First Time Mothers' Experiences of Prenatal Education and Support

by

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Table of Contents

Abstract

Traditionally, mothers in Nova Scotia have sought out prenatal education through in-person formats. Recently, however, more online resources have become available, for example, in 2014, a free prenatal education website was introduced by Public Health to replace in-person classes. The purpose of this inquiry was to explore mothers' experiences of prenatal information and support in Nova Scotia. Semi-structured interviews were conducted with eight first-time mothers. Feminist poststructuralism and discourse analysis were used to analyze how women's experiences were socially and institutionally constructed. Results revealed that pregnancy was a significant moment in time for all participants, yet becoming a mother encompassed more than the information they received. The findings of the study suggest that nurses, researchers, and policy makers may have to reconsider the structure of maternity programs to reflect the notion that women's transition of 'becoming a mother' is a process, beginning in pregnancy and continuing into the postpartum period.

List of Abbreviations Used

CHV	Community Home Visitor
FPS	Feminist poststructuralism
HRM	Halifax Regional Municipality
NCCMT	National Collaborating Centre for Methods and Tools
NSHA	Nova Scotia Health Authority
PHAC	Public Health Agency of Canada
PHN	Public Health Nurse
SOGC	The Society of Obstetricians and Gynaecologists of Canada
WHO	World Health Organization

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Chapter 1: Introduction

The prenatal period is a time of great change, that can provide expectant women and their families with an opportunity to prepare physically and emotionally for birth and early parenting (Perry, Hockenberry, Lowdermilk, & Wilson, 2010). Women often use the months of pregnancy to adapt to the maternal role, a complex process of social and cognitive learning. As such, the prenatal period can be considered an ideal time for healthcare providers to educate and support expectant women and their families to promote healthy decisions and nurture parenting skills, as it can create the foundations for healthy mothering.

Maternal care is a global health issue with the World Health Organization (WHO) declaring that antenatal care and health services need to be accessible to all pregnant women (WHO, 2016). The Canadian government supports the WHO position, encouraging provinces to provide programs and services for all women and families to achieve a healthy pregnancy and healthy outcomes for the baby (Public Health Agency of Canada (PHAC), 2016). In Nova Scotia, Public Health Services recognizes the importance of providing services and care to the prenatal population, as it is addressed in the province's Public Health Standards for 2011-2016, stating: "public health works upstream to support social, economic, and physical environments for healthy pregnancies, healthy birth outcomes, effective parenting, and healthy child and youth development" (Nova Scotia Public Health, 2011, p. 15).

The province of Nova Scotia (2014) recognizes that pregnancy is an important time for parents to acquire information about pregnancy and parenting practices. For many years, Public Health Services in Nova Scotia provided in-person education and support classes to pregnant women. Although face-to-face prenatal classes were meant to be available to all pregnant women, not all women chose to use these services. Although childbirth and prenatal educators

view prenatal classes as important and valuable sources of credible information, this opinion is not equally shared by the public or pregnant women (Morton & Hsu, 2007), which is evident in the steady decline in attendance of childbirth and parenting preparatory classes. Due to declining enrolment, in 2014 the Nova Scotia Department of Health and Wellness made the decision to introduce a free prenatal education website, "Welcome to Parenting," to replace the universal in-person prenatal classes (Province of Nova Scotia, 2014). The province's online prenatal education system allows parents to: "learn about healthy pregnancy, labour and birth, breastfeeding and more; get answers to your questions from experts in health, parenting and child development; and connect with parents online" (Province of Nova Scotia, 2014, para. 3).

Depending on the community women live in, there are a variety of options for prenatal education and support in Nova Scotia, some of which are universally provided and others have an associated cost (Capital Health, n.d.; Graceful Beginnings Birth Services, 2015; Province of Nova Scotia, 2014). Despite the variety of prenatal services offered – both by the government and community agencies – not all women choose to access these resources, a phenomenon not unique to Nova Scotia (Best Start Resource Centre, 2014). Whether women choose to access prenatal information and support from family, friends, health care professionals, lay home visitors, or online websites, little is known about why they make these choices.

The change to the delivery of universal prenatal education from in-person to online could have potential implications for pregnant women's experiences of and access to prenatal education and support, as there is little research that addresses how various online prenatal education is accessed, received, or affects women's perinatal experiences and health outcomes (Best Start Resource Centre, 2013). A Cochrane Collaboration systematic review conducted by Gagnon and Sandall (2007) to assess the effects of prenatal education found that the majority of

studies did not explore women's (and their partner's) expectations or views of prenatal education in depth (p. 3). While the available literature examining prenatal education commonly focuses on measureable health outcomes (Gagnon & Sandall, 2007), the insights that represent the personal and social practices and experiences of mothers navigating the available prenatal education services and programs in Nova Scotia are missing.

Upon reflection of this Nova Scotia context, I suggest that there is a gap in understanding how healthcare providers and community organizations can best support the health of mothers and their families who seek prenatal education and support. This gap calls for a deeper understanding of the personal and social experiences of mothers, and how their experiences of prenatal education and support are developed and influenced. Therefore, it is important to explore women's experiences regarding accessibility and their choices for face-to-face or online prenatal education as it can create new knowledge and subjectivities about current prenatal education practices in Nova Scotia.

Locating Myself in the Research

This study explored women's experiences accessing prenatal information and support. My interest in prenatal education in Nova Scotia arose from the interactions I had while working as a public health nurse (PHN) in Antigonish, Nova Scotia with women who were pregnant or had recently delivered a baby. In helping women navigate the variety of online and in-person prenatal and postnatal services and supports, I was exposed to the realities of mothers, and the institutional and political aspects within the health care system, as well as the limitations of the current services in meeting mothers' health needs.

In such a large geographic area as Antigonish county, issues of lack of transportation can create barriers to accessing services. For mothers living in the outlying rural areas of the county,

travel to Antigonish town is often necessary to access health and education resources, such as the regional hospital, public library, doctor's offices and health clinics, and the in-person prenatal classes offered at the Family Resource Centre; travel to Antigonish town from the furthest outlying community in the county could potentially take up to one hour or longer. And while the Welcome to Parenting website enables women and their families to access prenatal education in an online format, and is accessible anywhere there is an internet connection, the further away from Antigonish town a person lives, the fewer resources available, including internet access. For many families living in surrounding communities in the county such as Sherbrooke, or Ecum Secum, both located 62km and 98km away from town respectively, internet options are few, and often unreliable, with many people still using a dial-up connection.

With regard to the change in delivery of prenatal education in the province, the Nova Scotia Department of Health and Wellness reported that the decision was not made as a cost-saving measure but to instead offer an alternate way for mothers and families to access prenatal information in a time and format that meets the needs of families in this digital age (Province of Nova Scotia, 2014). The province also reported that the decision was implemented as a way to move away from one standard model of offering information. By introducing this "alternate" method of prenatal education, the province took away in-person classes, ironically leaving only one option. So, Welcome to Parenting is in fact a replacement, and not an alternative option as is implied.

As a public health nurse with the Early Years team in Antigonish, I had regular contact with pregnant women and new mothers who indicated they were either unaware of the Welcome to Parenting online modules, or they had trouble using the website, related to lack of internet and/or computer access and therefore did not use it as a resource. While mothers stated that they

4

did not use the provincial Welcome to Parenting website, mothers did frequently report using the BabyCenter app, "My Pregnancy & Baby Today," which allows users to follow their pregnancy day by day, and to receive expert information and tips (BabyCenter, 2017). Mothers reported that this app allows users to use cellular data if no internet connection is available, making it more accessible than Welcome to Parenting.

Mothers reported to me that while they appreciated the convenience of the apps, blogs, and websites, they still sought-out in person contact with healthcare providers, family, and friends to gain information and support. Mothers expressed the importance of forging personal connections with other mothers who were pregnant or who had recently delivered an infant, as they could relate to one another on account of common mothering experiences. The Antigonish Family Resource Centre offered in-person prenatal classes, facilitated by a community home visitor (CHV) and provided women an opportunity to meet other expectant women. For some women, establishing social support networks with other expectant woman was difficult if they did not have access to transportation to attend the prenatal classes.

Travelling to mothers' homes in rural Nova Scotia to provide nursing care revealed to me the impact lack of transportation and internet had on access to health services. I gained an understanding of mothers' unique situations, the challenges associated with the current delivery method, and mothers' desire to have accessible prenatal education that fit with their health needs and preferred learning style. Pursuing a Master's of Science in Nursing degree at Dalhousie University has provided me with an opportunity to increase my knowledge and understanding of the health needs of people, and to examine dominant discourses that inform the health of individuals and populations. Additionally, I have learned to appreciate the importance of examining the way in which healthcare decisions are made, implemented, and evaluated.

In conclusion, my experiences as a nurse and graduate student have sparked my interest in conducting research that will contribute to ameliorating the current prenatal education practices in Nova Scotia. My belief that there is a need to provide a venue for women's voices to be heard is directly linked to my belief that a qualitative feminist methodology will provide the framework from which to explore and understand first-time mothers' experiences of prenatal education and support in Nova Scotia.

Purpose

The purpose of this research was to explore women's experiences with prenatal education and support in Halifax Regional Municipality (HRM). There are a variety of options for mothers living in Nova Scotia to obtain prenatal information and support both in offline and online formats- such as Welcome to Parenting online prenatal information, private in-person classes, doulas, midwives, doctors, nurse practitioners, medical websites, blogs, and family and friends. The purpose and focus of this study was to broadly explore mothers' experiences accessing any form of prenatal education and support.

This research study was guided by a feminist poststructuralist framework (Cheek, 2000; Weedon, 1997), which was used to examine how women's prenatal experiences are constructed using the concepts of beliefs, values, practices, discourses, language, meaning, and relations of power. Feminist poststructuralism offers a framework to guide research that explores and critiques power relations found within institutions (Weedon, 1997). The chosen methodology provided a way to explore the state of prenatal education and support practices in Nova Scotia that attempt to be responsive to mothers' needs. It is because of this shift in education delivery that an opportunity to critically question the practice and reconstruct an alternate subjectivity

6

arises. By using feminist poststructuralism as the guiding theory and methodology, the study findings were rooted in Nova Scotia mothers' voices and experiences.

Research Question

The following research question guided the research study: How do first-time mothers experience prenatal education and support in Halifax Regional Municipality, Nova Scotia?

Significance of the Study

This research study sought to explore where, how, and why women attain prenatal information and support in Nova Scotia – insights that will help guide the way our healthcare system and communities support women to become mothers. The qualitative nature of this study provided rich descriptions of women's experiences, which is exactly what is missing from the literature and our healthcare system.

By exploring mothers' experiences of prenatal information and support, the study findings will be utilized to influence and optimize prenatal education delivery. Exploring the experiences of first-time mothers, as they navigate the prenatal and early postpartum period, will offer new ways of understanding how healthcare providers and communities can best support expectant mothers. The insights provided by mothers on the current realities of prenatal education and support in Nova Scotia will have the potential to support development of hospital, community, and public health programs and services that are responsive to mother's prenatal needs. The research study was responsive to recent policy recommendations and government initiatives which iterate the importance of the early years and the role healthcare professionals must play in assisting women and families to receive the support they need during pregnancy to ensure an infant's best start (Nova Scotia, 2012). Accessible and equitable prenatal education and support is intended to assist expectant women and their families in making informed, safe

decisions throughout their pregnancy and into early parenthood, which will, in turn, help to

ensure Nova Scotian infants and mothers are healthy.

Chapter 2: Literature Review

The following literature review examined theoretical and research literature on the factors that influence access and participation of mothers in prenatal education and support. The literature included a background historical perspective of prenatal education programs, briefly outline current approaches to prenatal education, discuss challenges and opportunities to meet the needs of mothers, outline issues of accessibility and equity, and finally comment on decision making in public health.

Historical Perspective

Prenatal education has been evolving for hundreds of years. Preparing for childbirth through education has always been a part of the pregnancy experience, although it did not always exist in the formal structure that it does today (Zwelling, 1996). Historically, women learned about pregnancy, birth, and mothering practices by witnessing and listening to other women's experiences as told by friends and family (Ateah, 2013; Smith, 2005). For "thousands of years," in all parts of the world, it was a 'women's network' that informed girls and pregnant women about labour and birth (Lothian, 2006; Nolan, 1998, p. 1). The impartment of knowledge from old to young generations, including support techniques during labour, the birth process, and newborn care, was a part of the socialization of young women to this normal event in women's lives (Nolan, 1998; Walker, Visger, & Rossie, 2009). Formal education classes were non-existent, and were likely believed to be unnecessary, as women gained first-hand education by being present at other women's deliveries, and supporting and assisting with the process (Lothian, 2006; Nolan, 1998; Walker, Visger, & Rossie, 2009; Zwelling, 1996).

Until the 17th century, childbirth was almost exclusively a female-dominated practice that occurred in the home; childbirth that occurred in a hospital setting was uncommon. Before the

invention of forceps and other assistive devices, men had been involved only in difficult deliveries, using harmful instruments resulting in babies not being born alive, and mothers often dying as well (Johanson, Newburn, & Macfarlane, 2002). The beginning of the 20th century saw many influential changes that would have long-lasting effects on women's perinatal experiences (Zwelling, 1996). For example, the Industrial Revolution created a middle class who could afford larger homes, employ servants, and move away from country life in favour of a town or urban lifestyle (Nolan, 1998). At that time, women were increasingly choosing to give birth in hospitals instead of their homes (Zwelling, 1996), as their delivery would be attended by a physician. The medical profession conveyed the message to women that a hospital birth, managed by a doctor, is safer than delivering in the home, and that pain management is possible in hospital due to analgesic medications (Nolan, 1998). This was true- the medical influence that occurred in the 19th and 20th centuries saw the development of new forms of analgesia, anaesthesia, and caesarean section deliveries. The implementation of antiseptic and aseptic technique lowered maternal mortality (Johanson et al., 2002). However, the institutionalization and medicalization of childbirth has shifted western society's perceptions and expectations of pregnancy and labour and delivery where healthcare providers, including physicians and nurses, are subjectively positioned as the 'experts' regarding birth and in a position of power with regard to sharing of information (Ernst, 1994; Lee & Kirkman, 2008; Lothian, 2008; Walker, Visger, & Rossie, 2009; Zwelling, 1996).

