Teenage Pregnancy Research Report
NORTHERN TASMANIA

First published July 2013

This report has been funded by UnitingCare Tasmania and commissioned by the Northern Early Years Group. The Northern Early Years Group (NEYG) is a group of services and agencies working with young children and their families across Northern Tasmania. The group includes people who work in government services, schools, neighbourhood houses, various community organisations and the University of Tasmania.

The statements and opinions contained within this document are solely those of the authors and not UnitingCare Tasmania or the Northern Early Years Group. They are based on the literature reviewed in conjunction with information and experiences provided by young people and services providers who participated in the research.

The authors wish to acknowledge the high level of support and input from both the Pregnant and Young Parent Support program and the cu@home program in providing the means to access and interview a number of young parents from Northern Tasmania.

The authors also wish to acknowledge and thank the young parents who contributed to this report and offered their time and experiences in an open, sincere and honest way. Their input provides critical information to service providers across the northern community in providing targeted services and support.

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Any queries regarding the content of this report can be directed to the authors at 03 63 347 028

The report design is by Halibut Creative Collective Tasmania.

This research project received ethics approval from the HUMAN RESEARCH ETHICS COMMITTEE (TASMANIA) NETWORK on the 7th September 2012. Ethics Ref: H0012627; and Department of Education Educational Performance Services on the 20th November 2012.
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Adolescence is a period of life dominated by transition. The passage from childhood into and through adolescence is comprised of a set of transitions that touch upon many aspects of the individual’s behaviour, development, and relationships. These transitions are biological, cognitive, social and emotional. Transitioning to parenthood is a significant life event for any individual, and has increased significance when it is happening at a time of other transitions such as adolescence.

With funding from UnitingCare, the Northern Early Year Group has sought to understand the local context in Northern Tasmania relating to young people and becoming sexually active, pregnancy and parenting. In doing so, they seek to not just understand but explore opportunities for local responses and co-ordination. The key findings of this research provide an insight into the literature and the experiences of young people and service providers to ensure a well informed and evidence based local context is achieved.
A range of key findings have emerged from the research project. The most significant and perhaps most surprising finding is the lack of understanding about how to appropriately use contraception, and particularly, the pill. This is a significant challenge for policy makers and service providers. In a world overcrowded with messages through a range of social and mainstream medias, understanding how to get the attention of young people in a timely way is not easy. What the research has shown is that sex education at school and conversations with parents is unlikely to be a preferred source of information for this age group. The research demonstrates the need to broaden the approach to include areas that relate to healthy relationships, sexuality and adolescent development in conjunction with exploring more contemporary approaches to getting messages across.

Accommodation is the other significant issue identified by young people once they become pregnant and continued into their parenting. Many of the young people participating in the research were already living independently prior to becoming pregnant. The instability of their living situations was already evident and then exacerbated by pregnancy. With the competing demands of appointments with providers including antenatal care, applications for Centrelink and potentially still trying to attend school, layered with not knowing from week to week where you might be living, it was generally found that appointments are let go in priority to finding somewhere to live. For many young people, this uncertainty of “where is home” continued once their baby was born.

Overall, young parents reported moving up to 5 times over a 12 month period from pregnancy through to the early months of parenting and the impact is significant. In line with a hierarchy of needs, if the service system can prioritise at a regional level the accommodation needs of young pregnant women, it will provide a more seamless approach to then supporting the broader needs including antenatal care, retention in education, health and wellbeing. This should be considered by the Northern Early Years Group and provider service system as a priority area for local action.

In conjunction with the need for accommodation, young people reported the confusion and complexity of the service system they were forced to navigate during pregnancy and parenting. With a range of providers funded to support various elements of need, navigating the system, potentially for the first time, was an added stress during an already stressful time. There was evidence of success where young people had the support of one significant adult who could assist them to negotiate the system with them. At times, this could be extended to advocating for them. This was particularly so with attending antenatal classes, attending to the complexity of Centrelink claims, negotiating and coping with staying at school as long as possible in conjunction with sourcing and negotiating accommodation.

There is an opportunity to look at “lead worker” models where a young person is allocated a worker who then can take the lead role across all providers to support the young person. This would include identifying and prioritising their needs and acting as the navigator and significant adult for the duration of the pregnancy and into the first months of parenting. Providing this level of intensive and personalised support would assist in ensuring many of the risk factors that may be present for individuals are identified and addressed in a structured and consistent approach. In a small region such as Northern Tasmania with an easily identified group of young women, trialling this approach and mapping outcomes is viable.

Throughout this research young people have demonstrated incredible openness to sharing their very personal experiences with the researchers. Their love and dedication for their children cannot be understated and their desire to help inform this community on how to support other young people should be noted. All the young parents highlighted their sense of being judged and feeling a stigma when transacting within the community, be it on a bus, in a store or in mainstream parenting programs and/or playgroup. As a community we need to practice acceptance and understand that age is not a determinant in what defines good parenting.

Finally, this report highlights the importance of understanding that young people are the experts of their own experiences and a key stakeholder when tackling a range of social issues and policy and program responses that impact on them.
Key Findings
The following key findings are based on the information, experiences and data from the Northern Tasmania contextual element of the report. The experiences of the young people participating in the research in conjunction with the feedback from a range of service providers have been used to inform the findings. Implications, policy and potential local area action is informed by the literature based on models and approaches undertaken in other jurisdictions.

**Being Sexually Active**

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<tr>
<th>Family relationships</th>
<th>Key findings</th>
<th>Implications/Opportunities</th>
<th>Policy area/Local action</th>
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<td></td>
<td>The more volatile the relationship between a female teenager and her mother, the more likely she is to participate in risk taking behaviors including sexually. In many cases this leads to leaving home prematurely.</td>
<td>The program response to this issue needs to be linked to schools that are most likely to identify at ages 13 – 16 the early indicators of disengagement and risk taking behaviors with family and with school. There is a gap in providing support/information for parents in dealing with some of the challenges of parenting adolescents.</td>
<td>Identify and trial an approach using a local school/champion to undertake a structured early identification/referral model. Bi-annual sessions for parents of adolescents to provide information and advice.</td>
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| Sex education | Young people name their peers and the internet as their primary source of information, support and advice about relationships and contraception. | Formal sex education programs in schools need to take account of the preferred approach of young people including websites and supported conversations amongst peers. | Identify and trial peer support sex education models and ensure sex education includes the opportunity to explore credible and youth friendly websites. |

| Contraception | Most young people know the range of contraceptions available and where and how to access them. Barriers to access include GP availability, transport and costs. | Policy and program responses should focus on increasing young people’s knowledge of appropriate usage of contraception. | Exploring options for mobile clinics and outreach services. |

| Using contraception | Many young people do not understand how to appropriately use contraception, and in particular, the pill. For example 20% of the survey participants believed the pill was effective even if you forgot to take it for 3-4 days. | Explore innovative approaches to educating/informing young people about the pill. | Develop and trial Phone Apps and potential for a local website with information and regular follow up texts to young women recently prescribed the pill. |

<p>| Emergency contraception | There is a widespread perception that young people are increasingly relying on the Morning After Pill as a regular means of emergency contraception | Not known. | Further research into the use and understanding of why this appears to be a preferred means of contraception and the long term implications for the health and wellbeing of young women. |</p>
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<th>Key findings</th>
<th>Implications/Opportunities</th>
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<tr>
<td><strong>Becoming pregnant</strong></td>
<td>The majority of young women participants described their pregnancies as unplanned and reported being on the pill at the time of conception.</td>
<td>Teenage pregnancy rates will not reduce while there are significant knowledge gaps about using the contraception pill.</td>
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<tr>
<td><strong>Support needs during pregnancy</strong></td>
<td>Instability of accommodation was the most pressing issue for the young women once they became pregnant.</td>
<td>Young women are less likely to access appropriate care and support if their accommodation is unstable.</td>
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<td>Most young women reported that they were uncomfortable and embarrassed to attend antenatal appointments and admitted entering labour with limited knowledge of what to expect.</td>
<td>The need for a nurturing and understanding significant adult as a consistent presence is critical.</td>
<td>Trial a lead worker model at point of pregnancy for a pre-determined period to undertake the care co-ordination and act as a support person, advocate and navigator of the system with the young person.</td>
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## Parenting

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<th>Implications/Opportunities</th>
<th>Policy area/Local action</th>
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<tr>
<td><strong>Support needs</strong></td>
<td>Many young parents experienced unstable accommodation and multiple moves during the first two years of their child’s life.</td>
<td>While accommodation is unstable a range of other needs are often overlooked, appointments are not met and a high level of stress impacts of both the young woman and their baby.</td>
<td>A shared, locally coordinated and prioritised approach to ensuring stable accommodation is established across service providers.</td>
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<td><strong>Single parenting</strong></td>
<td>Significant proportions were single parenting (living alone with their baby/child).</td>
<td>Parenting alone at a young age has implications on health and social areas, particularly in terms of isolation.</td>
<td>Increased need for parenting and social supports through programs such as PYPS to enable social inclusion.</td>
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<td><strong>Education</strong></td>
<td>Young parents express a desire to return to education but need to address a range of other issues and barriers for this to be possible.</td>
<td>There is no right time and each individual will have differing needs based on their living situation, support and health of themselves and their baby/child.</td>
<td>Flexibility in timing, learning options and support are critical in re-engaging young mothers into education.</td>
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<td><strong>Social inclusion</strong></td>
<td>All young parents described feeling judged by many in the community including in shops, on public transport and in the city centre.</td>
<td>Less likely to engage at a support service and community level due to feeling judged.</td>
<td>Need to work on positive image campaigns at a community level and ensure a family friendly approach regardless of the age of parents.</td>
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Poor outcomes associated with teenage pregnancy and parenthood for both parents and their children are well documented internationally, nationally and locally. At a local level, the comprehensive report: Making Choices Young People and Pregnancy in Tasmania completed in 2005 captures the research community’s conclusions on these risks to teen parents and their children:

- A teenage mother is more likely to be dependent on government assistance, have low education completion, a threefold chance of postnatal depression, difficulty developing parenting skills, have rapid, repeat pregnancy and abortion, and be more involved in the child protection system than their older counterparts; and
- The children of teenage parents have an increased risk of pre-term birth and low birth weight, mortality and morbidity during childhood, and a higher risk of physical and mental health problems in later life. They are also more likely to become teenage parents themselves.

Teenage fertility rates in Tasmania have remained high over the past 20 years relative to other Australian states, despite government and community sector efforts to intervene. Currently there is a two-tiered response to teenage birth rates. One is focused on providing appropriate sex education and contraception information to young people and the other provides services that proactively support young parents.

The Northern Early Years Group (NEYG) identified tackling teenage birth rates at a regional level as part of its Five-Year Strategic Plan and commissioned this research project through funding from UnitingCare Tasmania and the Lenten Appeal. The NEYG is focused on adding to, rather than duplicating, the work already completed in the Making Choices report and, as such, the Teenage Pregnancy Research Project has focused on investigating teenagers’ behaviour, values and attitudes to relationships, sexuality, pregnancy and teen parenting in Northern Tasmania.

Specifically, this research seeks to understand the psychosocial reasons behind teenage pregnancy rates and address two aspects of teenage behaviour:

- The gap between knowledge of and access to contraception, pregnancy prevention and sexual activity and behaviour in practice, and the experiences, perceptions and expectations of particularly high risk groups; and
- The decision-making process once pregnancy has occurred and the factors that influence pregnancy outcomes.

The outcomes from the research will be used to map a coordinated strategy with the aim of effectively addressing the teenage pregnancy rates in the north.

This report presents the findings of the research using three categories:
1. Becoming Sexually Active;
2. Pregnancy; and
3. Parenting.

Within these categories, the research explores:
- The literature; and
- The local context.

Additionally key findings and opportunities for further investigation are outlined for each category.

A range of case studies have been used throughout the research report, based on interviews with young parents who participated in this research. These case studies have been de-identified to ensure the privacy of the recipients.
The NEYG has focused this research on the northern region of Tasmania. They wanted the opportunity to hear and understand the experiences of teenagers and teenage parents and to map in detail the complexity of their lives in relation to sex, relationships, pregnancy and parenting in order to implement a strategic service sector response. The methodology encompassed both quantitative and qualitative measures designed to capture a wide cross-section of the teenage population.

The research involved four main components:

1. A review of current international and national research and literature that investigates influences that may be behind teenagers choosing parenthood, teen attitudes, values and behaviour to sexuality and effective programs that address teenage pregnancy rates;

2. Data collection and analysis at an international, national and local level about teenage pregnancy and fertility rates;

3. Exploration of teenage values, attitudes and behaviour about sexuality and contraception, teenage pregnancy and teenage parenting with teenage parents and teenagers through focus groups, individual interviews and surveys; and

4. Perception of teenage values, attitudes and behaviour from government and community services organisations working in the area.

3p Consulting has based the methodology on the understanding that the purpose of the Teenage Pregnancy Research Project is to undertake a high level of research that will provide a sound basis for renewed and targeted interventions that seek to address rates of teenage pregnancy and young parents in Tasmania.
Literature Review

The literature review has been designed to inform the project about outcomes of teenage parenting on both the child and their parents, the influence of targeted programs and the role services and service providers can play to support sexually active teenagers most effectively. In addition the literature review has also enabled validation of conclusions from this research with the broader research base and gauges its applicability to young people in the Tasmanian setting and the north of the state, in particular.

Analysis of the key themes from the literature review also informed the development of the in-depth interviews, the focus group discussions, survey questions and service providers' interviews.

A concerted effort was made to focus on research conducted in the last 5-10 years, identifying the most relevant case studies while ensuring lesser issues were not ignored. The authors were conscious of investigating literature that spanned different social, cultural, ethnic and geographical groupings in their research.

The literature review is contained within each of the three major categories and relates to national and international research that supports and informs the findings of the local context.

Local context

The data and background research component of the methodology has been designed to provide a statistical overview of teenage pregnancy in Tasmania and an in-depth analysis of the concentration of teenage mothers in the north. It also provides information about social, health and wellbeing outcomes for mothers and babies.

This component of our methodology has also mapped the service providers and programs that have contact with young people aged 14 - 19 years in the north. Any relevant state and Commonwealth policy directions and program initiatives have also been documented.

Interviews with young parents

Of critical importance to the research has been the engagement of young people directly. The project gained feedback from young people directly relating to their experiences. This has included:

In-depth interviews

The researchers have worked with programs such as PYP$ (Pregnant and Young Parent Support) cu@home and Tasmanian Aboriginal Health Centre to interview a number of young mothers and fathers who are participating in their programs.

The intent of the in-depth discussions has been to explore with the young people, through listening to their experiences, some of the following:

• Their attitudes, knowledge and use of contraception;
• Family attitudes to and support for their pregnancy;
• Motivations for and thoughts about continuing with the pregnancy;
• Attitudes to and experiences in education;
• Their expectation of motherhood;
• The role of the father; and
• Experience of birth and early parenthood.

Information from the discussions has been integrated into the overall report under the categories outlined. In addition, the researchers have developed a range of case studies which are also used throughout the report to ensure the voices and perspectives of young people are included.

Focus groups with young people

Two focus groups have been conducted with the aim of achieving a deeper understanding of the attitudes and issues surrounding teenage pregnancy and parenting from a range of individuals. They have included talking with young mothers and young fathers to gain a perspective from each group.
Focus groups with service providers

A two-hour focus group was held with a range of service providers from across Northern Tasmania. Invitees included Youth Health Nurses, School Social Workers, CHAPS nurses, GPs working at Cornerstone Youth Services, Sexual Health, Karinya workers, Family Planning, PYPS, cu@home and Gateway Services agencies. The discussion focused on their perceptions and experience of issues for young parents, motivators for continuing a pregnancy, outcomes for young families and their children, and what works well and what are the gaps.

Participants included:

• PYPS - UnitingCare Tasmania;
• Intensive Family Support;
• Launceston General Hospital Maternity Unit Teenage Antenatal clinic;
• cu@home - Department of Health and Human Services;
• Tasmanian Aboriginal Centre Health Service Midwife;
• headspace Launceston - Cornerstone Youth Services;
• Karinya Young Mums Support;
• Karinya Young Women’s Service;
• Babymums - City Mission Launceston; and
• Migrant Resource Centre.

Interviews with other key stakeholders

In addition to the service provider forum, a number of individual interviews have formed part of the research methodology. This includes:

• cu@home team meeting;
• Tasmanian Aboriginal Centre Child Health Child Health nurse;
• Tasmanian Early Years Foundation;
• Project Officer Indigenous Early Childhood Development;
• Project Manager, Kids Come First;
• Family Planning Tas;
• Radar School; and
• eLearning school.

Survey

An online survey has been developed and, through an ethics application process, was approved by the Department of Education for distribution across northern schools. Despite working with the department to organise distribution, the survey was not completed by students at any northern schools. The survey results contained within this report have therefore been derived from a random selection of young people rather than a school-by-school snapshot as was originally intended. The survey participants were made aware of the survey through a number of networks including organisations with youth programs, services frequented by young people and other social media networks accessed by young people. Information sheets relating to the survey and maintaining the privacy of individuals were available to young people before their completion of the survey.

The focus of the survey has been to explore young people’s attitudes to the following key areas:

• How respected they feel in relationships;
• Their aspirations;
• How they negotiate relationships;
• Who they go to for advice and support;
• What young people do and don’t want to talk to their parents/guardian about;
• Their values and attitudes towards sex;
• Their knowledge of sex and contraception; and
• Their self-image.

The survey provides a snap shot of the opinions, thoughts and knowledge of young people across a range of areas that are considered important when working with young people in a preventative, early intervention and primary health framework relative to their sexual activity.

Overall, the consultation and research elements of the methodology have provided a depth of information from a broad cross-section of stakeholders and literature to enable this research to present a comprehensive overview for understanding teenage pregnancy in Northern Tasmania.
Research limitations

This research project was subject to limitations in two ways—by the nature of the subject and by the inability to implement all aspects of the proposed methodology.

Specifically, this research explores the experiences of 25 teenage parents all of whom were contacted through the services that they were engaged with. The research did not capture the experiences and issues facing teenage parents who are disengaged from all services and who may be vulnerable across a range of factors.

Further, teenagers and teen parents respond to circumstances depending on their individual set of life experiences and as such the findings contained in the report are based on generalities that may or may not be applicable to all.

In addition to the above general limitations specifically this research is limited by the:

1. Inability to access all relevant data

There is no recorded data of the actual number of teenage pregnancies across the State and/or by region, rather the number of pregnancies that proceed to birth

- There is no recorded data about the number of teenage pregnancies that proceed to termination in Tasmania.

- There is no recorded data of the number and type of presentations of teenagers relating to sexual activity including contraception advice and prescription, pregnancy and STD testing

- There has been no attempt to access data on the numbers of teenagers who have withdrawn from education and then proceeded to parenthood while still of school age

2. The survey

The survey distribution methodology originally proposed was not able to be implemented due to an inability to circulate the survey in northern secondary and senior secondary schools. The comprehensive survey results provide useful information on the respondent’s sexual aptitude and attitude. However an un-even spread over the male-female gap should be taken into account. Though the results are balanced proportionally between genders, the age gap between the average male and female respondent was up to four years in favour of the female respondents. The survey participants were also spread across an unmeasurable geographical and socio-economic background. In some ways this gives merit to the findings: there is no bias towards any possible contributing influences. In other ways separating findings into sub-categories may have provided insights to the phenomenon that are not yet apparent.

3. Focus groups and individual interviews

It was anticipated that there would be both a geographical and gender spread in the focus groups. However convening focus groups was problematic. The researchers found that young parents preferred to participate in individual interviews rather than in group settings. As a result, fewer fathers were interviewed than anticipated and input from rural areas in the region was limited to George Town.

4. Literature review

International and national academic research is coupled with experiences from Australian service providers and other civil society groups to provide a framework for the report. An effort was made to focus on research conducted in the last 5-10 years, identifying the most relevant case studies while ensuring lesser issues were not ignored. The authors were conscious of surveying literature across different social, cultural, ethnic and geographical groupings in their research.

The authors of this report made a concerted effort to survey a broad spectrum of academic publications in the literature review. The literature review includes reports from a number of countries which focus on a number of factors that contribute to understanding teenage pregnancy. We cannot, however, be certain that all relevant studies were surveyed or that the studies surveyed provide a balanced view of the issue. With that in mind, an element of publication bias may exist throughout the report. This is an issue for any report of this nature.
Literature Review - overview
Introduction

Despite teenage pregnancy birth rates falling sharply across industrialised countries over the past 30 years, teenage pregnancies are seen as an important issue that continues to carry weight in political and social agendas. Briefly, the influences that have brought about such radical changes in society’s perception in a relatively short time include the availability of safe, effective and inexpensive contraception, changes to legalisation such as easier access to abortions, a move away from traditional family formation and the sexual codes that promoted childbearing within the family and an economic orientation that favours extended education, delayed childbearing, two-income households and careers for women. Additionally, current economic pressures have deepened the relative economic disadvantage of the low skilled.

Changes to attitudes concerning teenage pregnancy can be seen against the background of this complex interplay of socio-economic and cultural factors. Parenthood was once socially acceptable for (married) teenagers but, as the 2001 UNICEF Innocenti Research Centre report card states, “teenage births are now seen as a matter of public and political concern, demanding government action in those societies where teenage birth rates remain high.” Teenage parenting has become a social policy issue as the link between poor outcomes for mothers and their children and early parenting has emerged.

Teenage pregnancy and parenting: what are we tackling?

Outlined below is an overview of comparative teen fertility rates internationally, nationally, between states and in the northern region of Tasmania. This data snapshot is designed to provide a broad overview and context for where northern Tasmania is positioned in terms of teen fertility rates and the influence of socio-economic factors. The place of ethnic minorities is also addressed.

The international data outlines the rates for industrialised western countries as these countries have comparative economic, social and cultural environments and a similar concern about the circumstances for teen parents that are most closely aligned to Australia. The national Australian data records the teen fertility rates across each state and provides detail about the ages of teen mothers. Data focusing on northern Tasmania outlines in more detail comparative data by Local Government Area and examines the link between teen fertility and socio-economic status and implications for each of the areas, as well as providing actual numbers of teen mothers in the north of Tasmania.

International trends and comparisons

Comparing teen fertility rates between countries with similar economic status shows very different results. Analysis of these differences has led to current research which examines the specific socio-economic, community circumstances of each country in relation to teen parenting. The following table shows comparative teen fertility rates between industrialised western countries.

Figure 1: Live birth rate to women aged 15–19, 1999 figures (Ref.3)
Teen fertility rates have decreased slightly over the past 10 years for all of the countries listed above and from 2008 there has either been marginal changes or rates have remained steady.

**Link with socio-economic disadvantage**

Why teenage fertility can vary between countries of similar economic and cultural identity can be partly explained by how inclusive and equitable a society is rather than in its overall economic wealth. Countries such as the Netherlands, Scandinavian countries and Germany, which place a priority on promoting universal access to education, have strong social welfare supports and promote diversity, tend to have lower numbers of teenagers becoming mothers. Additionally there is some evidence that countries with lower relative income poverty rates also tend to have lower teen pregnancy rates. The U.S.A, for example, has the highest level of relative income poverty among the industrialised nations (OECD), with more than 23.1% of children under age 17 living in households with incomes less than 50% of the national median while the Netherlands has 6.1% and Germany 8.5%. The US also has the highest teen pregnancy rate among the OECD nations. Similarly, the UK and Canada with high comparative teen fertility rates also rank in the middle of the children living in relative poverty index at 15.8% and 13.3% respectively.

**Influence of ethnicity**

Ethnic minorities also impact on teenage pregnancy and birth rates. Teenage births among immigrant or ethnic minorities are often higher than the average for their nation as a whole. For example, the teenage birth rate in the US is about twice as high for black teenagers as for white (85 per 1,000 as opposed to 45) and higher still (94 per 1,000) for the Hispanic community. This also applies in New Zealand where the teenage birth rate varies from 30 per 1,000 overall to 74 per 1,000 among the Maori. Within Australia Aboriginal teenage fertility rate is three times the national average. Lastly, this is also highlighted in the Netherlands where the teenage pregnancy rates for ethnic minority groups can be more than three or four times that of the Netherlands as a whole, with Turkish ethnic minorities at 31 per 1,000 and Antilles at 40 per 1,000 as opposed to the Netherlands as a whole at 5.2 per 1,000 in 2009. In Tasmania, the total fertility rate for Aboriginal young people is consistently greater than the Tasmanian average (see table ABS Births Data Tasmania in the appendix).

In general, ethnic minorities experience high levels of disadvantage that are reflected in reduced access to health services, tertiary education and lower income levels. However, other factors also have an influence on teenage birth rates. Cultural and religious values that promote early marriage and childbirth, larger families and women not working outside the home are factors that impact on teenage birth rates in addition to the significant economic disadvantage experienced by minority communities. The influence of strong traditional values is also demonstrated in countries that have low teenage pregnancy rates, such as Japan and Korea, in which 80% or more of those who are pregnant are married. It is speculated that this relates to societies that place a high regard on following traditional values. Teenage pregnancy within marriage and with extended family support does not suggest the same adverse long-term consequences as teenage pregnancy that is followed by single parenthood, isolation and poverty.

**National picture**

In 2001, Australia was ranked 11th of 28 OECD countries with a teen fertility rate of 18.1 per 1,000 births and while that figure for both Australia and for other countries has consistently declined slightly over the past decade, the relative status and ranking of Australia remains the same.

The table below shows each Australian state’s teenage fertility rate over the past 20 years and shows that rates have dropped significantly in that time, although they have been comparatively stable since 2006.

**Table 1: Comparison of State Teenage Fertility Rates in Australia**

<table>
<thead>
<tr>
<th>Year</th>
<th>TAS</th>
<th>NT</th>
<th>QLD</th>
<th>WA</th>
<th>NSW</th>
<th>SA</th>
<th>VIC</th>
<th>ACT</th>
<th>AUST</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>38.1</td>
<td>98.9</td>
<td>36.9</td>
<td>31.2</td>
<td>28.0</td>
<td>26.3</td>
<td>21.0</td>
<td>19.9</td>
<td>27.6</td>
</tr>
<tr>
<td>1992</td>
<td>29.0</td>
<td>90.5</td>
<td>26.5</td>
<td>25.0</td>
<td>22.8</td>
<td>18.7</td>
<td>14.7</td>
<td>14.0</td>
<td>22.0</td>
</tr>
<tr>
<td>1997</td>
<td>27.3</td>
<td>75.5</td>
<td>25.6</td>
<td>21.2</td>
<td>19.5</td>
<td>16.2</td>
<td>12.4</td>
<td>13.5</td>
<td>19.8</td>
</tr>
<tr>
<td>2000</td>
<td>25.7</td>
<td>69.6</td>
<td>22.7</td>
<td>20.9</td>
<td>16.7</td>
<td>15.2</td>
<td>10.8</td>
<td>10.9</td>
<td>17.7</td>
</tr>
<tr>
<td>2004</td>
<td>24.8</td>
<td>57.8</td>
<td>21.7</td>
<td>19.7</td>
<td>15.1</td>
<td>13.8</td>
<td>10.6</td>
<td>8.1</td>
<td>16.0</td>
</tr>
<tr>
<td>2006</td>
<td>26.5</td>
<td>63.5</td>
<td>19.7</td>
<td>19.6</td>
<td>13.2</td>
<td>16.7</td>
<td>9.7</td>
<td>9.1</td>
<td>15.3</td>
</tr>
<tr>
<td>2008</td>
<td>27.5</td>
<td>51.9</td>
<td>24.7</td>
<td>22.7</td>
<td>13.9</td>
<td>18.3</td>
<td>10.6</td>
<td>8.0</td>
<td>17.2</td>
</tr>
<tr>
<td>2010</td>
<td>21.5</td>
<td>48.1</td>
<td>24.0</td>
<td>19.1</td>
<td>12.9</td>
<td>15.3</td>
<td>8.5</td>
<td>8.9</td>
<td>15.5</td>
</tr>
</tbody>
</table>

Reflecting the international data that links disadvantage with higher rates of teenage birth rates, those states with larger proportions of rural and remote areas, significantly low socio-economic status and high population of indigenous people have higher rates than those that don’t. Therefore, in 2010 Victoria and the Australian Capital Territory recorded the lowest teenage fertility rates in Australia (both at 9 births per 1,000), while the Northern Territory recorded the highest (48 per 1,000).

A young Aboriginal or Torres Strait Islander is six times more likely to be a teenage mother, with figures of 79 births per 1000, than their non-indigenous counterpart. These figures mean that 21% of all indigenous mothers are teenagers as compared to 3% for non-indigenous mothers. Similarly, analysis of teenage birth rates between Sydney suburbs shows that affluent suburbs have teenage birth rates at 5.4 per 1000 compared to poorer suburbs with figures such as 23.2 and 48 per 1000. It is suggested that teenagers in more affluent suburbs with better education and career prospects are better informed and motivated to use contraception and abortion while women in lower socio-economic groups are less likely to have the required knowledge and resources to access contraception or abortion services.

