# GIVING YOUNG MOTHERS A VOICE ABOUT THEIR OWN CARE

# GIVING YOUNG MOTHERS A VOICE ABOUT THEIR OWN CARE

By

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## ABSTRACT

This research project is based in a secondary analysis of data from The Ontario Mother and Infant Survey (TOMIS II) that considers women's perceptions of health care services. Of particular interest in this secondary analysis were the perceptions of young mothers aged 16-21. Three topics pertaining to intrapartum and postpartum care that were surveyed in the TOMIS II study were presented to young mothers in a focus group format. These topics include: (a) length of stay, (b) satisfaction of service (during and after delivery), and (c) learning needs. In addition to validating the quantitative data of the TOMIS II study, the focus group findings helped to interpret the data. The young mothers who participated in the focus groups for this research project clearly identified that supportive nursing care is critical to their intrapartum and postpartum experience. Among other recommendations, enhancing interpersonal qualities of health care professionals who work alongside young mothers during their hospital stay is essential for improving young mothers' level of satisfaction with services.

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## INTRODUCTION

For many women, regardless of their age, pregnancy and motherhood are positive and welcomed experiences (Cronin, 2003). The influence of images, myths and cultural norms impact the mothering experience and create ideologies about how women ought to engage in mothering (Koniak-Griffin, Logsdon, Hines-Martin & Turner, 2006). In Western society, the 'good' mother is a white, middle class, heterosexual, married woman (Breheny & Stephens, 2007). A young mother has little room to maneuver within this narrow definition and is all too quickly positioned disadvantageously.

As a hospital social worker on a labour/delivery and maternity floor, I work directly with mothers of all ages and have become particularly interested in working with young mothers. In my experience, these mothers tend to be stigmatized by health care providers, as they do not fit the image of 'good' mothers. Since they are (too) young, they are often perceived as immature, irresponsible, and inexperienced and we therefore assume they lack necessary knowledge and skills to parent successfully. Being single adds to this stigmatization and intensifies perceived risk factors. As a result, health care professionals often make assumptions about their needs and how they should be cared for while in hospital.

Similar to ideologies of mothering and motherhood, childbirth and postpartum hospital care in a medicalized and Western culture represents norms, myths and rituals that reflect mechanical tasks and routines (Cronin, 2003). Health care professionals play a pivotal role in service delivery that reproduces such standardized and routinized practices (Breheny & Stephens, 2007). For a young mother, it is even more challenging

to assert her needs and wants in an environment that is already critical of her role as a mother.

Case example:

> Julie is 17 years old and expecting her first child. Her pregnancy was unplanned. She and her boyfriend have only been together a few months and he is not interested in being a father. They broke up shortly after she found out she was pregnant. She seems unfazed by the birth father's decision to not be involved since she considers this her responsibility. Julie remains excited about the arrival of her baby. Not having excelled in school, she sees this as her chance to 'get things right'. Although finishing her high school education will now take longer, she remains keen in completing her diploma and plans to return to school a few months after the baby is born. In order to complete high school, Julie will stay on welfare. She is not proud of this, but reasons it's the best course of action that will allow her to continue with school so she can get a better job later on. Besides, who would want to stay on welfare forever? It's hardly enough to live on she comments.
>
> Julie is a pretty girl who is used to being gazed at by passersby. It is not uncommon for both men and women to compliment her appearance. Lately however, in the advanced stages of her pregnancy, people continue to stare but now comments are critical and even rude. Julie feels hurt by people's judgment and wonders 'how can people say such things when they don't even know anything about me?' Normally a social and outgoing person, she now finds it uncomfortable to be out in public and admits to going out as little as possible.
>
> Even going to doctor's appointments and prenatal classes is challenging because she continues to receive judgmental, negative attention. This is very disappointing to Julie because she wants to learn about caring for her baby and meet other moms who are having their first babies too. By the time Julie is ready to go to the hospital to have her baby she is used to hearing critical and rude comments and expects it will be the same there. Julie is hopeful she can get out of there as soon as possible because really, who would want to stay if they are going to be treated like that?
>
> As she predicts, there are nurses who don't seem to like her and she assumes this is because of her age. They don't say anything directly to her, but she senses it in their cool tone, their closed body language and their unavailability. With these nurses, even if they ask her if she needs help, Julie is quick to say no. Julie is pleasantly surprised by a couple of

> the nurses who treat her differently. These nurses are younger and they seem interested in her care. They are attentive, friendly, and respectful, which immediately puts her at ease. With these nurses, Julie is eager for their support and guidance, and finds she is more comfortable in asking questions about herself and her baby. Working with these nurses makes her hospital stay more positive and it is the part she likes the most. She wonders how differently she would have been treated if she were older. This thought saddens Julie as she too wants to be the best possible mother to her baby, just like older mothers do.

Rather than health care professionals deciding what type of care to offer young mothers, I think it is timely and necessary to hear from young mothers themselves. What meaning do young mothers ascribe to their intrapartum and postpartum care? Are their meanings and experiences different then those of older mothers? If so, how are they different?

Resisting and challenging dominant practices is a component of anti-oppressive practice that struggles to fundamentally change inequitable social systems (Baines, 2007). Working to dismantle unjust systems requires we recognize power imbalances and acknowledge the importance of lay knowledge in service delivery. Health care professionals caring for young mothers and their babies could benefit from a better understanding of the lived experience of young motherhood to enhance our ability in providing empathetic, holistic care.

Using a mixed methods approach, this research project presents findings from an existing study, The Ontario Mother and Infant Survey (TOMIS II), to young mothers in a focus group format for the intent of better understanding three topics pertaining to intrapartum and postpartum care. These topics included: (a) length of stay, (b) satisfaction of service (during and after delivery), and (c) learning needs. The purpose of

this research project is to explore the needs, perceptions and experiences of young mothers and to create opportunity for young mothers like Julie to be the experts in defining what factors are important about their intrapartum and postpartum care.

## LITERATURE REVIEW[1]

Mothering and motherhood continue to be popular subjects of study in contemporary research, which contributes to an extensive and expanding body of literature (Arendell, 2000; Glenn, 1994; Phoenix & Woollett, 1991). While earlier work has focused on the quality of mothering and its effects on a child, more recent scholarship has broadened to include mothers' understandings and experiences (Arendell, 2000).

Mothering and motherhood are universally associated with women and entwined with notions of femininity (Glenn, 1994), representing what is often characterized as the ultimate in relational devotion (Phoenix & Woollett, 1991). Even though there have been significant change in women's lives, motherhood continues to be a primary identity for many women and tends to be synonymous with womanhood (Arendell, 2000). Regardless of whether or not women become mothers, the institution of motherhood remains central to how women are defined by others and themselves (Phoenix & Woollett, 1991).

A common theme emerges in definitions of mothering: a collection of social practices that involves nurturing and caring for dependent children (Arendell, 2000, Glenn, 1994; Phoenix & Woollett, 1991). Despite this common theme, the way mothering should be performed is culturally derived, defined, and historically specific (Glenn, 1994; Phoenix & Woollett, 1991; Thurer, 1994). Each culture has its own ideology that includes a set of values, beliefs, expectations, norms and symbols (Thurer, 1994). An ideology can be described as a conceptual system by which a group makes

[1] Some of the material presented has been used in previously written term papers

sense of and perceives the world (Glenn, 1994; Rothman, 1989). Ideologies then serve as lenses that construct our experiences and understandings of motherhood (Glenn, 1994). Rothman (1989) reminds us that ideologies of mothering in North America exist not in isolation, but are entwined with complex ideologies of patriarchy, capitalism and technology.

As Foucault (1972) and Gergen (1985) indicate, the process by which we know and make sense of how to behave is generated and sustained through historically and culturally specific social processes constructed by ideologies. Social constructionism is an epistemological position which maintains that knowledge is interlinked with social process and social structure (Gergen, 1985). Social constructionism offers a useful framework for examining mothering and motherhood as it considers interpretative processes, interaction, social context and relationships, as well as an ability to account for interrelated systems of gender, race, ethnicity and class stratification (Arendell, 2000). Social constructions of ideal mothering and motherhood are politically powerful as they reflect state policy's definitions of 'the family' (Bonell, 2004; Phoenix & Woollett, 1991).

In the last quarter of the 20$^{th}$ century, Western countries became heavily industrialized and urbanized, requiring a high degree of skill and training for social and economic success (Grindstaff, 1988). In this competitive global market, the welfare state has also seen a shift from a social democratic tradition to a neo-liberal political culture that emphasizes self serving values and individual responsibility (Bonell, 2004). Privatization, decentralization and individualization have come to characterize the

politics of current social policy (Baines, 2007; Brodie, 1999). This socio-economic climate has implications for idealized notions of mothering and the institution of motherhood. For example, in a political culture that embraces neo-liberal values, notions of ideal mothering and motherhood tend to reflect images of a white, middle-class, heterosexual, nuclear family (Arendell, 2000; Breheny & Stephens, 2007). Based on these values, a life trajectory for women resembles childbearing proceeding education, employment and marriage (Duncan, 2007; Kelly, 1996; Phoenix & Woollett, 1991; Wilson & Huntington, 2005). Motherhood is sanctioned through certain social conditions that include financial independence and marriage (Breheny & Stephens, 2007). Failure to meet these normative expectations, that conform to governmental objectives of economic growth, results in mothers being viewed as deviant and therefore unfit (Phoenix & Woollett, 1991, Wilson & Huntington, 2005). Women who tend to fit such negative constructions are either 'young mothers', 'state dependent mothers' and/or 'lone mothers' (Phoenix & Woollett, 1991).

Such deviant behaviours are then pathologized which justifies a need for intervention and authoritative management (Phoenix & Woollett, 1991; Wilson & Huntington, 2005). From a white, middle class perspective, young mothers, are often constructed as vulnerable, needy, and at risk thus legitimizing authoritative intervention and surveillance (Cherrington & Breheny, 2005; Kelly, 1996; Phoenix & Woollett, 1991). Pregnancy and motherhood for young women is then transformed through a process of deviance labeling from a private matter into a public issue (Kelly, 1996; Phoenix & Woollett, 1991). This contributes to perceptions that identify young mothers

as being an 'at risk group' (within society) and 'a risky group' to society (McDermott & Graham, 2005).

Comparing all mothers to the idealized model of white, middle class mothers is problematic as it ignores structural, class, and ethnicity issues; it is important to be cognizant of the fact that there can be a great deal of variability among women within the same race and/or social class (Arenson, 1994; Phoenix & Woollett, 1991). For example, mothers living within different systems of privilege, whether race, social class, sexuality, or age, generate varying perceptions of what motherhood means and how it is understood by themselves and others (Glenn, 1994; Phoenix & Woollett, 1991).

Today, young motherhood is not a neutral subject; it is embedded in a range of discourses that are socially and politically charged. In Western political culture, young motherhood draws on images of stigmatized dependency and is negatively constructed as being a social problem and a social threat (Breheny & Stephens, 2007; Duncan, 2007; Kelly 1996; McDermott & Graham, 2005; Rains, Davies & McKinnon, 2004). Young mothers are spoken of as 'children having children', which means they have taken on dependents before becoming independent themselves (Davies, McKinnon & Rains, 1999; SmithBattle, 2000).