While the practice of informal knowledge sharing still holds true today, the delivery of prenatal education has also become embedded within dominant social and institutional health and medical discourses. Sjöö and Mor (1997) believe that it is society's loss of reverence for women and their ability to create life, combined with patriarchal dominance (Eisler, 1988), that

have influenced women's perceptions about their ability to give birth and mother. The evolution of prenatal programs, along with dominant societal views, have suggested that childbirth and parenting are not natural experiences, and that prenatal education is believed to be a critical support, perhaps even a necessity, for first-time expectant mothers. The philosophical assumptions underlying many prenatal education and parenting programs is that parenting can be taught (Gagnon & Sandall, 2007; Nolan, 1998). The influence of this societal discourse is evident in the provincial governance and implementation of prenatal education programs.

Current Approaches to Prenatal Education

The need for formal prenatal education arose from the institutionalization and medicalization of birth (Zwelling, 1996). The influence of medicalization of childbirth "heralded the need for experts to fill the gap by providing structured prenatal classes to prepare women for the rigours of childbirth and parenting" (Wickham & Davies, 2005, p. 75). The escalating power of the medical profession throughout the 20th century influenced government bodies to support the practice of prenatal classes.

Currently, maternity care services, which includes the universal delivery of prenatal education, is governed at the provincial level (The Society of Obstetricians and Gynaecologists of Canada (SOGC), 2008). For example, in Canada, prenatal education and support is available in varying formats to all expectant women and families (Godin et al., 2014). For many years, Public Health Services in Nova Scotia has provided universal and free education and support classes to pregnant women, which were at one point available in-person, however now the education is delivered in an online format. In Nova Scotia, lay home visitors and community home visitors usually work out of Family Resource Centres and make valuable contributions to prenatal women, even though they are not typically part of the public health system. To maintain

the option of in-person classes, many Family Resource Centres in Nova Scotia provide free group prenatal education classes facilitated by a community home visitor.

Registered midwives are another source of prenatal information and support for expectant women. Midwives provide expert primary care for healthy women and their babies throughout pregnancy, birth, and the first six weeks postpartum. Midwifery in Canada is grounded in the philosophical assumption that birth is a profound and meaningful event in a woman's life, not just a physiological process (Macdonald, 2006). The midwifery model of care is premised on "three principles of partnership" with the expectant woman and family, they are: informed choice, continuity of care, and choice of birthplace (including home birth) (Association of Nova Scotia Midwives, 2018). This woman-centered and partnership approach to maternity healthcare has been to shown to have positive outcomes for mothers, babies, and families. Research has demonstrated that midwives contribute to positive and satisfying pre, intra, and postpartum experiences (Nicholls & Webb, 2006; Waldenström, Brown, McLachlan, Forster, & Brennecke, 2000) as well as lower rates of medical intervention in labour (Johnson & Daviss, 2005). The Association of Nova Scotia Midwives (2018) reports that mothers who use midwifery services often report "positive feelings about their birth experiences and more confidence in the transition to new parenthood." Though it has been demonstrated that the care, information, and support provided by midwives in the prenatal period has several benefits and positive health outcomes, access to midwifery services is limited. In Nova Scotia, midwifery services are available only in three parts of the province- Antigonish, the South Shore, and Halifax (Association of Nova Scotia Midwives, 2018).

In addition to the publically available sources of education and support, there are private options that mothers can pay for in order to have additional education and/or support. Doulas, for

example, can be a positive addition to a woman's prenatal and childbirth support team. Doulas are not trained to provide medical, midwifery, or nursing care, instead, they act as an emotional support to women in labour (Association of Nova Scotia Midwives, 2018). Doulas use intricate and complex emotional support skills as they provide continuous labour support for women (Gilliland, 2011). Some doulas also provide childbirth education to prenatal women (Ahlemeyer & Mahon, 2015). Doulas' services are not covered part of the health care system nor are they covered by Medical Services Insurance (MSI), meaning that women who believe they would benefit from this service have to pay for it on their own.

There is also a presence of independent prenatal educators that are a part of a commercial framework in which women can shop around to find a class that is best-suited to their preferences (Wickham & Davies, 2005). Depending on location and availability, women's options for privatized prenatal education may include well-known methods (many developed in the United States) such as Lamaze, the Bradley Method, and the International Childbirth Educators Association (Lothian, 2008; Walker, Visger, & Rossie, 2009), and the emerging HypnoBirthing method (Varner, 2015). In reviewing the descriptions of these courses, it is apparent to me that they are tailored to the middle class. Each of these methods require a significant time commitment and the financial ability to pay for the classes (Lothian, 2008; Varner, 2015; Walker, Visger, & Rossie, 2009). This observation has been substantiated by research that has clearly identified prenatal class attenders as almost invariably being White, educated, and being partnered (Morton & Hsu, 2007; Nolan, 1998).

In Canada, parents living above the low-income cut-off of about $40,000 are more likely to attend health programs than those living below it (Public Health Agency of Canada, 2013). Communities marginalized by Indigenous status, immigration status, geographical isolation,

language, sexual identities, adolescence, and low socioeconomic status face barriers accessing in-person prenatal services (Chedid, Terrell, & Phillips, in press), ultimately contributing to prenatal health disparities (Muhajarine, Ng, Bowen, Cushon, J., & Johnson, 2012). Lothian (2008) posits that childbirth education is at a crossroads; change to traditional prenatal education practices is necessary in order to meet the needs of 21st century women and confront the challenges they face.

While not every method is readily accessible in all areas of Nova Scotia, particularly in rural communities, I believe it is fair to say that Nova Scotia women do have options in terms of formal and informal prenatal education, that is, if they wish, can afford, or feel comfortable accessing it. It has been widely documented that prenatal education is a service not all women choose to access, for example, in Ontario approximately only 25% of pregnant women participate in online or in-person prenatal education classes (Best Start Resource Centre, 2014). The province of Nova Scotia conducted its own research study, gathering information from women and healthcare providers to identify the prenatal education and support needs in the province (Nova Scotia Health Promotion & Protection, 2008). A total of 71 pre- and postpartum mothers participated in the study. Information was gathered through two waves of focus groups with pregnant and postpartum women to explore their postpartum education and support needs. Recruitment for the first wave took place through Family Resource Centres across the province, to increase the likelihood of reaching the women who live in "challenging circumstances" and would be less likely to access traditional prenatal education from Public Health Services (Nova Scotia Health Promotion & Protection, 2008, p. 3). The second wave of focus groups explored women's prenatal education and support needs in locations not previously covered in the first wave, as well with women who were more likely to access the services offered by Public Health.

Despite the efforts to recruit a diverse sample of participants, the report cautions that there are no guarantees that participants fell into either category. This is because, other than age, no other demographic information (highest level of education, income, marital status, etc.) was collected (2008).

The report, published in 2008, presented the strengths of the delivery method of in-person education and support, and presented areas of standard practice that could be improved. The results state that the method of in-person prenatal classes was shown to be effective at building women's confidence and knowledge about pregnancy, and alleviate fears of the birth experience (Nova Scotia Health Promotion & Protection, 2008). However, the results also indicate that the traditional method of prenatal education provided by public health could stand to be improved, as the in-person classes may not be utilized by the women most in need, defined as the "women who may benefit the most," such as women who live in challenging circumstances such as low income; information was medicalized, invoking fears about the birth process; and that the timing and location of classes was inaccessible or did not line up with the women's stage in pregnancy (Nova Scotia Health Promotion & Protection, 2008, p. 9). Although prenatal classes were meant to be available to all pregnant women, not all women choose to use these services. Due to declining enrolment in the in-person classes, the Nova Scotia Department of Health and Wellness made the decision to introduce a free prenatal education website, "Welcome to Parenting," as a means to replace the universal in-person prenatal classes traditionally offered by Public Health Services (Province of Nova Scotia, 2014). Since the implementation of Welcome to Parenting, Public Health has not released the numbers of women accessing this method of online prenatal education.

Prenatal Education: Challenges and Opportunities to Meet the Needs of Mothers

In the 1950s, prenatal classes in Canada taught expectant women skills in pain management for labour and birth in the institutional hospital setting (Best Start Resource Centre, 2013; Public Health Agency of Canada, 2009). Since that time, the underlying goal of prenatal education has evolved, now covering topics on pregnancy, labour and delivery, infant care, and family adjustment (Public Health Agency of Canada, 2009). However, even within Canada, the objectives, content, delivery, and processes of prenatal education vary considerably (Best Start Resource Centre, 2013; Nova Scotia Health Promotion and Protection, 2008). As such, this can pose challenges for evaluating prenatal education programs. It is important to state that in reviewing the literature, it was noted that prenatal education is poorly evaluated (Nichols, 1995), leading some researchers to question its value and utility (Gagnon & Sandall, 2007; Koehn, 2002; Walker, Visger, & Rossie, 2009). The lack of literature is noteworthy as it indicates a lack of value of mothering experiences by society and health funding bodies.

Despite the variability in delivery and evaluation of prenatal education programs, there is literature that supports the practice of prenatal education. For example, some studies have found a correlation between participation in prenatal classes and a reduction in a woman's risk of acquiring toxoplasmosis (Ernzen, 1997); an increased likelihood of arriving at the hospital at the appropriate time of active labour (Ferguson, Davis, & Browne, 2013); increased rates of vaginal births among women with low-risk pregnancies (Stoll & Hall, 2012); and increased breastfeeding initiation and duration rates (Ickovics et al., 2007; Su et al., 2007). While these measures are important, there are fewer research articles that study the less quantifiable outcomes, such as satisfaction with the birthing experience and feeling confident in early parenting practices (Nova Scotia Health Promotion & Protection, 2008). The gap between

16

tangible and intangible outcomes in the literature validates how some health outcomes appear to be less important than others (Aston et al., 2016).

Research by Aston et al. (2014; 2014a) indicates that during the postpartum period, mothers' feelings of increased confidence, normalcy, and reduced stress were health outcomes that both the mothers and PHNs who were interviewed believed to be critical, and to be just as, if not more, important as the physical health indicators. Similarly, in the prenatal period, support and empowerment are key components for women to feel prepared for the mothering role. The WHO (2016) reports that a positive pregnancy experience is defined as respecting physical and sociocultural norms, ensuring a healthy pregnancy for both mother and baby, safe transition from labour to delivery, and achieving a positive mothering experience, which includes maternal self-esteem, competence, and autonomy.

Koehn's (2002) literature review of childbirth education and preparation classes examined 12 published studies on the outcomes of childbirth preparation education. The results of her review indicated that the studies had methodological differences and flaws, that no conclusions could be made about the effectiveness of childbirth preparation (Koehn, 2002). The Cochrane Collaboration conducted a systematic review which evaluated studies on the effectiveness of individual or group prenatal education for childbirth or parenthood, or both (Gagnon & Sandall, 2007). The systematic review included nine published articles on randomized control trials of formal group and individual prenatal education programs that included information about pregnancy, childbirth, or early mothering/parenting (Gagnon & Sandall, 2007). The variables upon which the studies were evaluated include: knowledge attainment, sense of control, competencies related to infant care, and labour and birth outcomes.

This systematic review concluded that the effects of general prenatal education for either childbirth education or parenthood, or both, are inconclusive.

While prenatal education programs are recommended to parents to prepare them for birth and parenthood (Gagnon & Sandall, 2007), available programs do not always meet parents' needs (Nova Scotia Health Promotion & Protection, 2008; O'Sullivan, O'Connell, & Devane, 2014, p. 33; Svensson, Barclay, & Cooke, 2006). A meta-synthesis of qualitative studies examining the transition to early mothering found that women are largely unprepared for their new role as mothers, and experience feelings of being overwhelmed (Nelson, 2003). The continuous demands of infant care (McVeigh, 2000) and feelings of tiredness, fatigue, and isolation (McQueen & Mander, 2003; McVeigh, 2000; Rogan, Shmied, Barclay, Everitt, & Wylie, 1997) can all threaten a new mother's confidence in her ability to parent (Barnes et al., 2008, p. 34).

Findings from a research study conducted in Australia by Barnes et al. (2008) report that despite receiving formal prenatal information and support, the first-time mothers who participated in the study reported feeling ill-prepared for managing either the physical or emotional experiences of early mothering. The study suggests that in order to better support women's learning needs:

> Alternative pedagogical approaches that emphasize women's experience and facilitate peer support may result in women feeling more prepared for the mothering role, with the idea of a *continuing conversation* about mothering and infant care as the basis for new approaches (Barnes et al., 2008, p. 39).

The relational aspects of prenatal care and the peer support provided by an experienced mother to a new mother can be a valuable method of information sharing. However, institutionally and

socially, the idea of 'woman as expert' is often not considered or is rejected. There is evidence of this in the discourse of prenatal education in Canada where women are taught about mothering from healthcare providers that flows in a more unidirectional manner from doctor or nurse to mother (Ernst, 1994; Lothian, 2008; Walker, Visger, & Rossie, 2009; Zwelling, 1996).