In Australia, the majority of teenage births are to women aged 18 and 19 years (28% and 44% respectively). In 2010, the fertility rates for women aged 18 and 19 years were 21 per 1,000 and 33 per 1,000, respectively. In comparison, 4% of births to teenage mothers were to women aged 15 years or younger.

**Tasmania**

As shown by Table 1, in 2010 Tasmania had the third highest rate of teenage fertility in Australia at 21.5 per 1,000 following the Northern Territory and Queensland. This translates into 357 births across the state in 2010, a drop from 443 births in 2009.

The distribution of teenage fertility rates is uneven across the state with significantly high rates in each of the local government areas that correspond to areas identified as high need, that is, those areas that have few social and economic resources available to households and that contend with socio-economic disadvantage.

<table>
<thead>
<tr>
<th>Socio-Economic Disadvantage Quintiles (excluding Burnie LGA)</th>
<th>Tasmania</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Disadvantaged</td>
<td>53.9 (±2.7)</td>
</tr>
<tr>
<td></td>
<td>36.8 (±2.3)</td>
</tr>
<tr>
<td></td>
<td>20.0 (±2)</td>
</tr>
<tr>
<td></td>
<td>15.3 (±1.8)</td>
</tr>
<tr>
<td>Least Disadvantaged</td>
<td>8.8 (±0.9)</td>
</tr>
</tbody>
</table>


The Tasmanian Kids Come First project, an initiative established by the Tasmanian Government in 2008 tracks and provides wide-ranging data about Tasmanian children and young people data over time. The data is organised around 30 outcome areas with 115 specific indicators. The outcomes framework compiles information down to suburb level, by age, gender and Aboriginal status. Kids Come First aims to make information readily available to policy makers, programs and services to assist in planning, managing and monitoring services.

Teenage fertility rates are one of the specific indicators measured by the framework because while “many teenage births result in positive outcomes for both the mother and her child, teenage mothers are more likely to have poorer health, education and economic outcomes than older mothers”.

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22
The local context

Between 2007 and 2010, there were approximately 115 mothers aged between 15-19 years in the north of the state each year. There was an average of 4,430 young women aged between 15-19 years in those years.

Relative to the rest of Tasmania, the Northern Tasmanian rate of 26.1 per 1,000 is in line with the state figure of 26.2 and above the national teenage fertility rate of 15.5 per 1,000 young women aged 15-19 (2010).

Age Range

The table below (table 3) shows the average number of mothers over a four year period at each age in the North. The figures are in line with international and national figures and show that most teenage pregnancies occur at the upper end of the teenage age range with 40% of mothers being 19 years of age and less than 6% were aged 15 years (or under).

Table 3: Average Yearly Teenage Fertility Rate be age in the northern region (2007 - 2010)

<table>
<thead>
<tr>
<th>Region</th>
<th>Age</th>
<th>Number of Mothers aged 15 - 19</th>
<th>Female population aged 15 - 19</th>
<th>Northern Fertility rate (per 1,000)</th>
<th>Tasmanian Fertility Rate (per 1,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>15</td>
<td>6.8</td>
<td>956</td>
<td>7.1</td>
<td>4.7</td>
</tr>
<tr>
<td></td>
<td>16</td>
<td>10.8</td>
<td>881</td>
<td>12.2</td>
<td>11.4</td>
</tr>
<tr>
<td></td>
<td>17</td>
<td>19.5</td>
<td>891</td>
<td>21.9</td>
<td>22.7</td>
</tr>
<tr>
<td></td>
<td>18</td>
<td>32.3</td>
<td>852</td>
<td>37.9</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>19</td>
<td>45.8</td>
<td>850</td>
<td>53.8</td>
<td>57.7</td>
</tr>
<tr>
<td>Northern Average Yearly Total</td>
<td>115.5</td>
<td>4430</td>
<td></td>
<td>26.1</td>
<td>26.2</td>
</tr>
</tbody>
</table>

Teenage fertility rates in Northern Tasmanian Local Government Areas

Table 4 shows teen fertility rates for the each local government area (LGA) in Northern Tasmania against the state average. The figures show the differences between the LGAs, numbers of teenage mothers against the total number of female teens in the LGA, and the teen fertility rate for each LGA.

Table 4: Total Numbers and Rates of Teenage Fertility Rates in northern LGAs in Tasmania

<table>
<thead>
<tr>
<th>Region</th>
<th>LGA</th>
<th>Number of Mothers aged 15 - 19</th>
<th>Female population aged 15 - 19</th>
<th>Teenage fertility rate (per 1,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>Break O’Day</td>
<td>4.3</td>
<td>136</td>
<td>31.3</td>
</tr>
<tr>
<td></td>
<td>Dorset</td>
<td>4.3</td>
<td>195</td>
<td>21.8</td>
</tr>
<tr>
<td></td>
<td>Flinders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>George Town</td>
<td>11.8</td>
<td>221</td>
<td>53.2</td>
</tr>
<tr>
<td></td>
<td>Launceston</td>
<td>66.8</td>
<td>2144</td>
<td>31.1</td>
</tr>
<tr>
<td></td>
<td>Meander Valley</td>
<td>8.3</td>
<td>554</td>
<td>14.9</td>
</tr>
<tr>
<td></td>
<td>Northern Midlands</td>
<td>7.3</td>
<td>344</td>
<td>21.1</td>
</tr>
<tr>
<td></td>
<td>West Tamar</td>
<td>12.5</td>
<td>827</td>
<td>15.1</td>
</tr>
<tr>
<td>Northern Average Yearly Total</td>
<td>115.5</td>
<td>4430</td>
<td></td>
<td>26.1</td>
</tr>
<tr>
<td>Tasmanian Average yearly total</td>
<td>417.8</td>
<td>15965</td>
<td></td>
<td>26.2</td>
</tr>
</tbody>
</table>
Link with Socio–Economic disadvantage

Overall, Northern Tasmanian data reveals a high concentration of teenage parents living in the George Town and Launceston areas. The suburbs of Rocherlea, Mayfield, Ravenswood, George Town, Waverly had both high rates of teenage mothers as well as high numbers of teenage mothers. These suburbs comprised 30% of all births to teenage mothers in the North, but only 10% of the relevant population. The over-representation of teen parents in these suburbs can be partly explained by the availability of public housing in these areas.


Being sexually active
This section of the research focuses on the point when young people first become sexually active.

It links the key themes emerging from the literature review with the perspectives and experiences of teenagers in Northern Tasmania. This includes teenagers who participated in the survey, discussions with teenage parents through the focus groups, individual interviews and discussions with the service providers who work with them.

The research at the Northern Tasmania level has captured young people’s perspectives regardless of whether they are sexually active, pregnant or parenting. This enables a broad snapshot of the values, attitudes, knowledge and behaviours of young people relative not just to sex but also relationships, sexual health and their peers.

The key themes emerging from the both the literature and our consultations about being sexually active are:

- The role of family, peers and the community in influencing sexual choices;
- The role of schools in sex education;
- The influence of the internet on sex education of young people;
- Relationships and negotiation;
- Access to and use of contraception;
- Lifestyle and risk taking; and
- Role of education and aspirations for the future in influencing sexual choices and behaviour.
Sexually Active

Kassie was nearly 15 years old when she had her baby, Jayden, who is now 12 months old.

Kassie was in Grade 9 when she became pregnant but had been going to school less and less often since she started going out with Josh in Grade 8. She said that she started “acting up” at school in Grade 7 but that she had never really liked school and was “not much good at it”. When she was younger, Kassie had attended three different primary schools due to unstable housing. Kassie and her mother had lived in five different houses before Kassie was 10. Kassie’s mother had her when she was 16 years.

Her last move was when her mother moved in with her stepfather to public housing. She has a half-sister and a half-brother that were born when she was 11 and 12 respectively. Kassie was tasked with looking after them a lot when they were very young, getting them up in the mornings and looking after them at night. Her mother and stepfather were busy with their own lives and issues and left Kassie and her siblings alone on a regular basis.

She and Josh met each other when she was 14 and he was 18 and had been together for about 6 months. Josh lived with some mates in a rental property and Kassie spent most of her time there. Kassie and her mother had many arguments and disagreements and Kassie moved in to Josh’s share house and stopped going to school all together. Kassie says that they hung around, drank a lot and took a raft of recreational drugs.

Kassie reported that she and Josh never talked about what would happen when they had sex, what type of contraception would be best or whether they might decide to have children in the future. However despite not talking about contraception with Josh, Kassie wasn’t too worried because she had been on the contraceptive pill since she was 13 after her mother had taken her to her family doctor because she wanted to stop her from becoming pregnant. Since she moved in with Josh, filling the prescription and remembering to take the pill regularly was more difficult. Her knowledge of sexual health and contraception came via her mother and from talking to her friends. She has only vague and slightly uncomfortable memories of sex education classes at school prior to her dropping out.

Kassie went to headspace, a youth drop-in centre, for a pregnancy test because she felt sick. When the test was positive she told Josh the news first and then her mother. Kassie was shocked at the news. She acknowledges that she forgot to take the pill some days but she thought it would be OK because her doctor had told her that hormones from the pill stay in the body for several months.

Her mother thought she should have a termination and so did Josh but between the time of her pregnancy test, and thinking about what to do, she was over 12 weeks pregnant and “it was too late”. Although she had thought that she might like to have a baby sometime in the future Kassie wasn’t happy about being pregnant at 14. However while trying to make up her mind she reflected that she would be good at looking after a baby because she had been caring for her siblings since they were babies. She reports this experience as something she enjoyed and that she felt important and useful while caring for them. She was worried about where her life was going and knew that focusing on her baby would give her the motivation to change her habits.

Pregnancy

When she realised that she was going to have a baby Kassie was aware that she had to change her life style so she could look after her growing baby. She knew that meant she should stop drinking alcohol, smoking tobacco, using illicit drugs and try to eat a healthy diet. She also knew that she needed regular antenatal care. The headspace nurse referred her to the Launceston General Hospital’s specialist teenage antenatal clinic and she went with a friend for the first visit.

She stopped drinking and cut down on smoking cigarettes but still used cannabis with Josh. She also cut back on take away food. Her relationship with Josh was volatile, occasionally violent, and he continued to go out with his mates. However they decided to move in with Josh’s family as a temporary measure while they tried to find a place before they had their baby.
Money was a constant issue as Kassie was receiving a Centrelink benefit and this involved multiple appointments to organise payments. As she was younger than 16 she nominated Josh's mother's account to receive her payments. In the last months of her pregnancy Kassie left Josh and went to stay with some friends. This meant that she needed to arrange for her payments to be transferred to another account. Kassie often had very little money and consequently ate poorly. Over a period of 8 months since leaving her mother's house, Kassie lived in five different places.

During her first appointment with the antenatal clinic Kassie was referred to the cu@home program. headspace also gave her information about the program and other supports, such as the Pregnant and Young parent Support (PYPS).

After she and Josh split up Kassie decided to contact the cu@home program as she was worried about being prepared to have her baby. She did not have a place to live; she had a large Telstra debt ($3,000) and did not know what to do next. Additionally while she had some contact with her family, her relationship with her mother was not improving. She knew that if she committed to the program Kassie would move through a structured, intensive program, seeing the same worker, on a regular basis until her child was two years old.

Despite agreeing to enter the cu@home program Kassie had a lot of trouble remembering to keep appointments with the worker; mostly because her life was in turmoil. She had trouble finding somewhere to live, she was seeing Josh (on and off), and she reports that she was not always receiving her Centrelink benefits.

Kassie attended a total of four antenatal appointments during pregnancy mostly because Josh's mother went with her. When she stopped living with Josh at his mother's house it was hard to find someone to drive her to the clinic. This meant that Kassie knew very little about the process of labour and delivery and she reports that she had been pretty worried. She had felt uncomfortable with the hospital run parenting classes and hadn't attended the labour ward tour.

When she was in her last month of pregnancy, with the support of the PYPS and cu@home workers, Kassie received a place in a Karinya unit and participated in some birth and parenting preparation and was able to meet with other young pregnant women and young parents.

Kassie went into labour one evening and her friend accompanied her. She didn't talk about her experience very much but spoke about it being a bit of a shock but OK.

**Parenting**

Kassie says that parenting Jayden has been harder than she thought it would be and finds that taking care of Jayden is more difficult the older he becomes. With support from the cu@home worker she breastfed for 5 months and has come to rely on PYPS group for her social life. As she says: “I didn’t have many friends before”.

Josh and his family were involved with Jayden in his early months and had access to him for four hours once per week. After Jayden was 6 months old and no longer breastfed they had agreed that Josh would see Jayden once per fortnight overnight. Kassie is uncomfortable with Josh’s friends and doesn’t trust him to take care of Jayden safely and has refused him access for the last two visits. Her relationship with her Mum is a little better but still not close. Kassie says that her Mum tells her what to do all the time and it’s almost as though Jayden is “her child” and not Kassie’s.

Kassie would like to work so that she can change her circumstances. To do this she believes that she needs to complete some education and with support from a cu@home worker, she enrolled at City Campus. However getting to and from school via public transport with Jayden is difficult. It involves two buses and the timetabling means that she needs to leave early two days a week. The option of the eLearning Program required a level of self-discipline and organisation that Kassie doesn’t yet have. In addition to the practical difficulties of going to school, her lack of engagement in education in her early years still impacts her confidence about resuming formal schooling.

Kassie says that she is glad to have Jayden in her life but wishes that she had lived a bit before she became a mother and definitely wishes that she had done “better” at school so that she had more options for her future. Her biggest hope is to find work, probably in childcare, and to have a “proper” family one day.

Kassie also notes that one of the most difficult day to day problems is coping with stigma about being a young parent from the general public. It means she is uncomfortable going out to shop or using public transport and has no thoughts of participating in any mainstream activities that may be available such as playgroups or clubs etc.
Literature Review - Being sexually active

The teenage years are primarily concerned with a developing and emerging sexuality and this includes being sexually active.\(^1\) The context of teenage sexual behaviour and how it applies to teen pregnancy and birth rates in today's western industrialised countries is most easily viewed through a country's political, social and religious history that in turn influences its range of sexual health policies and program responses that target adolescents. The outcome of each country's range of responses can be demonstrated by marked differences in teenage pregnancy and birth rates between industrialised countries that have comparable levels of economic wealth.

Across industrialised countries, including Australia, the average age of sexual activity, including intercourse is about 16-17 years and current evidence internationally and nationally shows a steady trend downwards over the past 20 years and that this earlier participation in sex is especially evident for young women.\(^2\) Young people are having sex more often and younger than ever before. Depending on the country that young people live in, they may face conflicting messages about acceptable sexual behaviour. While there may be significant societal concern regarding non-marital sex, this sits alongside more permissive attitudes portrayed in popular media and what is freely accessible on the internet.

A Canadian study sought to understand how an adolescent might navigate this apparent conflict and what the influences of community, family, peer, and broader social contexts have on both their feelings about themselves as sexual beings and their sexual behaviour.\(^3\) They found, in part, that young people turn to their peers for support and confirmation about their sexual behaviour and also rely on specific information and advice from non-judgmental service providers such as youth-specific health clinics. However, young people generally felt uncomfortable talking to their parents about sex and were wary or conflicted towards sex education programs that concentrated on the risks and dangers of sex.

Other research has confirmed the important influence of family in shaping the values and attitudes of teenagers in relation to being sexually active and how this factor, together with the broader influences of peers and community, impact on the likelihood of sexual practices that lead to unwanted pregnancy and/or sexually transmitted diseases.\(^4\) Young people who, for example, feel that they have a high-quality relationship with their parents and who communicate regularly with them, teens who attend schools that they and their teachers perceive as safe (with low levels of crime and vandalism) and involvement in community activities are all factors that lead to a reduced likelihood of teen pregnancy. Conversely, sexual practices leading to unwanted pregnancy and/or sexually transmitted disease have been shown to link with other risk-taking behaviours such as alcohol and drug use, unstable family relationships or poor communication within the family unit, low socio-economic status, belonging to an ethnic or cultural minority and a lack of engagement in education and community activities.\(^5\)

Teenagers exploring their sexuality in countries where the perceptions around teenage sexuality and being sexually active are framed in more open and less conflicted terms in general have program policy and community responses that are not at odds with one another.\(^6\) In such countries, institutional messages, such as those promoted in schools and media campaigns, as well as family and community discourse about sex and adolescence, are all closely aligned.

In summary, within the Australian context, an adolescent's sexual decision-making relies on messages gained from their family, peer-group and local community contexts and is more broadly informed by the social and political factors at play at a state or national level.
Apart from the strength of a teen's social and community influences, addressing teenage pregnancy rates relies on adolescents' access to contraception and the understanding and knowledge of when and how to use it.

As argued by UNESCO’s 2009 International Guidelines on Sexuality Education, "schools provide a practical means of reaching large numbers of young people from diverse social backgrounds in ways that are replicable and sustainable." Young people spend a considerable amount of time at school. Additionally, they are most likely to have their first sexual experiences while attending school, and it is in this context that sex education has become an avenue for many countries to provide information to children about sexual and reproductive health and development. It is also seen as a means to help reduce teen pregnancy rates and sexually transmitted infections.

As outlined earlier, agreement on how to go about providing sex education and contraception to teenagers varies from country to country depending on its historical relationship to sexuality in general and to adolescent sexuality in particular. Put simply, the way a country approaches sexual education and provision of contraception to adolescents depends on whether a society has decided if information or innocence is the best way of protecting children from the problems associated with teenage sex.

This difference in approach can be illustrated by comparative responses of the US and the Netherlands to their teenagers’ sexuality in the areas of family and community, sex education, and contraception service provision.

1. US parents “dramatise” teenage sexuality by highlighting the dangers, conflicts, and the difficulties of becoming sexually active as a teenager while the Dutch “normalise” sexuality, viewing it as a normal part of adolescent development. Importantly, sexual intercourse in the Netherlands is seen as an acceptable part of adolescent development as long as youth are using contraceptives responsibly and involved in healthy relationships.

2. In the Netherlands, sex education is incorporated into most aspects of a child’s education and is usually integrated across school subjects and at all year levels. In contrast, sex education in the US is set out by state laws which govern what is taught in sex education classes and there is always an option for parents to opt out.

3. Dutch policy makers and health care providers, most notably family physicians, have made a deliberate effort to make contraception easily accessible to young people, while in the US there are varying policies and restrictions state to state.

It is clear from the above evidence that countries with low teenage pregnancy and birth rates also have a comprehensive social and policy response to sexual health and contraception programs for their young people. These encompass mandated sexual health and relationships education in the school system, community campaigns, and providing accessible, youth-specific sexual health services. The underlying principle informing policy responses is that sexual activity is understood to be developmentally normal during adolescence. Therefore, it should be considered “normal” to provide a program response based on knowledge and access to contraception.
What works

As the Netherlands and Sweden have comparatively low rates of teenage pregnancy in comparison with developed western countries, how they provide sex education to young people is considered to be a model that could assist in helping those countries that grapple with higher rates, such as the US, Canada, the UK and Australia. The Netherlands has the second lowest teenage birth rate and the lowest teenage pregnancy rate in the developed world at 4.1 per 1,000. In the past 30 years the Netherlands has reduced teenage births by 72% and has also maintained a low abortion rate among this age group.

While the Scandinavians and the Dutch have different approaches or systems to educating their young people about sex and contraception, they have common elements and these include:

- Society as a whole, as well as political and social policy, reflect an acceptance of sexual activity and contraception use among teenagers;
- All children have access to sex education;
- Sex education starts early and is addressed each year;
- An emphasis is placed on supporting adolescents to develop healthy, safe, responsible and positive attitudes towards sexuality, and to strengthen their skills in communication and negotiation about safe sex;
- There is a gender equality perspective and multicultural diversity, and;
- There is a strong link between the schools and contraceptive clinic services for adolescents.11

The above approaches can be compared with the US, which has a more ambiguous and shifting public and political approach to teenage sexuality and demonstrates clearly how policy decisions impact on teenage pregnancy rates. Most federal funding in the US to reduce teenage pregnancy rates in 2002, for example, was allocated to promoting an abstinence-only program response to contraception. Despite figures showing a steep decline in the 1990s and a flattening out in the early 2000s, teen pregnancy and birth rates increased among all ethnic and racial groups between 2005 and 2006 when abstinence-only programs became more widespread.12 Similarly, a central recommendation to the British government designed to help prevent the high teenage pregnancy and birth rates in the UK in 1999 by extending sex education programs into primary schools, was withdrawn because of community concern about children “losing their innocence”. This was at the same time as the government continued to spend considerable public money to support teen parents and their children.

In summary, countries that have relatively high rates of teenage births have a number of factors in common:

- divergent and disparate views of teenage sexuality that play out in the public and political arena;
- haphazard implementation of sex education;
- difficulty for teenagers accessing contraception including abortion;
- a high differential of wealth and poverty, and;
- a significant ethnic or cultural minority.

The first three factors outlined above have implications in tackling emerging adolescent sexuality and sex education policies. The link between teenage pregnancy and parenting and the final two dot points are examined in more detail in the pregnancy and parenting sections.
Sex education in Australia

Education relating to sexuality has been taught in Australian schools for well over 100 years but this has generally been ad hoc and as an addition to the curriculum rather than integrated. More recently, the public debate has shifted from whether it should be taught to whether it should be mandatory in all schools, based on the fact that if it is not, some young people are missing out. Research demonstrates that Australian secondary students see school programs as one of their most useful sources of information about sexual health and relationships.13

Sex education in Australian schools is regulated by a national curriculum set through the Ministerial Council on Education, Employment, Training and Youth Affairs (MCEETYA). No national curriculum currently exists in this area, however there is a broad policy agenda for the underpinning objectives in human relationship education. These have been developed by the World Health Organisation (1998) and include the ability to:

• make sound decisions about relationships and sexual intercourse and stand up for those decisions
• deal with pressures for unwanted sex or drug use
• recognise a situation which may turn risky or violent
• know how and where to ask for help and support
• know how to negotiate protected sex and other forms of safe sex when ready for sexual relationships.14

This broader agenda for sexuality education is generally endorsed by education authorities in Australia and enshrined in curriculum guidelines. Nevertheless it is not consistently or universally taught as states and territories have the responsibility of developing local curriculum frameworks. This means that where, how and to what degree sexuality education is included varies substantially. This is demonstrated in the following table, which was developed in 2010 as part of a desk review by the Australian Research Centre in Sex, Health and Society (ARCHS). The centre works collaboratively and in partnership with communities, community-based organisations, government and professionals in relevant fields to produce research that promotes positive change in policy, practice and people’s lives.15 The review methodology involved an internet search of information available from the designated state and territory curriculum authorities.

What this table demonstrates is a lack of consistency both in approach and content of the curriculum of sexuality education in Australian schools. As evidenced by the low teen pregnancy rates in the Netherlands for example, school sex education can be an effective forum to provide young people with the knowledge base to make responsible choices around reproductive health and as such to help reduce teenage pregnancy rates. It is therefore difficult to consider that the inconsistent and non-mandatory application of sex education through the school system in Australia is an effective means by which teenage pregnancy and birth rates can be reduced.
## State and Territory curriculum on sex education

<table>
<thead>
<tr>
<th>Curriculum body</th>
<th>Curriculum</th>
<th>Is it compulsory?</th>
<th>Where does it appear</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT Department of Education and Training</td>
<td>Curriculum Framework establishes Essential Learning Achievements</td>
<td>Not specifically</td>
<td>Essential Learning Achievements for Adolescence include knowledge of discrimination based on sexuality, human sexuality, negotiation, and positive relationships.</td>
</tr>
<tr>
<td>Board of Senior Secondary Studies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board of Studies N.S.W.</td>
<td>Curriculum framework outlines syllabuses and learning outcomes</td>
<td>Personal Development, Health and Physical Education are identified as mandatory key learning areas for years 7-10.</td>
<td>Personal Development, Health and Physical Education Syllabus. Includes positive relationships, sexual relationships and diversity of sexuality.</td>
</tr>
<tr>
<td>Queensland Studies Authority</td>
<td>Essential Learnings for middle years and senior years</td>
<td>Health and Physical Education is compulsory until Year 10 but Essential Learnings only explicitly includes sexual health at year 10.</td>
<td>Health and Physical Education includes sexual health. At HSC level, health education, and community and social studies (relationships).</td>
</tr>
<tr>
<td>South Australia</td>
<td>Essential Learnings for Middle years and senior years</td>
<td>Health and Physical Education is compulsory until year 10.</td>
<td>Essential Learnings in Health and Physical Education includes safe sexual behaviour, skills in negotiating sexual rights, sexual identity, positive relationships.</td>
</tr>
<tr>
<td>Department of Education Tasmania</td>
<td>Sets curriculum and standards</td>
<td>Health and Wellbeing is compulsory to Year 10.</td>
<td>Health and Wellbeing syllabus includes sexual and reproductive health, sexual identity, positive relationships.</td>
</tr>
<tr>
<td>Victorian Curriculum Authority</td>
<td>Victoria Essential Learning Standards</td>
<td>Victorian Government Schools Reference Guide identifies sexuality education as compulsory for all government schools from prep - year 10.</td>
<td>Sexuality education falls in the Health and Physical Education domain and the Interpersonal Development domain (e.g. respectful relationships). Also some content in the Science domain.</td>
</tr>
<tr>
<td>Curriculum council of Western Australia</td>
<td>Curriculum Framework consists of Learning Statements which outline Learning Outcomes</td>
<td>Health and Physical Education is compulsory until Year 10.</td>
<td>Learning statement on Health and Physical Education includes sexuality, sexual health, reproductive health, relationship skills. Content is extended at HSC in Health Studies.</td>
</tr>
</tbody>
</table>
Sex Education in Tasmania

Sex education in Tasmania has traditionally been the province of individual schools and taught through the Health and Wellbeing elements of the curriculum. In addition, schools have received some support through external providers with specialist knowledge in youth health services, clinics and specialist sexual health services. To date, implementation of a best-practice, consistent and comprehensive sex education program that can impact on teenage pregnancy rates is at a strategy stage and has not been implemented. The direction outlined in the Tasmanian Curriculum Policy states that: “all schools should offer all students a comprehensive, developmentally appropriate relationships and sexuality education program.”

There are a number of Tasmanian government policy and program responses to the high teenage pregnancy rates in Tasmania. Tasmania Together benchmark 4.1.3 has the aim of reducing teenage birth rates and the Office of Children (DHHS) 10-year strategy for children and young people has specifically highlighted reducing teenage pregnancy rates by “improving access to youth health services and delivering comprehensive relationships and sexual health education”.

Most recently the Making Choices Two Action Plan is a direct response to the Our Children Our Future, Tasmania’s Agenda for Children and Young People Action Area Two. Making Choices Two Taskforce brings together government and non-government services to ensure implementation of relationships and sexuality education in Tasmanian schools, introduce youth health clinics across secondary colleges if needed and/or improve referral pathways in colleges and extending the cu@home program to rural areas and vulnerable young people.

A direct policy initiative has been the recent launch of the Relationships and Sexuality Education Strategy for government schools expected to be implemented by 2014. This strategy recognises that there is an increasing interest and expectation by the Tasmanian community for relationship and sexuality education in Tasmanian schools. The three-year strategy aims to increase both the quality and extent of relationships and sexuality programs in Tasmanian schools. This includes the intention that programs will be:

- sequenced;
- development-appropriate;
- coherent; and
- inclusive of all students.

Overall, the strategy has three broad action areas:

1. Increase school and system awareness and accountability through curriculum policy guidelines for schools;
2. Work in partnership with local communities, schools, school networks, Learning Services and allied agencies; and

Further to the policy agenda, how the sexuality and relationships education is implemented and how it is viewed by students, will be discussed in the key findings section of this report.
Young people, the internet and sexuality/pornography

is a Victorian community education project which seeks to respond to the social and personal implications of increasingly pervasive and hard-core pornography, and its impact on young peoples’ perceptions of men, women and sexuality.\(^{19}\)

The project grew out of Maree Crabbe’s work in sexuality education with young people in secondary schools and community settings, in which she noticed that pornography was increasingly a source of sex education for young people.

Maree who is an adolescent sexuality expert and her colleague, David Corlett, developed the *Reality & Risk* project. The project aims:

1. To develop and promote a critique of the messages about men, women and sex conveyed in mainstream pornography; and
2. To articulate a framework of sex and gender based on an understanding of shared human dignity and respect, using concepts such as communication, consent, and mutual pleasure.

Stage 1 of the project initially included two components:

1. To develop education resources for use in secondary schools, including curriculum resources, audiovisual materials, teacher training and resources for parent education and policy development promoting critical thinking about pornography; and
2. To engage in public discourse about the implications of pornography consumption for young people, through production of a documentary film for broadcast, written articles and speaking events.