Ironically, the "problematization" of young motherhood coincides with declining adolescent birth rates in Western countries (Wilson & Huntington, 2005). Statistics show that adolescent pregnancies have continued to decline significantly since the last quarter of the 20$^{th}$ century (Kelly, 1999; McKay, 2006). More specifically, statistics pertaining to Canada reflect a concurrent decline in both adolescent birth and abortion rates since

1996 (McKay, 2006). In Canada, fertility rates have been declining among adolescent girls almost steadily since 1991 (Statistics Canada, 2007). In 2005, the fertility rate for girls aged 15 to 19 was 13.4 children per 1,000 women, compared with 13.7 children per 1,000 women in 2004 (Statistics Canada, 2007). This suggests that the "problematization" of young motherhood is buttressed by a shifting social, economical and political climate regarding the role of women in contemporary times (Wilson & Huntington, 2005).

Despite these statistics, many of the debates continue to characterize young mothers as having multiple disadvantages. For example, young mothers are reported to be at greater risk of experiencing psychological dysfunction, experiencing socioeconomic shortcomings, and having poor educational attainment (Breheny & Stephens, 2007; SmithBattle, 2000). Consequently, these mothers are portrayed as deviant, childlike, unsuccessful, and morally tainted (Kelly, 1996; SmithBattle, 2000). This negative construction is difficult to escape as it is embedded within social values and larger collective structures that tend to be absorbed as truth and accepted by mainstream thinking (Breheny & Stephens, 2007; McDermott & Graham, 2005; Rains et al., 2004; SmithBattle, 2000). These assumptions then shape and define programming and services that target young mothers (Rains et al., 2004) without reflecting the perceptions and lived experiences of young mothers themselves (McDermott & Graham, 2005).

The early part of the 20$^{th}$ century witnessed the development of the construct of adolescence, which represented a transitional stage from dependence to independence (Wilson & Huntington, 2005). With the influence of psychological and psychoanalytic

theories, adolescence was now considered to be a critical stage of development between childhood and adulthood (Luker, 1996; Phoenix, 1991; Vinovskis, 2003). Youth in their adolescent years were no longer believed to be "psychologically, emotionally, or physically prepared for adult responsibilities" (Luker, 1996, p. 35). Adolescence has come to be defined as a period when self-identity emerges, marked by 'storm and stress' due to common conflicts with those in authority (Phoenix, 1991).

Over the course of the 20th century, boundaries between childhood and adulthood have become even less distinct as compulsory education and increasing demands for post-secondary education have kept adolescents dependent for longer periods (Phoenix, 1991). Furthermore, legal recognition of social maturity is gradual since rights and responsibilities are attained at different ages (Phoenix, 1991). As a result, with indicators of adult status being harder to achieve, adolescence is rendered as an ambiguous period leaving young mothers in an even more precarious position (Luker, 1996; Phoenix, 1991).

Breheny & Stephens (2007) assert that identifying young mothers as adolescents draws attention to their position in this transitional stage and has negative implications. The typical adolescent is often constructed as having "poorly developed cognitive abilities... being self-centered, moody, insecure, irresponsible, unreliable and having low self-esteem" (Breheny & Stephens, 2007, p. 116). As a result, young mothers are assumed to lack parenting skills and are often characterized as lacking sensitivity and patience towards their children as compared to older mothers (Davies, McKinnon & Rains, 2001). Age alone makes these young mothers incompatible with ideals of 'good'

mothering, thereby rendering them 'bad' mothers (Breheny & Stephens, 2007; Kelly, 1996; Phoenix & Woollett, 1991). Given these concerns, an adolescent's decision to become a mother is often considered egocentric and likely due to romanticized and unrealistic notions of raising a child (Silva, 1996), which suggests that young mothers are uninformed and unable to appreciate the seriousness of adult responsibilities (Kelly, 1996). Duncan (2007) counters "there is little evidence that lack of knowledge 'causes' pregnancy, or that increased knowledge prevents it" (p. 308).

Although adolescent childbearing was at its peak in the 1950s, it did not provoke a societal crisis (Vinovskis, 2003). Most premarital conceptions were either quickly legitimized by marriage or young women were sent to maternity homes where they birthed their children and then placed them for adoption (Duncan, 2007; Luker, 1996; Addelson, 1999; Vinovskis 2003). In essence, adolescent and unwed pregnancy remained hidden. Women who did not marry were stigmatized and faced legal disadvantages (Vinovskis, 2003).

Influenced by the 'sexual revolution' and the 'women's movement', the 1960s and 1970s experienced a shift in social norms (Scheiwe, 2004). The availability of contraception and the legalization of abortion made it easier to avoid unintended pregnancies (Vinovskis, 2003). Declining marriage rates reflected an increase in women choosing to birth their babies out of wedlock (Addelson, 1999, Kelly, 1996, 1999; Luker, 1996). Women were also choosing to keep their babies rather then place them for adoption. (Arney & Bergen, 1984; Bonell, 2004; Kelly, 1996, 1999; Luker, 1996; Rains et al., 2004; Vinovskis, 2003). These shifting social norms challenged ideals of family

and motherhood from previous generations (Addelson, 1999; Kelly, 1996, 1999; Luker, 1996; Vinovskis, 2003).

Scheiwe (2004) and others (Bonell, 2004; Duncan 2007; SmithBattle, 2000) point out that young motherhood is often blamed for economic (state) dependency but research does not indicate that if these women were to postpone childbearing for ten years they would be at any less risk of low socio-economic status. For example, a study by Phoenix (1991) in the mid-80s involving adolescent mothers in Britain found that most mothers had already done badly in the educational and employment systems, and it did not seem that early childbearing had caused this or that deferring motherhood would have made a difference. Rather Phoenix (1991) notes that motherhood was a turning point which "spurred some women on" (p. 250) into education and employment.

It could be suggested then that the social problem is not early motherhood, but rather poverty and lack of opportunity (Duncan, 2007; Luker, 1996). Some argue that it is no coincidence that such views prevail at a time when white middle-class women are achieving higher education and attaining professional careers (Phoenix & Woollett, 1991; Wilson & Huntington, 2005). Nevertheless, because 'good mothers' are socially constructed as people who make independent economic provision for their children, those who depend on welfare payments cannot fit in with society's definition of 'good mothering' (Phoenix, 1991).

Given segmented labour markets create unequal access to pay and benefits, mothers of marginalized groups do not have the same choices as white, middle-class mothers in combining work and family life (Kelly, 1999). For example, in their study

with young mothers, Davies, McKinnon and Rains (1999) comment that half the women they interviewed (including four adolescent mothers) were self-supporting prior to the birth of their first child. "For them, having a child meant that they had to stop working, often with no alternative means of support other then welfare" (Davies et al., 1999, p. 47). These researchers found that the adolescent mothers (similar to the other mothers) in their study weighed the costs (transportation, day care) and risks (unreliable job market) of working and chose welfare to be the more responsible temporary course of action (Davies et al., 1999).

Missed educational opportunity remains another concern of early motherhood. As one author notes, "the earlier a woman bears children, the lower her formal educational achievement" (Grindstaff, 1988). This understanding assumes that young women have alternative opportunities in education and employment and also undervalues motherhood as a primary role for mothers who are economically disadvantaged (Cherrington & Breheny, 2005). Studies indicate that women who grow up in poverty face many odds against doing well later in life regardless of whether or not they become pregnant early in life; obtaining further education does not guarantee access to well-paid employment (Kelly, 1999). On the contrary, in circumstances where education and employment opportunities are limited, motherhood offers a rite of passage into adulthood (SmithBattle, 2000).

In addition to constructing young motherhood as socially and economically disadvantageous, it is constructed as being unethical (Luker, 1996). Not only are young mothers associated with the breakdown of traditional family values, but also they are

considered to be morally deviant because they do not abide by prevailing norms (Luker, 1996). In Western, middle class culture, early child rearing is the result of flawed values and unwise choices, which warrant public disgrace (Kaufman, 1999; Kelly, 1996). As a result, young mothers are subject to moral sanctions and public ridicule (Duncan, 2007).

The reproductive choices of young mothers contradict white, middle class normative life course ideologies which dictate that children should be raised in a nuclear family and that conception should follow marriage (Davies et al., 2001). Researchers in North America have consistently found that social class influences the various choices that result in early motherhood (Kelly, 1999). Young women with higher socioeconomic backgrounds are more likely to obtain abortions and/or place their children for adoption (Kelly, 1999; Luker 1996). Alternative life choices that entail early childbearing are stigmatized and judged negatively (Duncan, 2007; Kelly, 1999; Phoenix, 1991).

Although many young mothers describe their pregnancies as having been unplanned some authors note it does not mean that their pregnancies are unwanted (Addelson, 1999; Scheiwe, 2004). Davies et al., (2001) report that young women often welcome their pregnancies and embrace motherhood. Furthermore, some women viewed their pregnancy as an opportunity to "straighten up and turn their life around" (Davies et al., 2001, p. 91). SmithBattle's (2000) research involving adolescent mothers in the United States reports similar findings that describe motherhood as being a powerful catalyst for becoming more mature, and for directing their lives in positive ways. Motherhood often "anchors the self, fosters a sense of purpose and meaning, reweaves connections, and provides a new sense of future" (SmithBattle, 2000, p. 35).

These reconceptualizations reflect the reports that through motherhood, young women feel they had achieved maturity; they became responsible and caring adults (McDermott & Graham, 2005; Seamark & Lings, 2004). This positive self-identity is a key feature of resiliency since it confers self validation and social approval (Arenson, 1994; McDermott & Graham, 2005). However, the construction of this positive identity is made difficult for young mothers because they are positioned outside the dominant norms of what is considered 'good mothering' (McDermott & Graham 2005; Phoenix, 1991; SmithBattle, 2000).

Should young people desire a child and plan for pregnancy, they are often perceived as foolish, misguided and reckless (Grindstaff, 1988). This interpretation is contradicted by Davies et al. (2001) who report that for many of the young women in their study, the decision to create a family involves complex considerations about marriage, parenting and family support. The idea that childbearing is a morally complex decision is also suggested by Luker (1996) as she states, "for all women – rich and poor, teenage and older – decisions regarding childbearing and marriage have a great deal to do with feelings, values, beliefs, and commitments; they are rarely governed solely by the availability of a welfare check" (p. 177).

By treating young motherhood as a personal decision, policy makers fail to appreciate how mothering for many adolescents is not so much a failure of planning and rational choice but an inferred recognition of the limited possibilities available to them (McDermott & Graham, 2005; SmithBattle, 2000). There is evidence that suggests that early motherhood does not often result from ignorance or low expectations, it is rarely a

catastrophe for young women, and that young motherhood does not always cause poor outcomes for women and their children (Duncan, 2007). Rather, motherhood can be a positive experience for many young women (Arenson, 1994; Davies et al., 2001; Phoenix, 1991; Seamark & Lings, 2004; SmithBattle, 2000) and for some beginning motherhood early in life makes sense (Davies et al., 2001; Duncan, 2007; McDermott & Graham, 2005).

This 'oppositional' discourse (Kelly, 1996, 1999) refuses to position young mothers as individually irresponsible; rather it holds broader societal inequities accountable for the lack of support young mothers receive (Duncan, 2007; Kelly, 1996, 1999; SmithBattle, 2000; Weinberg, 2006). It is argued that young mothers serve a political agenda, as they are simply the most visible of a larger problem of social malaise that includes anxiety about sexuality, poverty, gender, class, and a changing world economy (Breheny & Stephens, 2007; Duncan, 2007; Kelly, 1996, 1999; McDermott & Graham, 2005; Weinberg, 2006).