It is important to acknowledge the apparent shortcomings of prenatal education, and to investigate the possible reasons for why the current approaches may not meet the expectations, needs, and/or preferences of mothers. In Morton and Hsu's (2007) ethnographic study of childbirth education in the United States, their findings indicate that prenatal education is a "cultural phenomenon, with deeply embedded values held by childbirth educators regarding the nature and importance of information, scientific evidence, and consumer choice" (p. 36). The historical influences on prenatal education, including the medicalization and institutionalization of birth appear to have greatly impacted women's perinatal experiences. As a result of the institutionalization of childbirth, the majority of first-time mothers today may never have held a newborn infant, seen a woman breastfeed, or be involved in the care of a young infant. They may have read about birth or seen portrayals of birth on television and in movies, but these women are unlikely to have helped another woman in labour and been present at the delivery of her child, experiences which are very different from those of their great, great grandmothers (Nolan, 1998). Professionals who are in the position of providing formal education to women about childbirth and early parenting have replaced the first-hand education women once received through their attendance at births of other women. The impact of this shift is seen in the development of curriculums and learning objectives with a focus on scientific and medical knowledge and other priority areas as determined by the educator (Morton & Hsu, 2007), with

little to no input from lay perspectives or lived experiences, such as women participants who are preparing to deliver or adopt an infant.

In 2008, the SOGC created the *National Birthing Initiative*, urging the federal and provincial governments to commit to maternity as a health care priority. The report stated that federal leadership is needed in seven key areas to ensure Canadian women and their babies receive appropriate care throughout the perinatal period. The first priority, entitled "Listen to women's voices" called for healthcare providers and policy makers to do just that (SOGC, 2008, p. 15). By ensuring that the needs and expectations of the mothers are heard, healthcare providers can provide maternity care that is patient-centered (SOGC, 2008). Despite the emerging literature on prenatal needs, and the call for healthcare providers to provide maternal-centered care, there is a lack of understanding of where women access prenatal education and support in Nova Scotia, as well as what women need and want. This study explored how, where, and why first-time mothers experienced prenatal information and support, providing valuable Nova Scotia specific results.

Accessibility and Equity

As part of a critical appraisal of the practice of prenatal education, issues such as accessibility and equity are relevant to the discussion. As previously discussed, in Canada, maternity care is regulated by the provincial government (SOGC, 2008). Within each community, province, and territory, the delivery and processes of prenatal services looks quite different as it depends on the strengths, weaknesses, and commitment unique to the government that must balance human resources, funding, and demographic issues (SOGC, 2008). Because of this, inequities in access to quality maternity care exist, which are particularly felt by the women who already face difficult life circumstances (SOGC, 2008). Seventeen years ago, in the year

2000, the Public Health Agency of Canada (PHAC) offered national guidelines on family-centered and newborn care that are still relevant today. Concerning the education of parents and caregivers, the guidelines state that "any educational endeavour must take into account people's differing learning styles, the time available for learning, the content, the skills to be shared, and the financial and personnel resources available" (Public Health Agency of Canada, 2000, p. 2.31). To help women make informed decisions, healthcare providers have a responsibility to ensure that women and their families have sufficient information. Women and their families can learn through a variety of strategies, including: prenatal classes, written material, books, community support groups, telephone help lines, and audiovisual materials (Public Health Agency of Canada, 2000, p. 2.31). However, these strategies are futile if women neither need or want them. As the SOGC (2008) recommends, it is crucial to listen to mothers' perspectives, and in doing so, healthcare providers will create spaces that are accessible and informed by the women who use these services.

It is important to consider women's experiences of inclusion or exclusion that might affect accessibility to prenatal education and support. Given the recent changes made to the delivery of prenatal education in Nova Scotia, issues of accessibility to technology are particularly relevant to the discussion. In order to register for online prenatal classes, both a computer and internet access are necessary, this is a significant barrier for women who have access to neither. One research study raises another concern that even if women have a computer and internet, the use of the online prenatal education resources is limited to the woman's literacy levels (both reading literacy and computer literacy) (Nova Scotia Health Promotion and Protection, 2008). While the decision to switch from in-person prenatal classes to online affects the whole province, this decision is especially impactful for women living in rural Nova Scotia.

In some rural communities, high speed internet services are not available, creating another barrier for women's use of online resources (Nova Scotia Health Promotion and Protection, 2008). Best Start Resource Centre (2013) located in Ontario describes online prenatal education as promising in its potential to reach a large audience, however, more evidence is required to determine its effectiveness. With that in mind, what is of particular concern is the fact that in Nova Scotia the only universal method of attaining prenatal education and support from Public Health is through online education. It is evident that some women are predisposed to challenges of access and equity in terms of maternity care, which may create experiences of exclusion from programs and services, possibly impacting their ability to attain prenatal information and support.

However, online may be a preferred delivery method of prenatal education for some mothers and families. Research from different parts of the world demonstrate that the internet is a common source of prenatal information and support for expectant women (Gao, Larsson, & Luo, 2013; Lagan, Sinclair, & Kernohan, 2010; Lima-Pereira, Bermúdez-Tamayo, & Jasienska, 2011; Narasimhulu, Karakash, Weedon, & Minkoff, 2016). Approximately 87% of Canadian households have internet access (Canadian Internet Registration Authority, 2017), supporting the notion that online health promotion strategies can be a practical and accessible delivery method of prenatal education, with the potential to reach more expectant parents, including those who are often underserved.

In a recent research study, Canadian government-based websites and online prenatal education "e-classes" were evaluated to determine the provision of accessible, inclusive, comprehensive, and evidence-based prenatal health promotion (Chedid et al., in press, p. 1). Results of this evaluation found that while online e-classes and federal, provincial, and public-

health based prenatal education websites are sources of comprehensive and evidence-based health information, capable of reaching a large and diverse audience, the researchers identified major gaps in online prenatal health promotion. These gaps included: "the availability of bilingual and multilingual resources, representations of non-traditional families, including LGBTQ parents, and lack of specialized pregnancy information targeted to women living with disabilities and communities of Indigenous peoples and immigrants" (Chedid et al., in press, p. 8). Neuhauser and Kreps (2003) note that online health communication is most effective when targeted groups respond to key messages emotionally as well as logically, and when the information resonates with individuals' social and/or life contexts. Because many pregnant parents are turning to the internet for prenatal information and support, online health promotion strategies must reflect the diversity of its audience. Chedid et al. recommend that governments, community organizations, and public health departments enhance the content of online prenatal health promotion classes to ensure the resources reflect the diversity of Canadian expectant parents.

Decision Making in Public Health

There have been recent structural changes in the way health care is organized and delivered in Nova Scotia. Recognizing that universal prenatal education programs rests with the provincial government and is delivered by Public Health, a review of the literature concerning institutional practices that impact services and programs like prenatal education was conducted. It was noted in the literature that Canada's Public Health infrastructure has weakened, which has had an impact on the system's ability to promote and protect the health of all Canadians (Guyon et al., 2017).

My experience as a public health nurse provided me with an inside look at how programs and services are structured and delivered in the community setting. Whereas hospital and physicians' services have been governed at the federal level since the mid- to late- 1950s, public health was decentralized from the beginning so the responsibility for service organization and implementation rested with the provinces (Stamler & Yiu, 2012). Over the last number of decades many Canadian provinces have introduced regional health authority structures responsible for health care delivery (Stamler & Yiu, 2012). This approach strives to integrate most or all health services into a single organization. In Nova Scotia, there has been recent changes and major restructuring to the delivery of health care services, including public health. From the previous nine health authorities across the province, health care services are now being delivered by four zones under one umbrella structure, known as the Nova Scotia Health Authority (Province of Nova Scotia, 2015). The province reports that this provincial approach to health care will result in improved coordination of resources and expertise (Province of Nova Scotia, 2015), however this remains to be seen. Several prominent Canadian public health academics and physician leaders have raised concerns about provincial centralization of Public Health. In a 2017 editorial, Guyon et al. refers to the centralization that has occurred in both Alberta and Nova Scotia, stating: "following these reforms, numerous PH [public health] experts now practice as senior PH leaders in departments of health, and thus struggle to protect scientific independence from political interference…" This raises important points to consider when exploring how public health decisions are made, as political factors may have greater influence than evidence-based and scientific information.

It appears that regardless of the changes made to the delivery of health care services, over the last number of years, "the public health infrastructure in Canada has been severely eroded"

(Stamler & Yiu, 2012, p. 27). The former director of the World Health Organization, Lee Jong-Wook stated that while there have been significant improvements in medical sciences, "there is a sense that science has not done enough, especially for public health, and there is a gap between today's scientific advances and their application: between what we know and what is actually being done" (WHO, 2004, p. xi). In a report prepared for the Federal, Provincial and Territorial Advisory Committee on Population Health, several findings identified system issues within public health, which included: discrepancies among provinces and regions in their capacity to address public health issues; a significant lack of resources and funding; and development of public health policies without "reference to specific data" (Sullivan, 2002, p. 1319). These system level issues can often lead to other challenges with regard to decision making about public health programs, services, and policies.

There is a growing body of literature that focuses on the role evidence has in the development of public health programs and policies. Results of a systematic review conducted by Liverani, Hawkins, and Parkhurst (2013) found that consideration must be given to the specific kinds of evidence used at different stages of the policy making process, as well as the ways in which different political and institutional practices contribute more or less to appropriate evidence utilization. Decision makers at "the institutional and government policy levels are increasingly aware of and value the need for research evidence, yet they face other competing factors (public opinion and pressures, fiscal restraints) when making policy decisions" (Stamler & Yiu, 2012, p. 166). While frontline public health professionals can often appreciate the balancing act required of decision makers, the effects of institutional decisions can make a significant impact on the services available to their clients, and a lack of transparency with regard to decision making can be frustrating.

In healthcare systems with limited resources, evidence of the effectiveness of services provided is necessary for decision making, and there is a need for policy makers to implement changes in healthcare systems based on scientific evidence (Brixval, Axelsen, Anderson, Due, & Koushede, 2014). The National Collaborating Centre for Methods and Tools (NCCMT) (2012) has created a model for evidence-informed decision making in public health to provide direction for healthcare providers and policy makers with public health decisions. The components of the model are: research; public health resources; community health issues, local context; and community and political preferences and actions. Ultimately, decision makers must draw on their explicit and tacit knowledge and expertise of public health in order to incorporate all the relevant factors into the final decision (NCCMT, 2012). For prenatal education programs, relying solely on scientific evidence can be problematic because the results of the systematic reviews and meta-syntheses conducted to date give inconclusive evidence on the effectiveness of prenatal education programs and measureable health outcomes (Gagnon & Sandall, 2007; Nelson, 2003). Utilizing a tool such as the one developed by NCCMT, where decisions include community preferences, encourages policy makers to factor in the voices of the community. To that end, the proposed qualitative study will uncover the as yet unheard experiences of women accessing prenatal education and support in HRM, and will support the development of policies and programs that reflect the needs and preferences of expectant women.

Summary

The recent change to the delivery method of universal prenatal education in Nova Scotia will have implications for pregnant women's experience of prenatal education and support. The shift to the exclusive, online method may be creating new and different experiences for first-time moms. It is evident in both the literature and the Canadian health care system that women's

voices concerning how to attain prenatal education and support are missing from the dialogue. This research study was timely, as it provided a deeper understanding into how new mothers experience prenatal education and support since the change in the delivery method of universally provided prenatal information. The results of the study will not only be useful to Public Health, but also to primary healthcare providers and community agencies, such as family resource centres, who work diligently in their practice to best support mothers and families in the perinatal period.

Chapter 3: Methodology

This chapter presents an outline of the underlying principles that will guide this research and why a qualitative methodology using feminist poststructuralism and discourse analysis was chosen to guide the study. Discussion will also include a description of the study setting, participant selection, data collection procedures, data analysis, ethical considerations, and methods to ensure rigor and trustworthiness.

Poststructuralism

Prior to starting my Master's degree, my understanding of research and nursing practice had been influenced by a positivist, linear way of thinking. Now, as a graduate student learning about critical social theory, reading texts by Cheek (2000) and Weedon (1997) on postmodern and poststructural approaches to research has resonated with me in their ability to address practice issues and inequities I witnessed as a registered nurse. My exploration of a poststructural approach to research has helped me to understand how this methodology can be used to influence and inform healthcare providers about aspects of mothers' realities of prenatal education and mothering. To aid my understanding of the poststructuralist framework chosen for this research study, it was helpful to explore the concepts of post-modernism and post-structuralism, and how they relate to one another.

The term postmodern was first brought to attention in the United States from architectural criticism, as a way to describe how artists and architects expressed themselves in their work (Lather, 1991). Originating in the arts community, postmodernism is now widely known as a historical concept and as "a descriptor for both a cultural aesthetic and a philosophical movement" adopted by academics and philosophers (Lather, 1991, p. 20). This philosophical movement served to challenge the governing structures that guide society and how reality is

28

represented in any form of writing or speaking (Cheek, 2000). Postmodern approaches reject the notion that realities of the human experience can be explained by one total truth or theory (Cheek, 2000). Instead, "postmodern thought emphasizes the plural nature of reality", and that there are "multiple positions from which it is possible to view any aspect of reality, including health care" (Cheek, 2000, p. 5). This approach allows researchers to work within, yet challenge dominant discourses (Lather, 1991).

As I read about postmodernism and poststructuralism I have come to realize that there are many similarities between the two approaches. There is such a substantial overlap between the two approaches that some writers use the terms postmodern and poststructural interchangeably (Cheek, 2000). However, Cheek (2000) and Agger (1991) note that there are differences between the two approaches, namely in their "focus and emphasis" (Cheek, 2000, p. 6).

