeling judged and at worst, misdiagnosis and poor medical care. Where services failed, this reinforced the mothers
feeling of stigmatisation. In turn, this led to feelings of powerlessness, active disengagement from services and seeking support in alternative ways.

Descriptions of quality suggest that young mothers’ needs can be met through universal provision. Due to their age and circumstances, young mothers do present unique needs but it is possible to account for these as part of a wider offer. What is crucial is ensuring a warm, non-judgemental welcome from practitioners and other parents to challenge anticipated stigmatisation.

**Research contributions**

This study included a small number of participants. No claim is made to the generalisability of the data. Having set out to provide insight into the experience of young mothers, this was achieved.

The mother’s narratives add to qualitative research which gives young mothers a voice. Notably, data highlights the resilience of these young women and their determination to be good mothers.

From the interviews it was clear that partners had little influence on the decision to become parents. This suggests that the notion of ‘maternal gatekeeping’ (Allen and Hawkin 1999), written about in terms of how women can shape fathers’ involvement in childcare, can come into play prior to a child being born.

Judgement and stigma were significant concepts across the interview data thus confirming the findings of other research (Kidger 2004, Duncan, 2007, Arai, 2009 and Robb et al 2013). Stigma manifested in a range of ways and for two participants started with negative reactions from family members early on in their pregnancy. The impact of judgement was considerable and confirmed Robb et al’s (2013) finding that mothers internalise this. In turn, this impacts on
how they view themselves, their confidence as mothers, expectations of what support will look like and in some cases, willingness to seek help.

There were several examples of mothers accessing ‘faceless’ support, for example on-line forums. To what extent this could be explained by the fact that the mothers are part of the technical generation was unclear – it appeared that this was in-part a strategic choice to avoid judgement. This finding introduces a new dimension to the concept of ‘resilient mothering practices’ as described by Graham and McDermott (2005) whilst also adding to the growing literature on the internet as a healthcare tool.

Since the research commenced there have been further changes to teenage pregnancy work in Leicestershire. Increasingly, teenage mothers are supported alongside other vulnerable mothers as opposed to being offered dedicated, targeted support. The data from this research will be useful in highlighting to practitioners that whilst this model can work for teenage mothers, there is still a need to be aware of their internalised stigma, the impact of this and how that can be redressed.

“Quality of care can only be improved by understanding patient experience with their own experience” (Darzi. Department of Health 2008:47)

This research provides insight from young mothers about their experience of services. Whilst providing ideas for how practice could be improved, data adds to our understanding of what ‘quality’ looks like thus enabling consideration of how services can achieve this. In the current climate, where pressure to reduce budgets and cut services is high, the insight that a warm welcome can make all the difference should be reassuring as this is, in many ways, a low cost solution.

Data supports Naidu’s (2009) suggestion that satisfaction with services leads to positive patient behaviour. This is useful when considering the most effective
way to improve health outcomes, for example increasing breastfeeding rates which are still lower amongst young mothers.

**Suggestions for practice**

*Practitioners*

The negative impact of judgement and stigma for the young mothers was significant as was a positive response from a practitioner to redress this. It is important to take account of the additional challenges that young mothers face and to respond positively to them. Saying ‘congratulations’ or proactively welcoming a young parent to a group or session impacts positively on how they view themselves and their future engagement.

Two participants referred specifically to lack of information from health practitioners and there were other examples of where medical advice given was misunderstood. Health literacy examines how low levels of literacy and numeracy become a barrier for many to obtain, read, understand and use healthcare information to make appropriate healthcare decisions and follow advice. When working with young mothers it is critical to ensure that information is clear, concise and understood to give mothers and babies the best start in life.

*Service providers and pathways*

Each of the mothers shared useful feedback about their experiences of services. Asking parents for feedback on services and how provision could be improved should be done consistently and robustly by all service providers.

Interview data highlighted inconsistencies in services accessed and in the understanding by mothers of the role and purpose of different services. This was emphasised in the fear of intervention from social care. This suggests that referral routes and pathways for young mothers in Leicestershire need to be
reviewed and promoted to ensure available support is utilised. Promotional information should outline the role and function of different practitioners. This would help to put mothers at their ease, allay fears that they are being singled out and treated differently due to their age and ensure they understand the benefits of accessing support.

It is important that service providers understand and take account of what ‘quality’ means to teenage mothers. Interview data suggests that they benefit from accessing provision alongside other mothers. It is important that practitioners do not see teenage mothers as a homogenous group but engage with them as individuals, ensuring their particular needs are met.