Authors who support this 'oppositional' discourse concur there is a need to address such root concerns before shifting attention to the individualized problem of young motherhood, adding that it is also important to include young mothers' perceptions in research in order to reflect on policy and programming (see Breheny & Stephens, 2007; Kelly, 1996, 1999; McDermott & Graham, 2005; Rains et al., 2004; SmithBattle, 2000; Wilson & Huntington, 2005). These authors assert that increased support to young mothers in their process of independence is required. This means accepting their choices to parent and promoting an expanded notion of family to include broader community

networks (Davies et al., 2001; Kelly, 1996, 1999; McDermott & Graham, 2005; Rains et al., 2004; SmithBattle, 2000; Wilson & Huntington, 2005). It is argued that programs and support services need to engage young mothers in respectful relationships that validate their strengths and aspirations (Arenson, 1994; Breheny & Stephens, 2007; deJong, 2001; Rains et al., 2004; SmithBattle, 2000).

There is a debate that exists between 'expert' knowledge and 'lay' knowledge, which reflects the tensions between positivist science and social science methodology (Kreuger & Neuman, 2006). Knowledge and knowing are complex issues that reveal multiple debates about not only the meaning of research and knowledge building, but also whose knowledge is viewed as legitimate and/or valued. In Western culture, claims to knowledge are made by quantitative science arguing quantitative data as impartial and truth-telling and thereby claiming legitimacy (Duncan, 2007; Wilson & Huntington, 2005). As a result, scientific discourses shape social policies that influence how we experience the world (Wilson & Huntington, 2005). This means that qualitative inquiry are rarely cited in government policy (McDermott & Graham, 2005), reflecting a common perception that qualitative research is less accurate and less rigorous (Wilson & Huntington, 2005). However, quantitative science does not account for the contextual nature of human behaviour, which in the case of young mothers means negative perceptions are over generalized and widely accepted by mainstream thinking (Duncan, 2007; McDermott & Graham, 2005; Wilson & Huntington, 2005). Researchers then represent authoritative voices in the production of knowledge and in shaping dominant social attitudes (Breheny & Stephens, 2007; Rains et al., 2004).

The other difficulty with policy formulation is the social location of policy makers whose own lives often reflect middle class values which means, "achieving human capital through education, training and career development is prioritized over early parenthood" (Duncan, 2007, p. 326). These perceptions reflect a particular life course that are heavily classed, which means that policy makers lack an appreciation of the lived experiences of young mothers (Duncan, 2007). Their skewed location/decision making position requires that policy makers and practitioners examine their own assumptions and challenge dominant perceptions that negatively construct young motherhood (Davies et al., 2001; SmithBattle, 2000). Listening to the concerns and considerations of young mothers is even more important to ensure the development of services and practices that are inclusive and respectful of their lived experiences as mothers and women (Arenson, 1994; Breheny & Stephens, 2007; Davies et al., 2001; deJong, 2001; Rains et al., 2004; SmithBattle, 2000; Wilson & Huntington, 2005). This position supports accounting for and legitimizing lay knowledge.

In health care settings, the negative construction of young motherhood makes it difficult for health care professionals to respond to young mothers on their own terms (Breheny & Stephens, 2007; SmithBattle, 2000). Clinical practice is further compromised by shortened hospital stays at delivery that make it difficult to customize care to the young mother's situation and experience (SmithBattle, 2000). These limitations exert pressure on clinicians to educate young mothers in parenting skills based on hospital protocols and middle class ideals, without eliciting their experiences, concerns and goals (Breheny & Stephens, 2007; SmithBattle, 2000).

As health care organizations strive to create a unique identity within a competitive arena, quality management in women's health care has been identified as a focal point for organizational identity (Stichler & Weiss, 2000). Evaluation of postpartum programming is important in order to ensure satisfaction and quality of service. For many mothers, the postpartum period is a time of transition, physically, socially and emotionally (Bondas-Salonen, 1998). In the case of young mothers, improving their satisfaction with their health care may help promote their future use of health care programs (Peterson, Sword, Charles & DiCenso, 2007).

Studies of satisfaction with inpatient postpartum care reveal that adolescent mothers are less satisfied than older mothers (Lena et al., 1993; Peterson & DiCenso, 2002). In a study that examined adolescents' perceptions of inpatient postpartum care, Peterson et al., (2007) report that adolescent mothers were satisfied with their care when they were actively involved in their own care, which relied on the nurse's ability to put her patient 'at ease'. In examining women's postpartum health experience, it has been suggested by Sword, Watt and Kreuger (2004) that qualitative approaches would be most appropriate for eliciting identified perceptions of what health means and the importance of various dimensions of health regarding women and their postpartum care.

Given that there is little research that reports on the perceptions and needs young mothers, particularly in relation to the similarities and differences from the larger group of postpartum women, the purpose of this study is to offer single, young mothers an opportunity to speak to their hospital experiences before going home with their baby.

## METHODOLOGY

Traditionally we tend to think of answering research questions using one methodological approach or another. Each methodological approach is based on its own set of assumptions regarding ontology and epistemology. The quantitative paradigm rests on positivism and is characterized by deduction, confirmation, theory/hypothesis testing, explanation, prediction standardized data collection, and statistical analysis (Johnson & Onwuegbuzie, 2004). In contrast to this, the qualitative paradigm rests on interpretivism and constructivism and is characterized by induction, discovery, exploration, theory/hypothesis generation, and the researcher is considered to actively impact data collection and analysis (Johnson & Onwuegbuzie, 2004). These two distinct and polarized research paradigms are often at odds with one another, each boasting its advantages and desirability (Sale, Lohfeld & Brazil, 2002). Regardless of such discrepancies, Biesta and Burbules (2003) assert they are linked by a commonality in social science research: to provide warranted assertions about human beings and the environments in which they live and evolve (Johnson & Onwuegbuzie, 2004).

With today's research world becoming increasingly interdisciplinary and more complex, researchers require a thorough understanding of multiple methods to promote collaboration, communication and to produce high quality research (Johnson & Onwuegbuzie, 2004). In response to this change, there has been a third research paradigm that has become increasingly recognized. This third research paradigm is known as mixed methods research, also referred to as triangulation, multiple

operationalism, integrative research, blended research and multiple methods (Johnson, Onwuegbuzie & Turner, 2007).

Mixed methods research focuses on the collection and analysis of both quantitative and qualitative data in a single study (Creswell, 2003). It is an approach to knowledge that attempts to consider multiple viewpoints and perspectives from varying standpoints of qualitative and quantitative research (Johnson et al., 2007). Since mixed methods research rejects the notion of restricting choices available to researchers, it is considered to be an expansive form of research that is "inclusive, pluralistic, and complementary" (Johnson & Onwuegbuzie, 2004, p. 17).

There are several models within mixed methods research. This research project reflects a sequential explanatory design, which is characterized by the analysis of quantitative data followed by the collection and analysis of qualitative data (Creswell, 2003). The purpose of this strategy is to use qualitative results to aid in the explanation and interpretation of quantitative data (Creswell, 2003). Qualitative data can "play an important role by interpreting, clarifying, describing, and validating quantitative results" (Johnson et al., 2007, p.115).

This research project used quantitative data from an already existing study. 'The Ontario Mother and Infant Survey' (TOMIS II) surveyed mothers of all ages at five different hospital locations in Ontario including one in Peterborough, Ontario . The purpose of TOMIS II was to further assess how postpartum women use services, identifying what is helpful and what is not. Based on the TOMIS II questionnaires and using data set from Peterborough Regional Health Centre, I selected three themes to

further analyze. These themes included data on reported experiences about (a) length of stay in hospital (b) information on mothers' overall satisfaction of services in both labour and delivery and maternity, as well as (c) information on learning needs once having been home with their baby for four weeks. Initially the data was examined to see if there were differences in reported experiences of women between 16 and 21 and other, older respondents (no participant was under 16 years of age).

A TOMIS II data subset (from Peterborough) was run to reflect the reported responses of just those mothers who were between the ages of 16 and 21 and then presented to eligible participants in a focus group format for feedback. The purpose in doing this was to better understand the quantitative data from the TOMIS II study by bringing qualitative interpretation to it based on young mothers' own perceptions and experiences. This study sought to contribute to thinking about how single, young mothers define their experiences of postpartum care and in what way they perceive their needs as different.

To be eligible to participate in this research project, candidates were English speaking, between the ages of 16 and 21, self-identified as single at time of delivery, and had a baby less than one year of age. To advertise for the study, recruitment flyers (Appendix A) were distributed through two community sites that included the public health unit and a family practice clinic (both in Peterborough).

The intention was to recruit two focus groups with six to eight mothers in each. However, the response rate was poor and I began to explore opportunities for expanding recruitment. During this process, I was offered an invitation to attend 'The School for

Young Moms' and facilitate a focus group during their lunch hour. Given this shift in my intended recruitment strategy, consultation with the McMaster University Research Ethics Board (MREB) was required and an addendum was filed and approval granted (Appendix B).

As has been identified, data collection for this research project was through a focus group format. The context of a focus group creates a different process than individual interviews as data are generated by interaction between participants that reflect spontaneity (Finch & Lewis, 2003). This approach seemed appropriate as I was presenting findings from the TOMIS II study and asking participants to comment on the data based on their own experiences. Focus groups can fulfill many needs in research (Brown, 1999) and in this research project it is meant to enrich the quantitative data of an already existing study.

It is important to differentiate focus group research from other types of qualitative research. An individual interview captures the single story of one participant; while in a focus group the dynamic and interactive exchange among participants captures multiple stories and diverse experiences (Brown, 1999; Morgan, 1997). Kreuger and Neuman (2006) identify that "the key feature of focus groups is the narrative of what develops around group issues deemed by the members to be significant, whether issues are ones of agreement or of disagreement" (p. 414), which means paying close attention to how language and ideas emerge.

In total, two focus groups were conducted. The first focus group was held at 'The School for Young Moms'. To ensure the mothers were not feeling coerced to participate,

the focus group was held in a separate room that did not interfere with normal lunch activities. The focus group was limited to one hour given I was facilitating during their lunch and did not want to impose on class routines. Four mothers partook in the focus group, all of who had only one child ranging in ages from 5-8 months. Two of the mothers were 18 years old, one mother was 17 years old and another mother was 16 years old. All four mothers identified themselves as being English Canadian with English being their first language. Three of the mothers self-identified as single at the time of delivery while one identified herself as living common-law with a partner. All of the mothers were in the process of completing their high school education. Three of the mothers reported their source of income as being welfare with a total income under $10,000. One mother identified her source of income as being wages with a total income between $10,000 and $19,000.

A second focus group was conducted at the local public library and lasted 90 minutes. Two eligible candidates were recruited and due to time constraints of this research project I could not postpone the group in hopes of recruiting additional participants. Both mothers were 21 years old; one mother had a 2 week old and a three year old and the other had a ten month old. Both mothers self-identified as unmarried, yet living with their partners at the time of their baby's birth. One mother identified as English Canadian and the other mother identified as Métis and African American. One mother had just completed college and the other had completed high school. Both reported their source of income as being welfare with a total income under $10, 0000.

Prior to beginning each focus group, the letter of information/consent (Appendix C) was reviewed with participants. It is the responsibility of the researcher to inform candidates about the research project ensuring participants have the opportunity to give free and informed consent (Canadian Institute for Human Research, 1998). Consent forms were signed prior to beginning each focus group. Participants were also asked to complete a brief demographic information form (Appendix D). With participants' permission, each focus group was audio taped. In appreciation of their participation in this research project, a $5.00 gift certificate was presented to each mother at the end of the focus groups. Refreshments were also provided during both focus groups.