A 2006 study of Australian schools found that 93% of males and 62% of females had been exposed to internet pornography and the average age that children first saw pornography was 11.\(^ {20}\) Given the pervasiveness of technology in modern Australia, it is almost impossible for young people to avoid pornography. In short, pornographic material is incredibly accessible to young people in 2013. In this way pornography is becoming normalised, particularly amongst young males. Research shows that young males are more likely than their female counterparts to consume pornography, to use said pornography for sexual excitement and to initiate the consumption of pornography.\(^ {21}\)

There is evidence to suggest that pornography is a significant contributor to young teen’s knowledge about sex. Research has shown that pornography is the most accessible source of specific sexual information, such as how to physically engage in the act, available to young people.\(^ {22}\)
Certain insignia of pornography have become commonplace in mainstream culture, such as females shaving their pubic hair or the mainstreaming of pornographic labels like Playboy. The pervasiveness of such insignia gives legitimacy to the idea that acts seen in pornography are acceptable.

The images that young people are seeing in pornography inform their own ideas about what sex is, and how it should be acted out. Troublingly, pornography is becoming more mainstream and more hard-core. Graphic content that used be to be rare, such as heterosexual anal sex and acts of physical aggression, are now common place and readily available. A survey of the 50 best-selling pornography videos in the United States showed that 88% of the films showed physical aggression and 48% contained verbal aggression. 94% of this aggression was targeted at women and 95% of said aggression was met with either pleasure or a neutral response.

This has normalised acts that, according to the research, women do not enjoy or find painful, degrading or violating and has linked aggression to sexuality. This has serious implications for young people’s capacity to develop a sexuality that is mutually pleasurable, fully consenting and respectful, and for gender equality in general. Accordingly, we are seeing young women internalising the messages that are found in pornography. For some young women, sex is not a mutually enjoyable act but one that is structured to appeal to men.

Pornography may also be having an effect on rates of teenage pregnancy and instances of sexually-transmitted infections (STIs). In 2009 there were more than 70,000 report cases of STIs in Australia. 75% of these cases fell in the 15-29 year old age bracket. This only represents reported cases and the real number may be much higher. Most cases of STI and teen pregnancy have occurred where people have deliberately neglected to use protection for a number of reasons. This could also be a lesson learned from pornography. Only 10% of male actors in the 50 best-selling pornography videos wore a condom.

Other acts frequently seen in modern pornography are also poor examples of sexual health, such as practicing anal sex without a condom or combinations of transitioning from anal sex to vaginal sex to oral sex.
The local context

To gain a deeper understanding of the thoughts, knowledge and perspectives of young people relating to being sexually active, a range of consultations have taken place. This includes a survey which was available to all young people in Northern Tasmania aged 13-20 in conjunction with the focus groups and individual interviews with young parents. A range of common themes emerged during the research relating to sexually active young people.

Family and relationships

One prominent theme that came out of the consultations with teenage parents was the extent and level of isolation from their family. This was articulated most clearly by young women and centred on estrangement and difficulties with their mothers. Ongoing and difficult family relationships were linked by the participants to their behaviour and living situation prior to becoming pregnant. While disruption in adolescence is part of normal development, the level of perceived alienation from family by teenage parents stood out in all parts of the cycle from being sexually active through to pregnancy and parenting.

The literature touches on this theme as a risk factor for teenage pregnancy, however the personal experiences related to the researchers by young people, both in focus groups and one-on-one interviews, combined with feedback from service providers, highlight the apparent impact on a young person’s decision-making in regards to sexual activity and continuing with a pregnancy.

As outlined earlier, studies have identified that many teenage mothers suffered from a number of material and emotional disadvantages prior to pregnancy. These were consistent with what was articulated by the forum and individual participants. Before young people were pregnant:

- Most said that they had poor relationships with their mother/father;
- Many had left the family home;
- Many had moved frequently as children; and
- Many were raised in single-parent households.

Of the 25 parents, all but two spoke about having difficult relationships with their family, and in particular their mothers, before and during their pregnancy. Of these young women who were 17 or under when they had their children, all had left the family home in their early teens, citing a range of issues including:

- Being unable to get on with (their mother’s) new partner;
- Violence and verbal abuse against their mother or themselves;
- Their perception of unrealistic expectations by their mother; and
- Lack of supervision (”she didn’t care what I did”).

Additionally, many of these young women had partners who were up to four to five years older.

More than 90% of participants had moved multiple times when they were children (from three to six times) and a significant number were from single-parent and/or multi-partnered families.

While it is difficult to link the decision to participate in risky sexual activity and continuing with a pregnancy to feeling unsupported within their family, it appears clear that a lack of emotional closeness and attachment to a significant adult, and particularly their mother, was a central theme for most of the teenage parents participating in the research.

The importance of a young person’s relationship with family in understanding aspects of sexual activity is also illustrated by responses to the survey. When asked, 73% of respondents would like to be able to talk more openly with their parents about having a good relationship; 45.9% would like to talk more openly about deciding when it is the right time to have sex and almost a quarter (24.3%) would like to talk more openly about how to get contraception. 16.2% would like to talk more openly about how to say no to sex if they feel they aren’t yet ready.
Negotiating sexual relationships

Evidence from the research suggests it is not common for young people to negotiate with sexual partners about contraception, with most young women making these decisions alone. When asked why, it was reported that they felt that such discussions were difficult or inappropriate. Just under half of the survey respondents reported they wouldn’t feel comfortable insisting on using contraception when having sex.

Further on discussion and negotiation, just under a quarter of respondents reported either being pressured to go further sexually than they wanted to or had lied to get out of a sexual situation (22.7% each).

For those who described themselves as being in a relationship, negotiating or speaking about sex and contraception was reported as rare or limited. Half of the individual interview participants had discussed having children together but had not agreed to get pregnant, the other half had never discussed having children together.

Focus group discussions that centred on negotiation and discussion generally focused on wishing that thing had been different. As Travis from the case study stated: “If and/or when a couple are going to have sex they should be prepared, should be on the same page...” The exception was two couples who had been in a long term relationship and planned their child/children. They had talked and made informed choices about their desire to be parents and their timing for this. These young women were in the older range of teenage parents.

Friendships and peer group

Relationships with friends and peer groups are a crucial part of young peoples’ development as they move into adulthood. The role they play in informing and supporting young people as they become sexually active is clearly illustrated in the feedback from our survey research participants.

Almost two thirds of young people responding to the survey said they felt most respect from their peers, followed by their immediate family and boy friend/girlfriend. In contrast, a third of respondents did not feel much respect from doctors and/or health workers and felt disrespected by the way teenagers are portrayed in the media.

The survey results also showed that most young people (88.9%) named their peers as the primary source of information, support and advice about relationships, sex and contraception and their closest friends as the person they would turn to if they had a problem. (83%)
Sex Education

The primary aim of sex education is to provide children with age-appropriate information about sexual health, contraception and negotiating choices about participating in sexual relationships. The most effective systems and methods for teaching children about sex, sexual health, contraception and relationships, have been well researched and documented.31 Sex education in those countries with low teen birth rates have a coherent sex education policy and program that is delivered through the school system from the early years, continues through to completion of a child’s schooling and is supported by accessible contraceptive services. Crucially these countries also have community acceptance that sexual activity is a normal part of adolescence.

Feedback from the young people participating in the research about their experiences with sex education has been derived from the focus groups, individual interviews and survey participants. This feedback highlights two issues. Firstly, the information and scheduling of sex education programs is inconsistent from school to school and therefore the detail, content and topics covered depend on each individual teacher’s level of knowledge, skill and experience. Secondly, the majority of sex education is concentrated in Years 9 and 10, by which time many of the young parents reported as already sexually active. In some cases, young parents participating in the research reported having already disengaged from school by year 9 or early year 10.

Outcomes of the 14 individual interviews included:

- Five had participated in sex education in years 9 and/or 10;
- Two in years 7 and/or 8;
- One in primary school;
- Two had a more comprehensive program extending from primary school to year 10; and
- Three had not participated in any sex education

The 11 forum participants all reported experiencing some sex education in schools and described it as - a little and mostly in years 9 and 10. Overwhelmingly, apart from one individual who participated in the more comprehensive program, the feedback was not positive. Comments included “boring”, “can’t remember”, “embarrassing” and “I didn’t go”. Common themes included the concentration on the biology and physical component of sex did not provide them with tools to negotiate about contraception with their sexual partners.

So where do young people learn about sex and relationships? Participants cited a range of methods for accessing information related to sexual development. These included the internet and social media, popular media such as television, movies and magazines, and friends and family, particularly their mother. Young men said they received most of the information from friends and the internet while young women cited friends and their mothers as primary sources of information. The survey respondents also cited friends as being the most likely source of information regarding sex and contraception (88.9%).

It was a shared view of service providers and young parents that, in hindsight, there was a lot of misunderstanding and ignorance across a range of factors involved in sexual activity. They included, for instance, how and why the pill works, that “you can’t fall pregnant if you have intercourse in the shower” and three young women who expressed surprise at their pregnancy as they were told by their mothers for various reasons that they would “never” be able to have children.

The survey results highlight a lack of detailed understanding and knowledge about sex and contraception with 37.8% of respondents being unsure if a girl could get pregnant while menstruating and 80% of young women respondents believing that birth control pills are effective even if they miss taking them for several days in a row. This misunderstanding is alarming in view of the fact that the average age of the young women respondents was over 17 years.
Contraception – access and knowledge

As the Secondary Students and Sexual Health (2008) survey data demonstrates, a majority of young people in Australia are sexually experienced. Over one quarter of those in year 10 and more than half of the year 12 students surveyed reported having sexual intercourse. However, the rates of contraception use are inadequate and this correlates with Australia’s teenage pregnancy and birth rates.

Access to contraception is a crucial component to reducing teenage pregnancy and birth rates. The literature outlines the criteria for optimum uptake of contraception by young people. Contraception and contraceptive advice needs to be accessible and affordable, be provided in a non-judgemental way and be confidential. The picture in Northern Tasmania is extremely variable and the young parents detail both the individual and systemic circumstances that impacted on their unplanned pregnancies.

Most of the young women participating in the research accessed contraception through specialist sexual health or youth specific services, such as headspace (most commonly) or population group services such as the Aboriginal Health Service. Only one young person reported they had accessed contraception through Family Planning where one reported being taken by her mother. The rest used a general practitioner, often the family doctor, but some sourced a GP outside their family practice.

Condoms are freely available in a variety of outlets around the north of the state, including at sexual health services and at free condom days at secondary colleges. Condoms can be purchased from a number of retail outlets. Despite this variety of ways to obtain them, data shows that condoms are not used reliably or consistently by young people. Results of the Secondary Students and Sexual Health survey showed that of the sexually active students:

- 50% reported always using condoms when they had sex;
- 43% sometimes when they had sex; and
- 7% never used condoms when they had sex.

This national research data is supported by the Northern Tasmanian data which demonstrates that despite being easy and free to access, condoms were used by only four couples out of the 25 young people interviewed as part of this research.

The most common contraception accessed by research participants was the contraceptive pill with twenty of the twenty five young people interviewed reporting this as their primary contraception. In addition to contraceptive pill, other contraception used by research participants included:

- four reported using condoms; and
- one person used Depo Provera (a long acting reversible hormonal contraceptive injected every 3 months).

Three people agreed that while they were using contraception, their use of it was either intermittent or they recognised that in hindsight the method had failed, for example they had gastro while on the pill or had not taken it regularly.

However, despite either not using contraception properly or intermittently, participants were “surprised” by their pregnancy and had not intended getting pregnant. The exceptions were two couples who had actively planned their pregnancy. This feeling was expressed repeatedly by forum participants with remarks such as “…it only takes once,” and “I thought it was hard to fall pregnant and couldn’t happen straight away.”

This lack of understanding about the correct use of contraception is reflected by responses to the survey. Only 28.9% of respondents felt they knew how to be sure to avoid pregnancy and only 26.7% felt clear about how to prevent contracting a sexually transmitted infection or disease.
This misconception may have implications for contraception information and sex education content. Highlighting the difference between fertility of teenagers in contrast to older people may also be helpful. The mainstream media often report on the difficulty of older women have in becoming pregnant and the high level of advertising relating to fertility treatments. Older parenting and the consequent difficulties in conceiving is today’s cultural norm and given that young people report that much of their understanding about sex is through popular media channels, it is a possible gap in understanding that may impact on their perception of their fertility.

**Contraception – types used**

**Oral Contraceptive-the Pill**

Many of the young people interviewed reported using the contraceptive pill as their preferred method of contraception. The shortcomings of the pill as contraception for this age group were clear and can be summarised as:

- lack of knowledge and understanding about how the pill functions to prevent pregnancy;
- the need for an adolescent to take the pill consistently over a long term; and
- the difficulty for adolescents to access and pay for filling the prescription.

Some service providers working with young parents and teenagers at risk of pregnancy recommend that Implanon (slow release progesterone inserted under the skin that works for three years) be used as the advantages mitigate the issues outlined above. Its advantages are described as:

- Convenience as the person does not have to remember to take anything;
- Long duration of use;
- Reliability; and
- Fertility returns quickly upon removal of implant.

**Emergency Contraception**

Consistent anecdotal evidence was raised by service providers, and confirmed by young people, in relation to the significant number of teenagers requesting the emergency contraceptive pill (often called the morning after pill) on a regular and repeat basis. The emergency contraceptive pill contains a hormone called levonorgestrel and can be bought without a prescription. The morning-after pill is licensed by the Therapeutic Goods Administration (TGA) to be used within three days of unprotected sex, but there’s evidence that it’s effective for up to four days. A recent study of emergency contraceptive pill recommendations by pharmacists across Australia found that most of them used the Pharmaceutical Society of Australia’s (PSA) written protocol to guide their supply. Pharmacists tended to follow the protocol rigidly, rather than using their discretion.

The concern expressed by service providers is that the emergency contraceptive pill is being used as the principal or a regular form of contraception by some young people. This is a practice that eventually leads to increased failure rates and does not prevent contracting STIs or assist in developing responsible sexual behaviour.

It is possible that the popularity of emergency contraception among teenagers as observed by service providers is due to its availability, the immediacy of the need and the fact that the one use of this pill is considered a less expensive option than ongoing prescriptions for the contraceptive pill.

There is concern that the long-term use of the emergency contraceptive pill could have unintended consequences. To date there have been no trials into the lasting effects on the health and fertility of users. Of particular relevance to teenagers is its effect:

- on women 16 and under;
- of long-term, routine use;
- when mixed with other drugs, and;
- on women’s ovulation and future fertility.
The use, frequency, age and the reasons why teenagers access the emergency contraceptive pill may warrant further investigation in order to more fully inform the sexual health sector.

In summary, it is clear that most young people understand the need to use contraception to prevent pregnancy and indeed say that they do despite evidence to the contrary. However, the devil is in the detail and as such the researchers found a number of barriers for young people to access appropriate advice and information about contraception and to taking contraception reliably. These include:

- The need to take into account teenage developmental stages, the impact on decision making and behaviour and in turn how these various stages impacts on compliance with taking/using popular contraceptives (in particular the pill) properly and avenues to address this;
- Understanding that the prevailing messages about sexual behaviour and contraception are primarily absorbed through family, friends and popular culture rather than through sex education in schools; and
- Limited access to youth-specific health services where they are just “one of the crowd” and the difficulty this presents for a rural teenage population.

**Accessing abortions**

Because of the sensitivity of discussing abortion in an open forum, investigation into experiences of terminating a pregnancy was confined to the individual interviews. Of these, six young people did not consider a termination at any stage. Of the other eight participants who considered a termination, three were past 12 weeks and “it was too late”, three were pressured to consider a termination by the father and/or their parents but didn’t want to, and two who were considering the option decided on reflection that they “couldn’t do it.”

Accessing an abortion has been described by young people participating in this research as a barrier to accessing termination. For a significant proportion of teenagers, accessing a termination for an unwanted pregnancy in this timeframe can be difficult. It was a common theme for the teenage parents to describe that by the time they realised they might be pregnant, had the pregnancy confirmed and then worked through the emotional decision, they were often past the 12 weeks.

**Lifestyle and risk taking**

Experimenting with drugs and alcohol is a component in contemporary teenagers’ lives and substance misuse and overuse is not uncommon, including for those young people we spoke to.

We do know from work done in the US and Australia that teenagers will often cite being too drunk or drugged as the reason that they participated in unprotected sex. In the Australian Secondary Students Sexual Health Study, for example, students cited being too drunk (17%) or pressure from their partner (18%) as the most common reasons for having sex when they did not want to. Additionally, the majority of students surveyed (80%) reported that they had drunk alcohol. Year 12 students were more likely to drink alcohol (90%) than their year 10 counterparts (71%). The study concludes that “rates of drinking will impact on the sexual behaviour and safety of the young people involved” and that the “two issues of sex and substance use must be addressed together.”
The local context

Results from the survey also shed some light on young peoples’ perception of sexual behaviour norms and also on the link between drug and alcohol misuse and risky sexual practices in the lives teenagers. A third of respondents (33.3%) felt that having sex was acceptable on the same night that you met someone and 13.3% felt that it is ok to have sex with someone if you are drunk and/or ‘high on drugs’.

Interestingly, for a significant minority of the young parents we spoke to, their unexpected pregnancy presented the opportunity to change a destructive lifestyle and to “clean up their act.” This particularly applied to those young people who had left home, were not attending school and/or were living with their boyfriend.

How important lifestyle choices are in the mix of factors that contribute to young women choosing to behave in a sexually risky way that leads to pregnancy is not clear from the feedback we received. All the young parents had a clear understanding that legal and illegal substance overuse and misuse was not “good”, and they also accepted that it was in part the reason for “forgetting” to use contraception regularly.

**Engagement in education and aspirations for the future**

Research tells us that disengagement from school is a risk factor for teenage pregnancy and birth. UK research shows that that the majority of young people were either engaged or disengaged from education by the time they were in Year 9. Many young people participating in the research described their own disengagement from school either prior to or during pregnancy.

Risk factors for disengagement are outlined in the Victorian Government’s report in 2009. As well as school factors, including student-teacher relationships and curriculum, the report listed a number of factors that impact on the school life of young people. These are consistent with the research participations feedback on their experiences and circumstances. Some of the relevant factors are:

- Issues relating to a young person’s individual life circumstances such as poor attachment, engagement in the child protection system, being part of an ethnic minority;
- The value that a family places on educational achievement and active involvement in school;
- Life events such as parental separation, family violence or other family dysfunction/difficulties;
- Peer group influences, such as young people who are not accepted by a peer group may feel alienated and choose to skip school as it is too emotionally difficult, and;
- Mapping aspirations, goals and plans for the future can affect engagement.

At a local level, young parents highlighted they had regularly moved house and schools in childhood and early teens. School became less central to the fabric of their lives and affected their engagement in learning and their capacity to form close peer relationships.

At the time of their pregnancy the following educational status applied to the young women participating in this research:

- eight had disengaged from school;
- two were in the workforce;
- three completed the current school year while they were pregnant; and
- seven stopped going to school when they realised they were pregnant.

In the younger, and arguably most at-risk group (17 and under), none were attending school at the time of pregnancy. While the pregnancies were not planned, there is clear evidence from the young parents interviewed, that not being engaged in school and/or having aspirations or goals for the future contributes to ambivalence about being a teenage parent. As more than one of the young parents said, “[it’s] the wrong time but it is meant to be.”

In summary, evidence from both the literature and feedback from local research participants suggests that a significant influence on the behaviour and actions of sexually active young people is their perception and experiences around relationships. Additionally, ignorance about how to effectively use contraception was also prevalent among both our research and survey participants and raises questions about how to best provide sex education and access to contraception to our teenage population.
## Local service providers - sexually active

<table>
<thead>
<tr>
<th>Name</th>
<th>Services offered</th>
</tr>
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<tbody>
<tr>
<td>headspace</td>
<td>A free youth health service for young people aged 12-25 years providing sexual health advice and services, including contraceptive, the morning-after pill, STI testing and pregnancy tests. Also provides general and mental health counselling and drug and alcohol workers.</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Family Planning Tasmania provides sexual and reproductive health services through bulk billing clinics. Online information service for young people <a href="http://www.fpt.asn.au/youth">http://www.fpt.asn.au/youth</a> Offers fee-for-service sex education program in schools</td>
</tr>
<tr>
<td>Tasmanian Aboriginal Centre</td>
<td>Health Service including GP, nurse and health worker clinic</td>
</tr>
<tr>
<td>Sexual Health service</td>
<td>Clinical services, counselling and education about sexuality</td>
</tr>
<tr>
<td>General practitioners</td>
<td></td>
</tr>
<tr>
<td>Link Youth Services</td>
<td>Buys essential health services and/or health items for people aged 12 to 24 who otherwise could not afford them. The fund assists disadvantaged young people across Tasmania.</td>
</tr>
</tbody>
</table>
### Example programs - Sexually Active Teens

#### International

<table>
<thead>
<tr>
<th>Internet and smartphone based</th>
<th>Bedsider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bedsider is an American website run by The National Campaign to Prevent</td>
</tr>
<tr>
<td></td>
<td>Teen and Unplanned Pregnancy. The website is largely targeted at women.</td>
</tr>
<tr>
<td></td>
<td>It is well designed and provides information about sex, contraception,</td>
</tr>
<tr>
<td></td>
<td>pregnancy and STIs in an easy-to-read manner. Some of its more notable</td>
</tr>
<tr>
<td></td>
<td>features are;</td>
</tr>
<tr>
<td></td>
<td>• Reminders: This is a service which sends a text or email to subscribers</td>
</tr>
<tr>
<td></td>
<td>about when to take their birth control pill, book in a pap smear or</td>
</tr>
<tr>
<td></td>
<td>their pre-booked doctor’s appointment.</td>
</tr>
<tr>
<td></td>
<td>• BootyLog: This is a downloadable app which allows users to upload</td>
</tr>
<tr>
<td></td>
<td>their own sex stories and read other’s stories anonymously. The stories</td>
</tr>
<tr>
<td></td>
<td>can be about awkward moments, advice on how to enjoy sex, tips on</td>
</tr>
<tr>
<td></td>
<td>sexual health and so on. Users are then able to comment on the stories</td>
</tr>
<tr>
<td></td>
<td>of others. This service has shown to be very effective at encouraging</td>
</tr>
<tr>
<td></td>
<td>young women to talk about their sex lives.</td>
</tr>
<tr>
<td></td>
<td>• RealStoriesRealPeople: These are feature articles with real stories</td>
</tr>
<tr>
<td></td>
<td>submitted by users. They are most often related to sexual health and</td>
</tr>
<tr>
<td></td>
<td>developing safe sex practices.</td>
</tr>
<tr>
<td></td>
<td>• Frisky Fridays: Sex stories and articles uploaded each Friday. These</td>
</tr>
<tr>
<td></td>
<td>stories are largely about enjoying sex, but always involve safe sex</td>
</tr>
<tr>
<td></td>
<td>practices.</td>
</tr>
</tbody>
</table>

#### In Case You’re Interested

<table>
<thead>
<tr>
<th>In Case You’re Interested</th>
<th>In Case You’re interested (ICYI) is a free text message service offered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>by Planned Parenthood in America. ICYI works by users sending in their</td>
</tr>
<tr>
<td></td>
<td>questions to the number which are answered within 24 hours. The service</td>
</tr>
<tr>
<td></td>
<td>is entirely anonymous.</td>
</tr>
</tbody>
</table>

#### Sexual Health for Parents

| Sexual Health for Parents | This is a program run by Planned Parenthood which uses social media to |
|---------------------------| promote the sexual health of teenagers to parents                    |


9. Adolescent Sexual Health in Europe and the US March 2011 © Advocates for Youth


11. Wellings K and Parker R London School of Hygiene and Tropical Medicine, UK Sexuality ‘Education in Europe 2006


13. Smith et al as quoted by Mitchell, Smith et al *Sexuality Education in Australia* 2011


Pregnancy
This section of the research focuses on the point when young people become pregnant and their experiences through the pregnancy.

It links the key themes emerging from the literature review with the perspectives and experiences of teenagers in Northern Tasmania. This includes teenagers who participated in the survey, discussions with teenage parents through the focus groups, individual interviews and discussions with the service providers who work with them. The research at the Northern Tasmania level has captured young people’s perspectives regardless of whether they are sexually active, pregnant or parenting.

The key themes emerging from the literature and local consultations about teenage pregnancy are:

• Impact of socio-economic disadvantage;
• Health outcomes;
• Education outcomes;
• Barriers to accessing medical, health and support services;
• Accommodation; and
• The importance and place of relationships.
CASE STUDY 2

Travis – father of Arielle 3 years and Dylan 8 months

Sexually Active

Travis’s girlfriend of 2 years, Kayla, fell pregnant when he was 19 and she was 17 years. Travis had left school after year 10 and was in the last year of his mechanics apprenticeship. Kayla was in Grade 12 and had intended to study aged care at TAFE.

They both lived at home but spent quite a bit of time at Travis’s friends’ places.

While they didn’t exactly plan to fall pregnant they had spoken about having a family after Travis had finished his apprenticeship and was earning a full wage and Kayla had completed her studies and was working. They wanted to be “set up” before they had a baby - in a house, with a car and fulltime work. They got carried away once and didn’t use a condom and didn’t think it would matter because they assumed it would take a few months at least to fall pregnant. However, as Travis says: “...it only takes once and you can, and probably will, get pregnant.”

Travis learnt most about relationships, sex, sexual health and contraception by talking to his mates and from the internet and from media such as TV shows and the movies. He also had a conversation with his mother about the importance of using contraception when he was 13 years. He remembers having sex education some time in primary school and again in Grade 10. However the strongest impressions and knowledge came from talking to his mates and media. In hindsight Travis says... “that if and/or when a couple are going to have sex they should be prepared, should be on the same page and to be aware that the image about sex and sexuality portrayed in the media is completely wrong and a fantasy-nothing is further from the truth.”

Pregnancy

When Kayla thought she might be pregnant Travis went with her to the doctor. After the pregnancy was confirmed he rang his sister to tell her first. A few weeks later they spoke face to face with his parents and then with her parents. Travis’s parents were pretty shocked but, after Kayla argued with her own parents about wanting to continue with the pregnancy, Travis’s parents were supportive of her moving in with Travis and living with them. Travis’s father was quite proactively supportive, particularly with practical details such as transport and purchasing equipment for the baby.

At about 6 months into the pregnancy Travis realised that he would need to make changes to his lifestyle and started by reflecting on the people that he hung out with. He made a clear decision about which of his friends would be appropriate to be around when he became a father and, for the last part of the pregnancy, worked hard to change some aspects of his leisure habits and cultivate new ones.

Travis was a supportive partner to Kayla during the pregnancy and felt that it is part of a father’s responsibility to make sure that his pregnant partner was looked after. For Travis this meant attending antenatal clinic appointments, prompting her to eat well, such as eating more fruit, and reminding her to limit any alcohol and drug intake.

They attempted attending midwife run childbirth education classes at the hospital but decided after attending once, not to keep going. As the youngest couple, they felt uncomfortable participating and preferred to use websites for their information. They were also the only couple in their peer group who was having a child and so talking to their friends about the pregnancy, and/or parenting was futile-they were generally not interested.

While Travis felt he was able to research the stages and development of pregnancy and to some extent parenting, he felt absolutely helpless and very ill prepared, while Kayla was in labour.

Unfortunately 3 weeks before Arielle was born, the business he worked for folded and Travis was without either a job or any qualifications as his apprenticeship was not complete. With financial support from Travis’s parents they had just moved into a rental property. To help make ends meet Travis sold his car, they used public transport and moved to cheaper accommodation.

Parenting

When Arielle was 4 months old Travis found a position with a business that meant he was able to complete
his apprenticeship and continue on to a full wage. He was extremely relieved to be able to support his family even though it also meant he was required to work long hours on a regular basis. Kayla elected to be a full time parent and discontinued her plans for further study. When Arielle was just over 2 years old they had a planned second child. Kayla has been involved with PYPS since Arielle was 4 months old. Although she doesn’t necessarily see eye to eye with all the participants, she feels comfortable at PYPS, and is not keen to attend other groups.

Both Travis’s and Kayla’s parents were delighted to become grandparents and are very supportive and both are involved in their grandchildren’s lives, babysitting, providing advice and helping in other practical ways.

Their second child, Dylan was 6 months old when Travis and Kayla separated. Kayla lived for a short while with her parents before finding a unit to rent. Travis is back living with his parents. While their separation is difficult they continue to make joint decisions about the children and Travis has regular contact with both children, having Arielle overnight on weekends and seeing Dylan at least once every weekend and sometimes on a week day evening. Support from both grandparents means that Kayla is able to contemplate enrolling in nursing at University.

Travis says that while absolutely nothing can prepare anyone for parenthood the best quality a father can have is patience. Travis is happy that he and Kayla are young parents because it is “…biologically better to have children when you are young and you have more energy.” However he wishes he had longer to develop good work habits and had more resources to support his family.