Both postmodern and poststructural approaches value plurality of thought and experience, and challenge the taken for granted aspects of reality (Cheek, 2000). With regard to their differences, Agger (1991) states that "poststructuralism… is a theory of knowledge and language, whereas postmodernism… is a theory of society, culture, and history" (p. 112). Whereby poststructural approaches tend to focus on the exploration and analysis of texts, with texts being any representations of reality in written, oral, or other format (Cheek, 2000). The way in which a text frames or represents an aspect of reality, meaning the underlying assumptions and practices that have been accepted as the norm, is of as much interest as what the text describes (Cheek, 2000). Poststructural approaches challenge the idea that language is a neutral, objective way of conveying reality. Rather, this approach exposes and examines language itself as being both constructed by, and constructive of, the social reality that it seeks to represent (Cheek, 2000, p. 40). To deconstruct texts, poststructuralists often refer to the work of French philosopher,

Jacques Derrida, who used discourse analysis to critique "humanistic discourses and their conceptions of subjectivity and language" (Weedon, 1997, p. 158). Attention is given to the participants' experiences and the associated meanings of these experiences so as to deconstruct dominant representations of participants' realities as well as to understand participants' subjectivity through how they make meaning from their experiences (Brown & Strega, 2005, p. 61). How discourse analysis, as a method of deconstruction, was used in this study will be discussed later in the chapter.

To summarize, postmodern approaches tend to be broader in scope, focusing on the cultural, societal, and historical aspects, whereas poststructural approaches emphasize the analysis of cultural and literary texts (Cheek, 2000). For this study, a poststructural lens was chosen to provide a guideline for understanding women's experiences of prenatal education, which has historically been absent from the discourse.

Feminism

To quote a well-known feminist theorist, hooks (2000) writes "Feminists are made, not born" (p. 7). As a woman in my twenties, my initial understanding of feminism was based on popular culture, and reading the work of contemporary feminist writer Chimamanda Ngozi Adichie. When I began work as a registered nurse providing nursing care in the homes of disadvantaged and marginalized women, I became more deeply invested in the feminist movement because of its focus on the oppression of women and issues of gender inequity. I was drawn to the idea that research using a feminist methodology could bring about change to the issues I was seeing in my nursing practice. After beginning graduate studies, my supervisor, Dr. Megan Aston, introduced me to feminist theorists such as hooks (2000), Butler (1992), Scott

(1992), and Weedon (1997). My understanding of feminism and feminist theory has since been influenced and informed by these scholars.

Given that the focus of the research was to explore women's prenatal experiences, gender was an important consideration and was attended to throughout the study. The focus of most perinatal programs is on mothers, infants, and families. The health needs of mothers, a predominantly female group, is a gendered issue that will be relevant to the research topic of prenatal education, and was appropriately analysed using a feminist lens that guided the study. Feminist theorists and researchers advocate for social change through critique and political action (Hall & Stevens, 1991). Feminist concepts that were used in the methodology of this research study included the social construction of class, gender, ethnicity, race, and other positions inherent in women's day-to-day lives (Gillis & Jackson, 2002).

Feminist theory is a critical approach to conducting research and can be applied to a variety of research methods. Many feminist researchers share the assumptions held by qualitative researchers and those who adopt a critical perspective, as many scholars believe that feminist theory emerged from critical social theory (Gillis & Jackson, 2002). Feminist research is not a research method itself, rather, researchers select the most appropriate method to answer the research question and apply feminist theory. Harding (1987) asserts that the chosen methodology should be consistent with feminist epistemology. The ontological position of feminist theory is one that is women-centered and grounded in women's experiences. Feminist theory contests the notion that there is one fixed truth and challenges the assumptions of knowledge as being positivist and deductive (Brown & Strega, 2005). The epistemology of feminist theory emphasizes the subjective nature of women's experiences, and accepts that there are multiple ways of knowing and being (Brown & Strega, 2005). The overall goal of feminist research is to

31

expose previously hidden female experiences and create a more equal representation of their

experiences (Lather, 1991).

A common feminist phrase is the personal is political (Aston, 2016). In Weedon's (1997)

book she writes:

> Feminism is a politics. It is a politics directed at changing existing power relations
>
> between women and men in society. These power relations structure all areas of life, the
>
> family, education, and welfare, the worlds of work and politics, culture and leisure. They
>
> determine who does what and for whom, what we are and what we might become. (p. 1)

Feminists are interested in the power relations present in women's experiences. The work of

French philosopher, Michel Foucault (1982), on the construction of power through regulated

communications can support the work of feminist scholars, as it can provide a way to analyze the

political and societal structures that oppress women. Included in Foucault's presentation of

power relations is the notion that those who are in a position of marginalization or oppression

can use their own power to challenge dominant discourses.

In this study, the methodology of feminist poststructuralism was used to explore how

first-time mothers experience prenatal education and support in Halifax Regional Municipality,

Nova Scotia, an area that has not been well researched to date.

Feminist Poststructuralism

As previously discussed, feminist theory can be applied to many research methods so

long as the methodology is consistent with the fundamental principles of feminist theory.

Poststructural theorists challenge feminist theorists who only focus on the individual without

attention to social context. For example, Scott (1992) writes that as feminist researchers,

attention must be given not only to "evidence of experience," but also "the historical processes

that, through discourse, position subjects and produces experiences" (p. 25). Feminist poststructuralism is characterized by the rejection of universality, truth, and top-down structures of power, and instead posits that realities are discursively constructed and that power is relational. It was a feminist poststructural approach that I chose to be the most fitting to address the study's research question as it allowed for the exploration of women's experiences of prenatal education in HRM, while uncovering meanings, values, and relations of power associated with their experiences.

Feminist poststructuralism (FPS) was chosen to be the guiding theory and methodology for all aspects of the research study. Feminist poststructuralism offers a conceptual framework for feminist research and practice as a way of building understanding about women's experiences with a focus on the relationships among language, subjectivity, social organization (processes) and institutions that create power relations within women's day-to-day realities (Weedon, 1997). Feminist poststructuralism challenges universally accepted and potentially hegemonic practices within the healthcare system (Aston, 2016; Cheek, 2000; Foucault, 1982; Weedon, 1997). Assumptions that are dominant within societal practices are based upon hegemonic beliefs and practices within socially and institutionally constructed discourses. For example, as birth in Canada became medicalized and institutionalized, so too did prenatal education. Since the 1950s, formal prenatal education has been an accepted and recommended service for expectant Canadian women. Formal prenatal education in Canada is underpinned by an authoritative medical discourse whereby healthcare providers, such as doctors and nurses, act as gatekeepers of information (Nolan, 1998; Zwelling, 1996). In reviewing the literature, it became evident that women's voices concerning their needs about the delivery of prenatal information and support are missing in our Canadian health care system. In this study, Foucault's

33

concept of power relations was used to explore how women use their power to navigate and negotiate current prenatal education practices in Nova Scotia. This will be discussed later in this chapter.

Feminist poststructuralism enabled an exploration of how participants' experiences were socially and institutionally constructed through different subject positions such as gender, race, sexual orientation, class, socio-economic status, and culture. In doing so, this study aimed to examine issues of access and equity for women in relation to prenatal education programs and services. Additionally, Foucault's (1982) concept of power relations and Cheek's (2000) and Weedon's (1997) ideas about gender and discourse analysis were used to explore and analyze texts, where texts refer to any representation of reality, that create conditions of marginalization and oppression for women who seek information and support during the prenatal period (Cheek, 2000).

Language. Language is essential to feminist poststructuralism, as it serves as the common factor in the analysis of social processes, meanings, power, and individual consciousness (Weedon, 1997, p. 21), and is therefore an appropriate starting point for the discussion of the methodology (Aston, 2016). Weedon (1997) reports individuals assign meaning to experiences by using language in a variety of ways. Weedon (1997) asserts that basic to the principles of poststructuralism is the plurality of language and rejection of the notion of one fixed truth. This is contrary to the hegemonic conservative discourse of language, which ascribes to the "essential fixity" of the human experience (Weedon, 1997, p. 80). Therefore, meaning changes depending on the setting or context. In order to understand how fixed beliefs, norms, and truths have been adopted in society, they need to be questioned.

Poststructuralism focuses on language, and particularly on how language is constructed, which resonates with feminist understandings of how language can influence women's lives (Strega & Brown, 2005). To deconstruct meanings of language, feminist poststructuralism helps one focus on issues of power by referring to the historically and socially specific discursive production of meaning (Weedon, 1997). In this sense, "language consists of a range of discourses which offer different versions of the meaning of social relations and their effects on the individual" (Weedon, 1997, p. 82). For this study, it was important to understand what 'education' and 'learning' meant to women as they prepared for the role of mothering. Their perspectives adds to the understanding of how this language influenced their experiences.

Discourse. Discourse, or the ways of thinking and speaking about aspects of reality, is an important concept to FPS (Cheek, 2000; Weedon, 1997). For Foucault, discourses create discursive frameworks that give priority to certain ways of thinking about reality and dismiss others (Cheek, 2000). A discourse consists of a set of common assumptions which, although they may be taken for granted as to be invisible, provide the basis for conscious knowledge (Cheek, 2000, p. 23). It is through discourse that power is realized in the realities of our words, thoughts, and actions. The same is true for prenatal support and education programs, which is represented by a particular discourse characterized by meanings and actions. The actions are adopted in daily practice, thus becoming the accepted norms, regulated by governmental and institutional structures and social processes. The practice of prenatal education is one that is premised on a historical and scientific/medical discourse, which has assumed dominance in contemporary understandings of women's preparedness of childbirth and parenting. It has had the effect of marginalizing alternate understandings or experiences of prenatal education practices, such as informal knowledge sharing, which at other times in history had been a common and dominant

practice. This study offered the mothers who participated an opportunity to explore their unique experience and how they negotiated power in their day-to-day lives as women and mothers.

Relations of power. Foucault is a theorist who, while not associating himself with any particular theoretical category, has been consistently linked in the literature with postmodern and poststructural perspectives (Cheek, 2000). For Foucault, much of his work focused on how societal institutions exerted power and controlled people's lives. He understood power as "operating in all levels and directions of society in an extensive network of power relations" (Cheek, 2000, p. 26). The concept of 'power as relational' is a "revolutionary way" of looking at and being in the world (Aston, 2016, p. 2253) as it challenges the traditional and dominant understanding of power as being oppressive and unidirectional (Cheek, 2000). It requires an appreciation for the differentiation between 'power' and 'power relations.' Power relations enable the exploration of people's interactions with one another and how people both are influenced by and can have influence over social and institutional contexts (Foucault, 1982). As opposed to thinking of power as being oppressive or unidirectional, it should be understood as a mechanism to negotiate or mediate one's circumstance (Aston, 2016).

Governmentality is a concept that Foucault developed through his analysis of the relationship between knowledge and power, and State regulation (Cheek, 2000). He wrote "power relations have been progressively governmentalized, that is to say, elaborated, rationalized, and centralized in the form of, or under auspices of, state institutions" (Foucault, 1982, p. 793). For Foucault, this meant that government employs strategies and techniques that authorities in society use to shape what a population believes: "the population is both subject and object of government" (Cheek, 2000, p. 27). With Foucault's conception, the power exerted by governmentality is often subtle, where the affected individual is influenced by powerful

discourses (Cheek, 2000). Formal prenatal education classes, both online and in-person, is an example of governmentality where a program was developed with guiding principles, a learning plan, and learning objectives with the overall goal of ensuring safe labour and delivery, as well as effective parenting (Lothian, 2008; Morton & Hsu, 2007; Walker, Visger, & Rossie, 2009).

Subjectivity and agency. The concepts of subjectivity and agency are integral to understanding Foucault's ideas of power relations and that power is relational. Subjectivity refers to an individual's ability to be conscious of self in order to be able to work with, through, and against social discourses that have an influence over everyone (Butler, 1992). When applied to this study, subjectivity provided a particular understanding of how women perceived themselves in relation to their environment and the supports, programs, and services they did or did not choose to access. The use of FPS challenged the socially constructed concept of mother as a neutral subject (Weedon, 1997) and analyzed the discourse of mothering. One principle of feminist research is that women are experts of their experiences and therefore a valid and credible source of data (Gillis & Jackson, 2002). As the research participants will be aware of their own personal, social, historical, gendered, and cultured position, the researcher recognizes that they have the potential to question, challenge, and possibly change their own circumstance. Butler (1992) asserts that being positioned as a "subject" means one actively participates in their own social constitution and therefore has subjectivity. Agency assumes that everyone has power, the potential to control their lives, and make meaningful change (Butler, 1992; Cheek, 2000; Weedon, 1997). This assumption offers a shift in power dynamics, enabling those who have not been traditionally in control of power to feel empowered (Foucault, 1982; Weedon, 1997).

Summary. It was the change to the delivery method of prenatal education classes from in person to online that sparked my interest in this research topic. In reviewing literature on the

historical, political, and institutional context within which prenatal education is situated, I became interested in questioning the practice on a deeper level. Both the literature review and my professional experience lead me to believe that the views and experiences of expectant women, the intended audience of these education classes, have been excluded from the conversation. More than descriptive research, a feminist poststructural approach provides a deeper analysis to explore what influences have shaped the practice of prenatal education and to uncover women's hidden experiences.

FPS guided by Cheek (2000) and Weedon (1997) provided a way to explore the state of prenatal education and support practices in Nova Scotia that aim to be responsive to women's needs. It is because of the possible disconnect between services offered and women's needs that an opportunity to critically question the practice and reconstruct an alternate subjectivity arose. FPS offers a framework to guide research that explores and critiques power relations found within institutions (Weedon, 1997). The application of feminist poststructuralism facilitated understanding women's experiences of prenatal education as this framework offered an explanation for where an individual's experience may come from, why it is contradictory, and how and why it can change (Weedon, 1997). In this research, understanding the experiences of women who will be first-time mothers as they navigate the prenatal and early postpartum period offers new ways of understanding how healthcare providers and communities can best support expectant women.