Both focus groups were conducted using a prepared interview guide (Appendix E). Essential to the focus group method is a semi-structured interview guide, using broad, open-ended questions (Brown, 1999; Morgan, 1997). At the beginning of each focus group I provided an introduction that outlined the structure and layout of the group and also addressed particulars about confidentiality and respect of each others' perceptions. Statistical data from the TOMIS II study was then presented to each focus group based on three themes that included (a) length of stay in hospital (b) information on mothers' overall satisfaction of services in both labour and delivery and maternity, as well as (c) information on learning needs once having been home with their baby for four weeks. This data was presented to both focus groups in percentile form and represented in graph and chart formats. Both focus groups were asked to comment on the data based on their own perceptions and experiences. There was opportunity at the end of both focus groups for some open discussion.

The facilitator(s) of the focus group plays a fundamental role in the conduct of a successful focus group, which requires both observational and facilitation skills that can promote a vigorous interchange of discussion and modulate possible conflict (Brown, 1999). At times, the facilitator(s) may be more in a position of listening in and observing as group discussion guide the narrative (Finch & Lewis, 2003). Finch and Lewis (2003) summarize Tuckman and Jensons' phases of group process, which include: 'forming', 'storming', 'norming', 'performing', and 'adjourning'. It is important for the facilitator(s) to be aware of these phases, as they will reflect mood and energy levels through verbal and non-verbal behaviour (Finch & Lewis, 2003). This is a normal part of group process and it is important for the facilitator(s) to allow for the dynamics, yet structuring and moving participants through the phases appropriately (Finch & Lewis, 2003).

## FINDINGS

Although the TOMIS II study included five acute care hospitals in mid and southern Ontario, this research project considers just the data gathered from the Peterborough site. The study sample included 250 women who: (1) had given birth vaginally to a single live infant, (2) were being discharged from hospital at the same time as their infant, (3) were assuming care of their infant at the time of discharge and (4) were competent to give consent to participate. Of the 250 women who participated at the Peterborough site, 23 women were between ages 16 and 21, while 227 were age 22 or older. Table 1 demonstrates comparisons in maternal demographics between younger mothers and older mothers at the Peterborough site.

| Table 1<br><br>**Maternal Demographics** | Mothers aged 16-21<br>N=23<br>n (%) | Mothers aged 22+<br>N=227<br>n (%) |
|---|---|---|
| First live birth | 19 (82.6) | 86 (37.8) |
| Married | 2 (8.6) | 174 (76.6) |
| Single | 6 (26.0) | 6 (2.6) |
| Self reported as English | 19 (82.6) | 225 (90.7) |
| Canadian | 23(100.0) | 226 (99.5) |
| English speaking | | |
| Not yet completed high school | 13 (56.5) | 11 (4.8) |
| Completed college or university | 2 (8.6) | 140 (61.6) |
| Income: under $19,000 | 10 (43.4) | 23 (10.1) |
| $20,000 to $39,000 | 8 (34.7) | 40 (17.6) |
| $40,000 to $59,000 | 2 (8.6) | 67 (29.5) |
| over $60,0000 | 0 | 81 (35.6) |
| Income source: wages/salary | 15 (65.2) | 194 (85.4) |
| Social assistance | 4 (17.3) | 5 (2.2) |

In the TOMIS II study, mothers completed a self-administered questionnaire prior to discharge from hospital and participated in a structured telephone interview at four weeks following discharge. Of the 250 mothers who were originally recruited, 186 (74.4%) participated in the telephone interview; 15 (65.2%) mothers age 16-21 and 171 (75.3%) mothers age 22+.

The data I presented to mothers in my focus groups was gathered in the telephone interview. Although I presented just the data from reported experiences of those mothers aged 16-21 in my focus groups, I have presented the data alongside the older mothers for comparison. Data were analyzed using SSPS 12.0. Chi square tests were used to determine if any statistically significant differences occurred between groups of mothers defined by age on length of stay, satisfaction of services (during labour and delivery and after delivery) and identified learning needs at four weeks postpartum. For all analyses, a *p* value of <0.05 was used to determine statistical significance.

A. Length of Stay

| | Mothers aged 16-21<br>N=15<br>n (%) | Mothers aged 22+<br>N=171<br>n (%) |
|---|---|---|
| Equal to or < 48 hours | 8 (53.3) | 118 (69.0) |
| 49 to 72 hours | 6 (40.0) | 43 (25.1) |
| > 73 hours | 1 (6.6) | 10 (5.8) |

The chi square *p* value is 0.434, which means there is no statistically significant difference between younger mothers and older mothers regarding the length of their stay. Most young mothers (53.3%) and most older mothers (69.0%) reported staying in

hospital 48 hours or less. More young mothers (40.0%) then older mothers (25.1%) reported staying in hospital between 49 and 72 hours after their baby was born.

Was your stay the right amount of time for you?

| | Mothers aged 16-21<br>N=15<br>n (%) | Mothers aged 22+<br>N=171<br>n (%) |
|---|---|---|
| Yes, definitely | 10 (66.6) | 132 (77.1) |
| Yes, probably | 3 (20.0) | 22 (12.8) |
| Not sure/Don't know | 0 | 1 (0.5) |
| No, probably not | 1 (6.6) | 8 (4.6) |
| No, definitely not | 1 (6.6) | 6 (3.5) |
| Missing | 0 | 2 (1.1) |

The chi square *p* value is 0.917, which means there is no statistically significant difference between younger mothers and older mothers. Most mothers both young (86.6%) and older (89.9%) reported that their length of stay was the right amount of time for them.

B. Satisfaction of Services While in Hospital

During labour and delivery:

| | Mothers aged 16-21<br>N=15<br>n (%) | Mothers aged 22+<br>N=171<br>n (%) |
|---|---|---|
| Excellent | 6 (40.0) | 121 (70.7) |
| Good | 7 (46.6) | 40 (23.3) |
| Fair | 2 (13.3) | 9 (5.2) |
| Poor | 0 | 1 (0.5) |

The chi square *p* value is 0.91, which means there is no statistically significant difference between younger mothers and older mothers. Most young mothers (86.6%) and most

older mothers (94.0%) rated their care during labour and delivery as being good to excellent.

After delivery:

| | Mothers aged 16-21<br>N=15<br>n (%) | Mothers aged 22+<br>N=171<br>n (%) |
|---|---|---|
| Excellent | 3 (20.0) | 83 (48.5) |
| Good | 7 (46.6) | 70 (40.9) |
| Fair | 2 (13.3) | 17 (9.9) |
| Poor | 3 (20.0) | 0 |

The chi square *p* value is 0.000, which means a statistically significant difference has occurred between younger mothers and older mothers. More older mothers (89.4%) rated their care after delivery as being good to excellent; whereas only 66.6 per cent of younger mothers rated there care as being good to excellent. More young mothers (33.3%) rated their care as being poor to fair, where as only 9.9 per cent of older mothers rated their care as being poor to fair.

C. Identified Learning Needs Four Weeks Post Discharge

| | Mothers aged 16-21 N=15 n (%) | Mothers aged 22+ N=171 n (%) | p value |
|---|---|---|---|
| Hospital routines | 6 (40.0) | 16 (9.3) | 0.000 |
| Breast feeding | 3 (20.0) | 47 (27.4) | 0.531 |
| Bottle feeding | 6 (40.0) | 21 (12.2) | 0.013 |
| Infant care & behaviour | 9 (60.0) | 56 (33.7) | 0.102 |
| Signs of illness in infant | 11 (73.3) | 81 (47.3) | 0.154 |
| Physical changes & self care | 11 (73.3) | 54 (31.5) | 0.005 |
| Emotional changes in self | 9 (60.0) | 44 (25.7) | 0.005 |
| Sexual changes & intercourse | 7 (46.6) | 35 (20.4) | 0.000 |
| Family changes | 4 (26.6) | 29 (16.9) | 0.345 |
| Community supports & services | 6 (40.0) | 32 (18.7) | 0.143 |

A statistically significant difference occurred between younger mothers and older mothers in five areas, namely, hospital routines, bottle feeding, physical changes and self care, emotional changes in self and, sexual changes and intercourse, which were identified more by young mothers. Young mothers primarily identified signs of illness in infant (73.3%), physical changes and self care (73.3%), infant care and behaviour (60.0%) and, emotional changes in self (60.0%) as being their unmet learning needs four weeks after their discharge from hospital with their baby. Older mothers primarily identified signs of illness in infant (47.3%), infant care and behaviour (33.7%), physical changes and self care (31.5%) and, breast feeding (27.4%) as being their unmet learning needs four weeks after their discharge from hospital with their baby.

## INERPRETATION OF THE FINDINGS

The aim of this research project was to elicit data on mothers' experiences about their intrapartum and postpartum care to bring context to the quantitative findings of the TOMIS II study. Data collected at both focus groups were audio recorded and transcribed verbatim by the student researcher. After having read transcripts numerous times, the content of the transcripts was analyzed in relation to the three major themes explored in the focus groups. These themes were then examined for sub-themes. Sub-themes have been reported based on 'group-to-group validation'; meaning that whenever a certain topic came up, it generated a consistent level of energy among a consistent proportion of the participants across the groups (Morgan, 1997). Code-mapping (Knodel, 1995) was used to retrieve segments that correspond with the respective themes and sub-themes. Knodel (1995) identifies coding as central to the analysis of focus group transcripts in order to draw conclusions about topics under investigation.

The data from the focus groups is presented according to emerging sub-themes relating to (a) length of stay, (b) satisfaction of service (in both labour and delivery and maternity) and, (c) identified learning needs four weeks following their discharge from hospital.

### Length of Stay:

After presenting the findings from the TOMIS II study, focus group participants were asked to reflect on their length of stay in hospital and to comment on whether they felt it was the right length of time for them. Similar to the quantitative findings

representative of 16-21 year old mothers from the TOMIS II study, most participants (66.6%) reported being in hospital for 48 hours after the birth of their baby. Those participants in the focus groups who had complications with either their own health or their baby's health stayed longer, up to one week. Regardless of their length of stay and again similar to the quantitative findings representative of 16-21 year old mothers from the TOMIS II study, most participants (83.3%) reported feeling that their length of stay was the right length of time for them. Among the comments regarding their length of stay were the following:

> I stayed for 48 hours and I thought it was good. (Respondent 3)
>
> I was there for 48 hours ... I think it was the right amount of time. (Respondent 4)
>
> I was in the hospital for 48 hours with him and I thought it was fine. (Respondent 1)

Even though most participants reported their stay was adequate in length, many participants described certain conditions which negatively affected their experience. These included feeling "alone", and finding nursing support inaccessible. This feeling of aloneness was echoed by many of the younger participants in the focus groups. One participant admitted to sneaking her boyfriend in overnight because she didn't want to be alone. Others commented:

> ...they wouldn't let my boyfriend stay... I was alone and it was scary. (Respondent 5)
>
> That was the only part [I didn't like] about my stay, was being alone overnight. (Respondent 3)

> I was lonely. I didn't even want my boyfriend to go home at night. (Respondent 6)

Those who felt less alone had their boyfriends stay beyond visiting hours and were given the option of their boyfriends to stay overnight in their room. Interestingly, these participants were the older mothers of the focus groups. Those who felt alone also described feeling that nursing support was inaccessible to them, particularly through the evening hours. This was due to either, not knowing how to access nursing support and/or feeling that requests for support were not acknowledged. Among statements of nursing inaccessibility were the following:

> Every time I tried to call the nurses because I was by myself all night. Every time I tried to call them, they wouldn't show up and I'd have to keep calling them and they'd say that they'd sent somebody but nobody came at all. (Respondent 5)

> [I] kept hitting the call button on the bed and no one was coming. (Respondent 3)

> They never really told me [how to get help], they really give you a lot of information after you have your baby and you're really not aware. (Respondent 3)

Participants who had not experienced complications with either their own health or their baby's health did not express an interest in extending their stays. Some participants also acknowledged that having support at home contributed to their readiness to leave hospital.