The one thing that Travis has found very difficult is feeling “judged” for his age when he is with his children. For him this was particularly difficult when Arielle was first born and he used to push the pram while they shopped—he was regularly targeted by members of the general public, bus drivers and shopkeepers, and made feel irresponsible and useless because he was a young father.

**Literature review - Teenage Pregnancy**

There continues to be two broadly different ways of framing discussions about pregnant teenagers who choose to continue to motherhood. The first focuses on examining and documenting the medical, social and economic implications for young mothers and their children, whereas the second approach involves more in-depth qualitative studies orientated to understanding young people’s perspectives about their choice.

Investigations into the first approach seek answers to concerns such as:

- Possible health risks to the pregnant teen and her growing baby;
- The ability of the teen parent to care for and support her child;
- The effect that pregnancy/parenting at a young age can have on the teen’s life plan, and;
- The social costs of supporting young mothers and their children.

Conversely, other studies work closely with young people and are interested in questions such as:

- Attitudes and values about sex and relationships;
- Aspirations for the future, including attitudes to education and employment;
- Their emotional health, and;
- Sense of stigmatisation from the general community.
Teen pregnancy and socio-economic disadvantage

One area of investigation that has been examined in both types of research is the association between teen pregnancy and motherhood and socio-economic disadvantage and the impact this has in the lives of pregnant teens. The most recent research agrees that many teenagers who choose to continue with their pregnancy are faced with multiple economic and social disadvantages that are likely to persist whether or not they are mothers. In 2006, in-depth qualitative and quantitative research was conducted across the UK with 41 teenagers who planned their pregnancies. The results of the research revealed that all of these young mothers experienced a range of indicative life circumstances during childhood and in the year prior to becoming pregnant. The authors described the kinds of material and emotional indicators that the young mothers they interviewed had experienced. Furthermore they concluded that these factors were instrumental in the young women's decision to become mothers.

Material disadvantage in childhood

- Parents separated or divorced;
- Parents unemployed or in manual jobs;
- Moved areas frequently;
- ‘Disliked’ area/location;
- Public housing;
- Numerous siblings or overcrowded accommodation;
- Money being ‘a worry’;
- Poor health and health of immediate family;
- Evidence of alcohol and/or drugs misuse within the family, and;
- Family claiming benefits.

Material disadvantage in the year prior to pregnancy:

- Unsettled living arrangements, for example thrown out of home or living in temporary accommodation;
- Dissatisfaction with education, and;
- Lack of money due to unemployment, working in a manual job, or at school or college (but wanting to leave).

Emotional disadvantage:

- Negative relationships in the immediate family (that is, violent and volatile);
- Bullying at school;
- Lack of open communication, and feeling unable to tell anyone in the family about personal issues;
- Lack of encouragement, for example regarding education, ambitions and general life direction, and;
- Separation from their partner with whom they became pregnant intentionally.

As well as being to some extent a result of disadvantage and poverty, parenting as a teenager has also been shown to increase the chances that the cycle is likely to persist. Work undertaken in Australia in 2006 tracked outcomes for young mothers showing that not only is early motherhood strongly associated with low educational achievement and poverty but also that their relative disadvantage increases over time. Almost all teenage mothers are reliant on income support payments and have low levels of education. By the time they are in their early 30s, women who were teenage mothers are less likely to be partnered, and if they are partnered they are more likely to have a low-income partner, and less likely to be purchasing their own home. Additionally, the same data analysis shows that marginalisation of this group has increased with the gap between the outcomes for teenage mothers and her non-parenting counterpart widening over the past 20 years.
Accessing Abortion in Tasmania

Access to abortion is one of the major influencing factors impacting fertility rates including teen rates. In Australia, each state and territory is responsible for laws in relation to abortions. The situation for Tasmania is outlined below and the impact of the current situation and its impact on the research participants are discussed in the local context section.

Overall, while there has been no known major research on access to abortion in Tasmania, anecdotal evidence from service providers and young people report many barriers to access. This includes knowledge of how to access an abortion in conjunction with costs. There are two private medical clinics providing terminations of pregnancy services and both of these are located in Hobart.

At the time of this research and report, the Tasmanian Parliament was considering amendments to abortion laws. The amendments have passed through the lower house and are due for consideration in the Upper House. These amendments remove abortion from the Criminal Code and allow abortion up to 16 weeks if the woman provides her consent and after 16 weeks if two doctors say it is medically, psychologically or socio-economically justified. Abortion is lawful in Tasmania if two medical practitioners agree that the continuation of the pregnancy would involve greater risk of injury to the physical or mental health of the pregnant woman than if the pregnancy were terminated. Counselling is compulsory. Laws relating to abortion are contained within the Tasmanian Criminal Code. The sections relating to abortion were last amended in December 2001. Under sections 134 and 135, women and doctors are liable for criminal charges for unlawful abortion.30

Section 164 defines a lawful abortion as one where:

(a) two registered medical practitioners have certified, in writing, that the continuation of the pregnancy would involve greater risk of injury to the physical or mental health of the pregnant woman than if the pregnancy were terminated; and

(b) the woman has given informed consent unless it is impracticable for her to do so.

The act further stipulates that “informed consent” means consent given by a woman where:

(a) a registered medical practitioner has provided her with counselling about the medical risk of termination of pregnancy and of carrying a pregnancy to term; and

(b) a registered medical practitioner has referred her to counselling about other matters relating to termination of pregnancy and carrying a pregnancy to term;

Further conditions contained in the legislation include that:

• one of the medical practitioners must be an obstetrics and gynaecology specialist;

• the termination must be performed by a registered medical practitioner; and

• no person is under a duty to participate in abortion, referring for abortion, or providing counselling for abortion. This clause is invalid if an abortion is medically necessary as a matter of immediacy to save a pregnant woman’s life or to prevent serious immediate injury.
Education outcomes during pregnancy

Young maternal age is overwhelmingly linked with low socio-economic status and education and this is seen by both policy makers and pregnant teens themselves as a key avenue to move from a position of disadvantage into employment and income self-sufficiency. The UK study mentioned above found that some teens they spoke with see their pregnancy as a “trigger event” to make changes in their lives and plan for the future by re-engaging with education.3 However, as indicated in the South Australian Healthy Young Parents in Education report in 2007, in reality many pregnant teens do not continue or re-engage in education as...“the lack of support means that these women often fail in this pursuit”.4

Education attainment rates help give a picture of the reality of the educational outcomes of pregnant teens and parents. In the US for example, half of the young women who were teen mothers received a high school diploma as compared to 89% of women who were not mothers.5 Additionally educational achievement rates were even lower for younger mothers (before 18 years) than if they were 18 years and above before parenting. Canadian data shows a similar pattern where the timing of motherhood was found to be significantly related to the chances of finishing high school or post-secondary education.6

From the evidence, why pregnant teens do not achieve academically in the same way as their non-pregnant peers can be summarised into three distinct areas involving individual factors, how education institutions incorporate pregnant teens into their system and education as a priority for intervention from service providers.

To illustrate these points, we can draw on the findings from the UK Sure Start Plus program evaluation report.7 The Sure Start Plus Program provided targeted and intensive support, across a range of outcome areas, to pregnant and parenting teens.

• How the circumstances of pregnancy and parenting impact individually. Short-term plans often do not involve plans to participate in education, with 40% of the mothers interviewed in the year since becoming pregnant having no immediate plans to return to work or study.

• Systemic barriers to continuing in education during pregnancy and parenting. Targeted support was found to increase school retention rates for those pregnant or parenting teenagers who were 15 or under (statutory school age) as targeted support increased participation rates to 83% when compared to a comparable control group who had participation rates of 60%. Furthermore this group continued their education without a break and their education achievements matched their non-pregnant peers. In contrast, the proportion of pregnant or parenting young people in education dropped to 33% when they were 16 and 17 years; and to 22% for those 18 years and older.

• Education as a priority for service providers. Despite the above achievements for those young people 15 and under, service providers were initially very wary of focusing on education, believing that many young women who became pregnant had a strong dislike of school and poor educational attendance prior to the pregnancy. As the report states: “They were concerned that the reasons for educational dissatisfaction should be addressed, rather than ‘forcing’ people back into education to meet the target. They were concerned, also, about pursuing this target in relation to more vulnerable young women who had crisis issues to address and those who expressed a desire to be full-time mothers”.

Education and Teen pregnancies in Australia

Within Australia there is a similar concern about the link between poor school retention and engagement rates and long-term outcomes for pregnant teens. Education is the responsibility of state governments and there are various strategies to support young people at risk of disengagement and vulnerable youth, including pregnant teens.

Most of the policy directions that focus on pregnancy are based on the requirements of the Anti-Discrimination Act 1991.8 Section 21 of the Sex Discrimination Act 1984 makes it unlawful for an educational authority to discriminate against a person on the ground of pregnancy.9 However, Pregnant and Productive, the report of the National Pregnancy and Work Inquiry conducted by the Human Rights and Equal Opportunities Commission in 1999, recommends that the Attorney-General amends section 13 of the Act to remove the state instrumentality exemption.10 It also recommends that the Department of Education Training and Youth Affairs develop a pamphlet of the Sex and Discrimination Act for secondary school students and produce materials for schools about managing the retention of pregnant students.

The table on the following page outlines state education policies in relation to supporting pregnant students.
<table>
<thead>
<tr>
<th>STATE</th>
<th>POLICY</th>
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</table>
| South Australia | In South Australia, school practice is guided by Gender Equity: A Framework for Australian Schools, and by administrative instructions and guidelines which require schools to support pregnant and parenting students to complete their education.  
Schools are encouraged to develop responses which meet their local circumstances and the needs of individual young women. This may include the development of interagency linkages with district and community service organisations. Some such agencies are registered with the department as training and professional development providers.  
The Department of Education, Training and Employment employs an Interagency Referral Process Manager to assist schools to develop appropriate linkages.  
The Department does not collect data on school-aged pregnancies, and does not require schools to track outcomes for pregnant students.  
Two papers have been produced to assist schools to support pregnant and parenting students: Pregnant Girls and Teenage Mothers: The Educational Implications (1991); and Pregnant Girls and Teenage Mothers, the Social Justice Action Plan Discussion Paper No. 10 |
| Victoria        | Victoria will provide a socially inclusive education system in which all children and young people receive the support they need to enable their engagement in school, their wellbeing, learning opportunities and pathways to further education, training or employment. Students at risk of disengaging or already disengaged will remain a priority for the Victorian government.  
The Department of Education, Employment and Training in Victoria provides advice for schools in relation to pregnant and parenting students as part of the Schools of the Future Reference Guide. The guide affirms the right of pregnant students to continue their schooling, but requires a medical certificate in relation to fitness to attend after the 34th week of pregnancy.  
Schools are encouraged to modify the curriculum program if necessary, and provide ongoing support either through internal processes or through the Distance Education Centre Victoria for students whose schooling is interrupted due to pregnancy |
| Queensland      | Education Queensland released its Pregnant and Parenting Students Policy in 1999. The policy requires principals to identify and address aspects of schooling which lead to differential outcomes for pregnant and parenting students and that students in the Queensland state school system are not disadvantaged on the basis of pregnancy or parental status.  
The policy encourages flexibility in school policies and practices relating to:  
• curriculum design,  
• teaching and learning strategies, and assessment;  
• classroom and school management;  
• uniform dress codes; and  
• temporary alterations in attendance patterns.  
It also directs principals to ensure that direct and indirect discrimination (including harassment) on the basis of pregnancy and parental status is addressed. School staff can access information which assists them to support pregnant and parenting young women to complete secondary education.  
Schools can obtain a booklet of advice and strategies on the retention of pregnant and parenting young women in education from Education Queensland. |
<p>| NSW            | The NSW Department of Education and Training bases its support for pregnant and parenting students on its Student Welfare Policy, which states “it is important that schools develop proactive strategies to inform school communities about the ways schools can help pregnant women and young mothers to continue their education without discrimination.” |</p>
<table>
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<tr>
<th><strong>STATE</strong></th>
<th><strong>POLICY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Northern Territory</strong></td>
<td>Pregnant Student Policy and Implementation Guidelines is underpinned by the Commonwealth Sex Discrimination Act which guarantees the right of pregnant students to attend schools, and specifies that “terms or conditions” of admission to school should not discriminate against a student’s participation, and that a student should not be subjected to “any other detriment”. The policy states that all schools should establish procedures to deal with pregnant students, that students who are pregnant should be encouraged to stay at school as long as possible, and that special circumstances, including any special requirements of the student, should be taken into account. It does not collect data on pregnant and parenting girls at school.</td>
</tr>
<tr>
<td><strong>Tasmania</strong></td>
<td>The Tasmanian Department of Education addresses the issue of pregnancy in its Equity in Schooling Policy as part of a focus on students who are at risk of leaving school early. It does not collect systemic data on the numbers of pregnant and parenting girls in its schools each year, nor track their school and post-school pathways, stating that schools are responsible for monitoring attendance. The Policy Statement on Pregnant Girls and Teenage Mothers identifies the likelihood of early school leaving among girls who become pregnant while at school and who opt to keep their babies. It discusses a range of other risk factors related to teenage pregnancy identified in much of the literature (welfare dependency, poverty, medical risks, heightened risks of abuse and neglect). The policy statement also identifies the factors which impact on decisions to leave school or stay, factors, it argues, which schools can address and accommodate the demands of caring for a baby, a lack of encouragement and practical support by the school to complete secondary education, and harassment by peers. Information supplied by Tasmania shows that some pregnant and parenting students are enrolled in the Tasmanian Open Learning Service under their exceptional circumstances’ criteria. However, since it is the policy of the Department to retain pregnant and parenting students in their usual schools, these students are only enrolled in Open Learning programs if they are unwilling to remain at school with support. Information for schools is also available as a result of a research project funded by the Department of Education in 1996. Pregnant Young Women and Teenage Mothers was published in 1997 and distributed to high schools and colleges in Tasmania. The report is succinct, easy to read and provides useful advice about the practical measures schools can take to assist school-aged mothers to complete their education. It makes six clear recommendations about things that need to be done to assist young women to stay at school: • Making a clear statement of the right of pregnant young women to complete school and the responsibility of the school to support them to do so. • Providing funding through district services for occasional support to assist young women remain in education; • Options for continuing education through non-school avenues such as distance education should be decided collaboratively by all stakeholders; • The Health Promoting Schools concept be supported to provide information, enhance the supportive school environment, and improve coordination between health and education services; • School leaving due to pregnancy motherhood should be recorded, and students encouraged to return; • A focus on developing skills to participate in the paid workforce should be part of the educational focus of young mothers.</td>
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</table>
Poor obstetric and maternal outcomes for teenagers and their children are documented internationally and nationally. Obstetric and medical risks for pregnant teenagers include pre-term labour, urinary tract infections, anaemia, pre-eclampsia, high rate of caesarean sections, pre-term birth and low birth weight infants resulting in increased mortality and morbidity of mother and child.

There is now consensus among researchers that the risks for adverse birth outcomes for teenagers are linked to socio-economic status and to the level of medical care that teenagers receive during their pregnancy rather than as a result of their young age. Risks for adverse birth outcomes for teenagers are linked to socio-economic status and to the level of medical care that teenagers receive during their pregnancy rather than as a result of their young age.11 Risky lifestyle factors and irregular or no antenatal care to monitor the physical health of the mother and baby contribute to poor outcomes of babies to teenage mothers. For example, in Tasmania 11.6% of teenage mothers reported using drugs during their pregnancy. Similarly, smoking is associated with low birth weight that is in turn associated with stillbirth. In Tasmania the self-reported smoking rate for teenage mothers is 34.9 per cent as compared to 23.9% of all mothers and smoking is a key preventable cause of low birth weight and preterm birth. Low birth weight (LBW) babies (less than 2 500 grams) are more likely to die in the first year of life and are more susceptible to chronic illness later in life, such as heart and kidney disease and diabetes.

Regular monitoring during the antenatal period means that most of the medical risk factors that lead to increased mortality and morbidity rates for teenagers can be managed. Understanding that many pregnant teens have pre-existing poor general physical health has meant that service providers have focused on encouraging teenagers to access regular antenatal care, to make lifestyle changes, such as stopping smoking, and to focus on nutrition as the avenue to lowering morbidity and mortality outcomes.

However, there are a number of barriers that pregnant teens experience when accessing mainstream services and medical care, including poor communication on the part of health professionals, overly complex systems, a lack of knowledge about what is available, multiple staff and a lack of self-confidence on the part of the young people. In response, a number of alternative service delivery models have been trialled to help overcome these barriers, such as youth-specific antenatal services, outreach and community-based services such as home visiting.

An explanation for the marginal successes that targeted service models have had on changing pregnant teens’ behaviours is contained in the evaluation report of the UK Sure Start Plus program and has its basis in the particular needs and circumstances of pregnant teenagers. Sure Start Plus is an on-going UK Government pilot initiative to support pregnant young women and young parents under 18 years of age. The core aims set out at the beginning of the program were to:

- Improve the social and emotional wellbeing of pregnant young women, young parents and their children;
- Strengthen the families and communities of pregnant young women and young parents;
- Improve the learning of pregnant young women, young parents and their children; and
- Improve the health of pregnant young women, young parents and their children.

Sure Start Plus programs were established in areas with high levels of poverty and social deprivation and these areas were selected because they were among those...
with the highest teenage conception rates in the country.

Of note here, one of the program objectives was aimed at improving a range of health issues for pregnant teenagers and in particular to provide services that would increase rates of early access to antenatal care (before the 14th week of their pregnancy) and decrease smoking. Additionally they sought to improve the levels of health information provided to young women during pregnancy and postnatally. The overall aim of the health component of the program was to reduce the incidence of low birth weight babies.

The evaluation report found that none of the above health objectives had been met or had only been met in part. Further, they found that accessing antenatal care by 14 weeks was an unrealistic timeframe given the circumstances associated with early pregnancy for many teenagers. Lastly, the report outlined the concerns raised by a number of service providers in relation to addressing smoking rates of mothers as it was considered an inappropriate and alienating target to focus on, particularly early in establishing the relationship and by doing so it was likely to put at risk any rapport and trust relationship they had developed with the teen client.15

Australia has a similar experience with both implementing teenage-specific service models and with adverse teenage maternal and child outcomes. The Royal Australian College of Obstetricians and Gynaecologists Standards of Maternity Care states, “where possible, specialist services should be provided for pregnant teenagers, such as peer parent education and support groups.”16 To this end, at least one maternity hospital in all states operates specific clinics for pregnant teens and some also offer outreach programs that have the aim of increasing access to maternity services. However, despite efforts to overcome barriers to access, very vulnerable groups such as Aboriginal teens, very young pregnant teens (under 16 years of age), those who live in rural or remote areas, and those with mental health and drug and alcohol issues are still significant under-users of health care and remain most at risk of poor outcomes. Impacting on entrenched disadvantage remains a difficult area for both mainstream services and targeted service models.

### Accessing services

Considerable work has been undertaken to understand the barriers for young people to accessing services that can benefit them. It is clear from feedback from young people that the crux of successful service is a positive relationship between the young woman and her service providers. Once a relationship is established, young women will access targeted interventions as long as they feel respected and consulted.

The Australian Government’s National Youth Affairs Research Scheme report Barriers to Service Delivery for Young Pregnant Women and Mothers’ for example, outlines the qualities needed on the part of service providers to develop and nurture a trusted relationship with young women.17 These include:

- Non-judgemental attitudes;
- Active listening;
- Knowledge of the young woman and her circumstances;
- Warmth and friendliness;
- Appreciation (praise) for young women’s parenting ability;
- Respect;
- Providing accurate information;
- Explaining procedures;
- Continuity of care wherever possible;
- Confidentiality; and
- Smiling.

In addition to these individual personal practice qualities, service delivery models that access difficult-to-reach
adolescents highlight the effectiveness of working with young people from a strength-based model where it is acknowledged that:

- Every individual, family, group and community has strengths, and the focus is on these strengths rather than pathology;
- The community is a rich source of resources;
- Interventions are based on client self-determination;
- Collaboration is central with the practitioner-client relationship as primary and essential;
- Outreach is employed as a preferred mode of intervention; and
- All people have the inherent capacity to learn, grow and change.\(^{18}\)

It is these elements of forming a relationship, preferably with one person, being listened to, being respected for the choices that have been made, and not being treated as a “welfare” issue mean that young people are more likely to access assistance and feel included both while they are pregnant and when they become parents.

Bronfenbrenner’s socio-ecological model provides one way of understanding factors that influence adherence with clinic appointments.\(^{19}\) The model posits that a child’s development/behaviour is influenced by interactions with others (e.g. family), experiences in various settings (e.g. school, hospital) and larger systems (e.g. social/political climate). Studies in other chronic illness groups regarding barriers to clinic attendance have identified factors at the micro and macro levels. For example, research has shown a relationship between clinic attendance and individual/developmental level factors such as forgetting and health beliefs.\(^{20}\) Family factors including parental supervision regarding appointment-making have also been identified. Interactions with the healthcare system appear to also be a contributor to poor clinic attendance, including dissatisfaction with clinical care (e.g. poor communication, multiple physicians providing medical care), long waiting periods, and provider behaviours (e.g. explaining all components of the visit, answering questions). Furthermore, even the time of the appointment can influence clinic non-attendance, with adolescents missing fewer appointments in the afternoon compared to the morning. Finally, societal and/or cultural factors may place adolescents at higher risk for non-adherence with clinic appointments. For example, beliefs regarding mistrust of the healthcare system, socio-economic status (e.g. transportation issues, lack of insurance), presence/absence of social support, and past negative experiences with medical teams play a key role in determining the motivation to attend routine appointments.
Relevant research

‘I felt like they were all kind of staring at me...’

Antenatal education is important in preparing pregnant women for birth and parenthood, but one of the most vulnerable groups, teenage mothers, is poor attendees. Lyz Howie and Caroline Carlisle report on a study to investigate this group’s perceptions of antenatal classes and what they consider would make them more accessible.

Midwives magazine: July 2005

Introduction

Antenatal education is part of the maternity culture, but teenagers are neither consistent nor committed attendees.21 Few studies address the part antenatal education plays in the delivery of parenthood preparation, sexual health, nutritional and educational issues. Due to the above concerns, a descriptive study was undertaken to discover the views of teenage mothers on antenatal education and what they perceived their needs to be.

Methods

This study focused on teenagers aged 17 or under at the time of delivery.

Main study

The aim was to explore what pregnant teenagers want from antenatal education. The objectives were to determine the information needs of teenage mothers, investigate the factors governing attendance or non-attendance at antenatal education classes and explore the views of attendees.

Findings

Socio-demographics and birth perceptions

The socio-demographic and socio-characteristic factors of the teenagers were recorded. Comparisons of age, in relation to substance use, clearly show that as the teenagers in this study mature, uptake of substance use increases.

The teenagers’ perceptions on issues associated with their birth were considered. They were asked to describe their fears and anxieties before the birth – in both attendees and non-attendees a ‘moderate amount’ of fear was most noticeable. Most had positive perceptions of their birth experience and, irrespective of attendance/non-attendance, felt prepared for birth.

Factors governing attendance or non-attendance

A number of reasons were given for non-attendance at antenatal education (see Figure 1). The age discrepancy between themselves and other attendees was a key factor in non-attendance, as illustrated in these interview quotes. Interviewees are identified by the number in brackets after each quote: ‘If I knew I was going to go to the classes with, with all the old people, I don’t think I would have went... I would have felt more comfier if they were all young, I felt like they were all kind of staring at me’ (one). ‘Everybody else is older, although it was all their first babies. They were like, a lot older. I did feel a bit put out at first, but I just got on with it’ (four).

Their own attitudes were also a reason for non-attendance, with seven teenagers stating they just did not want to attend: ‘Cause they’re teenagers, that’s what they do… they just don’t go anywhere do they?... I did get bored the first time I went... I kept going and then you get used to it’ (two). However, many teenagers felt they already had good support from their family at home (see Figure 1), rendering attendance less relevant: ‘I had my granny and all that... she still helps me to this day’ (two). ‘Well, I’m staying with my mum and dad and my brothers and that, they’ve been doing a lot and my dad’s there all the time as well so’ (three). Embarrassed by the comparison of their unplanned circumstances with expectations of older attendees at antenatal classes, they needed to feel valued and tried, despite excuses, to be more responsible. It was apparent that they were not typical of most class attendees.

To achieve successful attendance at antenatal classes, it is important to establish the most appropriate time. The questionnaire showed that the majority of respondents believed afternoons were best. Conversely the interviews did not support this finding: ‘First thing in the morning maybe or later at night... I still went to school till I was
six weeks, eh, six months’ (one). ‘Like probably, like, dinner-time, about sixish… during the day some of them might be at school or work so at night would probably be better’ (three). The ease of accessibility was the reason the teenagers gave for the health centre being the most popular location: ‘At my own doctor’s, probably, ‘cause that’s more closer for me to get to’ and ‘Well, like, if I didn’t have anybody to bring me here, my doctors is only at ***; I could just, like, it is just five minutes up the road, I could walk to them’ (three). As the majority of maternity care is within the community setting, this finding was not surprising.

Most teenagers would have attended a ‘Young mums club’, emphasising the importance of peer group support: ‘Just like, people your own age like, they are in the same situation as you… I was in an antenatal class with a woman, she was 31 and she’d IVF treatment to have a wain… I’d be sitting beside her’ (one). ‘You can, like, speak to other people your own age and see how they feel about what has happened, em, and like, how they are going to deal with it afterwards’ (four). Being part of a ‘Young mums’ club’ mattered to vulnerable girls who often felt labelled as ‘teenagers’. Opinions varied on the appropriate number of classes they wanted to attend. It was apparent that most would attend classes after an antenatal clinic and, importantly, most wanted to be accompanied by either their partner or mother.
Information needs of teenage mothers

The questionnaire explored issues that teenagers would like included in antenatal education – topics affecting childbirth and child care were of greatest interest.

The topics on substance use, diet and nutrition and sexual health were of least interest. At interview, teenagers provided support for the importance of preparing for delivery and parenting: ‘I think they just want to know what it’s going to be like when they have the wain… I think they would like to know everything about pain relief, everything I found out… exercises after you had the wain’ (two). ‘I needed the information about, like, about caring for her, like how to feed her and how to wind her and her nappies changed and all that’ (one).

Views of teenage mothers who attended the classes

This section of the questionnaire was only completed by teenagers who had attended the classes. Antenatal classes were held in a variety of settings, within the community and hospital. Unanimously, teenagers found travel problematic and local classes preferable: ‘I ended up going to the ones in the *** Health Centre ’cause the clinic, the antenatal care, is all up the stairs there. You don’t have to come down to the hospital… I just stayed down the road from it’ (one). ‘I feel it should have been more local and ‘just really travel, that’s one of the main things’ (four). All the teenagers felt the information given at the classes was ‘at a good level’. They were asked about what topics were covered. Pain relief was identified as most important, while asking a question was least enjoyed: ‘The pain relief was a good one and then your exercises. They two were the main ones that I really listened to’ (four). ‘Pain relief during labour, the labour, like the posture, the way you’d to sit… caring for your baby when they’re born and all that’ (one). One questionnaire respondent did not like talking about things that could go wrong. However, an interviewee specifically wanted to know more about problems or poor outcomes: ‘I think more bad issues should be included… ‘cause we did talk about, like, stillborn babies, what happens if this went wrong… I would have liked to know more about what could happen, instead of just like a hunky-dory birthing unit labour’ (four). Fear of the unknown was paramount. These girls needed courage to address their anxieties.

Discussion

It is crucial that the content of antenatal classes should be targeted at teenagers (Rozette et al, 2000). Many respondents wanted to know about pain relief and labour, but a small proportion felt it would make no difference to them. Two wanted to know more about adverse events or instrumental deliveries to help them prepare should such events occur. Not only should the focus be on topics around ante- and intrapartum care, but the study also demonstrated that issues of child care/child health, and postpartum events should be addressed. This is pertinent in helping teenagers develop parenting skills through information that could be related to practical baby care. Participants had little information on sexual health and contraception.

This should be a vital element of classes (Rozette et al, 2000) as it may prevent future unintended pregnancies and give teenagers knowledge and confidence about their bodies. A surprising finding was that many teenagers did not feel it was important to attend a labour ward/birthing unit tour. One reason for this may be that they did not know what a tour entailed, so did not feel it was relevant. If it were explained to them that seeing the environment might help them feel less afraid and more prepared, they could make a more meaningful decision. This might just be a coping mechanism for them to avoid thinking about the event or what it entailed because of the ‘fear factor’. Attendance rate at antenatal classes from this study was poor, as only nine out of 29 teenagers participated. One reason given for non-attendance was the feeling of being stigmatised because of their age. A higher attendance rate may have been achieved had the class been arranged specifically for teenagers. There was definite agreement from them that they would have attended such classes. This suggests the importance of maternity services providing effective and accessible teenage classes at a time and venue more suitable to their circumstances. Another factor governing non-attendance was the teenagers’ attitudes and the likelihood that ‘they just could not be bothered’. Evidence from other studies (Slager-Earnest et al, 1987; Smoke and Grace, 1988) highlighted that teenagers’ obstetric outcomes are better if they attend classes. It is important to find strategies to change teenagers’ attitudes from negative thoughts about antenatal classes, to positive ones about their benefits.