Research Design

This section details the design and approach I used to explore first-time mothers' experiences of prenatal education and support in HRM, Nova Scotia. As previously presented, this qualitative study was conducted using the theoretical framework of FPS. In the proceeding

sections I will provide an overview of the participants (sample size and recruitment), and the sources of data

Participants/sampling. As the research study sought to explore first-time mother's experiences with prenatal education and support, a particular group of women was recruited. Purposive sampling was used for the recruitment of participants who were willing to share their prenatal experiences. This approach involved seeking out "groups, settings, and individuals where and for whom the processes being studied are most likely to occur" (Denzin & Lincoln, 2000 p. 370; Gillis & Jackson, 2002). For example, participants were recruited through strategic advertising at local community centres, hospitals, and online social media pages directed toward pregnant women and/or mothers who have recently given birth.

Eligibility criteria. First-time mothers in the Halifax Regional Municipality who were within one year of adopting or birthing a live baby were invited to participate in the study. The decision to interview mothers in the postpartum period was made to allow women to experience early mothering, and identify how the prenatal education and support they did or did not receive made an impact on their postpartum experiences. Interviewing mothers within one year of birthing or adopting their baby ensured timely information was captured about their prenatal experience.

Study recruitment was inclusive of trans people and gay men who adopt, so long as potential participants self-identified as a mother. To be eligible, participants must have been able to speak and understand English. Participants had to have been 18 years of age or older, and also consented to being audiotaped during the interview. As the focus of the research study was to explore women's experiences of prenatal education and support specifically in Halifax Regional

Municipality, and due to the fact that data was collected through face-to-face interviews, potential participants must have lived in HRM at the time of the study.

Recruitment. In August 2017, I received approval for this study from the Research Ethics Boards at the IWK Health Centre and the Nova Scotia Health Authority (NSHA) (protocol #1022613) and subsequently began the process of participant recruitment.

Feminist researchers embrace the diversity of women's lives and experiences and attempt to include women of varying social class, culture, race, ethnic group, and so on in their sample (Gillis & Jackson, 2002). Multiple recruitment strategies were employed in an effort to recruit a diverse group of mothers with varying experiences. The primary recruitment tool for this study was the recruitment poster (Appendix A), which I designed using Microsoft PowerPoint. The poster included information about the study and the nature of involvement. Included in the advertisement was the fact that participants would be reimbursed for their time with a $25 gift card for a local grocery store. Potential participants were directed to contact the researcher via telephone or email if they were interested in participating or wanted more information about the study. Because the posters were created in electronic format and able to be shared online, the study was advertised on local social media pages that had a target audience of pregnant women, new mothers, and families. The posters were also professionally printed and were delivered to locations across the HRM that new mothers visit, including family resource centres and public libraries.

As I was interested in recruiting participants to the study who had recently delivered or adopted an infant, I initially began my process for participant recruitment with the IWK Health Centre, as it is located in the city of Halifax and provides primary health services for women, infants, and families. Through communication with a Media Relations Specialist at the IWK

(Appendix B), I described the study and requested that recruitment posters be uploaded to the IWK Health Centre's Facebook and Twitter pages. This was an important method of participant recruitment as the majority of participants reported they found out about my study through social media.

Sample size. The intent of a qualitative study is not to generalize, but to provide in-depth explorations of the particular phenomenon being studied (Patton, 1990; Pinnegar & Daynes, 2007). I had proposed to recruit six to eight first-time mothers to participate in the study. I was fortunate to have no difficulty recruiting participants- within a few hours of advertising the study I had mothers contact me expressing their interest in participating. Potential participants contacted me by either leaving a voicemail or emailing me and indicated their interest in the study. I would follow-up with these individuals by telephone to provide more information about the study, answer any questions they may have, and confirm their interest in participating. For interested participants, I used a pre-screen questionnaire (Appendix C) to establish participants' eligibility for the study. Once their eligibility was confirmed, we arranged a time and location for the interview. After only two days of advertising the study, I had eight participants confirmed to participate in the study. While I had more than eight mothers contact me to inquire about the study, the first eight mothers that met eligibility criteria were recruited to participate in the study. These eight mothers were considered enrolled in the study after they provided written informed consent to participate in the interview (Appendix D), which was completed face-to-face at the time our interview.

Participants. A total of eight first-time mothers participated in the study. All participants identified as heterosexual and lived with their partner. The majority of participants identified as Caucasian, and one mother identified as First Nations. The average age of participants was 32

years (range 28 to 36 years), and the average total household income was $107,500 (range $40,000 to $250,000). Participants' highest level of education ranged from high school diploma to master's degree.

Data Collection

      Interviews. Face-to-face, one-on-one interviews were conducted and followed a semi-structured research guide of open-ended questions to guide a discussion that facilitated an exploration of participants' experiences of prenatal education and support (Gillis & Jackson, 2002). While I did use an interview guide (Appendix E), the topics covered in each interview with the mothers were not exclusive. Having a semi-structured interview guide is consistent with a feminist theory methodology (Brown & Strega, 2005) as it allows for an open conversation between interviewer and participant, guided gently by open-ended questions (Rubin & Rubin, 2005). Feminist researchers endeavor for a "horizontal relationship" between researcher and participant (Gillis & Jackson, 2002, p. 285) and therefore the interviews were conducted in a conversational, non-hierarchical manner. Interviewing using a feminist perspective involves listening to the participant's experiences from their perspective and in their own words so to understand their experience (Hesse-Biber & Piatelli, 2007). I assured the participants that there were no right or wrong answers, as they were the experts of their experiences. Mothers were encouraged to provide as much detail about their experiences as possible.

      My approach to interviewing participants was similar to how I would conduct a home visit with a new mother when I worked as a public health nurse. Ultimately, I wanted mothers to feel comfortable sharing their experience with me, recognizing the fact that they have never met me and the fact that it may be an experience they have never shared before. To gain the participants' trust, I was an active listener, encouraging the participants to speak freely. I also

attended to the manner in which I spoke to the participants as well as my nonverbal

communication and body language throughout the interview so that participants felt comfortable

and trusted. In addition to the interview guide, I would probe participants for further details

about their experiences, for example, I would say "you said you felt _____ can you tell me more

about that?" or, "how did ___ make you feel?"

The setting for the interviews occurred in mutually agreed upon locations that were

accessible to the participant and myself. I ensured that the interview space could accommodate

infants, to allow for the mother to attend with her baby if she desired. Participant interviews were

conducted over a period of four weeks between August and September 2017. The length of

interviews lasted on average just over an hour in length. Each interview was audio-taped (with

participant consent) and was transcribed verbatim by myself. All identifying information was

removed from the transcripts, and pseudonyms were used. I transcribed each interview

immediately after they took place so that I maintained a level of familiarity with the interview.

Reflexivity. Reflexivity is defined as the critical thinking and reflection that is necessary

to examine the interaction between the researcher and the data during analyses (Gillis & Jackson,

2002). According to Hesse-Biber and Piatelli (2007), reflexivity is an integrated practice of

feminist researchers. In this process, the researcher explores personal feelings, values,

assumptions, and motivations, which may influence the study (Gillis & Jackson, 2002). The

topic of the research study is one of personal and professional interest to me, having practiced as

a PHN prior to beginning my Master's degree. I have first-hand experience working with

mothers in the pre- and postpartum period as well as working within the institutional structure of

Public Health Services. These past experiences may shape the findings, the conclusions, and the

interpretations of the data (Creswell, 2013), therefore it is important to engage in reflexive

journaling through notes and memos to situate and organize my thoughts. As this study explored women's prenatal experience, it is also important to note that I am a nulliparous woman in my mid-twenties. My exposure to pregnancy, childbirth, and postpartum has occurred through my experience as a student nurse on the labour and delivery, NICU, and postpartum units, as well as my experience visiting new moms in the community as a PHN. I acknowledge my position, knowledge and past experiences may or may not have had an influence on data analysis. I engaged in reflexive practice through constant reflection and discussions with my thesis supervisor and committee members.

Data storage. The interviews were audio-taped and transcribed verbatim by myself. The data consisted of the audio-recordings of the interviews, electronic transcriptions of the interviews, and hand written field and reflexive notes. Creswell (2013) offers principles for safe storage of qualitative data, some of which are relevant to the proposed study, such as: creating back up computer copies; use of high-quality audio recording equipment; and, systematically organizing the information gathered from the data collection process. For this study, data was stored on a secure server with saved back-up copies. Electronic data was password protected as per the IWK Health Centre and Nova Scotia Health Authority Research Ethics Boards. All hard copy documents related to the study were kept in a locked drawer in a locked office of the supervisor.

Data Analysis

"Discourse refers to a way of thinking about and understanding a topic through language, which creates a social definition and knowing of the subject" (Aston, Price, Kirk, & Penney, 2011, p. 1189). Discourse analysis was used to deconstruct the meaning of personal experiences of the participants and how they relate to social and institutional beliefs, values, and

practices. Guiding my use of discourse analysis was the philosophical work of Foucault (1982) and feminist scholars, including Cheek (2000) and Weedon (1997). Power is understood as relational and complex and that all people have the capacity to use their power versus a more traditional understanding of power as oppressive (Foucault, 1982). To examine personal, social, and institutional construction of beliefs, values and practices, during data collection and analysis I attended to participants' use of language, meaning and relationships. This method of data analysis allowed exploration in an in-depth manner of how and why first-time mothers accessed or did not access prenatal education programs, and support services. The resulting discourse provided new understanding and has the potential to influence practice.

There is not one way to conduct discourse analysis (Cheek, 2000), however concepts from poststructuralism and feminism provided a guide for analyzing the discursive representations of first-time mothers' experiences of prenatal information and support. Aston (2016) outlines five stages, or key components, of discourse analysis which served to guide the analytic process of this study, they are: 1) identify important issues, 2) applying beliefs, values, and practices, 3) social and institutional discourses, 4) responding to relations of power, and 5) subjectivity and agency (p. 2262).

I transcribed the interviews verbatim myself as this provided an opportunity for me to familiarize myself with the data. Following transcription, I read the interview, line-by-line, and highlighted the quotations I believed represented an important issue. I searched for moments when mothers talked about how they understood prenatal education, what they valued and believed about prenatal information and support, the underlying discourses informing the identified issue, how mothers negotiated relations of power, and what their practices and experiences meant to them. The first interview transcript was analyzed separately by myself and

my thesis supervisor with a follow-up meeting to discuss findings. I noted that when Dr. Aston and I met to review our individual analysis, the issues that we both identified as being important were similar. Emerging themes were compared and discussed for specific meanings and include the concepts of beliefs, values, practices, subjectivity, agency, language, meaning, relations of power, and discourse. I independently analyzed the transcripts of the remaining interviews; however, my thesis supervisor continued to provide on-going support with the analysis process as once I completed each interview analysis I met with my supervisor to review and discuss the findings and my interpretations. Themes were organized using the Microsoft Word computer program. I shared the analysis findings with members of the thesis committee, which proved to be a helpful activity. Their input added clarity to the meaning of the data and stimulated new ideas and perspectives about the research findings. This meeting supported critical discussions about the emerging themes and led to consensus about study findings.

Participants were not involved in the analysis of study findings; however, other methods were used to enhance the accurate representations of their perception of experiences. As various scholars (Lincoln & Guba, 1985) have described it, member validation is an ongoing process throughout a qualitative project. "Researchers informally engage in member validation every time they seek clarification for or elaboration of meaning and intention from the people they interview, or check out their evolving interpretations of the data they collect" (Sandelowski, 1993, p. 4). In this study, as a strategy to ensure accurate representation of participants' stories and transparency of their perception of experiences, clarifications were sought frequently during interviews, to validate their accounts. The incorporation of verbatim quotes throughout the analysis also serves to authenticate and instill participant's voices into the text, and enhance the accurate representations of their perception of experiences.

Trustworthiness

The criteria for data analysis to ensure trustworthiness in this study was, credibility, transferability, and dependability (Lincoln & Guba, 1985). Rigor and trustworthiness was maintained through accurate transcriptions of the in-depth interviews, and the use of memos and notes. Credibility involves the researcher accurately representing what the participants shared during the interviews (Gillis & Jackson, 2002). Credibility was attained in a collaborative partnership with my supervisor, Dr. Megan Aston who has extensive expertise with FPS and discourse analysis. Regular meetings and frequent communication with Dr. Aston verified the effectiveness of the research procedures and to confirm the ongoing analysis. The methodology of feminist poststructuralism provides a form of analytical accountability and therefore formal member checking is not necessary. Because the voice of participants is analyzed using discourse analysis, the researcher is expected to step back and allow the meaning of the words and context of participants to lead, followed by researcher interpretation and interpretation of the reader. Transferability is concerned with how the data applies to other settings, contexts and groups (Gillis & Jackson, 2002). With regard to transferability, it is important to note that consistent with the principles of poststructuralism, language is viewed as plural and rejects one fixed truth or meaning. Weedon (1997) states that "this does not mean that meaning disappears altogether" (p. 82). The findings of this research study are not generalizable; however, I will invite readers to make associations between elements of the study and their own experiences with prenatal education. Transferability was ensured through comprehensive descriptions, in-depth interviews, and quotations in the study publication to allow for readings to assess the appropriateness of the findings to other settings. Dependability refers to maintenance of quality throughout the research process, in both the "stability and trackability of changes in the data over time" (Gillis &

Jackson, 2002, p. 216). Dependability was established by keeping an audit trail of the decisions and rationale related to all components of the research process.

Ethical Considerations

Inherent in all research involving human beings, is respect for persons, concern for welfare, and justice (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, 2010). This research study on women's experiences of prenatal education and support involved human participants, as such there were strict guidelines that had to be followed. The ethical components of the research study ensured the three core principles of the Tri-Council Policy Statement were adhered to.