Satisfaction of Services:

After presenting the findings from the TOMIS II study, focus group participants were asked to reflect on their experiences in hospital and rate their satisfaction of service in both labour and delivery and after delivery. Similar to the quantitative findings representative of the 16-21 year old mothers in the TOMIS II study, all participants in the focus groups rated their satisfaction of service in labour and delivery as being good to excellent. To the participants in the focus groups this meant having their pain needs met and having supportive nursing care. As described by the participants, supportive nursing care meant nurses who had a friendly disposition, who were approachable, who were patient with them and who listened to them. Among the statements that pertained to positive experiences were:

> They [the nurses] were really patient with me and they were very kind. (Respondent 3)

> I liked the nurses in the birthing suite. They were nice. They put me in the shower and gave me popsicles. (Respondent 2)

Similar to the quantitative findings representative of the 16-21 year old mothers in the TOMIS II study, most participants rated their satisfaction of service as being lower on the maternity ward (after delivery) then in labour and delivery. Most participants (83.3%) rated the service after delivery as being fair to good, while only one participant rated the service she received as excellent.

In both labour and delivery and after delivery, participants attributed a higher rating of satisfaction with more supportive nursing care, particularly since nurses were most involved with their own care and their baby's care. Both focus groups identified

differences in supportive care between older and younger nurses. All participants reported feeling more comfortable with younger nurses and reported more positive experiences with younger nurses. Younger nurses were described as being more attentive to their needs, more approachable, as well as, more pleasant. Among comments pertaining to the differences in supportive care provided by younger and older nurses were the following:

> I think the younger nurses take more time. (Respondent 1)
>
> ...older nurses it's just their routine, like they don't care, they've been doing it for what like 23 years... new [younger] nurses ...they're so interested in everything and they want to give you the best care and they want to give you every single little detail. (Respondent 3)
>
> The first nurse I had was younger and she was so nice. The next nurse I had was older and she was paying no attention to me, so it seems they had different beliefs on whether you should be a young mom or what the expectations were. (Respondent 2)

One of the focus groups identified feeling even more satisfied with care received from student nurses. The discussion among participants suggested they perceived student nurses as being more their equal, which meant they were recognized as peers and allies. Some comments included:

> Daytime was good because I got to hang out with the student nurses...They were like my age... They made it fun. (Respondent 3)
>
> I liked having the student nurse that was there too ... [having] someone your age is a change from all the nurses. You just feel a little more comfortable. (Respondent 2)
>
> Yeah, the one [student] nurse kept sneaking those big long pads and mesh things. You were supposed to use your own after a bit, but she kept stealing them for me. (Respondent 5)

You don't feel judged by student nurses. (Respondent 3)

There was consensus among participants about the importance of feeling heard by nurses and physicians. Both focus groups acknowledged feeling less satisfied if their concerns were not taken seriously. Many participants also attributed their age as a factor for not being taken seriously. They described feeling negatively judged and stigmatized and reported that due to their younger age, they felt assumptions were often made about them. For example, on describing her concerns about her baby's fetal heart rate dropping (to her nurse), one participant stated "she's like 'it's okay, it's okay'... she wasn't acknowledging what I was saying to her" (Respondent 1). Other comments included:

> They shouldn't judge you because you are young... Just because you're young doesn't mean that you're going to be a bad mom or that you're going to go out and have four more kids right away.
> (Respondent 6)

> Look at the person's situation, don't judge people, you know they're your patients; you're supposed to take care of them.
> (Respondent 3)

> And just because of our age, don't treat us differently then other people.
> (Respondent 2)

Unsupportive nursing care was also associated with unavailable support. Participants indicated they did not seek support and/or ask questions if they perceived a nurse to be unsupportive. One participant stated, "If you have any concerns about anything or about your baby, you should be able to ask and not feel like there's a problem" (Respondent 1).

To increase satisfaction of service, aside from more supportive and consistent nursing care, participants offered suggestions that may have helped in making their experiences more positive. These suggestions included, more flexibility regarding visiting hours, better food, and more timely education of hospital routines so that information could be better processed.

Learning Needs Four Weeks Post Discharge:

After presenting the findings of the TOMIS II study, focus group participants were asked to think back to when they had been home from hospital for four weeks and to consider whether they had any unmet learning needs. In the TOMIS study, findings indicate that young mothers primarily identified signs of illness in infant (73.3%), physical changes and self care (73.3%), infant care and behaviour (60.0%) and, emotional changes in self (60.0%) as being their unmet learning needs four weeks after their discharge from hospital with their baby.

There was variance in the response to this question. One focus group identified infant care and behaviour as being an unmet learning need, particularly concerning infant cries. For those who had some complications with labour and required cesarean sections, they identified wanting to have learned more about what to expect regarding surgery. Others identified wanting to have learned more about formula feeding and how to properly prepare bottles.

The 'pressure' to breastfeed was raised by both focus groups, which created stress for many participants. Both focus groups described this 'pressure' as forceful and

intrusive and also identified it as characteristic of unsupportive nursing care. Participants described feeling guilty if they didn't at least attempt to breastfeed, even if it wasn't their preference to do so. Although participants indicated they knew breastfeeding was better for their babies, they would have preferred formula feeding presented as an option so they could make a decision that felt most comfortable to them. Some comments included:

> I didn't like how forceful they were about breastfeeding. It's like there was no other option and even if they knew that I was up with her for three hours trying to breastfeed her, they wouldn't offer me a supplement. (Respondent 5)
>
> All the nurses do is grab them and push and pull [when trying to help with breastfeeding]. (Respondent 2)
>
> They make it sound like such a big thing [breastfeeding], like it's the biggest thing ever and you're so awesome if you can do it. (Respondent 3)
>
> Once you stop, you just feel so bad about yourself, you feel like your gonna well, not hurt your baby, but not do what's best for your baby by not breastfeeding. (Respondent 5)
>
> I felt like I was giving my baby poison when I gave her formula... I just got really upset about it 'cause I thought that breast milk was the only way to go. (Respondent 3)
>
> She [pediatrician] made me think I was depriving him if I wasn't gonna breastfeed him and if I was producing so much it was a waste. (Respondent 1)
>
> The doctors are really pushy. (Respondent 6)

Although many participants acknowledged feeling emotional at some point after the birth of their baby, participants did not identify wanting to have learned more about

what to expect emotionally. Some participants attributed their emotional well being to stress, particularly due to the health of their infant. For example, those whose babies had medical complications or experienced challenges in feeding their baby described feeling more emotional. Other topics that were not addressed by either focus group included signs of illness in infant, sexual changes and intercourse and family changes.

Interestingly, focus group participants indicated they didn't feel the hospital was necessarily the place to have their learning needs met. One focus group indicated they felt well supported by a program in the community that serviced young mothers. Participants that were involved with this community program indicated it was a good resource and a place where they could seek responses to unanswered questions. Others who had support at home felt this was also a resource for asking questions about unmet learning needs.

Both focus groups raised the 'poop' pamphlet as being extremely helpful in normalizing their infants output. Many participants identified that it was very helpful to have a pamphlet they could continually reference. Some participants felt that receiving additional information about baby care in written format would be more helpful so they could have something to look back on once at home. Some comments included:

> It'd be nice for first time moms [if] they gave them a little booklet that had a bunch of information. (Respondent 2)
>
> Yeah, like a starter package kit. (Respondent 4)

In summary, the qualitative findings gathered from the focus groups have helped to interpret the quantitative data that is representative of the 16-21 year old mothers from

the TOMIS II study. In keeping with the quantitative findings of the TOMIS II study, most participants (66.6%) identified staying in hospital for 48 hours after the birth of their baby and most participants (83.3%) reported that their stay was the right length of time for them. Two sub-themes emerged from the length of stay topic. These were characterized as 'feeling alone' and 'nursing support as inaccessible'.

Similar to the quantitative data representative of the 16-21 year old mothers from the TOMIS II study, focus group participants identified being less satisfied with service after the delivery of their baby than service received during the delivery of their baby. During labour and delivery, focus groups rated their satisfaction of service as being good to excellent. After the birth of their baby, on the maternity floor, most participants rated their service as being fair to good. Both focus groups indicated that a higher satisfaction of service was attributed to receiving more supportive nursing care, which for participants in these focus groups meant nursing care that was friendly, approachable, patient and attentive to their needs. Emerging from the satisfaction of service topic, were three sub-themes that included: 'differences between younger and older nursing care', 'student nurses as allies' and 'not feeling heard because of their age'.

There was much variance in response to the unmet learning needs topic and less similarity to the quantitative data representative of the 16-21 year old mothers from the TOMIS II study. One focus group identified infant care and behaviour as being an unmet learning need, particularly concerning infant cries. Other participants identified wanting to have learned more about formula feeding and how to properly prepare bottles. Participants who had experienced complications with labour and required cesarean

sections identified wanting to have learned more about what to expect regarding surgery. One sub-theme that emerged from the discussion was the 'pressure to breastfeed'. Other sub-themes included 'feeling supported outside the hospital' and 'written material as a resource'.

## DISCUSSION AND IMPLICATIONS

Using a sequential explanatory design (Creswell, 2003), this research project used qualitative findings to aid in the explanation and interpretation of quantitative data. The findings from the focus groups helped to clarify, describe and validate the quantitative findings from the TOMIS II study.

Both focus groups communicated that, regardless of how long their stay was in hospital after their baby was born, the most important factor about their experience were the interpersonal qualities of the nursing care they received. Interpersonal qualities that attributed to supportive care included friendliness, patience, being approachable, being attentive and being respectful with a non judgmental attitude. Focus groups identified their primary care providers as nurses since these were the health professionals they spent the most amount of time with while in hospital. Higher rates of intrapartum and postpartum service satisfaction were attributed to experiencing higher quality nursing care that included the above mentioned interpersonal qualities. This finding is in keeping with other studies that have considered young mothers perceptions of postpartum care (see Cronin, 2003; Lena et al., 1993; Peterson & DiCenso, 2002; Peterson et al., 2007).

Although focus groups identified nurses as playing a critical role in the supportive care they received, all health care providers could benefit from reflecting on the feedback these young mothers provided about their service in hospital regarding their own professional practice. Physicians, mid wives, lactation consultants, social workers and, house keeping personnel are among other health care professionals who may be involved in the intrapartum and postpartum care of young mothers in hospital. Researchers have

suggested that health care providers do contribute to the utilization of health care (Breheny & Stephens, 2007; Lena et al., 1993; Peterson et al., 2007) and these relationships can empower or devalue young mothers' experiences (Breheny & Stephens, 2007; SmithBattle, 2000). Focusing on health care providers shifts attention from young mothers as inadequate and addresses the social context of these young mothers and their children.