This could be difficult to achieve with this population. Carefully worded advertising of the classes may demonstrate that antenatal classes are neither ‘authoritarian’ nor ‘like school’. This may help to change attitudes, because it would convey to the teenagers that their views were valued and respected within the maternity services. Although it has been established that the teenagers were from a lower socio-economic class, it was evident that more than half the participants lived at home with parents or significant family members who, according to the teenagers, had provided real support. This
suggests that although the majority of the teenagers’ home environments where they were bringing up their babies were supportive, antenatal education was not considered important. Other studies suggest that if teenagers attended antenatal classes, they were more likely to have adequate antenatal care (Covington et al, 1998; Rozette et al, 2000; Timberlake et al, 1987). The majority of teenagers would have been more likely to attend antenatal classes if they had coincided with their visits to the clinic, so timing was an issue. This may be because teenagers have difficulty with travel/transport. Their views were that early evening classes would be more appropriate than afternoon ones because of school and work commitments. Pregnant teenagers have a high school drop-out rate and often miss out on further education or gainful employment (McVeigh and Smith, 2000) – efforts should be made to encourage teenagers to continue their education to achieve their potential.

Teenagers who did attend felt it was important to take part in classes within their own age group, rather than with older women because they felt stigmatised and self-conscious (Rozette et al, 2000). They felt more rapport with their peers because of their shared circumstances. Such a class may provide a more conducive atmosphere in which to make friends, take part and feel less isolated. If they felt more able to share their real uncertainties and express their feelings, they would feel more secure.

**Conclusion**

It is imperative that the components of antenatal classes address teenagers’ needs, incorporating issues such as sexual health and contraception. Factors governing non-attendance must be addressed. Fear of stigmatisation due to age played an important part, and solutions should be developed to address this. It is crucial that antenatal care is focused specifically for teenagers, taking into account their requirements and views about it. Therefore, planned provision, within the maternity services, of appropriate classes should be developed for teenagers, and encouragement to attend these should be paramount.

**Acknowledgement**

This information was a direct reference from [http://www.rcm.org.uk/midwives/features/i-felt-like-they-were-all-kind-of-staring-at-me/](http://www.rcm.org.uk/midwives/features/i-felt-like-they-were-all-kind-of-staring-at-me/)
The local context

As outlined in the literature the capacity to access positive emotional support and good physical care are the most crucial components that optimise health outcomes for baby and teen mother. The young women participating in this research instinctively understood this and, whatever their circumstances, actively sought to have in place elements of care for themselves and their babies while they were pregnant.

However, while addressing physical and medical health concerns are of understandable importance, they are only part of a myriad of competing issues that arise during pregnancy. It is factors associated with teenagers’ pre-pregnancy lives that have the most impact on young people choices, behaviour and outcomes at this time.

A prime motivator during pregnancy for all the research participants was the need to prepare for the birth of their baby. This meant being conscious of taking care of oneself physically and finding support. Priorities focused on some or all of the following:

• forming significant and supportive relationships,
• finding stable housing,
• achieving some sort of financial income and
• maintaining relationship with their partners

Depending on if these elements were in place, the next in importance was adjusting their lifestyle and accessing antenatal care and birth preparation.

These priorities are explored more fully in this section of the report.

Forming significant and supportive relationships

As outlined in the previous section, the theme of seeking significant relationships while being sexually active is extended through to pregnancy. The single most common experience for young women was the separation from their primary family at the time of pregnancy. This occurred for many young women either prior to pregnancy or at the time of, regardless of other risk factors including socio-economic background, poverty and risky lifestyle behaviour or other circumstances of their lives.

Where the family relationship may have been disengaged prior to pregnancy, the relationship with the family was sometimes re-established as a result of the pregnancy. Where this happened, outcomes such as having stable housing and continuing to go to school were more likely for the young woman during the pregnancy.

While many of the research participants described having difficult relationships with their families, they all sought to “bond” with at least one adult once they realised they were pregnant. Regardless of their circumstances, young women sought to establish, maintain or re-establish a relationship with a key “other”. This ranged from their own parent/s, partner’s mother or father, a grandmother or in some cases, a trusted service provider. For those young women who were estranged from their own family, many reported a supportive relationship at least initially with their boyfriend’s mother. A key factor that engendered trust in these young women was being proactively supported. This included being taken to antenatal appointments, being offered room in the house and meals, being there for support and advice across the range of issues that arose. In two cases these relationships continued even if the young women and her boyfriend were no longer together.

Housing

The single biggest issue facing pregnant teens is to find and maintain stable and suitable housing. The cycle of moving house that started before pregnancy for many of the young people, continued through their pregnancy and into parenthood. Across the young women interviewed, the average number of house moves during pregnancy was three. Ten of the
research participants were asked directly how many times they had moved from the time they found out they were pregnant to within the first 6 weeks of the birth of their child with the following response:

- 1 person moved 11 times;
- 1 moved 7 times;
- 3 moved 5 times;
- 2 moved 4 times; and
- 3 moved 3 times.

The disruption and distress of moving and trying to prepare to be a mother is extremely difficult and a priority for services is to ensure that any pregnant teenager has a stable home. After moving into accommodation supplied by a housing program a young mother said that at last she could relax, knowing she had somewhere to live with her baby even if everything else was not going well. This sentiment was echoed by all the research participants.

**Achieving financial stability**

All the young people participating in the research relied on government benefits for their income during their pregnancy. A key area of identified need emerging from the research is the level of support required in negotiating and completing the necessary paperwork. This was reiterated by young people and service providers. Providing a high level of support and often advocacy with Centrelink is considered a priority need.

**Relationship with their partners**

All but two of the young people we spoke with considered themselves to be in committed and long-term relationships at the time they became pregnant. Ensuring that the relationship continued was one of the top priorities for young women during their pregnancy and their ability to navigate the changes to their lives was clearly associated with the quality of support from their partners particularly if the young woman was estranged from their family.

For instance young women were more likely to attend antenatal clinic if their partner was with them and were also more likely to pay attention to their general health such as diet and exercise. The fathers from the focus group were committed to their role and were able to articulate the scope clearly. They said for instance that it is “a fathers responsibility to make sure that the pregnant partner takes care of themselves” and they felt that it was their responsibility to work and provide for child and family.

However a significant number of relationships broke down during pregnancy and these were mostly for those whose partner was older than them, where domestic violence was involved and where the environment and lifestyle was volatile. Service providers report that it is an extremely turbulent time for the young women when these relationships breakdown and impacts on all parts of their lives.

**Adjusting their lifestyle**

The researchers found that young women in Northern Tasmania have understood the public health messages concerning the importance of eating well, stopping smoking tobacco and drinking alcohol and taking drugs during pregnancy. When asked what changes they had made to their lifestyle once they were pregnant, all but one young woman said they ate more healthily and stopped drinking and smoking.

However, how they apply the health messages is interesting on two fronts.

- Despite good intentions on the part of the young people, service providers report that the most vulnerable group under-report the use of drugs. Service providers such as cu@home, headspace, Aboriginal Health Service, PYPS and Karinya say that drug and alcohol use are an issue in pregnancy, particularly for the most vulnerable group of teens and in particular the younger group. Some, for example, stopped drinking and smoking tobacco but continued to smoke cannabis because they didn’t think that it was a problem for the baby.
There is a lack of understanding about what constitutes a healthy diet or why good nutrition is important during pregnancy. While many young people named up a change to a healthier diet as something important once they found out they were pregnant, when asked how they had changed their diet, many young people said things like “I cut back on takeaways”, “just ate the same” or “ate what was recommended” but were unable to articulate or remember what food groups they ate.

As illustrated by the lack of understanding about the correct use of contraception, it seems young people need explicit, concrete and precise information repeated often across multiple providers they engage with if they are going to translate health advice into day-to-day practice in their lives. The issue of health literacy more broadly in adolescence is an area for potential research.

**Antenatal Care**

Antenatal education is part of the maternity culture, but teenagers are neither consistent nor committed attendees. This is consistent in the Northern Tasmania research with many young people and service providers describing an ad-hoc and inconsistent approach to accessing and maintaining antenatal care.

The most common theme that emerged during the research was the extent to which other aspects of their lives were organised. In addition, the level of support available by an adult was considered critical in accessing and maintaining support. The young people that missed antenatal appointments cited the following as the key reasons:

- Lack of transport (including the person that drove them to appointments was sometimes too busy).
- Feeling intimidated by the system if they were alone.
- Feeling awkward and embarrassed in having detailed conversations with service providers.
- Something more critical to deal with: i.e. appointment with Centrelink, organising housing etc.

Midwives from the Launceston General Hospital teenage antenatal clinic confirmed that keeping appointments is often problematic for young people. Their perception of this is not based on accessibility to the service or feeling intimidated by the hospital environment. They had put in place a range of options to address the low attendance rate and as an example, establishing an outreach clinic did not change attendance patterns. However, they did relate that many teenagers come to appointments with their mother or a friend and that they are more likely to come if there is an incentive such as a visit to the labour ward.

Birth preparation classes run specifically for teenagers were not well attended and are no longer in place. Young parents interviewed said that they felt acutely uncomfortable going to classes and preferred to speak about having the baby with someone close to them. Preparation and knowledge about the birth process was an obvious gap for young people. When asked about how they went about preparing to be a parent, one very involved young father said that while he was able to access pregnancy and parenting advice online or via his family, he felt completely at a loss during labour and extremely frightened. Other comments from the young women ranged from “don’t want to think about it”, “I was scared and didn’t have any idea about what was happening”.

A model of good practice and an alternative way of delivering antenatal services is the centre-based and/or home visiting midwifery model run from the Tasmanian Aboriginal Health Service. Continuity of staff means that each young person is more easily tracked if appointments are missed and information and advice can be specifically tailored to individual need. In essence the midwife becomes the “trusted” adult to the young person.

All service providers spoke of what they described as “a lack of emotional maturity” in pregnant teenagers that had more of an impact the younger they were. This lack of maturity was an issue that service providers said impacted a young person’s ability to make good choices, to prioritise their time, and to keep appointments. cu@home workers for example say that they have learnt over time that many of their clients will agree to schedules and activities that they do not want or are unable to do as they are uncomfortable about saying no. This then results in them not being at home at agreed times. This may explain in part, why young people are considered by some services to be “unreliable” clients.

This is not a new issue or an issue confined to
pregnant young women. Across a range of clinical areas, studies have been undertaken to more deeply understand the reasons for lack of attendance. Non-adherence with regularly scheduled clinic appointments represents one of the most costly problems in outpatient care, both in terms of economical and human resources spent. In many studies, poor clinic attendance has been associated with the adolescent developmental period, female gender, minority status, history of previously missed appointments, and lower socio-economic status (SES).24

Young people’s narrative around keeping appointments and accessing the range of programs and services in Northern Tasmania are supported by the literature. Please see page 61-69 of the literature review for a more detailed discussion about this issue.

Education

As outlined earlier, many of the young people had disengaged from education prior to becoming pregnant with only three of the young people participating in the research continuing with their school year while they were pregnant.

Young people and service providers report multiple barriers to continuing schooling for those who wish to do so. Evidence is clear (see literature review) that those young people who continue to go to school without a break or with minimal interruption are more likely to complete their current year and also to continue to further education after the birth of their child.

Young people reported a range of reasons for not continuing at school. These included:

- Had already disengaged from school prior to becoming pregnant;
- Stigma felt from peers and teachers;
- Not feeling well/tired etc.; and
- Inflexibility by the school in the later months of pregnancy.

The importance of continuing education during pregnancy to enable a more seamless transition back into learning after pregnancy cannot be understated. However, the complexity of this issue should not be underestimated. Discussion with the research participants would indicate that it is important not to make the assumption that every young person who got pregnant and was already disengaged from school or then dis-engaged from school, would have continued or returned to education if they had not become pregnant. The broader issues that related to their dis-engagement will still be present and therefore attempts to address needs that are pregnancy and parenting related are only part of the overall issue. More targeted research regarding this would potentially provide insight into the multiple and complex nature of this issue and provide evidence to inform potential strategies, policy and program responses.
### Local service providers - Pregnancy

<table>
<thead>
<tr>
<th>Name</th>
<th>Services offered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>cu@home</strong></td>
<td>cu@home is a program offered by the Child Health and Parenting Service for young first-time parents 15-19 years of age</td>
</tr>
<tr>
<td><strong>Pregnant and Young Parent Support</strong></td>
<td>PYPS is an information and support programs for young parents and young pregnant women under the age of 25. PYPS is a resource that assists young parents in preparing for the birth of their child and meeting the new demands of being a new parent.</td>
</tr>
<tr>
<td><strong>Launceston General Hospital Maternity Unit Antenatal clinic</strong></td>
<td>Provides care for women within Northern Tasmania for pre-pregnancy counselling, pregnancy, birth and post natal care. Women can choose from a number of options including share care with their family doctor in conjunction with the antenatal clinic, midwives clinics and Team Midwifery. A modern birthing unit provides for inpatient birthing facilities and the option of staying in hospital post natafly or going home with midwifery support from the Extended Midwifery service.</td>
</tr>
<tr>
<td><strong>Accommodation:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Karinya Young Mothers Support housing program</strong></td>
<td>Run in partnership with UnitingCare Tasmania Eight Housing Tasmania units across Launceston to accommodate mums and mums-to-be aged to 16 to 19 years.</td>
</tr>
<tr>
<td><strong>Thyne House</strong></td>
<td>Accommodation for those aged between 18-25</td>
</tr>
<tr>
<td><strong>Thistle Street</strong></td>
<td>Supported accommodation for those at risk of homelessness</td>
</tr>
<tr>
<td><strong>Centrelink</strong></td>
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## Example programs - Teenage pregnancy

<table>
<thead>
<tr>
<th>Name</th>
<th>Services offered</th>
</tr>
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</table>
| TOPS (Teen Outreach Pregnancy Service) U.S. | This program offers a range of services that assist with pregnant teens negotiating their choices. Though they offer information on contraception, sexual health and abortion they are primarily focused on providing services to teens who have decided to keep their baby. The offer the following programs  
- Free Teenage Pregnancy Classes  
- Free Childbirth Classes for Teenagers  
- Free Parenting Workshops  
- Free Workshops for Teen Dads  
- Information and Support Services for Parents of Pregnant Teens.  
The comprehensive website also offers a range of relevant information including audio and video clips that feature young people talking about their own experiences and information for parents of teenagers.  
In addition, their onsite services include a baby boutique with second hand baby clothes and other essential items.  
http://www.teenoutreachaz.org/ |
| The Power Program Queensland | POWER is a program that caters for pregnant and parenting high school students from any school in Brisbane based at Mabel Park State High School. Students who show a commitment to their education and who are willing to finish their senior years are invited to enquire about the program.  
Students attend classes with other non-parenting students in the school. The program includes an on-site crèche for the children of the students, weekly personal development and parenting classes, access to a child health nurse fortnightly, access to weekly antenatal classes, pick up and transport to the local bus and train station as well as intensive counselling and case management by qualified social workers.  
The parent friendly space contains a computer lab, a kitchen, and a room for students to use morning, during lunch breaks, in the afternoon and during spare periods.  
Information about the program is available at http://www.mabelparkshs.eq.edu.au/powerprogram.htm |
| The Massachusetts Alliance on Teen Pregnancy | The Massachusetts Alliance on Teen Pregnancy was founded in 1979 by eleven Boston-area agencies seeking to improve teen parent services. The Massachusetts Alliance on Teen Pregnancy is the ONLY organization in Massachusetts dedicated to ensuring that state policies and programs effectively address the complex issues associated with teen pregnancy. The mission of the Massachusetts Alliance on Teen Pregnancy is to provide statewide leadership to prevent teenage pregnancy and meet the service needs of pregnant and parenting teens and their children through policy analysis, research, education, and advocacy.  
Information can be viewed at http://www.massteenpregnancy.org/ |


This section of the research focuses on the point when a young person becomes a parent and what influences the quality of the experience. This section is also concerned with outcomes for the children.

It links the key themes emerging from the literature review with the perspectives and experiences of young parents in Northern Tasmania. This includes discussions with teenage parents through the focus groups, individual interviews and discussions with the service providers who work with them.

The key themes emerging from both the literature and consultations about teenage parenting are:

- Support structures and needs;
- Changing relationships, including family and peers;
- Single parenting;
- Education-pathways to future employment;
- Aspirations for the future;
- Inclusive communities – feeling judged; and
- Outcomes for children.
CASE STUDY 3

Penny 14 years  
Evan 2 years

Sexually Active

Penny realised she was pregnant three and a half months after having unplanned sex at a music festival with someone she didn’t know. She says she was drunk and she couldn’t remember the circumstances of what happened and wasn’t really sure she had had sex until she well into the next day. She just wanted to forget all about it.

Penny bought a home pregnancy test after she realised she had not menstruated for some time and was absolutely devastated when the test was positive. She seriously considered having an abortion, however by then she was about 15 weeks pregnant and accessing termination was both difficult and cost prohibitive.

Penny’s parents were separated and she had no contact with her father since she was a toddler. Her mother had not re-partnered. Penny left home as soon as she started working and lived with her older sister in a small flat. Penny trained and then worked as a beauty therapist after completing Grade 10. Penny did well at school and had been clear about her career path since she was 13 years.

Penny learnt about relationships, sexual health and contraception mostly from her sister. She gained some other information from school sex education classes in Grade 9 and 10, although she had some trouble recalling the content. Her mother never talked about anything to do with sex apart from telling her to be careful not to fall pregnant.

Her mother was initially shocked and disapproving when Penny told her she was pregnant and they didn’t speak with each other for a few months. However as the pregnancy progressed her attitude softened she was cautiously supportive although she believed that Penny should take total responsibility to care of herself and her baby with minimal help from her. Penny’s main emotional support was her sister.

Penny did not try to find or contact the probable father of her child. She says that she preferred not to make her situation more difficult than it was.

Pregnancy

Once she decided to continue with her pregnancy Penny was careful with her health. She had always eaten well and she continued to do so. She also stopped drinking alcohol and using drugs. She had never smoked tobacco.

She often felt very depressed and found it difficult to motivate herself to exercise or to make the effort to catch the public transport necessary to attend the antenatal clinic for pregnancy checks. Consequently Penny attended minimal appointments and looking back says she was unprepared for labour or parenting.

Penny finished work when she was seven months pregnant. Penny felt judged by her work colleagues and by some of her clientele so she was relieved to finish work.

Just before she finished work Penny moved into a small bedsit as there was not going to be enough room for her and the baby at her sister’s place.

Parenting

After Evan was born Penny’s sister came around every day for the first week to help her out and her mother also helped in a practical way by cooking her meals and helping with the laundry in the early weeks. Otherwise she spent time in her unit alone with Evan. A midwife also visited her over a period of two weeks. Penny trusted her, finding her a great support and has continued to have contact with her regularly, travelling to whichever clinic she is working from.

Parenting has been extremely difficult for Penny. She found parenting a young baby almost overwhelming and therefore although Penny is uncomfortable in group situations she attended PYPS sessions at every opportunity in Evan’s first year. She found that being with people in the same situation as herself and being able to speak with the facilitator helped her “get through” some of the hard parts of early parenting. Otherwise Penny’s main adult interactions were with her sister.

As Evan became older Penny’s mother gradually had more contact with both Penny and Evan and when Penny had to leave her bedsit she moved in with her
mother for a short while. Penny moved again to a unit when Evan was 13 months old and has been there ever since.

Penny is clear about the direction she wants her life to take and returned to study at Hair and Beauty School when Evan was 12 months old to continue gaining qualifications. However in the last 6 months she has decided to change to Child Care Studies. Being a parent to Evan has been difficult, but has also been fascinating to watch him develop she says. She has come to believe that children deserve to have high quality care and this is the direction she wants to work in.

### Literature review - Teenage Parenting

Parenting at any age can present a series of challenges but becoming a teenage parent can be particularly difficult while developing into adulthood and when living in a social context where the average age of most first time mothers is 28.9 years.¹

Responses to teenage parenthood in western industrialised countries is framed by policies that assume teen parenting is a result of ignorance and helplessness on the part of young people, even though it is not necessarily clear whether it is age per se or life circumstances that are associated with the relatively poor outcomes of teenage mothers and their children.² The paradigm of teenage parents as a welfare issue plays out in practice in two key ways. Firstly, teen parents feel disengaged and stigmatised by their community, and secondly there is a gulf between the actual experiences of teenage parents and policy and program responses.

A strong theme emerging from recent research, particularly the United Kingdom, is how positive and central their children are to the lives of young parents and that for many young parents their baby increased their happiness, being young was seen as a benefit for their children and becoming a parent provided impetus to change direction and focus on providing for their children.³ In contrast to teens’ positive experience about being a parent, policy is often focused on how to prevent teenagers becoming parents in the first place and to re-engage them in institutions and services that often do not acknowledge their parenthood and/or where “children are seen as obstacles”.⁴

However, while teen parents are in general positive about parenthood, in addition to the new task of mothering, issues that were present during pregnancy often continue to be apparent during parenting and the support needed to deal with these issues depends on socio-economic status, individual circumstances and skills and to a certain extent, the mother’s age.

### Impact of socio-economic circumstances

As established earlier, statistically young people from lower socio-economic backgrounds are at higher risk of being teenage parents and the accompanying impacts of intergenerational poverty and lack of opportunities for education and employment follow young people from pregnancy into parenting. Potential poor long-term outcomes for teenage parents and their children are indistinguishable from the poor outcomes that are more generally related to poverty and as such teen parents are more likely than their older counterparts to have poor mental health, poor housing, and low educational attainment.⁵

So, while satisfaction and pride about being a parent is often the impetus for many to contemplate changing their life and circumstances, entrenched issues related to intergenerational poverty mean that interventions attempting to address some issues, such as re-engagement with education and training, psychosocial wellbeing, drug and alcohol misuse and poor mental health and self-esteem are often evaluated as unsuccessful.

In contrast, targeted services that provide practical help, support and advocacy to teen parents when accessing appropriate housing and financial benefits are assessed by both young parents and service providers as important and useful and able to positively affect change.⁶
Barriers to Accessing Support

Support for young parents tends to fall into two categories; programs which teach practical parenting skills (assessing the health of your baby, changing nappies etc.) and programs which address broader concerns such as financial hardships and social inclusion.

Although general support programs for new mothers are available, teen mothers and single mothers are the least likely to access it and when they do, they are unlikely to continue with the programs. It has been shown that children from families with poor social support networks, such as extended families and peer networks, and that make limited use of new parent support programs are at increased risk of poor health and developmental outcomes.

There are a number of factors that contribute to this. Many young mothers stated that they found leaving the house to be a terrifying prospect and placed them in a vulnerable position where they could be easily judged by society. Taking public transport to health centres, for example, meant that some young mothers had to take multiple buses while carrying bags, prams and their child which they found to be stressful and at times embarrassing. Some teen mothers had even become wary of visiting support services due to their experiences with similar services during their pregnancy, stating that they felt judged and stigmatised by health care professionals. Other reports state that lack of publicity about services, costs, rigid eligibility criteria, limited availability and a general tardiness in response to perceived emergencies were also significant barriers to accessing support services.

Some interesting research conducted in Australia shows that the age of the parents has only a modest impact on the outcomes for their child. Rather it is more likely underlying issues of socio-economic disadvantage that contribute to the outcomes discussed in the previous chapter, for example higher rates of school absenteeism and difficulty accessing the labour market. With this in mind, support for young parents may be more effective if it was targeted towards addressing these underlying issues rather than placing too much emphasis on the age of the parents.

Early intervention parenting programs are an example of such an approach. Research conducted in Australia in 2006 showed that teaching parenting skills as early as practical reduced the instances of child maltreatment and increased the overall wellbeing of parents and child in the immediate term. These programs focus on developing caring families and positive parenting habits which support safe and supportive environments for children to develop.

Parenting Support

Research evidence indicates that intensive parenting interventions can produce good outcomes for children and also that teen parents have positive and enthusiastic responses to parenting support programs. There are many different types of teen-specific parenting programs/services but they can be categorised under the umbrella of either improving knowledge or skills about parenting or providing support aimed at helping to reduce the stresses associated with parenting.

Examples of the former include formal and informal interventions to increase parenting skills, improving parent/child relationships through attachment therapy and bonding, early learning programs and therapeutic interventions. These programs can be delivered in the home or in formal group settings and are commonly staffed by trained service providers and/or health professionals. The latter involves providing respite, direct support, general and targeted support groups and visiting specialist presenters for example.

The Sure Start Family and Parenting Support evaluation outlines both good practice principles of parenting support and characteristics of evidence based parenting programs and are reproduced on the following page.
Good Practice Principles of parenting support | Characteristics of evidence based parenting programs
--- | ---
Their primary focus on improving the relationship between parents and children, and helping parents to parent better | Provided by early years practitioners (or volunteers) who have received additional training and who get ongoing support while delivering programs.

Active support of parenting from pregnancy through toddlerhood and beyond, and often including at least one evidence-based program. | Aimed at encouraging new ways of parenting or changing established ways of parenting.

Use of very clear models or theoretical approaches that clearly informed the way in which all staff within the centre worked with parents to achieve change | Involve the use of specific methods of intervention with parents, and may use specific techniques to enable parents to parent differently.

Modeling of good relationships with both parents and children; and the skills and insight of staff, who delivered the programs effectively through a combination of training, supervision and experience. | Are goal-driven, with specified objectives to be achieved during the intervention and specific tasks to be undertaken.

Based in theory and often guided by the use of a manual.

Evidence suggests that the effectiveness of parenting and support programs for teenage parents and their children is dependent on the expected outcomes. Home visiting and community based programs have been shown to have the most impact, both in the short and long term. While this includes improved parent/child relationships there is no significant effect on parenting stress, mental health or social inclusiveness for the teen parent or on improvements on child developmental outcomes.

The key message from the literature is that the incidence of teenage pregnancy and therefore teenage parenting is strongly linked to the quality of experiences young people themselves had through their own childhood. The need to provide support services that take into account the broader socio-economic and developmental status of young parents is essential in conjunction with longevity of program funding to ensure continuity of practice.
Education

Internationally and nationally an explicit objective of policy makers and service providers is to increase the proportion of teen parents in education and/or training with the ultimate aim of participation in the workforce.\textsuperscript{17} As such, research has focused on understanding barriers that confront young parents when they try to continue with or to re-engage in their education and/or training and many of these are detailed in the Pregnancy section of this review.

In summary the barriers discussed can be seen as either structural/institutional and/or as an outcome of individual experiences, particularly early disengagement from school. In addition to barriers faced by pregnant teens, young parents are also of course parenting and this may mean a gap or delay in returning to school. It may and usually does also mean that additional practical supports are needed for a young person with a baby than when she was pregnant.

Service sector responses to engaging young parents in education include efforts to change the existing school structures and systems to accommodate young parents or to establish specific education/training programs that target pregnant or parenting teenagers.\textsuperscript{18}

Within Australia, for example, the Shine project, Healthy Young Parents in Education, provided a series of recommendations designed to overcome barriers and to support pregnant and parenting teens to access the public education system.\textsuperscript{19} While the final report gave a number of recommendations related to health and education departmental services, there were also practical strategies put forward by young parents that they nominated as crucial elements needed to help support them stay at school. The strategies encapsulate the outcomes of research and show that young parents require both practical supports and an encouraging culture and environment to maintain their schooling. They were:

- The importance of providing education that meets the social and intellectual needs of the student, while also acknowledging the student’s parenting responsibilities;
- Allowing newborns (not toddlers) to be with the mother in class when and if necessary;
- Good quality and site-specific childcare;
- Accessible and regular public or school-based transport provision; and
- The importance of a pregnant and parenting friendly culture within the school.\textsuperscript{20}

Other key areas identified in the report included uniforms, furniture, breast/bottle feeding and nappy changing areas, support for young fathers, etc.

Despite the structural barriers to continuing with education some pregnant and parenting school-aged women do continue to engage in education. The Shine report found that those young people who did stay in the education system had tangible goals that required them to remain at school. Furthermore nearly half were clear that they needed to stay at school so they could access higher education. The researchers conclude that there is a need for educational programs that academically prepare them for further study and that “It illustrated a genuine concern with ‘alternative’ educational pathways that provide young mothers with subjects that focus on their mothering and home-making skills, rather than providing the skills and knowledge to achieve educational or employment goals.”
Examples of schools that have actively sought to support pregnant and parenting teens are, most notably, Plumpton High School in NSW, and Mable Park State High School in Queensland and Burnside High School in NSW. Development and implementation of these school programs is reliant on the proactive input of the school's principal and as such can alter depending on the drive and commitment of individuals. Often they are highly dependent on additional sources of funding and as programs come and go as governments and policy priorities change, it is difficult to find examples of long term, systemic approaches that have enabled successful outcomes for retraining young mothers.