Prior to beginning the study, ethical approval was sought from IWK Health Centre and Nova Scotia Health Authority Research Ethics Boards. Once ethical approval was granted, I began the process of participant recruitment as previously described. I followed the process of free, informed, and ongoing consent. Prior to beginning the interview, participants received information on the purpose of the study, time commitment, who may participate, and the risks and benefits of the study. This research study endeavored to explore women's experiences with prenatal education and support. Having a baby and mothering can be a positive, exciting, complex, difficult, and emotional experience. It is was anticipated that women will have a range of experiences, some of which may be positive, and some may be negative. The study posed minor risk to participants. It was possible, that if a participant has had a negative perinatal experience, the interview could have evoked difficult emotions and memories. To prepare for that, I created a list of healthcare providers and services who participants could contact following the study if they felt they would benefit from further discussion or debriefing. Although there

were no known individual physical benefits to the study, the discussion between the participant and myself might have validated or supported decisions of mothering practices.

Participants were given a written letter with the above information. The letter was written in lay language at a grade seven literacy level. Before the interview began, I read this letter to all participants and verified the participant's understanding of the nature of being involved in the study. I allowed time for participants to ask questions. Evidence of consent was obtained through a signed consent form, which all participants signed before the interview began, verifying that they have agreed to participate in the research study.

Based on the ethical principle of respect for persons, confidentiality of the participants will be of top priority (Gillis & Jackson, 2002). While anonymity could not be guaranteed, it was conveyed to participants that their participation in the study, along with personal information and other potential identifiers will be kept confidential. I labeled the transcripts with a pseudonym and removed any identifying information from transcripts and reports.

I iterated that participation in the study is voluntary, meaning that the participants agreed to be a part of the study out of their own free will and without any coercion (Gillis & Jackson, 2002). As a gesture of thanks and as a remuneration for their time, all participants were given a $25 gift card to a local grocery store. Creswell (2013) supports this practice as it helps to create a researcher's reciprocity with the participants. In accordance with Dalhousie University and IWK Health Centre policy, each participant also signed a form at the time of the interview indicating they had received the gift card for participating in the study.

It was reinforced to the participants that they were free to withdraw from the study at any point before or during the interview. They could physically leave the interview, or they could refuse to answer any question. The participant would not be disadvantaged in any way if they

withdrew from the study. If the participant presented to the interview location, regardless of whether the interview was completed or not, the participant would have received the $25 gift card.

Participants were told that they had up until one month after they had been interviewed to withdraw their data from the study. The time period of one month was chosen as an appropriate length of time because once analysis of the interview transcripts has been started it would be difficult to remove the embedded analysis of the interview data. Prior to the start of the interview I verbally reconfirmed the participant's consent to participate and to audio record the interview session.

Chapter 4: Findings

This chapter presents the findings and interpretations based on analysis of the interviews I conducted with eight first-time mothers. The overall question that this thesis sought to address was: **How do first-time mothers experience prenatal education and support in Halifax Regional Municipality, Nova Scotia?** In my endeavour to answer this research question, the focus and intent of each interview was to explore participants' prenatal experiences by asking open-ended questions about the information and support mothers received in their pregnancy. What emerged from the interviews, however, was the fact that mothers wanted to discuss more than their prenatal experience. Pregnancy was an important moment in time for all participants, yet becoming a mother encompassed so much more than the prenatal information and support they received, and mothers wanted to share other meaningful moments with me. For example, many participants used the interview as an opportunity to also share their childbirth and/or postpartum experiences. This is an important finding in and of itself as I believe it demonstrates how becoming a mother (from pregnancy to childbirth to early parenting) can altogether be an overwhelming life experience. While the language used to describe these moments attempts to separate these experiences into distinct time periods- "pre", "intra", and "post" partum- the experiences mothers have shared with me demonstrate how there is continuation and overlap between and among these moments in time. For that reason, you will note while reading this chapter that even though I concentrate on mothers' prenatal experiences (as it is the focus of this thesis) there is a continuity that flows into the postpartum period and I have purposely chosen to integrate several of the relevant childbirth and postpartum experiences mothers shared. Bringing to light the connections that exist between prenatal, childbirth, and postpartum has implications for prenatal education programs, and will be explored further in the discussion (Chapter 5).

As the participants each shared stories of their unique lives as mothers, it was apparent that there were similarities among their experiences of prenatal information and support, and becoming a mother. The application of discourse analysis provided a clear understanding of how mother's subject positions had been constructed through institutional and social discourses. The analysis will be organized by themes: 1) perceptions of prenatal advice: from fearmongering to empowering; 2) negotiating beliefs, values, and practices: hot topics in pregnancy and postpartum; 3) mothers' perinatal choices, expectations, and experiences; and, 4) first-time mothers' need for social support. Each theme will be presented through quotations and examples from the women's experiences which have inspired the themes.

Perceptions of Prenatal Advice: From Fear Mongering to Empowering

For all participants, being pregnant and becoming a mother for the first time was an important and life-changing moment. While a few participants had gathered some information pre-pregnancy, most participants reported that it was after they found out they were pregnant when they started to engage in the practice of seeking prenatal information and support. To become more knowledgeable about pregnancy, childbirth, and mothering practices, participants described seeking out information and support from friends, family, and care providers, as well as books and online websites. The information mothers received evoked different reactions- there were mothers who perceived some information and advice to be fearful, and other mothers believed the advice to be empowering. This theme will explore participants' perceptions of the prenatal information and support they received and the dominate discourses that shaped the representation of and understandings about prenatal advice.

In the absence of personal experience, participants often reported having difficulty constructing meaningful expectations of labour and delivery and childbirth. Several mothers

reported that they had difficulty preparing for the significant moments of childbirth and/or becoming a mother, describing it as "unknown" and "nerve-racking". Mothers' construction of childbirth as "unknown" is indicative of shift in who holds authoritative knowledge in Western societies about this practice. In this study, mothers expressed a desire to consult with 'experts' to understand experiences that historically, women themselves understood better (Lothian, 2006).

Participants' struggle with the unknown was also described in the context of fear, with some mothers reporting they felt "scared", "terrified", or "nervous" related to childbirth or how they would adapt to their new role as mother. Many mothers explained that they wanted to "be prepared for anything" during childbirth, and therefore did extensive research during their pregnancy to find out as much information as possible. While the practice of looking for information and support was generally helpful, as it provided answers to mothers' questions, some mothers expressed the fact that the abundance of information, stories, and advice outlining what pregnant women should and should not do, as well as the various complications that can occur, contributed to their existing stress.

While there are varying cultural beliefs, values, and practices about childbirth, sometimes these beliefs and values can transcend culture. As one author described it: "in no known culture in the world is the pivotal life event of childbearing treated with indifference or neglect" (Callister, 1995, p. 327). Indeed, all cultures view childbirth as a profound moment, worthy of celebration, however there are other constructions of childbirth that exist within cultures and societies as well. What emerged in this study, was that mothers also experienced feelings of fear and nervousness as they spoke of preparing for birth. As the present study was situated within Western society, with a dominant medical system, this had an impact on how mothers experienced and perceived prenatal information about birth.

Through my analysis of interviews, it became evident that in their search for prenatal information and support, some mothers experienced feelings of fear. One key discursive framework was identified as shaping mothers' perceptions of prenatal advice, which was a discourse of fear. The role fear has on women's perceptions of pregnancy and childbirth is a phenomenon that has garnered growing interest and research over the last 20 years; researchers and clinicians have taken note of this development in Western societies and as a result, there is a collection of international literature and research studies to support the emergence of this discursive frame in this study (Fisher, Hauck, & Fenwick, 2006; Hall et al., 2009; Hildingsson, Nilsson, Karlström, & Lundgren, 2011; Toohill, Fenwick, Gamble, & Creedy, 2014; Zar, Wijma, & Wijma, 2001).

In this study, mothers experienced the discourse of fear in different ways. For one mother, Karen, this discourse consequently reinforced the social construction of childbirth as a scary and fearful experience. Karen experienced this discourse through the abundance of "bad" stories she heard in her pregnancy, which influenced her beliefs and expectations of becoming a mother and made her feel "terrified". When Karen was asked about her experience being pregnant, she responded:

> It was definitely nerve-racking for sure because you don't know what to expect as a first-time mom. And you always hear… everybody always tells you the worst stories so you don't really hear the positive. So, going into it, of course you're terrified not knowing what to expect, but it ended up being a lot easier than I thought anyways.

Karen joined an online Facebook moms group to connect with other moms and talk about issues they were experiencing. While it was helpful to know what was "normal," her participation in this group did create worry too. Karen shared:

> It was [helpful] yeah, but I found it a little scary, too. Because a lot of people would post the bad things that were happening and miscarriages and stillborns and stuff like that. And, of course, when you're pregnant that's the last thing you want to think of. And, of

course, those groups kind of, the more people post of it, you're like, "oh my god, is this going to happen?" So, it creates more worry but at the same time, there's some things that were more reassuring. So, it kind of worked both ways, I guess.

It appeared to me that different points of reference were used to contextualize Karen's fears, from the unknown stemming from her subject position of "first-time mom" to internalizing the "bad stories" she heard from other mothers. Karen's participation in an online Facebook mom group contributed to her fear which manifested itself in the way she developed "inaccurate perceptions of personal risk of negative birthing experiences and outcomes" (Fenwick, Toohill, Creedy, Smith, & Gamble, 2015, p. 242).

For mother Heather, her preoccupation with the potential for pregnancy complications was embedded in her previous personal experience of having had two miscarriages. As she shared her experience with me, it became apparent that her two previous miscarriages influenced the decisions she made while she was pregnant with her son. The history of having miscarriages loomed over Heather, and the way she questioned practices during her pregnancy seemed to indicate that she felt as though the two previous losses were a result of something she had done. Concerned that she could have another miscarriage, Heather questioned most everything she did during her pregnancy – from hot baths to caffeine to the types of food she could eat. Heather said, "So, everything was "am I doing this right?"

Heather's fear related to her anticipation of negative experiences directed the type of information she sought and endorsed. To address some of her concerns and questions, Heather did go online in search of information. And while this was beneficial in some cases, some of the information she found provoked new fears and was sometimes more harmful than helpful, stating:

> I read that you can't take hot baths when you're pregnant and then I was like "well, I've had hot baths when I was pregnant, so is my baby going to have spina bifida?" … So, sometimes it's helpful but sometimes it does more harm than anything…

Heather's fear and concerns about having another miscarriage were valid, and grounded in her previous experience of having two miscarriages. Heather's experience introduces a discourse of risk that exists around pregnancy (Lupton, 1999). Heather described how the threat of miscarriage caused her stress, especially given her history. Thus, Heather sought to contain and control risk as much as she could by modifying her diet and certain practices. Her experience demonstrates how the personal disciplinary practices (Foucault, 1982) that expectant mothers undertake and believe they must undertake disempowers them and invokes fear concerns for the well-being of their unborn baby.

Given the fragile nature of her pregnancy, Heather preferred information and support to come from her physician as opposed to online. Heather valued that her doctor was someone familiar and knew her history- it wasn't advice from "a hundred moms." Having the support from her doctor gave her the confidence to make choices that were best for her during her pregnancy, which sometimes went against what she read on the internet.

Just as Karen and Heather shared how their experience searching for advice online contributed to their fears and concerns about complications, other mothers also commented on how the source of prenatal advice (stories, information, support, etc.) can influence mothers' feelings and perceptions. Several mothers made it clear to me that they valued prenatal information that was validated by research, which was informed by the value these mothers placed on science and evidence-based information. Often, mothers attributed their need for prenatal advice to be scientific to their educational background and professional careers. These factors frequently informed the strategies for where these mothers sought out information and

why they avoided sources of prenatal advice they deemed to be not credible. Sonia said: "…

Google can be your worst and best friend, especially, like I said, I have a science background …

I like things that are scientific articles with citations and journaling and, you know, actual

sources, credible things like that." Anna shared a similar sentiment, saying: "I think with my

background I know not to look at certain things. I like science-based information." These quotes

exemplify how some mothers aligned their beliefs with discursive medical books and websites

for prenatal advice, believing this information is more credible. Sonia shared the following

suggestion to other new mothers looking for prenatal information:

> …If you're concerned about your pregnancy in general, you know, go to the [hospital] sites, seek out medical people and medical stuff. Just don't go and read, you know, whattoexpect.com threads or whatever because, you know, if you have preeclampsia or whatever… seek out actual medical things, go to the [hospital] sites, you know, stuff like that. Just don't read to read 'cause you're gonna put yourself in preterm labour 'cause you're gonna be terrified.

Sonia recognized that the internet ("Google") is a useful place to get prenatal information if

mothers access reputable hospital and "medical" websites; at the same time, she noted that

caution must be given to some of the information found online, particularly social media

websites and forums or "threads", as information from those sources are primarily mothers'

accounts of their unique, personal experiences and not generalizable. Like Karen and Heather

had experienced, Sonia recognized the potential for prenatal advice from non-credible sources to

contribute to a mother's fear. Tiler was another mother who endorsed information from websites

that were created by reputable organizations, saying "they [credible websites] would just give

you basically the facts and things that could happen instead of just personal opinions." It is

important to note that neither Anna or Sonia nor Tiler indicated they were opposed to receiving

information about possible complications, but that they preferred that this information come

from reputable sources as opposed to vicarious stories as told by mothers with whom they had no personal connection.