Helping relationships require reflexivity and mutual involvement, which requires us to constantly consider "how our values, beliefs, location and social difference from clients, as well as our access to various forms of power, affect client-worker interactions" (Strega, 2007, p. 77). There are no simple answers to the dilemmas of hierarchical relationships in helping professions. Inequalities and injustices are enacted through power relationships that arise from differing social locations between a worker and a client (Allan, 2003; Baines, 2007; Strega, 2007). However, if we are alert to the dynamics of history, location and politics, it allows us to better understand clients and ourselves within a broader context as opposed to an individual context, thereby enabling us to remain curious to question underlying assumptions and beliefs (Strega, 2007).

Acknowledging my own social location is critical to the work I engage in with young mothers. I am not a neutral participant; I am a white, heterosexual female who has had a privileged upbringing that has afforded me the opportunity to pursue post-secondary education and to establish a career. These traits generate power imbalances that would be markedly different then many of the young mothers with whom I work. My positioning as a social worker in a health care setting also creates a power imbalance

and potentially carries much authority particularly when considering child protection issues. Practice that is informed by middle class values only serves to penalize those who are not white and middle class.

Being self-reflexive also means considering how lay knowledge and knowing take shape through interaction. From a postmodern influence and a social constructionist lens, knowledge is developed between people through daily interaction, thus requiring one to recognize taken for granted ways of knowing (Allan, 2003). Being attentive to the notion that knowledge and social relations are socially organized fosters reflexive inquiry and illuminates social processes (Fook, 2000; Hick, 2005). This means challenging ideologies of motherhood that reflect white, middle class values since health care providers tend to reinforce these prevailing norms. Ignoring such structural inequalities limits the possibilities of young mothers' relationships with health care providers because it positions health care providers as experts who have the power to police. If young mothers are feeling scrutinized and under surveillance, they may become distrustful of health professionals and consequently be less likely to follow or seek advice (Breheny & Stephens, 2007).

Rather, helping young mothers to identify their strengths and supporting these strengths needs to be a priority. When working with young mothers, health care providers need to avoid stigmatizing stereotypes that promote maternal feelings of being a 'bad mother' (Koniak-Griffin et al., 2006). Young mothers may internalize these negative attitudes and value judgments which may compromise their own maternal behaviours and self esteem (Koniak-Griffin et al., 2006). Focus group findings

revealed that young mothers felt stigmatized and negatively judged by providers. They attributed their feelings to providers responding negatively to their age. Participants indicated that these negative experiences were characterized by what was perceived as unsupportive nursing care and, in such situations, young mothers consequently and purposefully did not seek nursing support. This scenario suggests that there is a complex connection between the quality of relationships and self-perceptions, which means that promoting supportive nursing care is critical to endorsing a confident self image in young mothers.

In her qualitative study with adolescent mothers, Hanna (2001) reported that these mothers often felt silenced and that their opinions did not matter to health care providers. Adolescent mothers in her study described nurses as authoritarian mother figures who denied them a sense of control. These qualities would not be conducive to supportive care.

Humanistic nursing care focuses on celebrating and nurturing human potential and encourages the nurse to establish a more accepting, life-affirming relationship with patients, rather then focusing on the mechanical tasks (Arenson, 1994). Demonstrating increased sensitivity to young mothers' perspectives and acknowledging their strengths could enhance the nurse-patient relationship, which could potentially not only help to optimize care, but also enhance both short-term and long-term outcomes for young mothers and their children (Arenson, 1994). It is important to note that, this approach to relationship building could be utilized by all health care professionals engaging with young mothers, not just by nursing staff.

In their study that considered adolescents' perceptions of inpatient postpartum nursing care, Peterson et al (2007) suggest that nurses who offer friendly, patient, respectful and understanding care, help to put young mothers at ease, which helped young mothers to feel more comfortable in identifying their needs. When this happened, young mothers in their study reported feeling more actively involved in their own care, which increased their level of satisfaction with service. It is important for young mothers to feel they are in partnership with their care providers (Michels, 2000). If young mothers are more actively involved in their own care, they are likely to feel more confident as mothers. Focus groups in this research project would concur; young mothers have the right to be actively involved in identifying and determining their needs about their intrapartum and postpartum care, thereby generating increased confidence in their role as mothers.

According to Freire (2007), the oppressed are persons who have been deprived of their voice and therefore deprived of their freedom. He advocated liberation through dialogue, a conversation between equal partners seeking understanding of the world around them. Freire (2007) argued that it is not the role of the individuals to speak to people only about their own view of the world, or to attempt to impose that view on them, but rather to dialogue with people about their views. In such a dialogue, no one person is the expert, but each has valuable input to share with the other.

Approaching young mothers through a 'Freire-ian' lens may prompt conversations that are reflective of caring values. Rather than health care providers expressing expert opinions about young mothers' intrapartum and postpartum care, there

is open dialogue and active listening. This circumstance creates an opportunity for lay knowledge, thereby rendering the young mother as an expert in her own care, informing health care providers about what is important to her. Health care providers that intentionally engage in dialogues with young mothers may actively enhance not only the mothers' satisfaction of intrapartum and postpartum care, but also their participation in community and health care services generally.

As has been indicated in this research project, most participants reported their length of stay as being 48 hours, which is reflective of shortened postpartum stays in Ontario hospitals. This means that in-hospital teaching is limited and will be most beneficial to young mothers if it reflects individualized needs (Sword & Watt, 2005). As was demonstrated in the focus groups, learning needs can vary from mother to mother even within homogenous groups. However, young mothers in the focus groups raised issue with how information was delivered and suggested receiving information in a manner that is more sensitive to their physical and emotional needs. They also proposed receiving additional information in written format to take home with them and identified that being able to refer to a booklet or pamphlet for further guidance was important. This recommendation is supported in other research that suggests repeating instructions to reinforce teaching, as well as offering written material to take home for ongoing reference (Montgomery, 2003; Sword & Watt, 2005).

Shorter stays in hospital require that community based resources play an active role in addressing learning needs (Sword & Watt, 2005). Interestingly, this resonated within the focus groups as many participants identified their affiliation with community

services and indicated the support available through these programs as being more appropriate for addressing learning needs rather than in hospital. Participants also identified the importance of having family and friends available to them for ongoing support. This suggests that establishing supportive relationships during the prenatal period prior to delivery of their baby is an important factor for young mothers.

Forming long-term, supportive relationships with care providers has been identified as a principal method to help young mothers stay connected to health care services and to help improve maternal and child well-being (Bensussen-Walls & Saewyc, 2001). Knowing what needs to be learned and readiness to learn is more likely to occur once (young) mothers are at home with their babies, which means community supports and services play an important role (Sword & Watt, 2005). Hospital personnel ought to work collaboratively with antenatal and postnatal services to enhance this support network. Giving young mothers an opportunity to participate in program development may also help identify learning needs and promote ongoing active involvement with community services.

The results of this research project are intended to inform those involved in the design and delivery of women's intrapartum and postpartum health care services about length of stay, satisfaction of services and identified learning needs from the unique perspectives of young mothers. As Cronin (2003) states, health care professionals need to begin to base their practice and interventions on the needs of young mothers rather than relying on traditional approaches used with older mothers.

This research project suggests a few factors regarding intrapartum and postpartum care for young mothers. Of most importance is positive relationship building between young mothers and their health care providers that promotes and reflects supportive, caring relationships. Given the stigma attached to young parenting, health care providers need to understand that young mothers enter into service already feeling that they are going to be judged and treated negatively and/or differently then other patients. Therefore onus lies with health care providers to engage young mothers in respectful and supportive relationships that are sensitive to their social context and their individual needs. If we are to focus on improving the quality of relationships, then it would be reasonable to assume that regardless of how long (or how short) a young mother stays in hospital postpartum, she is likely to feel more satisfied with her care.

During this climate of shortened hospital stays, it is perhaps unreasonable to think that hospitals are able to address a wide array of learning needs in such a short period of time. The strengthening of community services to ensure that young mothers have ongoing support available to them after their discharge from hospital is likely to benefit maternal and child well-being. As identified by focus groups, it also means leaving (more) written material with young mothers to ensure they have information to reference once they are home with their babies. Hearing from young mothers about the type of medium to best convey this information may provide additional insight into their learning needs. For example, offering information in a DVD format or audio format in addition to written format may be more conducive to the learning of some young mothers.

Building strong partnerships with community services and promoting prenatal and postnatal follow up with such services could also better support the learning needs of young mothers. As focus groups indicated, learning in hospital was not always optimal, rather knowing where they could go and who they could rely on for ongoing teaching and support was critical.

The findings represented in this research project have implications for the practice and policy development in health care services that involve caring for young pregnant women. Promoting collaborative networking with community services that tend to young mothers antenatal and postnatal care will help to strengthen intrapartum and postpartum services.

## CONCLUSION

Recognizing young mothers as unique individuals and listening to their perspectives increases the potential for gaining trust, encouraging openness, and developing effective interventions to improve their satisfaction of intrapartum and postpartum care. If health outcomes for young mothers and their babies are to be improved, it is important that these mothers feel fully supported by those who care for their health and their infants' health. In order to develop progressive practices that are responsive and respectful of young mothers, we need to listen to their concerns and considerations about their perceptions of intrapartum and postpartum care.

Working from a mixed methods approach, a sequential explanatory design was utilized to further understand young mothers' perceptions about their intrapartum and postpartum care. Using quantitative findings from the TOMIS II study, young mothers offered qualitative interpretations that reflect their own lived experiences. This research project offers a secondary analysis of the TOMIS II findings.

Although external validity is limited due to the small sample size, this research project could be considered an initial exploration of young mothers' perceptions about their intrapartum and postpartum care. Replication and enlargement of this study could help to increase the generalizability of the findings. Results of an enlarged study could then be used to design more quantitative studies with broader applicability.

Another limitation of this study is the influence of researcher bias. Given my involvement with young mothers during their hospital stay, I have a biased view about how health care professionals service young mothers. I believe that we could better serve

young mothers and engage them in a more collaborative manner that is respectful of their lived experiences. I am aware than that my beliefs influenced my research question and the design of this research project, including interview questions posed to the focus groups. Even though I worked carefully and repeatedly reviewed interview data, I am also aware that my bias may have influenced the analysis of the findings.

Areas for further research could include surveying a larger group of young mothers to see if the findings in this study apply to most young mothers. It would be interesting to engage young mothers in more in-depth interviewing at various stages, for example, initiating contact prenatally and then re-interviewing at three or six months postpartum and again at one year postpartum. It would be interesting to see if perceptions shift to reveal alternative insights and how such perceptions impact a young mothers' continuum of care. Discussions about her sources of support, what she has found helpful and not helpful and how she feels about herself as a parent may be a place to start for further inquiry.

The young mothers who participated in the focus groups for this research project clearly identified that supportive nursing care is critical to their intrapartum and postpartum experience. Enhancing interpersonal qualities of health care professionals who work alongside young mothers during their hospital will help to improve young mothers' level of satisfaction with hospital services. Young mothers who feel well supported are likely to move into their maternal role more easily (Cronin, 2003).

In many respects, the young mothers whose experiences fill these pages are no different from older mothers; they want to be respected and actively involved in

determining the needs of their intrapartum and postpartum care. By listening to these young mothers' perceptions and acknowledging that their lived experience is of value, perhaps we can begin to appreciate motherhood at all ages.