A best practice example that endeavours to address the barriers to education confronting pregnant and parenting teenagers is the Canberra College Cares Program and a full description of the service is provided here.

Canberra College partners with ACT health and other key government and non-government agencies to provide a “one-stop” shop for pregnant and parenting students called CCCares. CCCares offers Year 12 Certification; goal oriented learning packages, on-line learning, and vocational education and employability skills within a mainstream ACT Government College context.

The campus is designed with open plan learning environment and also kitchens, playrooms, sleep rooms, change rooms, 2 medical suites, gymnasium and outside play areas on site.

In addition to the education and learning programs the campus provides other supports that attempt overcome barriers to continuing education such as:

- Health support including Family and Child Health nurses, child immunisations, on site antenatal nurse visits, dental health;
- Playgroups and child minding;
- Transport assistance and driver training; and
- Nutrition and cooking programs and fitness instruction.


Alternative models designed to support young parents who have disengaged from school, before or during their pregnancy or after birth, tend to concentrate on intensive support and training outside the institutional setting. A feature of these models is that parenting skills are often the base of a young parent’s study or training. Again typical examples are found in Australia and include the Supporting Teenagers with Education Mothering and Mentoring (STEMM) program from Queensland and the On Our Patch program in Tasmania. The STEMM program provides life skills and parenting programs for teens and works in partnership with Education Queensland, TAFE and the University of the Sunshine Coast to work toward qualifications. The On Our Patch program documents and collects evidence of an individual's activities and skills that takes place in group settings, such as early learning or parenting programs, and this evidence is then assessed against competencies by a registered training organisation and credited.

In conclusion, education and/or training with the aim of employment and income self-sufficiency is perceived as an opportunity by young parents and has become a priority for policy makers. Many young parents see education as the key step to transition out of their past and current circumstances and to provide their children with lives different to the one they may have experienced. Transforming this into reality is complex and depends on providing education and training programs that acknowledge they may be working with young parents who have been disengaged from education for many years, well before they become parents and that the traditional school systems do not have the flexibility to cater for teenage parents in its current form or in the long term.
Outcomes for children

Until recently most of the available research about teenage childbearing has concentrated on the lives, circumstances and outcomes for mothers and despite evidence that teen parenting is intergenerational there is limited knowledge about outcomes for children of teen mothers.

In general however many papers conclude that, outcomes for children of teenage parents have been found to be associated with socio-economic status and therefore differ only marginally from children of older mothers who live with similar conditions.\textsuperscript{24} For example, studies that compared the physical and mental health outcomes of Inuit children of teenage mothers with their older counterparts showed that once socio-economic variables were taken into account the two groups did not differ in terms of chronic conditions (respiratory, ear infections and dental health etc.) or pro-social behaviour or conduct problems.\textsuperscript{25}

This study is of interest because teenage parenting is considered normal in Inuit culture (20% of all births are to teenagers) and teenage parents do not feel judged and/or stigmatised by providers as can be the perception of teens in western industrialised countries. Inuit teenage parents’ access to health and education is consistent with the rest of the population, which may be a contributor to the outcomes for the children.

In contrast, a UK study that examined outcomes for young adults born to teenage mothers, concluded that compared to older mothers in the same circumstances are, on average, typically worse off in two ways.\textsuperscript{26}

1. Low income. On average young adults of teen mothers have lower chances of higher educational attainment, greater risks of inactivity and teenage childbearing, smaller probability of being in the top decile of the income distribution and greater probability of being in the bottom decile of the earnings distribution.

2. Single parent families. Children of teen mothers have worse outcomes if they grew up in a non-intact family, but not so much so if they grew up in a low-income family.

They also found that these outcomes were similar for mothers aged 24 years and any correlation disappeared when the mother was 28 years.

US studies outline risks to children born to teens and are clear outcomes are significantly worse than those for children of older mothers. For example:

- The children of teen mothers are more likely to be born prematurely and at low birth-weight, raising the probability of infant death, blindness, deafness, chronic respiratory problems, mental retardation, mental illness, cerebral palsy, dyslexia, and hyperactivity.
- Children of teen mothers are 50% more likely to repeat a year, less likely to complete high school and have lower performance on standardized tests than those born to older parents.
- The children of teen parents are more likely to live in poverty and suffer higher rates of abuse and neglect than would occur if their mothers delayed childbearing.
- The sons of teen mothers are 13% more likely to end up in prison.
- The daughters of teen parents are 22% more likely to become teen mothers themselves.\textsuperscript{27}

In conclusion, the literature identifies multiple risk factors for children born to teens but is less clear about whether this is associated with age per se, with socio-economic status or with giving birth at an age that is outside the cultural norm.

As can be seen by this literature, much of the research on teenage parenting is slanted towards parenting in lower-socio economic groups and families at risk of domestic violence and/or disturbance. This is not to say that the majority of teen parents are from lower socio-economic backgrounds or that there is lack of successful programs. Rather this is a reflection of the currently available research on teen parenting.
The Local Context

One of the strongest messages that emerged from the interview and focus group participants was an underlying sense of pride and satisfaction about being a parent. Notwithstanding the challenges of parenting, participants were in general clearly proud of their children, were positively and proactively engaged with their children and felt satisfied about being a parent. This sense of worth and pride was noticeable not only for those parents who had planned to have children sometime in the future but also for those for whom parenting was a complete surprise. It was apparent across all age groups—essentially as with most parents, they loved and wanted their children. How this pride and love translates into everyday parenting and in the long term is dependent on the type and extent of support and resources that the young parents have access to and their expectations and skills about parenting.

Being a teenage parent

When asked if the reality of parenting was as they had expected, responses from young parents varied across the spectrum from being “easier” than they expected to a “total shock”. However as is the case with their older counterparts, in general, perceptions about parenting from teen parents can be summarised as difficult but rewarding.

Specifically, of the eight mothers who commented on the statement that “being a mother is what I expected”:

• 3 young mothers were unsurprised about the parenting role, although they found the reality to be more intense than they had anticipated. All of these mothers had been significantly involved in the care of much younger siblings.

• 1 found it to be a very different type of experience to what was anticipated but after adjustment considered parenting to be “fine”.

• 2 described the reality of caring for their child as “being a shock, being very challenging and that it (parenting) remains so” and definitely not what they expected.

• 1 found that the needs of their child changed all the time and that it was hard to “keep up”.

• 1 described the number of tasks associated with parenting to being extremely “hard”.

Young fathers in the focus group also clearly articulated their views and understanding about parenting and while their individual experiences varied there was agreement that:

• You “can never be ready” to have a baby, nothing prepares you...;

• Fatherhood requires maturity and that this was described as “if you can take care of yourself and take responsibility for yourself you can be a parent”; and

• A primary quality required of a father is patience.

In addition to the qualities needed to parent effectively young fathers also emphasised that they considered a core part of their role was to physically provide for their children and partner. This sentiment was expressed repeatedly and the ability to perform this part of their role contributed to either pride or a sense of failure about themselves as fathers. Some of the fathers felt that a drawback of being a young father was that they had not had time to develop the skills or resources that would enable them to provide for their family. For example, participants regretted that there had not been enough time to develop “good” work habits, or to have secure employment so that they could provide a home and a car.

Parenting Support

Family

Family support is extremely helpful for all parents and it could be argued even more so for teenagers. Participants cited a range of support provided by family and they included accommodation, child care both regular (for education for example) and in emergencies, transport, financial help and emotional support. Family encompassed siblings, cousins, step mothers/fathers, in-laws as well as mothers and fathers.

Outcomes from the interviews and feedback from service providers indicates that young parents who are able to establish or maintain positive contact with their family after the baby is born have clear aspirations for the future and are more likely to be engaged in education or are working by the time their children are toddlers. Some young parents who do not have close family contact are also able to achieve these particular outcomes but feedback suggests that this is more challenging.

Workers from the cu@home program report that many of their clients have dysfunctional and negative relationships with their mothers. In their assessment such relationships impact on the young mother’s bonding and mothering with her own child, meaning that the young mother’s support structures are tenuous and changeable and this can contribute to a diminished sense of well being.

Positive contact with family was proactively sought by most parents interviewed and difficult family relationships tended to improve after the baby was born, although
not for all. Of the individual interview participants, 10 of the 14 reported that their relationships with their family had improved after they had their baby and spoke of being “closer to family” and being able to “talk to my mother now”. Focus group participants reported similar experiences with all but three detailing the importance of family support to helping them with the day to day activities associated with parenting. Family was also nominated by 72% of participants as being the primary source of support in an emergency.

Those participants who did not have close relationships with family said that they relied on their partner or friends in the first instance and then service providers if and when they needed support and two individuals said they felt they had no one they could turn to for help.

**Friendships and peers**

A normal experience of parenting is that friendship and peer groups tend to change and this experience is echoed by teenage parents. Most focus group and individual interview participants reported that their friendship and peer groups had changed since becoming parents. For young fathers this was often a deliberate decision and was based on the understanding that responsible parenting required them to be selective about their peer group and friends. All the fathers in the focus group had deliberately assessed if their friendship group and the associated activities were appropriate in the context of being a parent and all reported that they had maintained very few friendships from before they became fathers.

Young mothers also reported that their friendship groups had changed or contact with their friends had become much less frequent since becoming a parent and for 20% this contributed to feeling isolated and lonely and unhappy with their social life.

**Service Support**

As explored in the Pregnancy section a common theme for young parents is how isolated and uncomfortable they feel when accessing mainstream support services such as parenting groups or social clubs etc.

In this context support groups such as those facilitated by PYPS (Pregnant and Young Parent support) provides an extremely important avenue for young parents to socialise with their peers. Many of the attendees’ nominated the PYPS group as the only contact they had with other parents and although values and attitudes within the group vary considerably the opportunity to be with peers overcame any disquiet they felt about these differences.

Additionally all the research participants were reliant on targeted support services for support and to help navigate through the issues associated with parenting. They also tended to be multiple services users and all but two cited having contact at some point with PYPS, cu@home and headspace. These three services were seen as crucial component to the young parents support structure.

**Single parenting**

Research shows that there is a higher than normal risk of single parenting if you are a teenager and that single parenting is associated with ongoing poverty and a range of other poor maternal outcomes. Young parents in the north reflected these statistics with 88% of participants not in a live in relationship with the father of their child/ren and while some had re-partnered (just under half) many were single parents.

While access rights and visitation schedules from the separated parent (usually fathers) were not specifically addressed in the focus group sessions or the individual interviews, difficulties /disruption associated with access arose regularly as a topic. Given that many teenage fathers are not present in their child’s life from a very young age any barriers to contact may make a difference to the quality, frequency and longevity of paternal contact.

In addition to the frequent comments from young mothers, service providers, on behalf of both parties, also nominated disputes and difficulties involving access as an issue. As with many separated families, access can often be the cause of ongoing problems and this area was highlighted by both young parents and service providers as an area that could be researched more comprehensively in order to gain a deeper understanding of the particular issues around access for young people.

**Education and aspirations for the future**

Research participants describe education as a pathway to employment that will in turn lead to financial and material security. This perception is supported by the literature. All (parent) research participants expressed interest in finding pathways to complete or continue their education most aspired to be working. In summary, the research found that young parents:

- Understood that education was crucial if they were going to earn a reasonable income;
- Were, for the most part, engaged in some sort of education (Certificate level generally); and
- Found there were significant barriers to
participating in education. The two most common issues nominated were child care and transport.

Many of the young parents did not complete year 12 and their aspirations for employment often depend on reasonable levels of academic proficiency if they are to continue onto to tertiary level. Service providers and employment agencies expressed the difficulty of providing adequate training to this cohort of teenage parents. In summary, as discuss the area of education and training for pregnant and parenting teenagers is complex and requires further investigation.

A significant number of participants (approximately a third) expressed personal aspirations for the future and these focused on having stable, respectful, long term relationship and having another child but only after everything else was “in order”- that is they had stable accommodation (ideally their own home) and were financially secure.

More detailed discussions about plans for the future emerged in the focus group sessions and a general sense of dissatisfaction with their current situation articulated, particularly for those who were single parenting. For instance more than half of the group wanted to leave Launceston hoping for more opportunities in other places.

Career options of interest included:

- Nursing/Midwifery;
- Hairdressing;
- Cleaning;
- Child carer; and
- Chef/hospitality.

Outcomes for Children

A significant proportion of parents interviewed expressed a range of perceived developmental delays with their children including physical and intellectual developmental delays and in some cases, medical conditions, behavioural issues and autism. Of the 14 individual interviewees, two reported that their children were autistic, one child was diagnosed with cerebral palsy, one attended St Giles for behaviour management and assessment for possible ADHD. It is unclear if the numbers of parent reported conditions are diagnosed and if so, are at a higher proportion than the general population. As detailed in the Pregnancy section maternal morbidity and mortality data does indicate that teenagers are more at risk of having low birth weight and premature babies and that these conditions are associated with a range of ongoing physical and intellectual issues. This may be an area that requires further research as if there are a greater proportion of children of teenagers that require professional intervention and support there maybe implications for resource allocation and service and program development and delivery.

Children Protection and teenage parents

One adverse outcome for the children of teenage parents cited in international literature is that children of teenage parents are over represented in the child protection system. Research participants were not asked about their experiences in relation to child protection, however service providers, including cu@home and PYPS workers indicated that a proportion of their clients were in contact with child protection services.

The researchers were unable to obtain data to investigate this risk in the local or Tasmanian context. We received advice from Children and Youth Services (DHHS) that there are a number of confounding factors regarding this issue which could not be satisfactorily addressed within the required timeframe. These issues included:

- The close association between socio-economic status and maternal age as well as socio-economic status and involvement with child protection services;
- The high mobility of teenage parents;
- A lack of high quality data; and
- The impact of access to support services such as cu@home.
### Local service providers - Parenting

<table>
<thead>
<tr>
<th>Name</th>
<th>Services offered</th>
</tr>
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<tbody>
<tr>
<td>cu@home</td>
<td>This program starts during pregnancy but provides most of its services during the first 2 years of the child's life. In regards to parenting the aim is to promote parents'/caregivers getting to know and understand their infant.</td>
</tr>
</tbody>
</table>
| PYPS (Pregnant and Young Parent Support)                  | While PYPS is an information and support program for young pregnant women under the age of 25 its main activity is support of young parents in meeting the new demands of being a new parent.  
  The PYPS program aims to:  
  • Support young mothers through pregnancy  
  • Reduce the impact of family violence  
  • Reduce the isolation of young parents  
  • Support young parents to be the best parent they can  
  • Inspire good parenting and encourage the valuing of positive parent/child relationships  
  • Raise the self-esteem of every individual.                                                     |
| Child Health and Parenting Service                        | Provide a universal health check for children up to 4 years  
  Provides targeted early intervention                                                               |
| Child and Family Centres                                 | Provide a “one stop shop” that support families with children 0-5 years                                                                                                                                            |
| Tasmanian Aboriginal Centre health program                | Provides outreach and centre based midwifery care  
  Provides child health nurse outreach and centre based care  
  Provides parenting/play groups for teenage parents                                                   |
| Education and Employment                                 | LINC: offer literacy support  
  Department of Education schools and colleges  
  Registered Training Organisations  
  On our Patch: community based training                                                                 |
| Babymums City Mission                                    | Provides accommodation  
  Parenting programs  
  Outreach and education programs                                                                        |
| Housing                                                   | The same avenues for accommodation apply as during pregnancy.  
  Provide accommodation for pregnant and parenting teenagers                                           |
| Karinya Young Mums ‘n Bubs                               | Accommodation supporting 18 to 25 years old.                                                                                                                |
| Thyne House and Thistle Street                            |                                                                                                                                                                                                               |
## Service model examples - Teenage parenting

<table>
<thead>
<tr>
<th>Multi-service models</th>
<th>Terra Centre-Canada</th>
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<tbody>
<tr>
<td></td>
<td>Offers a range of services for expectant mothers up to age 19 and expectant fathers up to age 24. The services they offer are:</td>
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<tr>
<td></td>
<td>• a program that offers emotional and medical support and guidance during their pregnancy;</td>
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<td></td>
<td>• life skills classes on parenting and looking after your child;</td>
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<tr>
<td></td>
<td>• free Childbirth classes for teens;</td>
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<tr>
<td></td>
<td>• free workshops for new dads;</td>
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<td></td>
<td>• access to a licensed social worker;</td>
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<td></td>
<td>• mentor service which encourages parents who have used the services of the Terra Centre to support new enrollees; and</td>
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<tr>
<td></td>
<td>• a job search program which helps teen mothers return to the workforce. This includes a child minding service for when mothers attend interviews.</td>
</tr>
<tr>
<td></td>
<td><a href="http://terracentre.ca/">http://terracentre.ca/</a></td>
</tr>
</tbody>
</table>

| Sure Start Plus-UK | Aims to reduce teenage pregnancies at both national and local levels developed from 2001 |
|                   | Provides personal packages of support for pregnant and parenting teenagers |
|                   | Responds to local need and circumstances with a range of programs that target health, employment and housing |
|                   | http://www.education.gov.uk |

| Teen Parent Support Programme (TPSP)-Ireland | There are 11 Teen parent support sites across Ireland. The sites provide teenage parents with support and advice until the child is 2 years. |

<table>
<thead>
<tr>
<th>Targeted pilot programs</th>
<th>Teenage Parent and Jobless Families Program</th>
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<tbody>
<tr>
<td></td>
<td>This is a program run by the Australian Government which assists young parents under the age of 19 who are living in one of 10 selected areas across the country (including Burnie, Tasmania). The service provides support to teenage parents until their child is six years of age. This includes assistance in finding work, finishing their HSC Certificate or Certificate 2 equivalent qualification.</td>
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<tr>
<td></td>
<td>This program also has an offshoot internet forum for young mothers called Love.Learn.Grow. This forum provides information on raising a child in Australia, such as where and when to get immunisations, as well as an opportunity for young mothers to share their stories.</td>
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<thead>
<tr>
<th>Websites</th>
<th>Pregnancy Birth &amp; Baby (<a href="http://www.pregnancybirthbaby.org.au">www.pregnancybirthbaby.org.au</a>)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>A comprehensive website that covers all aspects of teen pregnancy, child-birth and parenting. It contains information about what choices an expectant teen has and where to go for further advice. It also runs a telephone hotline service with trained counsellors and medical professionals to assist teens in need. This is a free service. This site is intended to be a 'one stop shop' for information on teen pregnancy and parenting, which can then refer clients to other services.</td>
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<tr>
<td></td>
<td>TEENPARENT.tv (<a href="http://www.teenparent.tv">www.teenparent.tv</a>)</td>
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<tr>
<td></td>
<td>An interactive website for teen parents based in Canada.</td>
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<td></td>
<td>Standup Girl (<a href="http://www.standupgirl.com">www.standupgirl.com</a>)</td>
</tr>
<tr>
<td></td>
<td>Teen parent forum and information site.</td>
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</tbody>
</table>


21 Information about the STEMM program can be found here: [http://www.stemm.com.au/](http://www.stemm.com.au/)


Appendix One
Teen Pregnancy Survey Results
Teen Pregnancy Survey Results

1. Are you:
There were a total of 58 respondents to the survey. Of these 58 respondents, 31 were female (53.4%) and 27 were male (46.6%).

2. How old are you?
There was a significant age difference between the two largest age groups in the survey. 22.4% of respondents were aged 13 and 19% of respondents were aged 19. 13.8% of respondents were aged 14 and 18. 48.2% of respondents were 17 years or younger.

3. What school do you attend?
The greatest concentration of respondents attend Launceston College (30.2%). This is followed by Riverside High School (15.1%). 18.9% of respondents study in private/independent education facilities. 1.9% of respondents attend schools outside of the Launceston region, on Flinders Island.

4. What year are you in at school?
The respondents of the survey were spread between years 9 through to year 12. More than half (56.6%) were in their college years (year 11 and 12). The greatest concentration of respondents were in year 12 (43.4%) followed by year 9 (22.6%).

6. This question is about respect in relationships and how respected you feel by people in your life. On a scale of 1-5 with 1 being not very and 5 being very, how valued or respected do you feel by each of the following?
Respondents felt most respected by their friends (60.9%) followed by their parents (48.9%) then their partner (43.5%). 65.9% of respondents felt respected or very respected by their teachers/educators, with 21% indicating they did not feel respected by them. 30.4% of respondents did not feel respected by doctors or health care workers. No respondents felt they were not very respected by their friends, parents/guardians, other family members or their educations.

No respondents felt very respected by either society in general or the media. Only one respondent felt any respect at all from the media. 49% of respondents felt either not very respected (21.3%) or not respected (27.7%) respected by media.
7. Who would you turn to if you had a problem? Choose no more than 3.

83% of respondents would turn to their closest friends if they had a problem. Parents/guardians and boyfriend/girlfriend were the next likely groups, 70.2% and 53.2% respectively. School social workers/counsellors were the least likely group for respondents to turn to if they had a problem (4.3%).

8. Which of the following (if any) would you like to be able to talk openly with your parents or guardian about? Please choose no more than 3.

73% of respondents would like to talk more openly with their parents about having a good relationship. 45.9% of respondents would like to talk more openly about deciding when it is the right time to have sex. Almost a quarter (24.3%) would like to more openly about how to get contraception. 16.2% would like to talk more openly about how to say no to sex if they feel the aren't yet ready.

9. How much do you agree or disagree with each of the following statements?

70.2% of respondents expect to be successful in life. More than half felt that their adults in their life have high expectations of them (52.2%). Only 13% of respondents strongly agree that they are attractive, 28.3% disagreeing with the statement. All respondents agree to an extent that pregnancy is a big deal, 76.1% strongly agreeing with that statement. 60.9% of respondents strongly agree that having sex with someone is a big deal with only 6.5% disagreeing the same statement. Only 4.3% of respondents strongly agree that people will be liked if they have sex with more than half (55.3%) disagreeing with the statement altogether.

10. How much would you say each of the following contribute to how good you feel about yourself?

Respondents placed a high emphasis on intelligence and education as contributors to their self-worth. How smart they are (61.7%) and how well they do in school (66%) were the biggest contributors to how good the respondents felt about themselves. Only 2.1% of respondents indicated that intelligence and education were not important to them. 47.8% of respondents stated that their looks were very important to their feelings of self-worth with only 6.5% indicating that it did not affect them. Family was also an important contributing factor to self-worth, with 44.7% stating that it contributed a lot to how they felt about themselves.
Sex was the least likely contributor to self-worth. 55.3% of respondents answered that someone wanting to have sex with them did not affect their feelings of self-worth and 46.8% stated that having sex at all was not important to their self-worth. Having a boyfriend/girlfriend and their athletic ability were also not big contributors to self-worth (42.6% and 45.7% respectively).

11. At what age do you think most people first have sex?

There was a spread of ideas about the age that people first have sex. 26.7% of respondents think that people first have sex at 13 and 24.4% think people first have sex three years later, at age 16. 2.2% of respondents think that people first have sex in their early 20’s. 6.7% think that people first have sex at age 13 or earlier.

12. Please complete this question: It’s ok to have sex with someone…? Please tick all that apply.

66.7% of respondents felt that it was ok to have sex once you are in a committed relationship. 60% felt that it was ok at any time, providing that you used protection. A third of respondents (33.3%) felt that having sex was acceptable on the same night that you met someone. 13.3% felt that it is ok to have sex with someone if you are drunk and/or high.

13. Please answer true or false for each of the following statements. If you’re unsure please tick “don’t know.”

8.9% of respondents believe that a female can’t get pregnant if it is a) the first time she has had sex or; b) the first time that their male partner has had sex. More than half of respondents (55.6%) believe that abstinence is the only way to completely prevent a pregnancy. A third (33.3%) or respondents believe that a girl can get pregnant while menstruating. 37.8% of respondents were unsure about the same question. 20% of all respondents believe that birth control pills are effective, even if they miss taking them for several days in a row.

14. Which, if any, of the following have you used for information about sex and contraception? Please tick all that apply.

A respondent’s friends were the most likely source of information regarding sex and contraception (88.9%). The next most common sources were teachers/educators and the media (television, movies, magazines etc.) with 55.6% each. Just fewer than half the respondents (48.9%) have used their parents/guardians as a source for information about sex and contraception. The internet, too, was a popular source for information, with 40% getting information from a Health Website and 48.9% searching for information using Google. No respondents seek out information from religious leaders.
15. How much do you agree with the following statements?

84.4% of respondents feel they have the right to change their mind about sex, even if it involves stopping the act. 57.8% feel comfortable insisting on the use of contraception when having sex. 37.8% answered they did not know to the same question. 59.1% of respondents find that talking to their parents or guardians about sex is more awkward than it is helpful. 43.2% agree that girls have more respect for guys who wait to have sex. If the situation is reversed, only 31.1% agree that guys have more respect for girls who wait to have sex, with 42.2% of respondents disagreeing with this statement. 28.9% of respondents feel that fate plays a role in pregnancy. 26.7% of respondents think that it is embarrassing for young people to admit to being a virgin. 62.2% disagree with that statement. Only 28.9% of respondents feel that they know everything they need to know about avoiding pregnancy and only 26.7% feel that they know all they need to know to prevent contracting a sexually transmitted infection or disease. 60% of all respondents answered that pregnancy would be the worst possible outcome from having sex with a spread of 56% male and 65% female. Males were more worried than females about contracting a sexually transmitted disease (40% and 25% respectively). No respondents felt that losing someone because you would not have sex with them was the worst scenario provided.

16. Which, if any, of the following have you ever done? Please tick all that apply.

45.5% of respondents stated that they have hooked up with someone and regretted it. Females were twice as likely to answer yes to that statement. 42.1% of females have been pressured to go further sexually than they would have liked, and 47.4% of females have lied to get out of a sexual situation.

17. When you are deciding whether or not to have sex, whose opinion, besides your own, matters most? Choose up to 3.

Both male and female respondents agreed that the opinion of their partners was the opinion that mattered most, besides their own (45.8% and 50% respectively). 43.2% of respondents answered that no one else’s opinion matters. No respondents felt that the opinions of their siblings or religious leaders matter to them when deciding whether to have sex or not.

18. Which of the following would be worse?

60% of all respondents answered that pregnancy would be the worst possible outcome from having sex with a spread of 56% male and 65% female. Males were more worried than females about contracting a sexually transmitted disease (40% and 25% respectively). No respondents felt that losing someone because you would not have sex with them was the worst scenario provided.
Appendix Two
Online survey results –
male versus female comparisons
Male versus Female Comparison

1. Are you male or female?
There were a total of 58 respondents to the survey. Of these 58 respondents 31 were female (53.4%) and 27 were male (46.6%).

2. How old are you?
There was a significant spread of ages across the genders. The majority of females were aged 17 or older (87.1%) with the greatest concentration at age 19 (29%). The majority of the males were 16 or younger (70.3%) with the greatest concentration at age 15 (37%).

3. What year are you in at school?
There was a significant gap between the schooling level of males and females in the survey. 73.1% of males were in year 9 and 10 (high school level) whereas 85.2% of females were in years 11 and 12 (college level). 42.3% of males were in year 9, compared to only 3.7% of females. Most of the females were in year 12 (66.7%).

6. This question is about respect in relationships and how respected you feel by people in your life. On a scale of 1-5 with 1 being not very and 5 being very, how valued or respected do you feel by each of the following?
In regards to respect, both males and females answered that they feel most respected by their friends. Females were 10% more likely to feel respected by their partner than males. Twice as many males did not feel respected by Drs and Health Care Workers than girls with only 8% of males feeling strongly respecting by them. Females answered they felt more respected by society in general, with 40% of males answering they did not feel respected by society at all. No females answered that they felt respected by the media, with 27.3% indicating they felt not very respected by the media.

7. Who would you turn to if you had a problem?
Both males and females were more likely to turn to their closest friends if they had a problem before any other option, 84% and 81.8% respectively. Males were 20.9% more likely to turn to their parents than females.
8. Which of the following (if any) would you like to be able to talk openly with your parent or guardian about?

![Bar chart showing the percentage of males and females who would like to talk openly with their parent or guardian about various topics.]

87% of males would like to speak more openly with their parent(s)/guardian about how to have a good relationship. Females were 42.6% more likely to want to speak with their parent(s)/guardian about love than males. 28.6% of females want to talk more openly about saying no to sex if they are not ready.

9. How much do you agree with the following statements?

72.7% of females strongly agree that the adults in their life have high expectations of them compared to only 33.3% of males. Both males and females indicated they were generally happy with the person they are right now, with 54.2% of males and 54.5% of females strongly agreeing with that statement. 9.1% of females do not think having sex with someone is a big deal compared to only 4.2% of males. Both males and females were reluctant to call themselves attractive. 90.5% of females strongly agree or maybe agree that males are pressured to have sex to prove that they are cool. 44% of males disagree with that statement. There was some discrepancy between males and females in regards to what age most people first have sex. 80% of females believe that people have sex at or after age 15 whereas 80% of males believe people first have sex before age 15. 40% of males believe that most people first have sex at age 13, compared to 10% of females agreeing with that statement. 40% of females believe that most people first have sex at age 16.