The mothers who participated in this study were all exposed to or experienced a discourse of fear around pregnancy, childbirth, or mothering, but how they reacted was different. All mothers negotiated relations of power and used their agency to challenge the dominant discourse. For some participants, this was evident in their decision to establish a support network of mothers who shared similar beliefs, values, and practices as they did. For example, one way Karen countered the effects of fear-provoking information she read online on Facebook was for her to seek out positive stories. Karen relied on one of her friends who had recently delivered a baby for positive and affirming information and support. Listening to her friend's positive experiences helped to calm her fears and worries as she prepared herself for childbirth and becoming a mother. She appreciated that her friend focused on the positive and did not create unnecessary worry by sharing the negative or "bad" stories. When talking about her friend, Karen said:

> She wasn't one of the ones that was telling all the bad stories. She would tell the good and leave out the bad. You know, she wouldn't tell me the bad ones, she'd only tell me, you know, the decent ones.

Karen believed there was an overwhelming amount of "bad" stories and stories that go into detail about how things can go wrong, so when her friend shared "good" stories she appreciated that it made her feel less afraid.

Anna's experience is different than the experiences of the mothers who perceived prenatal advice as fear provoking, as Anna believed the prenatal information and advice she received was empowering. Anna searched for information and support through multiple means to prepare herself for childbirth and early parenting. Her preparations included physically ensuring

58

her body was strong and ready for childbirth, but also acquiring information she believed would

help inform and support a healthy delivery. Because she believed in the importance of being

well-informed about pregnancy and birth, she sought out a wide variety of resources to ensure

she was making decisions that aligned with her beliefs and values. She attended in-person

prenatal classes, a workshop on pain management strategies for labour, in addition to seeking out

information from online websites, family, friends, and healthcare professionals. By

recommendation of her sister, Anna watched a video about the different directions labour can

take. When watching the video, she maintained a degree of skepticism about its truth as it was

created by a naturopath and fell outside of the scientific and medical discourse she preferred.

While Anna promptly recognized practices she would not do, like taking herbal remedies, some

of the information did resonate with her beliefs and values concerning induction, epidurals, and

Cesarean sections. Anna said:

> I took it with a grain of salt knowing who was doing it. So, my sister actually said, "you
> know, not all this in here is probably what your speed is, it's not my speed, but some of
> the information is interesting about the spiral- the funnel of going in that direction, the
> funnel of going in this direction for your labour." It was by a naturopath out of the States,
> her last name is Brown I think. And I think that's what she does, is she does a lot of birth
> support. But, she also talked about stuff that I wouldn't do. I'm not going to take herbs
> and things like that. I'm not aware of what they do.
>
> …You have an induction and then the pain is so unbearable because your body just has
> all this extra oxytocin and it's just like pow, pow, pow and you can't even get a grip on
> your contractions that you end up asking for the pain meds. And then, the pain meds
> could slow down the baby and the heart rate and then you end up having forceps or you
> end up having a C-section anyways… It wasn't really fear mongering; it was good for me
> to ask the questions of "what is the incidence?" "If I get induced what is my probable
> chance of having a C-section?"

The video introduced Anna to the different paths labour can take and the possible ramifications

of each. She did not believe the information in the video was intended to purposely or needlessly

instill in her a fear of childbirth- as this was not her response. Instead, this video empowered

Anna to learn about these interventions in the context of her geographical area. The video gave

her some in-hand information to ask healthcare providers about statistics for interventions like

induction and C-section.

For mother Tiler, she believed that books, compared to websites, provided "a lot more

detailed information when it came to the actual birthing part… what could possibly happen and it

was very detailed." While Tiler did want to "be prepared for everything" she shared that some of

the information she read caused her to feel scared. She said, "I can remember reading a part

where if the baby got stuck in the birth canal… I was praying that didn't happen. That was a

scary one to read." However, what she read in the book was slightly misleading and out of

context because, like Anna, Tiler sought out more information on what she had read and realized

it was not a common occurrence. She said: "it [online resource] actually had numbers, like

percentages, so it was a little bit more calming 'cause it's not something that [happens often]."

After Tiler had delivered her baby she realized that while she was pleased to have had prior

knowledge about medical interventions like induction and epidural, as she had to have both in

her labour, she also would have wanted to have known about complications like vaginal tearing.

Tiler shared:

> The only thing I didn't get much information about until I actually got home and
> researched it myself, was how to take care of a tear and stuff. I actually had to google
> that… All I was told was I had a second-degree tear and I knew nothing about that.

The experience Tiler shared with me reminds me of the purpose of prenatal education, which is

to provide expectant women with information about childbirth and postpartum in an effort to

prepare them for these upcoming experiences. The risks associated with childbirth today are few,

yet mainstream prenatal education (books, websites, healthcare providers, etc.) have a duty to

inform women of these potential complications. The intent of sharing information about

complications isn't to scare mothers- it's to inform and prepare mothers for this possibility.

Tiler's example led me to the realization that within all the prenatal information she received, she

focused on the complications and risks- things like induction, assisted deliveries, and the baby

"getting stuck" in the birth canal. And yet, while she reported feeling scared after learning about

those complications, Tiler said she would have also wanted to have known about the

complication of vaginal tearing. So, even though she felt "scared" because of the information she

received, she believed it was important information to have. This leads to the question of why is

information about complications fearful for some mothers? This will be explored in the

discussion (Chapter 5).

For Anna, the knowledge she had going into labour was empowering- she knew what she

was and was not comfortable with. She was aware that some women take medication or have

interventions in their labour, not fully understanding the effect they will have. For her, not being

informed would be a "scary" situation. Anna challenged the assumption that women lose control

in childbirth. She reacted to the discourse of fear of childbirth, which she termed "a very real

thing", by questioning practices like induction and C-section and creating a plan to have a

delivery that aligned with her beliefs and values.

> So, I do know people have told me anecdotally their situation that was like "I didn't
> really know what I was getting." Which to me, is a little scary- that situation- because if
> you're overwhelmed and you have a bit of a fear of delivering, which I think is a very
> real thing, you're probably going to say yes to some stuff that you may not in a clear,
> conscious mind, or if you knew ahead of time probably what the roll off would be.
> I did know what kinds of interventions and I did my birth plan ahead of time… well
> "plan", loosely a plan of kind of like we talked about what ideally and what, you know,
> I'm okay with.

Anna valued and believed in utilizing her pregnancy as a time to prepare for childbirth. She used

her knowledge and understanding of "the spiral of labour" to ensure that her delivery would not

"spiral" in a direction she was uncomfortable with. Anna acknowledged that some women

experience a fear of childbirth, however this was not the case for her. She negotiated what she knew about childbirth to develop a plan for how she envisioned her labour unfolding. The culmination of Anna's preparations was when it was time for her to deliver her infant, as she reported feeling "strong" and "mentally prepared" and "focused". Additionally, she felt "very powerful" in her labour.

Summary. Throughout the interviews, it emerged that experiencing feelings of angst and concern was a common and ongoing struggle for many of the mothers in my study. Upon closer examination of this phenomenon, it became evident to me that participants experienced a discourse of fear when exposed to certain prenatal information and support. Many participants commented that prenatal advice was, or had the potential to be, fearful. The mothers shared examples of how the information they received prenatally contributed to their feelings of stress, worry, and fear about pregnancy, childbirth, and mothering.

In this study, how prenatal advice conveyed certain understandings of the reality of pregnancy, childbirth, and becoming a mother is of as much interest as what the prenatal advice conveyed (Cheek, 2000). Findings from this theme demonstrate that the source of prenatal information- whether it be books, healthcare providers, friends, family, or online websites- can be influential to how mothers perceive this information. Mothers paid close attention to the source of prenatal information- several mothers spoke of differentiating between sources to determine its credibility. Participants shared that information found online from unregulated websites like Facebook groups, blogs, forums, and threads had the potential to provoke fear. On the other hand, mothers spoke positively about the information and support received from healthcare providers and friends in relation to reducing feelings of apprehension about labour and birth.

Certainly, not all mothers in the study felt scared because of the prenatal advice they received, in fact, for mother Anna, the prenatal information and support was empowering. All the mothers' approaches to dealing with or being exposed to fear supports Foucault's belief in people's agency to challenge their circumstances to create change so that they are making decisions about how they experience their lives. For example, Karen sought out positive birth stories from her friend- someone she knew and could trust. In Heather's case, her past experiences of having miscarriages directed the prenatal information she sought and endorsed. Recognizing the information found online from "other moms" was contributing to her stress instead of being informative, Heather placed more weight on advice provided to her by her physician, as she had an established relationship with her doctor. All the examples the mothers provided represent the agency they had within themselves to resist the discourse of fear through challenging the practices that contributed to them experiencing this discourse.

Negotiating Beliefs, Values, and Practices: Hot Topics in Pregnancy and Postpartum

Mothers in this study received a wealth of information during their pregnancy (elicited or not), from many different sources. Mothers' social networks (family, friends), care providers, and broader social environments and discourses played a role in constructing their beliefs, values, and practices about pregnancy, birth, and mothering practices. This theme will explore how mothers negotiated their decisions when they were exposed to and/or experienced judgement, "mom-shaming", and conflicting information and support in their pregnancy and early postpartum period. Mothers used moments of conflict, uncertainty, and tension as an opportunity to reflect on their own beliefs and values to make decisions about prenatal and postpartum practices that they were comfortable with. This theme demonstrates how mothers negotiated different beliefs, values, and practices related to 'hot topics' commonly discussed in

the pre- and postpartum period. I will show how mothers both engaged with and resisted the dominant discourses of exclusive breastfeeding and baby care. An interesting finding was that despite being "first-time mothers", some participants provided examples of how they challenged dominant discourses regarding breastfeeding and infant care to make decisions that they believed were best for them, which sometimes meant going against expert guidelines. In the departure from expert advice, participants demonstrated how they redefined and relocated the meaning of expertise as they negotiated decisions after the birth of their babies. Two subthemes were created from the analysis of the mothers' stories: 1) Exclusive breastfeeding discourses: Mothers challenge and embrace, and 2) Mothers shift the meaning of 'expert'.

Exclusive breastfeeding discourses: Mothers challenge and embrace. Breastfeeding was a common example that mothers reported experiencing strong prenatal messaging about. Because this topic was an obvious source of tension for some participants, I have chosen to explore how mothers negotiated different beliefs and values about exclusive breastfeeding as it helps to identify how and why mothers either challenged or embraced the dominant health care discourse of exclusive breastfeeding.

In the following quote, Giselle explained how she believed much of the information presented in the private prenatal education classes she attended was from the facilitator's "personal values" about infant feeding. The facilitator's values were evident to Giselle in the way she conveyed information about breastfeeding. Giselle's words were:

> …She [facilitator] said "there's no good reason you should ever have not to breastfeed." And that was really appalling for me because I have a friend with a mental health condition… And so, when you present health information like that you don't know who is sitting in the audience and who is going to have to make these difficult decisions and I firmly believe that can contribute to people's postpartum depression… You're saying something that's really value-based, like you personally feel there's no good reason but that's not actually true, some people have to decide "do I want to be mentally sound? Or do I want to feed my child breastmilk?"

Because breastfeeding has been scientifically proven to be the ideal source of nutrition for infants, healthcare providers often do encourage expectant women to plan to exclusively breastfeed their babies for the first six months. When talking to mothers about breastfeeding in this way, healthcare providers often refer to benefits of exclusive breastfeeding that have been substantiated by medical research studies, and in doing so, perpetuate the language and practices of exclusive breastfeeding discourses. Giselle's quote is an example of her interaction with a healthcare provider who constructed the practice of breastfeeding through a dominant health care discourse on exclusive breastfeeding that considers "breast is best". Giselle used her friend as an example of a mother who opposed the health care discourse by choosing not to breastfeed so that she could continue to take medication that supported her mental well-being. In making this decision, her mother friend challenged the discourse and the message that breast is always best. Giselle recognized that normalizing discourses, like health and medical representations of breastfeeding, have the potential to be perceived by mothers as oppressive and contribute to feelings of guilt, anxiety, and depression. While Giselle had personally chosen to breastfeed her baby, she recognized that for the mothers who couldn't breastfeed, or who chose not to, these breastfeeding messages could have significant negative impacts, like postpartum depression.

In my conversations with some participants about prenatal messages about breastfeeding, I recognized that exclusive breastfeeding can often be represented as a practice consistent with being a "good mother". Giselle summarized the representation of breastfeeding in this way:

> …A lot of the breastfeeding information out there is really, I want to say is really values-based by middle-aged white women who are kind of preaching to younger women, women of child bearing age that, you know, you have to do this and if you don't do this you're not a good mother. And not even really explaining how breastfeeding works in a concrete way.

I interpreted Giselle's quote as an example of how health care discourses of exclusive

breastfeeding can be based on essentialist understandings of women's bodies and their

connection to biological functions of breastfeeding. Giselle alluded to the fact that there is an

expectation that mothers will be successful in their endeavour to breastfeed their infants, despite

having little insight into "how breastfeeding works", giving the impression that breastfeeding is

an easy practice and will come naturally to mothers. If mothers are unable, unsuccessful, or

choose not to breastfeed, there is a concern that they will be viewed as "not a good mother." As

noted in Giselle's example, the association of breastfeeding with good mothering and therefore

formula feeding as bad mothering "has been argued to be a key characteristic of the dominant

infant feeding discourse" (Knaak, 2010, p. 349).

Giselle's quote resonates with the experiences of other mothers in this study. A few

mothers spoke about how they had planned prenatally to breastfeed their baby but in the

postpartum period their plans changed, for a variety of reasons, and decided to incorporate

formula into their infant feeding plan. When mothers were unable to fulfill their breastfeeding

expectations, they reported experiencing moments of tension. Here is Mavis' experience:

> …Man, people need to get over that, they really need to get over that. If your baby is eating, I really don't give a shit what you're feeding them… I mean, we never thought I would have a problem breastfeeding. We are part of a farm share; we eat pretty well 90% organic. I exercise regularly, I took all the prenatal vitamins- I did everything. Everything was perfect and my milk just didn't come in… I mean, people need to stop beating up on people because they're not either breastfeeding at all, or exclusively, 'cause it's like, "you try feeding a kid." I did everything, even now, I got the blue Gatorade on the go, I'm taking domperidone 'cause a side effect of it is it helps you lactate. I'm taking milk thistle, again, everything organic.