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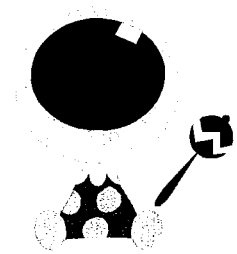
Appendix A

McMaster University

Inspiring Innovation and Discovery

# Looking for young mothers...



Do you have a baby under age 1?
Are you single?
Are you between 16 and 21?

If so, I want to hear from YOU...

- Tell me about your hospital experience after delivery and before going home with your baby?
- Did you feel supported?
- Did you learn what you needed to?
- Did you feel prepared to go home with your baby?

Your participation in this study will be in a group with other young mothers

If you are interested in participating in this study, please call:
Stephanie Vilneff at (705) 743-9880

Appendix B

**McMaster University Research Ethics Board (MREB)**

c/o Office of Research Services, MREB Secretariat, GH-305/11, e-mail: ethicsoffice@mcmaster.ca

**CERTIFICATE OF ETHICS CLEARANCE TO INVOLVE HUMAN PARTICIPANTS IN RESEARCH**

**Application Status: New** ☐ **Addendum** ☑ **Renewal** ☐ **Project Number** 2008 021

**TITLE OF RESEARCH PROJECT:**

Giving Teenage Mothers a Voice in Their own Care

| Faculty Investigator (s)/ Supervisor(s) | Dept./Address | Phone | E-Mail |
|---|---|---|---|
| S. Wait | Social Work | 23771 | waitms@mcmaster.ca |
| **Student Investigator(s)** | **Dept./Address** | **Phone** | **E-Mail** |
| S. Vilneff | Social Work | 705-743-9880 | sturek2002@yahoo.ca |

The application in support of the above research project has been reviewed by the MREB to ensure compliance with the Tri-Council Policy Statement and the McMaster University Policies and Guidelines for Research Involving Human Participants. The following ethics certification is provided by the MREB:

☐ The application protocol is approved as presented without questions or requests for modification.

☐ The application protocol is approved as revised without questions or requests for modification.

☑ The application protocol is approved subject to clarification and/or modification as appended or identified below:

**COMMENTS AND CONDITIONS: Ongoing approval is contingent on completing the annual completed/status report. A "Change Request" or amendment must be made and approved before any alterations are made to the research.**

| Reporting Frequency: | Annual: Mar-17-2009 | Other: |
|---|---|---|

Date: Mar-17-2008 Dr. D. Maurer, Chair/ Dr. D. Pawluch, Vice-chair

June 18, 2008

Appendix C

June 2008

**Letter of Information /Consent**

**Giving Young Mothers a Voice About Their Own Care**

**Student Investigator:** Stephanie Vilneff
Department of Social Work
McMaster University
Hamilton, Ontario, Canada
**(905) 525-9140 ext. 27091**

**Faculty Supervisor:** Dr. Susan Watt
Department of Social Work
McMaster University
Hamilton, Ontario, Canada
**(905) 525-9140 ext. 23771**

**Purpose of the Study**

In this study, I want to hear what you have to say about your hospital experiences following the birth of your baby. As a social worker in a hospital setting who works with mothers of all ages, it has been my experience that health care professionals can make a lot of assumptions about the needs of young mothers because they are often considered to be too young. As a result, we often make decisions about how young mothers and their babies should be cared for in hospital without taking into account young mothers perceptions. I am hoping to find out from young mothers who participate in this study how their needs differ from other women and what they consider their needs to be in hospital before going home with their baby.

**Procedures involved in the Research**

If you volunteer for this study, you will be asked to participate in a group with up to 7 other single, young mothers. In this group, I will present information from another study that describes mothers' experiences before going home with their babies. This information will include a) their length of stay, b) their satisfaction of services while in hospital, and c) their learning needs while in hospital.

Once I have presented the information to you in the group, I will ask you to comment on the information based on your own experiences. More specifically, I want to know whether you agree with it or not and in what way your experience was the same as or different from those women. I also want to know if there is anything you would have liked to be different about the care/support you received before going home with your baby.

The group will last about 1-1/2 hours and it will be held at The Peterborough Public Library. Short breaks with refreshments will be offered throughout the group. The focus group will be audio taped.

**Potential Harms, Risks or Discomforts:**

It is not likely that there will be harm or discomfort associated with your participation in this study. However, some of the questions I ask and the discussion that is generated may bring up some unpleasant memories or cause you some anxiety. You may also worry about what others have to say. To lessen these risks, I will be reminding the group before we start our discussion that no one needs to participate in any part of the discussion they if prefer not to and that you are free to leave whenever you want. I will also be asking the group to respect each others' views and to keep what is said within the group, although I cannot guarantee that everyone will do this.

If a participant identifies that she is uncomfortable or I sense her discomfort in the group, I will offer a break and remind the group that they don't have to respond or comment on questions they do not wish to answer.

**Potential Benefits**

Although you will receive no direct benefits from taking part in this research project, I hope that what I learn will help me understand more about your care needs as single, young mothers. Your feedback could help guide practice and policy recommendations for mothers your age.

**Payment or Reimbursement:**

In appreciation for your participation, you will be provided a $5.00 gift certificate redeemable at Tim Hortons.

**Confidentiality:**

I will ask the other members of the focus group to keep what you say confidential, but cannot guarantee that they will do so. Please keep this in mind while the discussion is going on.

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission. This means that I will not be using your name in my research report, nor will I be using any information that will allow you to be identified. Your privacy will be respected.

The information obtained by me will be kept in a locked cabinet and will only available to me and my research supervisor. Only my supervisor and I will actually listen to recordings of the group. Following the completion of my report, the information will be destroyed.

**Participation:**

Your participation in this study is voluntary. If you decide to participate, you can decide to stop at any time, even after signing the consent form. If you decide to stop participating, there will be no consequences to you.

In cases of withdrawal, any data you have provided to that point will be destroyed unless you indicate otherwise. If you do not want to answer some of the questions you do not have to, but you can still be in the study. Your decision whether or not to participate will not affect your continuing access to services at the Peterborough Public Health Unit or at the Brookdale Family Practice Clinic. Neither of these services will be aware of your participation in the study.

**Information about the Study Results:**

You may obtain information about the results of the study by contacting me directly and I will provide you with a 1-2 page summary of the findings. The summary will be available to those who are interested in August 2008.

**Information about Participating as a Study Subject:**

If you have questions or require more information about the study itself, please feel free to ask me directly or contact my faculty supervisor:
Student Investigator: Stephanie Vilneff (705) 743-9880
Faculty Supervisor: Dr. Susan Watt (905) 525-9140 ext. 23771

This study has been reviewed and approved by the McMaster Research Ethics Board. If you have concerns or questions about your rights as a participant or about the way the study is conducted, you may contact:

McMaster Research Ethics Board Secretariat
Telephone: (905) 525-9140 ext. 23142
c/o Office of Research Services
E-mail: ethicsoffice@mcmaster.ca

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**CONSENT**

I have read the information presented in the information letter about a study being conducted by Stephanie Vilneff of McMaster University. I have had the opportunity to ask questions about my involvement in this study, and to receive any additional details I wanted to know about the study. I understand that I may withdraw from the study at any time, if I choose to do so, and I agree to participate in this study. I have been given a copy of this form.

_____
Name of Participant (Please print)

_____
Participant's Signature

_____
Researcher's Signature

# Appendix D

**Demographics Sheet** (to be completed before focus group with researcher)

1. Is this your first pregnancy? Yes_____ No_____

2. Is this your first live birth? Yes_____ No _____

3. Age of participant: _____

4. Marital status at time of baby's birth? M___ CL___ Living with partner___ Single___

5. Were you born in Canada? Yes___ No___

6. Is English your first language? Yes___ No___

7. Which ethnic or cultural group do you most identify as reflecting your heritage?
___English Canadian ___French Canadian ___Aboriginal Canadian ___Chinese
___Jewish ___South Asian ___Italian ___Portuguese ___Other:_____

8. What is your highest level of education?
___Elementary school or less ___Some high school ___Completed high school
___Some community college or tech school ___Completed community college or tech school
___Some university __Completed bachelor's degree

9. Total income, before taxes and deductions, of all household members from all sources in the past 12 months.
___No income ___Under $10,000 ___$10,000 to $19,000 ___$20,000 to $39,000
___$40,000 to $59,000 ___$60,000 to $79,000 ___Over $80,000

10. What is the main source of income?
___Wages and salaries ___Income from self-employment ___Dividends and interest ___Employment insurance ___Worker's compensation ___Welfare (provincial or municipality)
___Child support ___Spousal support (alimony) ___Other:_____

11. Did you have a family doctor at the time of your baby's birth? Yes____ No____

12. Who took care you during your pregnancy? ___Fam MD ___OB ___Midwife
___Other:_____ ___No formal care during my pregnancy

13. Which of the following services did you use during your pregnancy?
___Prenatal education classes ___Public health nurse ____Other:_____

14. Did you breastfeed your baby? Yes____ If so, for how long_____
No____

Appendix E

## INTERVIEW GUIDE[2]

### Introduction

Welcome everyone. I'd like to begin with thanking you all for being here today. I also want to review a couple of things before we get started.... I anticipate our time together will be about an hour and a half. We will formally break for about ten minutes midway through the group, during which time you can stretch, get a snack and/or use the bathroom. The group will be audio-taped. During our discussion today, it is important to remember that there are no right or wrong answers, rather all your ideas, opinions and experiences are equally as valuable. That being said, it is essential to be respectful of one another's perspectives and to be mindful of not sharing what is said by someone here today outside of this group. Does anyone have any questions before I move along?

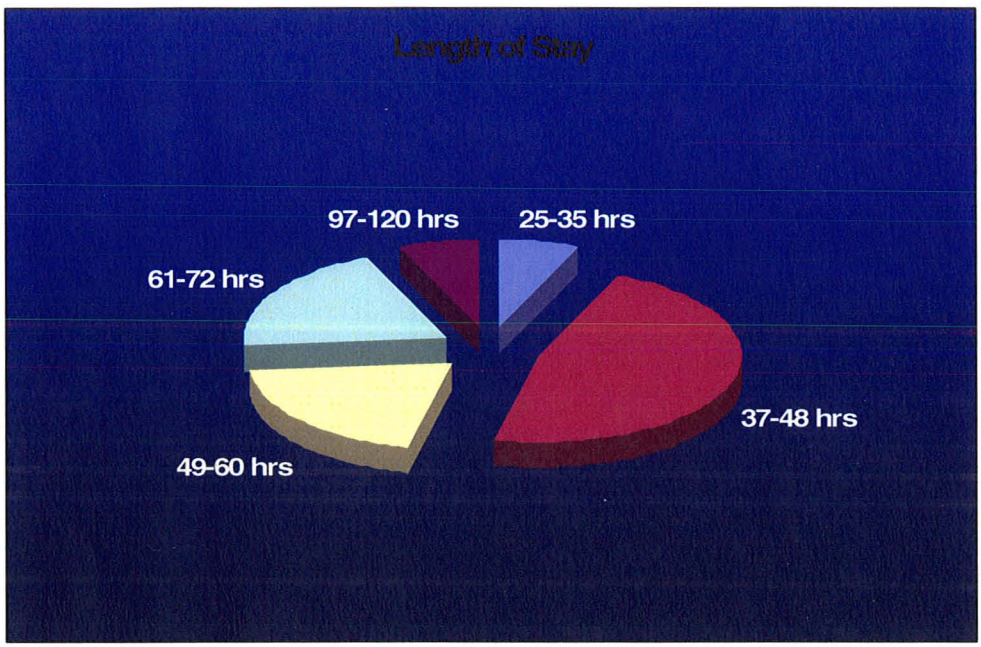
The information that I will present to you today is from a province wide survey called TOMIS II (The Ontario Mother and Infant Survey). The study included participants from five different hospitals in Ontario. The purpose of the study was to inquire about the type of health and social services mothers' use in the first four weeks after their discharge from hospital when they've had a baby. During this group, I am going to share with you what mothers between the ages of 16-21 told the researchers and then ask you to comment on your own experiences.