10. How much would you say each of the following contribute to how good you feel about yourself?

In general, females indicated that intelligence and performance at school were important to their self-worth, 72.7% answering that those facts are very important to feeling good about their selves. 8% of males answered that their family life did not affect their self-worth. Females were 30.3% more likely to consider their looks when deciding their self-worth. Males were more concerned with their culture and background than females, with 16.7% answering that it was very important to their self-worth and 70.8% answering that it was somewhat important. In contrast 45.5% of females answered that it did not affect them at all. Athletic ability was seen to be of little importance to contributing to a person’s self-worth with 40% of males and 45.8% of females answering that it does not affect them. Males placed almost twice as much emphasis on money as a factor in feeling good about their selves than females. Neither group placed great importance on someone wanting to have sex with them in determining their self-worth, with more than half of each group saying it does not affect them.

11. At what age do you think most people first have sex?

![Bar chart showing the percentage of males and females who believe most people first have sex at different ages.]

There was some discrepancy between males and females in regards to what age most people first have sex. 80% of females believe that people have sex at or after age 15 whereas 80% of males believe people first have sex before age 15. 40% of males believe that most people first have sex at age 13, compared to 10% of females agreeing with that statement. 40% of females believe that most people first have sex at age 16.

12. Please complete this question: It’s ok to have sex with someone…? Please tick all that apply.

![Bar chart showing the percentage of males and females who believe it’s ok to have sex with someone at different times.]

In general, females indicated that intelligence and performance at school were important to their self-worth, 72.7% answering that those facts are very important to feeling good about their selves. 8% of males answered that their family life did not affect their self-worth. Females were 30.3% more likely to consider their looks when deciding their self-worth. Males were more concerned with their culture and background than females, with 16.7% answering that it was very important to their self-worth and 70.8% answering that it was somewhat important. In contrast 45.5% of females answered that it did not affect them at all. Athletic ability was seen to be of little importance to contributing to a person’s self-worth with 40% of males and 45.8% of females answering that it does not affect them. Males placed almost twice as much emphasis on money as a factor in feeling good about their selves than females. Neither group placed great importance on someone wanting to have sex with them in determining their self-worth, with more than half of each group saying it does not affect them.
Both males and females generally agreed that it is okay to have sex as long as you use protection (68% and 50% respectively). 80% of women think it is okay to have sex once you are in a committed relationship. 16% of males and 10% of females answered that it is okay to have sex if you are drunk or high.

13. Please answer true or false for each of the following statements. If you’re unsure, please tick “Don’t Know.”

16% of boys think that girls cannot get pregnant the first time she has sex. The same percentage again believes that a guy cannot get a girl pregnant if it is the first time he has had sex. 80% of females believe that abstinence is the only way to completely avoid pregnancy. 40% of males and 15% of females believe that a girl cannot get pregnant if she is menstruating, with only 12% of males answering that it is possible. 80% of females believe that birth control pills are effective even if you miss taking them for two or three days in a row.

14. Which, if any, of the following have you used for information about sex and contraception? Please tick all that apply.

Friends are the number source of information about sex or contraception for both groups. Females are far more likely to obtain information from their doctor than males (55% and 4% respectively). Females are 36% more likely to get information from their partner. Close to half of each group get information through internet searches. Males were 15% more likely to information from a sports coach than girls.

15. How much do you agree or disagree with each of the following statements?

8% of males do not feel they have the right to change their mind about having sex with someone. Females are 43% more likely to feel comfortable saying “no” to having sex than males (75% and 32% respectively). 32% of males and 25% of females do not know all they need to know about preventing pregnancy. Only 8% of males believe they know all they need to know about preventing sexually transmitted infections or diseases. 70.8% of males feel that talking to parents about sex was more awkward than helpful. 80% of girls do not believe that being a virgin is embarrassing. 48% of males believe that if it is your time to get pregnant it will happen, regardless of the precautions you take. 90% of females disagree with this statement.

16. Which, if any, of the following have you ever done? Please tick all that apply.

45.5% of respondents stated that they have hooked up with someone and regretted it. Females were twice as likely to answer yes to that statement. 42.1% of females have been pressured to go further sexually than they would have liked, and 47.4% of females have lied to get out of a sexual situation.

17. When you are deciding whether or not to have sex, whose opinion, besides your own, matters most? Choose up to 3.

Both male and female respondents agreed that the opinion of their partners was the opinion that mattered most, besides their own (45.8% and 50% respectively). 43.2% of respondents answered that no one else’s opinion matters. No respondents felt that the opinions of their siblings or religious leaders matter to them when deciding whether to have sex or not.
18. Which of the following would be worse?

![Bar chart showing responses to different scenarios]

60% of all respondents answered that pregnancy would be the worst possible outcome from having sex with a spread of 56% male and 65% female. Males were more worried than females about contracting a sexually-transmitted disease (40% and 25% respectively). No respondents felt that losing someone because you would not have sex with them was the worst scenario provided.
Appendix Three
Data
### Average yearly fertility rate x age (2007 - 2010)

<table>
<thead>
<tr>
<th>Region</th>
<th>Age</th>
<th>Number of Mothers aged 15 - 19</th>
<th>Female population aged 15 - 19</th>
<th>Northern Fertility rate (per 1,000)</th>
<th>Tasmanian Fertility Rate (per 1,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>15</td>
<td>6.8</td>
<td>956</td>
<td>7.1</td>
<td>4.7</td>
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<tr>
<td></td>
<td>16</td>
<td>10.8</td>
<td>881</td>
<td>12.2</td>
<td>11.4</td>
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<tr>
<td></td>
<td>17</td>
<td>19.5</td>
<td>891</td>
<td>21.9</td>
<td>22.7</td>
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<tr>
<td></td>
<td>18</td>
<td>32.3</td>
<td>852</td>
<td>37.9</td>
<td>38</td>
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<tr>
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<td>19</td>
<td>45.8</td>
<td>850</td>
<td>53.8</td>
<td>57.7</td>
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<td></td>
<td></td>
<td><strong>Northern Average Yearly Total</strong></td>
<td>115.5</td>
<td><strong>4430</strong></td>
<td><strong>26.1</strong></td>
</tr>
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</table>

### Average proportion of teenage parents enrolled in the cu@home program (2009-10 to 2011-12)

<table>
<thead>
<tr>
<th>Region Rooted in LGA</th>
<th>Mothers enrolled in cu@home</th>
<th>Teenage mothers eligible for cu@home</th>
<th>Proportion of teenage mothers enrolled in cu@home</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Break O’Day</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Dorset</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Flinders</td>
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<tr>
<td>George Town</td>
<td>3.3</td>
<td>13</td>
<td>26.3</td>
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<tr>
<td>Launceston</td>
<td>16</td>
<td>42</td>
<td>38.4</td>
</tr>
<tr>
<td>Meander Valley</td>
<td>3</td>
<td>8</td>
<td>39.1</td>
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<tr>
<td>Northern Midlands</td>
<td>3.7</td>
<td>10</td>
<td>35.5</td>
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<tr>
<td>West Tamar</td>
<td>2.7</td>
<td>10</td>
<td>27.6</td>
</tr>
<tr>
<td>Northern Average Yearly Total</td>
<td>29</td>
<td>89</td>
<td>32.6</td>
</tr>
<tr>
<td>Tasmanian average yearly total</td>
<td>108</td>
<td>325</td>
<td>33.3</td>
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</table>
# Teenage Mothers’ Health and Wellbeing Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Teenage Mothers (Northern Region)</th>
<th>All Mothers (Northern Region)</th>
<th>Teenage Mothers (Statewide)</th>
<th>All Mothers (Statewide)</th>
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<tbody>
<tr>
<td></td>
<td>#</td>
<td>% / rate (per 1,000)</td>
<td>#</td>
<td>% / rate (per 1,000)</td>
</tr>
<tr>
<td>Teenage Fertility Rate (2007 - 2010)</td>
<td>115.5</td>
<td>26.1</td>
<td>-</td>
<td>-</td>
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<tr>
<td></td>
<td></td>
<td>-</td>
<td>417.8</td>
<td>26.2</td>
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<tr>
<td>Smoking During Pregnancy - self reported (2007 - 2010)</td>
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<td>48%</td>
<td>437.8</td>
<td>26%</td>
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<td></td>
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<td>202.8</td>
<td>49%</td>
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<td></td>
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<tr>
<td>Illicit Drug Use During Pregnancy - self reported (2007 - 2010)</td>
<td>11</td>
<td>10%</td>
<td>60</td>
<td>4%</td>
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<td></td>
<td></td>
<td></td>
<td>30</td>
<td>7%</td>
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<tr>
<td>Attendance at 8 week Child Health Assessment (2010-11 to 2011-12)</td>
<td>69</td>
<td>80%</td>
<td>1240</td>
<td>80%</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>259.5</td>
<td>80%</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Exclusive Breastfeeding at 8 week Child Health Assessment (2010-11 to 2011-12)</td>
<td>13.5</td>
<td>20%</td>
<td>660</td>
<td>51%</td>
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<tr>
<td></td>
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<td></td>
<td>47.5</td>
<td>17%</td>
</tr>
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Source: Department of Health and Human Services, Kids Come First Project, Unpublished Data
Appendix Four
Ethics Application

List of Attachments

1. Consent form 3rd party provider__________________________section 15
2. Consent form individual female & male_____________________section 15
3. Consent form parent for minor____________________________section 15
4. Focus group consent form______________________________section 15
5. Focus group young migrant women________________________section 13
6. Focus group young women______________________________section 13
7. Focus group young men______________________________section 13
8. Individual interview men______________________________section 13
9. Individual interview women______________________________section 13
10. Information sheet focus group CALD______________________section 13
11. Information sheet 3rd party survey________________________section 13
12. Information sheet focus group male______________________section 13
13. Information sheet focus group sps______________________section 13
14. Information sheet individual interviews___________________section 13
15. Information sheet focus group female______________________section 15
16. Letter to school principals and service providers______________________________section 10
17. Project consultant brief_________________________________________section 9
18. School questions__________________________________________section 13
Tackling Teenage Pregnancy Project
Third Party Providers

1. I agree to take part in the research study named above.
2. I have read and understood the Information Sheet for this study.
3. The nature and possible effects of the study have been explained to me.
4. I understand that the study involves providing information about the project and the survey to students, providing time and log-on facilities to student groups who agreed to participate.
5. I understand that participation involves the no risk(s).
6. I understand that all research data will be securely stored on the 3p Consulting premises for five years from the publication of the study results, and will then be destroyed.
7. Any questions that I have asked have been answered to my satisfaction.
8. I understand that the researcher(s) will maintain confidentiality and that any information I supply to the researcher(s) will be used only for the purposes of the research.
9. I understand that the results of the study will be published and that none of students can be identified as a participant.
10. I understand that participation is voluntary and that students may withdraw at any time without any effect.

Participant's name: ________________________________

Participant's signature: ________________________________

Date: _____________________
Tackling Teenage Pregnancy Project

Consent form for individual Interview participants

1. I agree to take part in the research study named above.
2. I have read and understood the Information Sheet for this study.
3. The nature and possible effects of the study have been explained to me.
4. I understand that the study involves completing a questionnaire about my thoughts and experiences about being a teen parent. The interview will last approximately ½ an hour and I can review my answers at any time during the session.
5. I understand that participation involves the risk(s) that I may feel distressed when discussing my circumstances. I understand that I can stop the interview at anytime, choose to speak privately with my service provider if I wish. I can also contact an experienced youth counsellor.
6. I understand that all research data will be securely stored on the 3p Consulting premises for five years from the publication of the study results, and will then be destroyed.
7. Any questions that I have asked have been answered to my satisfaction.
8. I understand that the researcher(s) will maintain confidentiality and that any information I supply to the researcher(s) will be used only for the purposes of the research.
9. I understand that the results of the study will be published so that I cannot be identified as a participant
10. I understand that my participation is voluntary and that I may withdraw at any time without any effect.

If I so wish, I may request that any data I have supplied be withdrawn from the research until September 2012.

Participant's name: ____________________________________________

Participant's signature: _________________________________________

Date: ________________
Statement by Investigator

☐ I have explained the project and the implications of participation in it to this volunteer and I believe that the consent is informed and that he/she understands the implications of participation.

If the Investigator has not had an opportunity to talk to participants prior to them participating, the following must be ticked.

☐ The participant has received the Information Sheet where my details have been provided so participants have had the opportunity to contact me prior to consenting to participate in this project.

Investigator’s name: _________________________________

Investigator’s signature: _______________________________

Date: _______________
Tackling Teenage Pregnancy Project

Parent/Guardian consent

1. I agree for my son/daughter to take part in the research study named above.
2. I have read and understood the Information Sheet for this study.
3. The nature and possible effects of the study have been explained to me.
4. I understand that participation involves the no risk(s).
5. I understand that all research data will be securely stored on the 3p Consulting premises for five years from the publication of the study results, and will then be destroyed.
6. Any questions that I have asked have been answered to my satisfaction.
7. I understand that the researcher(s) will maintain confidentiality and that any information I supply to the researcher(s) will be used only for the purposes of the research.
8. I understand that the results of the study will be published and that none of participants can be identified.
9. I understand that participation is voluntary and that individuals may withdraw at any time without any effect.

Parent/guardians s name:_____________________________________________________

Participant (young person's name)_____________________________________________

Parent/guardians signature:_____________________________________________________

Date: __________________________
Statement by Investigator

☐ I have explained the project and the implications of participation in it to this volunteer and I believe that the consent is informed and that he/she understands the implications of participation.

If the Investigator has not had an opportunity to talk to participants prior to them participating, the following must be ticked.

☐ The participant has received the Information Sheet where my details have been provided so participants have had the opportunity to contact me prior to consenting to participate in this project.

Investigator’s name: ________________________________

Investigator’s signature: _____________________________

Date: ________________
Tackling Teenage Pregnancy Project
Consent form for Focus Group Participants

1. I agree to take part in the research study named above.
2. I have read and understood the Information Sheet for this study.
3. The nature and possible effects of the study have been explained to me.
4. I understand that the study involves discussing my thoughts and experiences of parenting as a teenager in a group situation. The session will last approximately 1 ½ hours and that I can review the recorded information at any time during the session.
5. I understand that participation involves the risk(s) that I may feel distressed when discussing my circumstances and that I can leave the session at anytime, choose to speak privately with the facilitator or my service provider. I can also contact an experienced youth counsellor if I wish.
6. I understand that all research data will be securely stored on the 3p Consulting premises for five years from the publication of the study results, and will then be destroyed.
7. Any questions that I have asked have been answered to my satisfaction.
8. I understand that the researcher(s) will maintain confidentiality and that any information I supply to the researcher(s) will be used only for the purposes of the research.
9. I understand that the results of the study will be published so that I cannot be identified as a participant.
10. I understand that my participation is voluntary and that I may withdraw at any time without any effect.
   If I so wish, I may request that any data I have supplied be withdrawn from the research until September 2012.

Participant’s name: ________________________________

Participant’s signature: ________________________________

Date: ________________________________
Statement by Investigator

☐ I have explained the project and the implications of participation in it to this volunteer and I believe that the consent is informed and that he/she understands the implications of participation.

If the Investigator has not had an opportunity to talk to participants prior to them participating, the following must be ticked.

☐ The participant has received the Information Sheet where my details have been provided so participants have had the opportunity to contact me prior to consenting to participate in this project.

Investigator’s name: ______________________________________________________

Investigator’s signature: __________________________________________________

Date: ______________________
Focus group questions young migrant women

Thank you for agreeing to participate in the focus group. For your time, we would like to say thank you by offering you either an iTunes or phone credit voucher to the value of $10.00

The purpose of the focus group is to listen to your story about your experiences both just before you became pregnant, during your pregnancy and now as a young parent living in Tasmania.

As such, we have a range of topics that we would like your thoughts, feelings and opinions on.

Firstly,

How do you feel about your community -

• where they lived,
• what they liked
• what they didn’t like
• what they would change

What about your friendships and relationships

• most trusted and why
• shared experience and common interests
• qualities-good listener, non-judgmental and understanding
• who and why would you turn to with a problem
• who would you not turn to with a problem

Think about the time when you were thinking about and then started to have sex

• what knowledge and information you had about sex,
• physical and emotional readiness,
• what type and stage in the relationship you were in and

Looking back, if there was one piece of advice you would you give yourself once you became sexually active, what would it be?
Can you tell us about your knowledge, choices and issues both before and now that you are a young mum regarding contraception and sexual relationships?

• Perceived knowledge of sex and relationships
• Access to information-web etc
• Access to formal sex education
• Emotional and physical readiness for sex
• Is it love or just lust?
• Is there an appropriate age to start having sex?
• Gender differences and sexual double standards
• Attitudes to having sex with many people
• Sex as a matter of choice
• Whose responsibility is it anyway?’
• STIs and Pregnancy
• Service issues

Now we would like to hear your thoughts about the local culture and attitudes around teenage pregnancy and your experiences:

• ‘16 years old is too young to be a parent’.
• Is there a sense of respect for those girls who had fallen pregnant
• Why would it be difficult to talk to parents, boyfriend, friends or doctor or nurse?
• What things might affect your decision
• Is abortion an option?
• What should be improved or done differently so teenage pregnancies (then bringing up the child) take place in good conditions with appropriate support?’

We know that many young people use facebook and other social media to share their stories and life events, for example putting photos on facebook just after the birth of their child, how do you feel about this?

Have you got examples from your own experience as a mother or from your friendship group?

What impact do you think this has on other young people?

Do you use face book and other blogs or social media to share your parenting joys and challenges?

Do you ever get comments on facebook etc that you feel makes judgments around your decision to be a young mother?

What sorts of things contribute to how you feel about yourself?
• How smart I am
• How well I do in school
• My talents
• My family
• My looks
• My spirituality
• My ethnic background
• My athletic ability
• How much money I have
• Being in a relationship
• Someone wanting to have sex with me
• Having sex

Future aspirations - where do you see yourself in five years time?”

Are there any other general comments or areas that we haven’t covered that you would like to share with us?

Thank you for your time today
Focus group questions young women

Thank you for agreeing to participate in the focus group. For your time, we would like to say thank you by offering you either an iTunes or phone credit voucher to the value of $10.00

The purpose of the focus group is to listen to your story about your experiences both just before you became pregnant, during your pregnancy and now as a young parent living in Tasmania.

As such, we have a range of topics that we would like your thoughts, feelings and opinions on.

Firstly,

**How do you feel about your community -**

- where they lived,
- what they liked
- what they didn’t like
- what they would change

**What about your friendships and relationships**

- most trusted and why
- shared experience and common interests
- qualities-good listener, non-judgmental and understanding
- who and why would you turn to with a problem
- who would you not turn to with a problem

**Think about the time when you were thinking about and then started to have sex**

- what knowledge and information you had about sex,
- physical and emotional readiness,
- what type and stage in the relationship you were in and

**Looking back, if there was one piece of advice you would you give yourself once you became sexually active, what would it be?**
Can you tell us about your knowledge, choices and issues both before and now that you are a young mum regarding contraception and sexual relationships?

- Perceived knowledge of sex and relationships
- Access to information-web etc
- Access to formal sex education
- Emotional and physical readiness for sex
- Is it love or just lust?
- Is there an appropriate age to start having sex?
- Gender differences and sexual double standards
- Attitudes to having sex with many people
- Sex as a matter of choice
- Whose responsibility is it anyway?’
- STIs and Pregnancy
- Service issues

Now we would like to hear your thoughts about the local culture and attitudes around teenage pregnancy and your experiences:

- ‘16 years old is too young to be a parent’.
- Is there a sense of respect for those girls who had fallen pregnant
- Why would it be difficult to talk to parents, boyfriend, friends or doctor or nurse?
- What things might affect your decision
- Is abortion an option?
- What should be improved or done differently so teenage pregnancies (then bringing up the child) take place in good conditions with appropriate support?’

We know that many young people use facebook and other social media to share their stories and life events, for example putting photos on facebook just after the birth of their child, how do you feel about this?

Have you got examples from your own experience as a mother or from your friendship group?

What impact do you think this has on other young people?

Do you use face book and other blogs or social media to share your parenting joys and challenges?

Do you ever get comments on facebook etc that you feel makes judgments around your decision to be a young mother?

What sorts of things contribute to how you feel about yourself?
• How smart I am
• How well I do in school
• My talents
• My family
• My looks
• My spirituality
• My ethnic background
• My athletic ability
• How much money I have
• Being in a relationship
• Someone wanting to have sex with me
• Having sex

Future aspirations - where do you see yourself in five years time?”

Are there any other general comments or areas that we haven’t covered that you would like to share with us?

*Thank you for your time today*
Focus group questions young men

Thank you for agreeing to participate in the focus group. For your time, we would like to say thank you by offering you either an iTunes or phone credit voucher to the value of $10.00

The purpose of the focus group is to listen to your story about your experiences both just before your partner became pregnant, during the pregnancy and now as a young parent living in Tasmania.

As such, we have a range of topics that we would like your thoughts, feelings and opinions on.

Firstly,

How do you feel about your community -

• where they lived,
• what they liked
• what they didn’t like
• what they would change

What about your friendships and relationships

• most trusted and why
• shared experience and common interests
• qualities-good listener, non-judgmental and understanding
• who and why would you turn to with a problem
• who would you not turn to with a problem

Think about the time when you were thinking about and then started to have sex

• what knowledge and information you had about sex,
• physical and emotional readiness,
• what type and stage in the relationship you were in and

Looking back, if there was one piece of advice you would you give yourself once you became sexually active, what would it be?
Can you tell us about your knowledge, choices and issues both before and now that you are a young parent regarding contraception and sexual relationships?

- Perceived knowledge of sex and relationships
- Access to information-web etc
- Access to formal sex education
- Emotional and physical readiness for sex
- Is it love or just lust?
- Is there an appropriate age to start having sex?
- Gender differences and sexual double standards
- Attitudes to having sex with many people
- Sex as a matter of choice
- Whose responsibility is it anyway?
- STIs and Pregnancy
- Service issues

Now we would like to hear your thoughts about the local culture and attitudes around teenage pregnancy and your experiences:

- ‘16 years old is too young to be a parent’.
- Is there a sense of respect for those girls who had fallen pregnant
- Why would it be difficult to talk to parents, girlfriend, friends or doctor or nurse?
- What should be improved or done differently so teenage pregnancies (then bringing up the child) take place in good conditions with appropriate support?’

We know that many young people use facebook and other social media to share their stories and life events, for example putting photos on facebook just after the birth of their child, how do you feel about this?

Have you got examples from your own experience as a father or from your friendship group?

What impact do you think this has on other young people?

Do you use face book and other blogs or social media to share your parenting joys and challenges?

Do you ever get comments on facebook etc that you feel makes judgments around your decision to be a young father?

What sorts of things contribute to how you feel about yourself?

- How smart I am
• How well I do in school
• My talents
• My family
• My looks
• My spirituality
• My ethnic background
• My athletic ability
• How much money I have
• Being in a relationship
• Someone wanting to have sex with me
• Having sex

Future aspirations -where do you see yourself in five years time?”

Are there any other general comments or areas that we haven’t covered that you would like to share with us?

Thank you for your time today
Individual interviews and focus group question areas

We are undertaking research in Tasmania regarding the circumstances, knowledge and views of young men who are parents. We would be pleased if you could complete this short questionnaire with us. All your answers will be completely confidential and we will not record your name.

To show our appreciation of your time in participating in this interview, we would like to offer you either an iTunes voucher or a phone credit voucher to the value of $10.00

Individual questions - young men

In the month that your partner became pregnant ...

(Please tick the statement which most applies to you):
✓ I I/we were not using contraception
✓ I I/we were using contraception, but not on every occasion
✓ I I/we always used contraception, but knew that the method had failed (that is, broke, moved, came off, came out, not worked, etc) at least once
✓ I we always used contraception

In the month my partner became pregnant.....
(Please tick the statement which most applies to you):
✓ I was in a relationship for more than 3 months with my child’s mother
✓ I was in a relationship for more than 6 months with my child’s mother
✓ I was in a relationship for more than 12 months with my child’s mother
✓ I was not in a relationship with my child’s mother

In terms of becoming a father, I feel that my pregnancy happened at the ...
(Please tick the statement which most applies to you):
✓ the right time
✓ ok, but not quite right time
✓ wrong time

Just before my partner became pregnant ...
(Please tick the statement which most applies to you):
✓ I I intended my partner to get pregnant
✓ my intentions kept changing
✓ I did not intend for my partner to get pregnant

Just before my partner became pregnant ...
(Please tick the statement which most applies to you):
- I wanted to have a baby
- I had mixed feelings about having a baby
- I did not want to have a baby

Before my partner became pregnant ...
(Please tick the statement which most applies to you):
- I had participated in sex education at school
- I had participated in sex education at a health centre (if yes, please tell us where i.e. Family Planning, headspace, etc.)
- I had talked to my GP or local health professional about sexual health
- I had not participated in any formal sex education

Before my partner became pregnant ...
(Please tick the statement which most applies to you):
- My partner and I had agreed that we would like to be pregnant
- My partner and I had discussed having children together, but hadn’t agreed to get pregnant
- We never discussed having children together

When you realised your partner was pregnant, did you encourage her to improve her health by:
(Please tick all that apply):
- stopping or cutting down smoking
- stopping or cutting down drinking alcohol
- eating more healthily
- seeking out medical/health advice
- took some other action, please describe
or
- did not encourage any of the above before or during pregnancy
or
- I don’t know

When you realised your partner was pregnant, did you discuss the possibility of .......
(Please tick the one that most applies):
- a termination
- considered a termination but decided not to support it
- considered a termination but did not know how to access it
- considered a termination but could not afford it

When you realised you your partner was pregnant, who did you speak to first....... 
(Please tick the one that most applies):
- my mother and/or father and/or guardian
- a sibling
- my friend/s
- my teacher, social worker or another trusted adult
- a health professional or service provider
- no-one
Since becoming a father, I find.......  
(Please tick as many as apply to you):  
☐ my friendship groups have changed  
☐ my life is still the same  
☐ I am still at school or continuing my education  
☐ I am happy with my social life  
☐ I have a better relationship with my family  
☐ I often feel lonely or isolated from my friends  
☐ being a father is what I expected  
☐ I have other friends who have children too

Who do you go to when you need support.......  
(Please tick as many as apply to you):  
☐ my mother and/or father and/or guardian  
☐ my partner  
☐ my friend/s  
☐ my teacher, social worker or another trusted adult  
☐ a young parents support group  
☐ a health professional or service provider (if so, please list)  
☐ no-one

Where do you see yourself in five years time?  
(Please tick as many as apply to you):  
☐ completed my education and working  
☐ working  
☐ continuing my education  
☐ having another child/children  
☐ leaving the area  
☐ other – please specify

What is your home suburb?

How old are you now?

How old were you at the time when your partner became pregnant?

What school were you enrolled in when you became pregnant?
Individual interviews and focus group question areas

We are undertaking research in Tasmania regarding the circumstances, knowledge and views of young women who are mums. We would be pleased if you could complete this short questionnaire with us. All your answers will be completely confidential and we will not record your name.

To show our appreciation of your time in participating in this interview, we would like to offer you either an iTunes voucher or a phone credit voucher to the value of $10.00

Individual questions - young women

In the month that I became pregnant ...

(Please tick the statement which most applies to you):
- I we were not using contraception
- I we were using contraception, but not on every occasion
- I we always used contraception, but knew that the method had failed (that is, broke, moved, came off, came out, not worked, etc) at least once
- I we always used contraception

In the month I became pregnant.....

(Please tick the statement which most applies to you):
- I was in a relationship for more than 3 months with my child’s father
- I was in a relationship for more than 6 months with my child’s father
- I was in a relationship for more than 12 months with my child’s father
- I was not in a relationship with my child’s father

In terms of becoming a mother, I feel that my pregnancy happened at the ...

(Please tick the statement which most applies to you):
- the right time
- ok, but not quite right time
- wrong time

Just before I became pregnant ...

(Please tick the statement which most applies to you):
- I I intended to get pregnant
- my intentions kept changing
- I did not intend to get pregnant

Just before I became pregnant ...

(Please tick the statement which most applies to you):
- I wanted to have a baby
I had mixed feelings about having a baby
☐ I did not want to have a baby

Before I became pregnant ...

(Please tick the statement which most applies to you):
☐ I had participated in sex education at school
☐ I had participated in sex education at a health centre (if yes, please tell us where i.e. Family Planning, headspace, etc.
☐ I had talked to my GP or local health professional about sexual health
☐ I had not participated in any formal sex education

Before I became pregnant ...