A briefing on the research findings will give practitioners an opportunity to consider what this means in practice. A written briefing will also be developed and shared with partners in Leicestershire in an attempt to engage with services which have traditionally been positioned outside of teenage pregnancy work, e.g. primary care and community safety teams.

**Challenging stigma**

Stigmatisation of teenage parents is not a new concept. The mothers’ narratives present how stigma impacts upon their confidence, their view of themselves and their engagement with support. Each of the mothers wanted their babies and were keen to be good mothers. By sharing this research with practitioners in Leicestershire it is hoped that this will help to challenge misconceptions about teenage pregnancy and highlight the importance of recognising and supporting individual’s needs to ensure they can fulfil their aspiration to be good mothers.

**Limitations of the research**

Four interviews were undertaken. This was less than the number planned due to challenges outlined below. However, interviews provide valuable insight. The
research aimed to investigate teenage mothers’ needs and their experiences when accessing services in pregnancy and as new mothers. In this respect, this was achieved.

The small sample arose from some challenges with recruitment. One issue was time and minimal opportunities to attend groups to recruit. Whilst recruitment didn’t rely on gatekeepers, there were often workers present at groups who would introduce me as the researcher or make comments about the research. In at least one case this impacted negatively on recruitment. A worker made a comment to the mothers that the research was ‘not about judging their parenting’. I felt that this comment undermined my presentation of the research and was therefore not surprised when no participants came forward from this group. Providing practitioners with a more detailed briefing about the research and expectations when I attended groups to recruit participants might have assisted this.

The intention at the beginning of the study was that the research would provide insight from young mothers that would allow recommendations for improving practice to be made to services. The small sample and limited data generated meant that it is not possible to generalise from the data. What can be done in a limited way is provide some ideas on how practice could be improved based on what participants said.

Final reflections

Undertaking the research

The process of conducting this study gave me insight into the world of research. I experienced first-hand the challenges of recruiting participants and juggling research around work/life commitments. The stage of the study that I enjoyed the most was undertaking the interviews. The mothers talked easily and openly and seemed to appreciate sharing their experiences.
The four interviews ranged in terms of confidence and mood of the mothers. This impacted on how I felt after the interview as highlighted by the following reflective diary note;

22nd April ‘Last night I felt overwhelmed by all the work still to do. I was tired but also very affected by Dana and how completely worn out she seemed – she was putting on a brave face but beneath the surface she was cracking’

One of the biggest challenges for me was separating the role of researcher from the ‘day job’. During the interviews it was sometimes hard to listen and be objective – my natural reaction was to try and help where issues were raised.

Having worked in teenage pregnancy for almost 15 years I came to the research with broad knowledge and assumptions. Separating prior knowledge from the empirical data was a challenge throughout the study. It was important for me to keep going back to what the data itself was saying to ensure that conclusions were not being drawn from the broader knowledge base. Another challenge, was having realistic expectations about how far research findings could be used to inform practice.

*Learning about the topic*

Conducting this research gave me an increased awareness of the impact of stigma on young mothers. Each of the mothers interviewed faced challenges due to their age and circumstances but overcoming their own internalised stigma and that of others was in many ways the biggest challenge of all.

Having been part of the teenage pregnancy strategy from the beginning, my view was that the best support for teenage mothers needed to be specialist and targeted. This view has changed. The interviews suggest that there are advantages to young mothers of accessing support alongside other mothers.
This model could have broad, longer term benefits by bringing different people together and indirectly challenging judgement and preconceptions.

It was interesting that in all of the interviews there seemed to be an absence of traditional family support and in three cases an absence of their own mother. This was not a circumstance I had noted in my work with teenage mothers and could be explored further in future research.

Many aspects of support for young mothers in Leicestershire were experienced positively, which was pleasing but examples of poor care described were concerning. As in the case of Brady et al (2008), I plan to ‘make the research count’ by sharing what the insight suggests could be improved with practitioners in Leicestershire.

Dissemination of the research

Research findings will be shared with those who took part in the research and with Practitioners and Managers.

An easy to read research briefing paper will be written and sent to interview participants. This will also be provided to practitioners who run young parent groups with an offer of attending a group session to discuss the findings with parents who attend.

I plan to commence discussions with Public Health and offer a briefing on the research at an Annual Teenage Pregnancy event scheduled to take place in April 2017. This will provide an opportunity to share the findings and have them considered in service planning.
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