Young mothers sometimes have different experiences and needs than older mothers. I would like to find out about your experiences and how they compare to the larger group. We'll talk about how long you were in hospital, what you think about the care you received in hospital, and your learning needs once you were home with your baby. Finally, if there are other aspects of your experience that you would like to share, there will be time to do this at the end. Do you have any questions at this point?

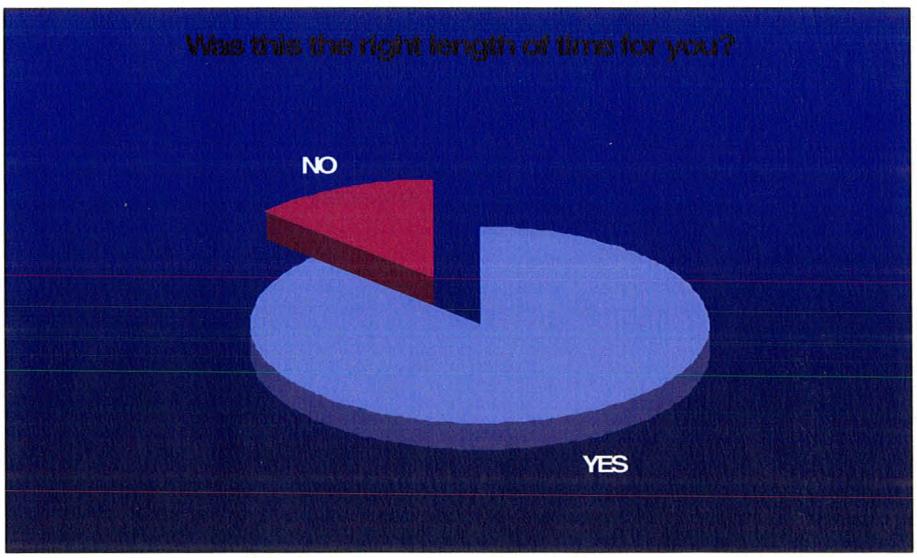
### Length of Stay:

Let's start by talking about length of stay in hospital. As you can see by this chart, in the TOMIS II study most mothers (47%) reported staying in hospital between 37 and 48 hours; 20% of mothers stayed between 49 and 60 hours and another 20% stayed between 61 and 72 hours.

[2] The graphs and charts included in the interview guide were presented in poster format to the focus groups




Based on their reported length of stay, mothers were asked whether they thought this had been the right amount of time. In response, most mothers (87%) reported that their length of stay was the right amount of time for them.




I'd like to know what you experienced and whether or not this was the right amount of time for you?

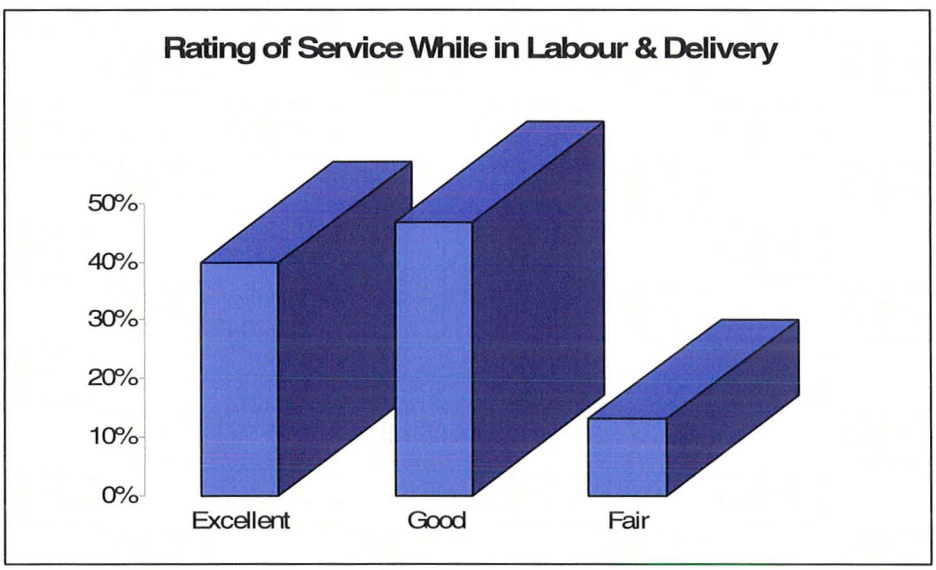
Prompting Questions:

1. Did you feel ready to go home when you were discharged? How did you know this?
2. Did some of you want to stay longer? Why?
3. Did some of you want to go home sooner? Why?
4. For those of you who wanted to stay longer, were you offered a longer stay? If so, did you stay?

**Satisfaction of Services While in Hospital**

Let's move onto satisfaction with services during your hospital stay. Mothers in the TOMIS II study were asked to rate their satisfaction of services while in hospital during a.) labour and delivery and b.) after delivery (on the maternity ward).

Let's take a look at how they rated the service during labour & delivery: most mothers (47%) reported feeling the service they received in labour & delivery was good; 40% reported it to be excellent and 13% reported it as being fair.

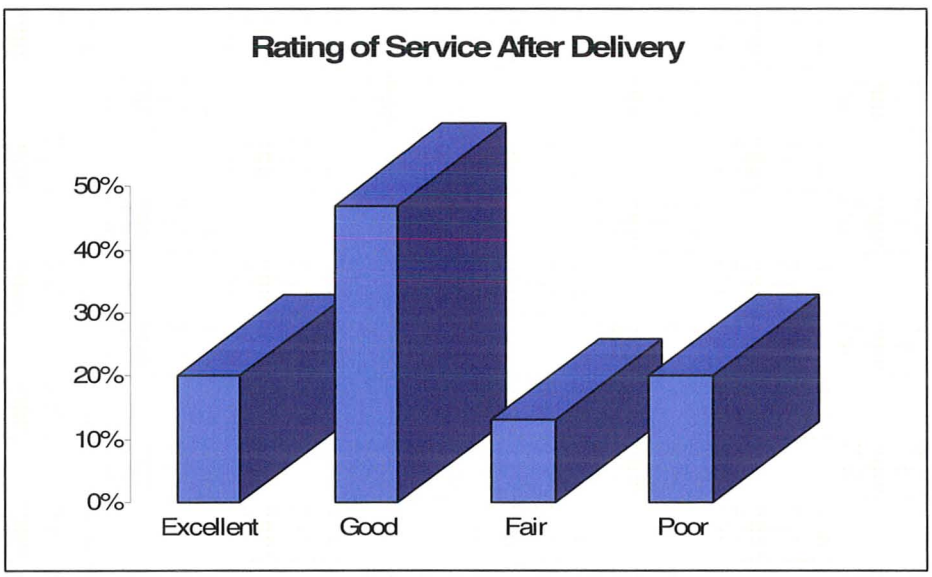



During labour and delivery, what were your experiences? Is it what you expected?

Prompting Questions:

1. What did you like/dislike about the care you received?
2. What would you like to have seen different about the care you received?
3. Did you find the care supportive? How so? If not, why?

Moving onto satisfaction of service after delivery: most mothers (47%) reported feeling the service they received on the maternity floor was good; 20% reported it to be excellent, 13% reported it as being fair and 20% reported it as being poor.




While on the maternity ward, what were your experiences? Is it what you expected?

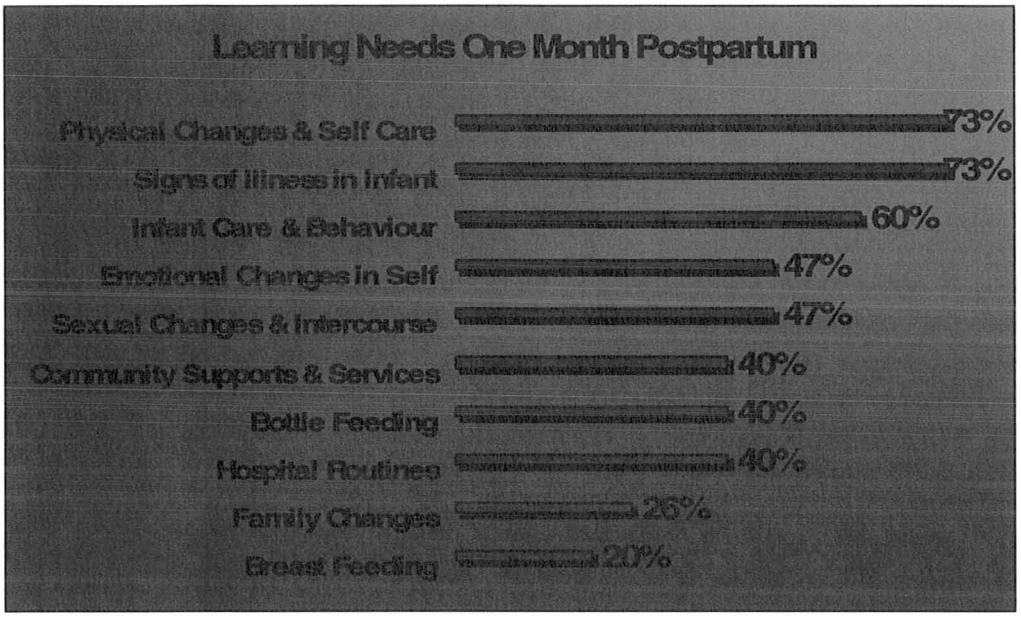
Prompting Questions:

1. What did you like/dislike about the care you received?
2. What would you like to have seen different about the care you received?
3. Did you find the care supportive? How so? If not, why?

BREAK – 5mins (refreshments offered)

**Learning Needs**

Let's move onto what you would've liked to have learned before going home with your baby. At four weeks after their discharge from hospital, mothers in the TOMIS II study were asked if they would have liked to have learned more about various topics in hospital. As you can see by the chart, mothers reported that they would have liked to have learned more about several things which included; signs of illness in their infant, physical changes and self-care, infant care and behaviour, emotional changes, sexual changes, community supports and services, hospital routines, and bottle feeding.




Thinking back to when you'd only been home with your baby a few weeks, can you recall there being anything you would've liked to have learned more about before leaving hospital with your baby?

Prompting Questions:

1. Did you feel prepared to care for your baby when you were discharged from hospital?
2. If yes, who/what helped you to feel prepared? What did you learn that helped you to feel prepared?
3. If no, why? What do you think you needed to know in order to feel more prepared to care for your baby when going home?

This next 20mins is meant to be an open discussion….

It is all well and good to reply to what other mothers have to say about their experiences but you are unique young women and I wonder if you could share the best and worst of your experiences in having your babies.

Prompting Questions:

1. If you had an opportunity to change anything about your experiences (good or bad) what would it be?
2. Is there anything in particular you want service providers to know about your experiences/service needs?