(Please tick the statement which most applies to you):
☐ My partner and I had agreed that we would like to be pregnant
☐ My partner and I had discussed having children together, but hadn’t agreed to get pregnant
☐ We never discussed having children together

When you realised you were pregnant, did you do anything to improve your health

(Please tick all that apply):
☐ stopped or cut down smoking
☐ stopped or cut down drinking alcohol
☐ ate more healthily
☐ sought medical/health advice
☐ took some other action, please describe
or
☐ did not do any of the above before or during pregnancy
or
☐ I don’t know

When you realised you were pregnant, did you......

(Please tick the one that most applies):
☐ did not consider a termination
☐ considered a termination but decided not to
☐ considered a termination but did not know how to access it
☐ considered a termination but could not afford it

When you realised you were pregnant, who did you speak to first......

(Please tick the one that most applies):
☐ my mother and/or father and/or guardian
☐ a sibling
☐ my friend/s
☐ my teacher, social worker or another trusted adult
☐ a health professional or service provider
☐ no-one

Since I have been a mother, I find......
(Please tick as many as apply to you):
☒ my friendship groups have changed
☒ I wish I was still at school
☒ I am still at school or continuing my education
☒ I am happy with my social life
☒ I have a better relationship with my family
☒ I often feel lonely or isolated from my friends
☒ being a mother is what I expected
☒ I have other friends who have children too

Who do you go to when you need support…….
(Please tick as many as apply to you):
☒ my mother and/or father and/or guardian
☒ my partner
☒ my friend/s
☒ my teacher, social worker or another trusted adult
☒ a young parents support group
☒ a health professional or service provider (if so, please list)
☒ no-one

Where do you see yourself in five years time?
(Please tick as many as apply to you):
☒ completed my education and working
☒ working
☒ continuing my education
☒ having another child/children
☒ other – please specify

What is your home suburb?

How old are you now?

How old were you at the time of your pregnancy?

What school were you enrolled in when you became pregnant?

Were you attending school day to day when you became pregnant?
Focus Group for Young Women from CALD Background

3pConsulting and the Northern Early Years Group are undertaking a project here in the northern region so as to better understand why young and men women in Tasmania may become young parents and how services can come together to best support both young people and young parents.

We will present the findings of the research at a Teenage Pregnancy Forum to be held in Launceston that will be open to young people, parents and all services involved with young people in the northern region. A written report detailing the findings will be completed and presented to the Northern Early Years Group.

To help our research project we will be talking to young women aged 14-20 years humanitarian entrants living in Launceston and surrounds. The focus group will be asking for your thoughts and experiences on:

- Values and attitudes to relationships
- Attitudes, knowledge of contraception
- Family and peer relationships attitudes/support
- Self concept/esteem
- Attitudes/experience to education
- Attitudes/experience to education
- Motivations/thoughts about with pregnancy
- Expectations of motherhood
- Experience of birth and early parenthood
- Role of the father of the baby

The focus group session will run for 1 ½ hours and will have a maximum of eight young fathers. During the session you and your fellow participants will be asked by us to contribute your knowledge, thoughts and views about aspects of the above topics. The focus group will arrange a suitable venue and transport as required. The Integration Manager from the Migrant Resource Centre will attend the session.

Taking part in the focus group discussion is completely voluntary and you may choose to leave at anytime. If you do wish to leave, but you still wish to contribute your ideas, you may choose to speak privately with one of us or with Migrant Resource Centre staff and we can then add your contribution to the research.
If you feel uncomfortable or distressed because of the discussion you can speak to staff at the Migrant Resource Centre or with an experienced youth counselor at headspace on 6335 3100 or email headspace@cornerstoneyouthservices.com.au.

If you choose to participate, your responses will be respectfully and carefully treated. Confidentiality guidelines will be discussed and agreed to with participants prior to any discussion and only first names will be used. Names will not be recorded.

Your input to the discussion will be written down on an Ipad by one of the facilitators. You will have the opportunity to view and add to, or to change, how your input was recorded at any time during the focus group session. The information will be de-identified and securely stored electronically on our server. The information will be destroyed after 5 years.

To show our appreciation of your time in participating, we would like to offer you either an iTunes voucher or a phone credit voucher to the value of $10.00.

If you have any questions about what we are doing or how the focus group will work please contact 3p Consulting on 6334 7028 and ask for Anne.

This information sheet is for you to keep.

We would really appreciate your involvement in this research. To participate please sign the following consent form and return it to your service provider.

“This study has been approved by the Tasmanian Social Sciences Human Research Ethics Committee. If you have concerns or complaints about the conduct of this study, please contact the Executive Officer of the HREC (Tasmania) Network on (03) 6226 7479 or email human.ethics@utas.edu.au. The Executive Officer is the person nominated to receive complaints from research participants. Please quote ethics reference number [Hxxxxx].”
Tackling Teenage Pregnancy Project Survey Information Sheet

For Schools

3pConsulting has been engaged by the Northern Early Years Group to undertake research in the northern region so as to better understand why so many young women in Tasmania become young parents and to facilitate a more co-ordinated and strategic approach locally with the view to reducing the teen pregnancy rates in Tasmania. The Northern Early Years Group is comprised of representatives from government and non-government agencies working collaboratively to improve outcomes for children aged 0 to 5 years and their families. In 2010, the Northern Early Years Group developed a strategic plan and undertook extensive community consultation to identify priority projects and teen pregnancy has been identified as a priority issue for action by the Northern Early Years Group.

Despite programs and resources that have sought to address teenage pregnancy rates over the years the high levels persist in Tasmania, particularly in areas that already have a greater proportion the population that are already at risk.

To facilitate research we will be surveying young people aged between 14 and 18 years across the northern region. The survey will have the aim of exploring young people’s:

- Values and attitudes to relationships
- Knowledge of contraception
- Family and peer relationships attitudes/support
- Self concept/esteem
- Attitudes/experience to education

We will be present the findings of the research at a Teenage Pregnancy Forum to be held in Launceston that will be open to young people, parents and all services involved with young people in the northern region. A written report detailing the findings will be completed and presented to the Northern Early Years Group.

No identifying information will be sought. In addition to questions about the above areas the survey will ask respondents to provide their age, gender and suburb of residence. Completion of the survey will signify implied consent to participate.

Participation in the survey is voluntary. Students will be asked in their home groups if they are interested in participating in the survey. Teachers will provide students with an information sheet about the project and time and access to log onto to the on-line survey. The survey will be completed while being supervised by a class teacher.

Following data collection the survey will be deleted. The data and data analysis will be securely stored electronically on our server and destroyed after 5 years.
We are more than happy to meet with you at your convenience to discuss any part of the project and to provide any information that may assist you to inform potential participants.

We would really appreciate your involvement in this valuable research project. If you have any questions about the project or the survey please contact our office at 3p Consulting on 6334 7028.

“This study has been approved by the Tasmanian Social Sciences Human Research Ethics Committee. If you have concerns or complaints about the conduct of this study, please contact the Executive Officer of the HREC (Tasmania) Network on (03) 6226 7479 or email human.ethics@utas.edu.au. The Executive Officer is the person nominated to receive complaints from research participants. Please quote ethics reference number [Hxxxxx].”
Tackling Teenage Pregnancy Project Participant Information Sheet

Focus Group for Young Fathers

3pConsulting and the Northern Early Years Group are undertaking a project here in the northern region so as to better understand why young and men women in Tasmania may become young parents and how services can come together to best support both young people and young parents.

We will present the findings of the research at a Teenage Pregnancy Forum to be held in Launceston that will be open to young people, parents and all services involved with young people in the northern region. A written report detailing the findings will be completed and presented to the Northern Early Years Group.

To help our research project we will be talking to young fathers aged from 14-20 years across the northern region. The focus group will be asking for your thoughts and experiences on:

- Attitudes, knowledge and use of contraception
- Motivations/thoughts about continuing with pregnancy
- Family attitudes/support during pregnancy
- Expectations of fatherhood
- Attitudes/experience to education
- Experience of birth and early parenthood
- A mother’s role

The focus group session will run for 1 ½ hours and will have a maximum of eight young fathers. During the session you and your fellow participants will be asked by us to contribute your knowledge, thoughts and views about aspects of the above topics. We will arrange a suitable venue and transport as required.

Taking part in the focus group discussion is completely voluntary and you may choose to leave at anytime. If you do wish to leave, but you still wish to contribute your ideas, you may choose to speak privately with one of us or with your service provider and we can then add your contribution to the research.

If you feel uncomfortable or distressed because of the discussion you can speak to an experienced youth counselor at headspace on 6335 3100 or email headspace@cornerstoneyouthservices.com.au.

If you choose to participate, your responses will be respectfully and carefully treated. Confidentiality guidelines will be discussed and agreed to with participants prior to any discussion and only first names will be used. Names will not be recorded.
Your input to the discussion will be written down on an Ipad by one of the facilitators. You will have the opportunity to view and add to, or to change, how your input was recorded at any time during the focus group session. The information will be de-identified and securely stored electronically on our server. The information will be destroyed after 5 years.

To show our appreciation of your time in participating, we would like to offer you either an iTunes voucher or a phone credit voucher to the value of $10.00

If you have any questions about what we are doing or how the focus group will work please contact 3p Consulting on 6334 7028 and ask for Anne.

This information sheet is for you to keep.

We would really appreciate your involvement in this research. To participate please sign the following consent form and return it to your service provider.

“This study has been approved by the Tasmanian Social Sciences Human Research Ethics Committee. If you have concerns or complaints about the conduct of this study, please contact the Executive Officer of the HREC (Tasmania) Network on (03) 6226 7479 or email human.ethics@utas.edu.au. The Executive Officer is the person nominated to receive complaints from research participants. Please quote ethics reference number [Hxxxxx].”
Tackling Teenage Pregnancy Project Focus Group Information

For Service Providers

3pConsulting has been engaged by the Northern Early Years Group to undertake research in the northern region so as to better understand why so many young women in Tasmania become young parents and to facilitate a more co-ordinated and strategic approach locally with the view to reducing the teen pregnancy rates in Tasmania. The Northern Early Years Group is comprised of representatives from government and non-government agencies working collaboratively to improve outcomes for children aged 0 to 5 years and their families. In 2010, the Northern Early Years Group developed a strategic plan and undertook extensive community consultation to identify priority projects and teen pregnancy has been identified as a priority issue for action by the Northern Early Years Group.

Despite programs and resources that have sought to address teenage pregnancy rates over the years the high levels persist in Tasmania, particularly in areas that already have a greater proportion the population that are already at risk.

To facilitate research for the project we will be undertaking surveys of 14-18 year old students, focus groups with young parents and with service providers. We will be present the findings of the research at a Teenage Pregnancy Forum to be held in Launceston that will be open to young people, parents and all services involved with young people in the northern region. A written report detailing the findings will be completed and presented to the Northern Early Years Group.

The focus group for northern service providers will provide a forum to elicit perceptions and experience of issues for young parents, motivators for continuing a pregnancy and outcomes for young families and their children, what works well and what are the gaps in service. All service providers working in the 03 area and that have interactions or run programs for teenagers and teenage parents.

Feedback from the forum will be used to inform the project and its recommendations.

We would really appreciate your involvement in this valuable research project. If you have any questions about the project or the survey please contact our office at 3p Consulting on 6334 7028.

“This study has been approved by the Tasmanian Social Sciences Human Research Ethics Committee. If you have concerns or complaints about the conduct of this study, please contact the Executive Officer of the HREC (Tasmania) Network on (03) 6226 7479 or email human.ethics@utas.edu.au. The Executive Officer is the person nominated to receive complaints from research participants. Please quote ethics reference number [Hxxxxx].
Tackling Teenage Pregnancy Project Participant Information Sheet

**Individual Interview**

3pConsulting and the Northern Early Years Group are undertaking a project here in the northern region so as to better understand why young and men women in Tasmania may become young parents and how services can come together to best support both young people and young parents.

We will present the findings of the research at a Teenage Pregnancy Forum to be held in Launceston that will be open to young people, parents and all services involved with young people in the northern region. A written report detailing the findings will be completed and presented to the Northern Early Years Group.

To help our research project we will be asking questions to young parents aged from 14-20 years who live in the northern region. We will be asking you to answer questions about your thoughts and experiences on:

- Attitudes, knowledge and use of contraception
- Motivations/thoughts about continuing with pregnancy
- Family attitudes/support during pregnancy
- Expectations of fatherhood
- Expectations of motherhood
- Attitudes/experience to education
- Experience of birth and early parenthood

The interview will take about ½ hour to complete and will be conducted at a venue that ensures privacy and that you are comfortable in. We will come to where you are and/or will arrange transport to and from the venue if required.

Taking part in the 1:1 interview is completely voluntary and you may choose not to complete the questionnaire at anytime. If so, we will destroy any feedback that you have completed. If you still wish to contribute your ideas, you may choose to speak privately with your service provider and we can then add your contribution to the research.

If you feel uncomfortable or distressed because any of the content in the questionnaire you can speak to an experienced youth counselor at headspace on 6335 3100 or email headspace@cornerstoneyouthservices.com.au.

If you choose to participate, your responses will be respectfully and carefully treated. We will not record identifying information and your answers will be completely confidential.
The information from the interview will be de-identified and securely stored electronically on our server. The information will be destroyed after 5 years.

To show our appreciation of your time in participating in this interview, we would like to offer you either an iTunes voucher or a phone credit voucher to the value of $10.00

If you have any questions about what we are doing or how the focus group will work please contact 3p Consulting on 6334 7028 and ask for Anne.

This information sheet is for you to keep.

We would really appreciate your involvement in this research. To participate please sign the following consent form and return it to your service provider.

“This study has been approved by the Tasmanian Social Sciences Human Research Ethics Committee. If you have concerns or complaints about the conduct of this study, please contact the Executive Officer of the HREC (Tasmania) Network on (03) 6226 7479 or email human.ethics@utas.edu.au. The Executive Officer is the person nominated to receive complaints from research participants. Please quote ethics reference number [Hxxxxx].”
Tackling Teenage Pregnancy Project Participant Information Sheet

**Focus Group for Young Mothers**

3pConsulting and the Northern Early Years Group are undertaking a project here in the northern region so as to better understand why young and men women in Tasmania may become young parents and how services can come together to best support both young people and young parents.

We will present the findings of the research at a Teenage Pregnancy Forum to be held in Launceston that will be open to young people, parents and all services involved with young people in the northern region. A written report detailing the findings will be completed and presented to the Northern Early Years Group.

To help our research project we will be talking to young mothers aged from 14-20 years across the northern region. The focus group will be asking for your thoughts and experiences on:

- Attitudes, knowledge and use of contraception
- Family attitudes/support during pregnancy
- Motivations/thoughts for continuing with pregnancy
- Attitudes/experience to education
- Expectations of motherhood
- A father’s role
- Experience of birth and early parenthood

The focus group session will run for 1 ½ hours and will have a maximum of eight young mothers. During the session you and your fellow participants will be asked by us to contribute your knowledge, thoughts and views about aspects of the above topics. We will arrange a suitable venue and transport as required.

Taking part in the focus group discussion is completely voluntary and you may choose to leave at anytime. If you do wish to leave, but you still wish to contribute your ideas, you may choose to speak privately with one of us or with your service provider and we can then add your contribution to the research.

If you feel uncomfortable or distressed because of the discussion you can speak to an experienced youth counselor at headspace on 6335 3100 or email headspace@cornerstoneyouthservices.com.au

If you choose to participate, your responses will be respectfully and carefully treated. Confidentiality guidelines will be discussed and agreed to with participants prior to any discussion and only first names will be used. Names will not be recorded.
Your input to the discussion will be written down on an Ipad by one of the facilitators. You will have the opportunity to view and add to or to change opportunity how your input was recorded at any time during the focus group session. The information will be de-identified and securely stored electronically on our server. The information will be destroyed after 5 years.

To show our appreciation of your time in participating in this interview, we would like to offer you either an iTunes voucher or a phone credit voucher to the value of $10.00

If you have any questions about what we are doing or how the focus group will work please contact 3p Consulting on 6334 7028 and ask for Anne.

This information sheet is for you to keep.

We would really appreciate your involvement in this research. To participate please sign the following consent form and return it to your service provider.

“This study has been approved by the Tasmanian Social Sciences Human Research Ethics Committee. If you have concerns or complaints about the conduct of this study, please contact the Executive Officer of the HREC (Tasmania) Network on (03) 6226 7479 or email human.ethics@utas.edu.au. The Executive Officer is the person nominated to receive complaints from research participants. Please quote ethics reference number [Hxxxx].”
Recruitment of participants

Letter to School principals and service providers

Date:

Dear..

3pConsulting has been engaged by the Northern Early Years Group to undertake research here in the northern region so as to better understand why so many young women in Tasmania become young parents and to facilitate a more co-ordinated and strategic approach locally with the view to reducing the teen pregnancy rates in Tasmania. Despite programs and resources that have sought to address teenage pregnancy rates over the years the high levels persist in Tasmania, particularly in areas that already have a greater proportion the population that are already at risk.

To facilitate research we will be talking to, and surveying young people aged between 14 and 20 years across the northern region. The focus groups and surveys will have the aim of exploring:

• Their attitudes, knowledge and use of contraception
• Family attitudes/support to their pregnancy
• Motivations/thoughts for continuing with the pregnancy
• Attitudes/experience to education
• Their expectation of motherhood
• The role of the father
• Experience of birth and early parenthood

Demographic information specifically age, gender and postcode of residence will also be sought. All information will be de-identified and confidentiality processes are in accordance with Ethics Committee guidelines.

We are seeking your assistance either recruiting suitable candidates, and/or administering the survey to those students that fall within the age group.

Will add timeline once established/known

We are more than happy to meet with you at your convenience to discuss any part of the project and to provide any information that may assist you to recruit participants.

Regards
TACKLING TEEN PREGNANCY

PROJECT BRIEF – MARCH 2012

PROJECT BACKGROUND

Teen pregnancy rates in some Tasmanian communities are comparable to third world countries and have remained persistently high for the past 20 years and are second only to Aboriginal communities in the Northern Territory.

UnitingCare Tasmania operates the Pregnant and Young Parents Support program and demand for this service continues to increase annually. Currently, in northern Tasmania alone we have more than 100 pregnant and young parents on our books and of those 30% are pregnant young women between the ages of 14 to 19 years. Risks to babies and young children in pregnancy and parenting in the early years among teenage parents are well documented (e.g Tasmanian Making Choices Report 2005 attached). They include higher dependency on government assistance and therefore low income, low education completion rates, a threefold increase in postnatal depression, lack of parenting skills, higher instances of repeated pregnancies, and possible increase in child abuse and neglect due to a concentration of psychosocial factors associated with being young parents.

UnitingCare Tasmania is a member of the Northern Early Years Group. This group is comprised of representatives from government and non-government agencies working collaboratively to improve outcomes for children aged 0 to 5 years and their families. In 2010, the Northern Early Years Group developed a strategic plan and undertook extensive community consultation to identify priority projects. (See attached). Teen pregnancy has been identified as a priority issue for action by the Northern Early Years Group.

PROJECT BRIEF

UnitingCare Tasmania in partnership with the Northern Early Years Group is seeking to contract a reputable social researcher to undertake a piece of local research to better understand why so many young women in Tasmania become young parents and to facilitate a more co-ordinated and strategic approach locally with the view to reducing the teen pregnancy rates in Tasmania. Despite programs and resources that have sought to address teenage pregnancy rates over the years the
high levels persist in Tasmania, particularly in areas that already have a greater proportion the population that are already at risk.

Background research indicates that most interventions to date have focused on sex education and contraception information to young people. This proposal seeks to more fully understand the psychosocial reasons behind teenage pregnancy rates, identified as gaps in understanding and to coordinate effective responses.

The “Making Choices” report identified gaps in current understanding and recommended that more research be undertaken in a number of areas. We intend to narrow our focus to two aspects:

- The gap between knowledge of contraception, pregnancy prevention and behaviour in practice and the experiences, perceptions and expectations of particularly high risk groups
- The decision making process once pregnancy has occurred and the factors that influence pregnancy outcomes

**PROJECT SCOPE**

The proposed project includes

1. Literature/desk top review of current programs and interventions aimed at reducing teenage pregnancy rates

2. Undertaking quantitative and qualitative research with adolescent mothers and fathers, particularly in the 14-19 year age group who are in contact with key service providers in the north, such as the Pregnant and Young Parent Support, CU@Home, Headspace, family planning and high school and college education. It is proposed that part of the research component will comprise in-depth interviews with 20-25 young parents including young fathers and those from CALD backgrounds. Participants might also include those who are now older than 19 years but who had their first child under the age of 19 years. Further tools to reach a wider cohort will involve surveys, face book and focus groups.

3. Presentation of findings and recommendations for action to a northern forum that will be convened by the Northern Early Years Group (proposed to be held in August 2012). The purpose of the forum is:
   - To provide up to date and current information including results of research undertaken, government initiatives and policy directions and all program activities undertaken
   - To map a coordinated strategy with the aim of effectively addressing the high teenage pregnancy rates in the north
It is envisaged that the format of the forum will be a half day and the agenda will include:

- Local Context: Short information session about the data and a presentation of research outcomes
- Statewide Context: An overview of previous work and government initiatives including the proposed Statewide taskforce on Teenage Pregnancy
- Round table presentation on all activities taking place in the area of teenage pregnancy and young parents from service providers
- Forming a strategic direction and coordinated approach designed to impact on both the outcomes for young parents and their children and on teenage pregnancy rates in the north and at a local level.

DELIVERABLES

The expected project outputs from the consultant/researcher are:

- A comprehensive report addressing the research questions, including recommendations going forward; and
- Presentation of the Project Findings to the planned community forum.

PROJECT MANAGEMENT

UnitingCare Tasmania will be the project manager on a day-to-day basis, however it is expected that the successful consultant will attend monthly meetings of the Northern Early Years Group meeting (up to 4 meetings).

TIMING

It is expected that research phase of the project, including the final written report, will be completed by July 2012, with the forum to be held by the end of August 2012.

SUBMITTING YOUR PROPOSAL

Formal and written submissions should be forwarded by 5 pm on Friday 20th April 2012 and should include project methodology, approach and proposed timelines and fees. Submissions must be presented in either a hard and electronic format with the proposed budget for the project up to approximately $20,000.

Please submit proposals to:

Flora Dean
UnitingCare Tasmania
PO Box 1467
LAUNCESTON TAS 7250
SELECTION CRITERIA

Selection of the successful respondent will be based on, but not necessarily limited to:

- Demonstration of a clear and comprehensive understanding of the requirements of the brief;
- Demonstrated ability to provide the required outputs within the requirements of the brief;
- The ability to complete the project within the desired timeframes;
- Experience in relevant work of a similar nature;
- Value for money; and
- Referees

Contact Persons

The main contact persons for the study would be:

- Flora Dean
  Business and Community Development
  UnitingCare Tasmania
  34 Paterson Street
  LAUNCESTON TAS 7250
  Phone: 03 6333 8000
  Email: flora.dean@tas.unitingcare.org.au

- Christine Long
  Director of Nursing (Chair of NEYG)
  Child, Health and Parenting Service (DHHS)
  13 Mulgrave Street
  LAUNCESTON TAS 7250
  Phone: 03 6336 2138
  Email: christine.long@dhhs.tas.gov.au

Attachments

- Northern Early Years Plan 2010 - 2015
Possible Survey Questions Draft to be completed on line.

This survey is part of a research project that we are undertaking in Tasmania regarding the factors that may contribute to teenagers becoming young parents.

We would be pleased if you could complete this short survey to help us with gathering information for this project. The survey will take approximately 10 minutes to complete. All your answers are completely confidential. If you don’t wish to complete the survey none of your answers will be available to use. The survey will be destroyed as soon as the data is collected. Please talk to your home group teacher if you have any questions before you start the survey. Thank you

Demographics

1. Gender
Are you:
Male
Female

2. Age
What is your age?
13
14
15
16
17

3. Postcode
What is your postcode?

4. Current schooling year
What year you are you in?
Year 9
Year 10
Year 11
Year 12

5. School
Which school do you at? Please tick one:
Launceston College
Newstead College
Brooks High
Riverside High
Deloraine High
Prospect High
Port Dalrymple
St Helen’s District
Scottsdale High
King Meadows

Peers/Parents- Examining supportive relationships and why

On a scale of 1 – 5 with 1 being not very and 5 being very, how valued or respected do you feel by each of the following?

- Boyfriend/girlfriend
- Parents / guardians
- Friends
- Other family members (i.e. aunts, uncles, cousins etc)
- Teachers/Educators
- Doctor/s, health workers
- Members of the opposite sex
- Society, in general
- The media (The way people like you are portrayed in TV, movies, etc.)

Who would you turn to if you had a problem?

- Boyfriend/girlfriend
- Parents / guardians
- Closest friends
- Other family members
- Teachers/Educators
- Doctor/s, health workers
- School Social worker/counsellor

Which, if any, of the following would you like to be able to talk openly about with your parent or guardian?

- How to have a good relationship
- How to know when I’m in love
- Determining the right time to have sex
- How to prevent STDs
- Help to get contraception
- How to prevent pregnancy
- How to keep a good reputation
- How to say no to sex, if I’m not ready
- Other, please list

Self concept/esteem
How much do you agree or disagree with each of the following statements (some of these questions are for males or females individually):

- I expect to be successful in life
- The adults in my life have high expectations of me
- Getting pregnant or getting someone pregnant is a big deal
- I am happy with the person I am right now
- Having sex with someone is a big deal
- I consider myself to be sexually attractive
- I think all guys really want from me is sex
- Other guys pressure me to have sex with girls to prove that I'm cool
- I feel as if society expects me to fail in life
- Girls think all I want from them is sex
- Other people make me feel like sex is the only thing I have to offer anyone
- I feel as if my parents or guardians think I will fail in school/life
- Other girls pressure me to have sex with guys to prove that I'm cool
- I feel like sex is the only thing I have to offer someone to make them like me

How much would you say each of the following contribute to how good you feel about yourself?

- How smart I am
- How well I do in school
- My talents
- My family
- My looks
- My ethnic background
- My athletic ability
- How much money I have
- Having a boyfriend or girlfriend
- Someone wanting to have sex with me
- Having sex

Values

At what age do you think most people first have sexual intercourse?

- Before age 13
- 13
- 14
- 15
- 16
- 17
- 19
- 20
- 21
- Age 22 or older

It's ok to have sex with someone...? Please tick all that apply.

- Once you're in a committed relationship
Any time as long as you use protection
On your first date
The same night you meet them
If you’re drunk or high
None of the above

Knowledge
Please answer true or false for each of the following statements. If you’re unsure, please tick “don’t know.”

• A girl can get pregnant the first time she has sex
• A guy can get a girl pregnant when he has sex for the first time
• The only way to completely prevent pregnancy is by not having sex
• Condoms have an expiration date
• A girl can get pregnant during her period
• Wearing two condoms at the same time is more effective at preventing pregnancy and STDs than wearing just one
• Birth control pills are effective even if a woman misses taking them for two or three days in a row

Which, if any, of these sources have you actually used for information about sex and contraception?

• Your parents or guardians
• A health website
• Your friends
• Your healthcare provider
• Your teachers/educators
• TV, movies, magazines, etc.
• Your partner
• Your siblings
• Your religious leader
• None of these

Other – please list

Negotiation and relationships

How much do you agree or disagree with each of the following statements?

• “I have every right to change my mind about having sex with someone, even if it means stopping the action”
• “I am always comfortable insisting that my partner and I use protection/birth control when we have sex”
• I’m completely comfortable saying "no" to having sex, even if my partner really wants to
• Having sex with someone won’t make me stay in a relationship I don’t want to be in
• Girls have more respect for guys who want to wait to have sex
• I know all I need to know about how to prevent pregnancy
• I know all I need to know about how to prevent sexually-transmitted diseases or infections (STDs or STIs)
• Guys have more respect for girls who want to wait to have sex
• Having conversations with parents or guardians about sex is more awkward than helpful
• It’s embarrassing for young people to admit to being a virgin
• It doesn’t matter whether you use birth control or not, when it is your time to get pregnant, it will happen
• If I have sex with someone, he or she is more likely to stay with me

Which, if any, of the following have you ever done? Please tick all that apply
• Hooked up with someone and regretted it afterwards
• Been pressured to go further sexually than you wanted to
• Lied to get out of a sexual situation
• Pressured someone to go further sexually than they wanted to
• Lied to get someone to have sex with you
• None of these

Which of the following would be worse?

• Getting pregnant / Getting someone pregnant
• Getting a sexually-transmitted disease (STD)
• Having sex with someone when you don’t really want to
• Losing someone because you wouldn’t have sex with them

When you are deciding whether or not to have sex, whose opinion, besides your own, matters most?

• Your parents or guardians
• Your partner
• Your friends
• Religious leaders
• Your siblings
• Someone else
• No one else's opinion matters