In her pregnancy, Mavis did not anticipate she would have difficulty breastfeeding. Exclusive

breastfeeding was a practice consistent with her beliefs and values of living a healthy, mostly

organic lifestyle. When her milk did not "come in" and she wasn't able to produce enough milk,

she renegotiated her beliefs and values about breastfeeding, and determined that it was more important to supplement breastfeeding with formula in order to meet her infant's nutritional needs rather than to continue struggling to exclusively breastfeed. While she was comfortable with her decisions about how she chose to feed her infant, she commented that she experienced criticism and judgement because she was not exclusively breastfeeding. It is interesting to examine Mavis' experience as it demonstrates how this discourse of exclusive breastfeeding can both support and challenge a mother's choice to breastfeed, but it also shows how a mother's perspective of this discourse can change over time depending on her circumstance. Mavis appeared to have embraced the health care discourse of exclusive breastfeeding prenatally but when she experienced difficulties with milk supply in the postpartum period she struggled with this discourse as she believed it was unsupportive of her decision to feed her infant a combination of breastmilk and formula.

There are many institutional and social discourses with differing beliefs, values, and practices when it comes to pregnancy, birth, and mothering practices. Infant feeding is just one example of the many contentious issues mothers must make decisions about. Depending on which discourse a mother aligns her beliefs with, she may experience judgement from those who have different beliefs and values. In my interview with Sonia, she referred to the judgement mothers experience as "mom shaming." Sonia said:

> But, oh my gosh, mom shaming is such a thing. It's not even fit. It's actually, it's horrible. It's horrible. I almost realize that I like my mom groups more 'cause there's some girls from the States and some girls from PEI, and some from Ontario. But, they're not judgemental at all. It's, you know, 'fed is best'. Okay, your kid's not crapping all over the house, who cares if you wear cloth or disposable? Like, who cares? I find some moms who are the same age as me that I went to school with, they're very judgemental.

It is important to note that it is not just healthcare providers who perpetuate the language and practices of the health care discourse on exclusive breastfeeding, it can be other mothers as well.

Sonia had planned to breastfeed her baby but decided to switch to formula feeding in the postpartum period, a decision she felt judged for by some mothers she went to high school with. She found a network of like-minded mothers online, who she found to be extremely supportive. The message "fed is best" does not position one feeding method as better than the other, instead it is inclusive of all mothers regardless of how they choose to feed their baby. I interpreted Sonia's statement "fed is best" as an example of her and her online mother friends responding to the dominant health discourse of exclusive breastfeeding by challenging the message "breast is best."

Karen was another mother who gave an example of how health care discourses on exclusive breastfeeding can challenge a mother's choice to breastfeed her baby. She reported that in her pregnancy she had developed a plan for how to feed her newborn- a combination of breastfeeding and bottle feeding- a plan she and her partner were both comfortable with. However, in the days that followed the birth of her baby she was made to feel as though this plan was not respected and unsupported by some healthcare providers at the hospital. Karen spoke of the tension she experienced in the hospital where she did not receive adequate support to help her follow the feeding plan she decided on in her pregnancy, she said:

> Our plan wasn't really taken into consideration there because we had that, you know, "we're fine feeding him formula, like we just want him fed." And they just pushed breastfeeding a lot. So, that was very stressful. And yeah, that made it so that, you know, I kind of wasn't wanting to breastfeed by the time we left…

Karen's personal beliefs and values around infant feeding differed from the healthcare providers at the hospital, who continued to push exclusive breastfeeding despite her resistance. This created a relation of power between the care providers and Karen. She anticipated that she would have control over how she would feed her infant, however it didn't feel that way to her, saying: "So, I didn't expect that once I stood up that it would still be pushed. I figured it would, it would

kind of be our choice in the end, but it didn't really feel like that." When asked how this

interaction with health care providers made her feel, Karen said:

> Yeah, it was definitely disheartening because you don't know as a first-time mom, but at
> the same time, you have the instincts too. So, you want to trust the medical professionals,
> but at the same time, you want to do what works best for you and what you think is going
> to be best for your infant. So, I just felt like our needs weren't really listened to, and more
> of an agenda was pushed. You know, you felt very vulnerable and just pushed into
> something that you weren't too sure of.

Karen recognized that she was being "pushed into something" she "wasn't too sure of" because

how the healthcare providers wanted her to feed her infant was different than the feeding plan

she developed prenatally. Karen experienced conflict between different discourses- the health

care discourse on exclusive breastfeeding and her personal breastfeeding discourse, each

meaning different things for her. It appeared to me that the healthcare providers were only

interested in pushing 'their' discourse of exclusive breastfeeding and did not meet her halfway to

explore both discourses, specifically what her personal beliefs and values about feeding were and

how they intersected with medical benefits and values of breastfeeding. Karen articulated that

because her beliefs and values about infant feeding were not attended to she decided to go

against the recommendations of the healthcare providers, which I interpreted as an example of

her agency to resist and challenge the health care discourse of exclusive breastfeeding. While she

self-identified as being a "first-time mom", a subject positioning sometimes associated with lack

of knowledge or confidence in mothering capabilities, she recognized that she ultimately had the

power and agency to make decisions about which feeding plan would be best suited to her and

her infant.

In contrast to the mothers' experiences that were just presented, both Anna and Veronica

were mothers who embraced the health care discourse of breastfeeding and felt supported in their

decision to exclusively breastfeed. Anna had the support of her sisters who both had experience

breastfeeding and Veronica had the support of a lactation consultant and public health nurse.

Both mothers credited their breastfeeding success in part to the information and support they

received from the individuals who had similar beliefs, values, and practices about exclusive

breastfeeding. Both Anna and Veronica commented on the fact that the "Loving Care" books

parents receive at the hospital after delivering their baby are good resources for new parents, and

while Veronica preferred the in-person, individualistic support she received from healthcare

providers, Anna believed that the Loving Care books, in particular the breastfeeding book,

should be made available prenatally. Anna stated:

> 'Cause when are you going to read this? I mean, you could if you really wanted to, but
> especially the breastfeeding one. If you want breastfeeding rates to go up you got to tell
> people. I mean, in my mind I was dead set I was breastfeeding, it's what I wanted to do,
> but people who are on the fence… Or, if they don't know that day 5, day 3 when your
> milk comes in- engorged- and you have these feelings that you don't understand what
> they are and you're super emotional. And then you might have some soreness and if the
> soreness lasts for a certain amount of time that's not normal, get your latch checked-
> people don't know that. So, you know, reading that ahead of time and having my sisters'
> experience breastfeeding…

Because Anna had prenatally embraced the health care discourse of exclusive breastfeeding, it

was a practice she was "dead set" on, she sought out anticipatory guidance from her sisters and

books to ensure she was prepared to meet her goal of exclusive breastfeeding. She recognized

that breastfeeding does not come without challenges, like engorgement and issues with correct

latch, but because she knew to expect them, in the postpartum period she was able to cope with

these short-term struggles. She believed that if other expectant women had 'the breastfeeding

book' prenatally and knew what to expect, the rates of breastfeeding would increase. Because

both mothers had positive interactions with individuals who embraced the discourse of exclusive

breastfeeding, Anna and Veronica felt supported in their decision to exclusively breastfeed their

babies.

Giselle provided another example of her exposure to prenatal information about breastfeeding she believed to be "subjective", which I interpreted as information that was based on another person's personal beliefs and values. She told me that it was important to her that she continue to be social after having her infant by attending her book club, the gym, and other social outings with her friends. At the prenatal class, she and her husband inquired about how he could feed their baby when she was out with her friends, mentioning specifically the use of a breast pump. Giselle shared the response of the facilitator:

> And she said, "no, she should never be without the baby, she should always be with the baby so that you can feed the baby just by breast not by bottle." And, in what way is that setting a woman up for success when you say she should never be able to get out the house or never be able to be separated from the baby?

Giselle went on to say:

> That's really scary because, you know, a woman needs to take care of herself too and say I wanted to have a social outing once a week to go see girlfriends and, you know, have the chance to connect without having my child there. That doesn't make me a bad mom, in fact, the thing we know about caregivers is that caregivers should have respite.

In these series of quotes, I interpreted them as another example of how the health care discourse on exclusive breastfeeding believes "breast is best" and that the use of a breast pump is regarded as a less acceptable method of infant feeding. Additionally, I interpreted these quotes as a demonstration of Giselle's power in her ability to recognize and challenge the facilitator's beliefs that perpetuated a social construction of mothering as sacrificing and infant-centric. Although mothers are encouraged to practice "self-care", this is generally positioned in such a way that the self-care will ultimately result in better mothering practices. Supporting mothers' desires and needs beyond the practices of mothering, such as social outings with friends and going to the gym for physical activity are simply not viewed as a priority or necessary within a health or social discourse that perpetuates the belief that mothers should sacrifice personal care for the

sake of their babies. Obviously, the beliefs, values, and practices of Giselle and the facilitator of the prenatal class differed. The facilitator saying that mothers should never be without the baby was "really scary" to Giselle, pointing out the fact that caregivers (mothers) need respite. This mother was strong and thoughtful, and instead of accepting the facilitator's word as truth, she challenged it, used her agency, and intentionally chose to pump in addition to breastfeed. This decision allowed her to continue to feed her child breastmilk while being able to connect socially with friends without always having to bring her infant.

While Giselle reported her experience of attending in-person prenatal classes was "awful", overall she said it did initiate important conversations to have with her partner, which clarified their beliefs, values, and practices about infant feeding and other parenting practices. She said:

> …The good thing that came from this was that actually it was so extreme and so awful that it led us to have all these conversations with each other that really led us to be like "yeah, no, this is our values and we both believe the same thing." So, we both believe I'm going to pump breastmilk and I'm going to go to the gym… And so, I found that it actually contributed to our relationship in a positive way because we were so appalled by this woman.

I believe Giselle's quote is reflective of how all mothers felt in this study when exposed to prenatal information and experiences that put into question their personal beliefs, values, and practices. When mothers in this study were exposed to prenatal information from a health care discourse on exclusive breastfeeding, it provided an opportunity for self-reflection and for mothers to clarify their personal beliefs and values and decide how they wanted to react to information from this discourse. For some mothers, like Anna and Veronica, it appeared that this discourse was supportive of their beliefs, values, and practices of exclusive breastfeeding and ultimately helped them to meet their personal breastfeeding goals. On the other hand, Giselle, Sonia, Karen, and Mavis' experiences indicate that advice influenced by a health care discourse

72

on exclusive breastfeeding has the potential for non-breastfeeding mothers to feel judged and criticised. This subtheme highlights how the dominant health discourse of exclusive breastfeeding can mean different things to each mother, and mothers often choose to seek out peers who embrace similar discourses, as they will be more likely to support rather than judge their decisions. As the next subtheme will show, when mothers' practices were at odds with dominant discourses and expert guidelines in the postpartum period, it provided an opportunity for mothers to renegotiate their beliefs and values and develop and trust the knowledge they had as first-time mothers.

Mothers shift the meaning of 'expert'. All participants in the study were first-time mothers and described themselves as being learners about information related to pre- and post-natal care. All mothers described seeking expert, scientific advice from health care professionals which demonstrates a desire to obtain information from a health or medical perspective. Often, mothers would identify these experts as being family physicians, obstetricians, public health nurses, and other professionals with a health background. Mothers commented that they relied on these experts in their pregnancy for prenatal information, but also for anticipatory guidance related to their upcoming childbirth experience and responsibilities of becoming a mother. By prenatally aligning themselves with a discourse that values expert knowledge, these women presented themselves as being responsible mothers making active and well-informed decisions about infant feeding and other baby care practices (Murphy, 2003). Mothers' reliance on experts in the prenatal period is an example of how they responded to the quiet coercions of disciplinary power (Foucault, 1977).

As the previous subtheme demonstrated, when mothers' personal beliefs and values were different than those of experts from dominant health discourses like exclusive breastfeeding,

73

mothers used it as an opportunity to consider what was important and meaningful to them. As this subtheme will show, when mothers spoke of how they negotiated beliefs, values, and practices after having their babies, the endorsement of expert advice did not occur as easily as it did prenatally. When participants spoke of their transition to the postpartum period, I noted that several mothers said that following the expert recommendations they learned in their pregnancy was not always feasible or appropriate for their situation, and so instead had to renegotiate their beliefs, values, and practices in order to make decisions that were more appropriate to their circumstance. Adapting expert guidelines to their unique situation proved to be a meaningful moment for several mothers in this study as it encouraged mothers to recognize they had intuitive or 'expert' knowledge about what was best for their infants. In so doing, mothers shifted the meaning of 'expert' to include the knowledge they had of their own baby.

I noticed that the birth of mothers' babies introduced a shift in how they negotiated relations with experts, like health care providers. While mothers still subjectively positioned themselves as a first-time or new mother, this subjectivity had new meaning, one where they had their own expertise of what was best for their infant. Mothers Karen and Heather both described situations where they had to renegotiate the information they learned prenatally from experts as the professional guidelines were not always realistic for how they cared for their babies. For example, while Heather was pregnant, she became familiar with policies and guidelines about infant care. In particular, she learned about sudden infant death syndrome (SIDS) and the recommendations set forth by experts to prevent its occurrence. She recognized the seriousness of SIDS and as a result was quite nervous, stating "it's terrifying, it's scary." She was aware of the current professional guidelines that were in place to help reduce SIDS, however, from her experience as a new mom, she believed they were difficult to follow. Heather said:

> …until you get home and, you know, your baby is screeching and there is nothing that you can do… A book tells you to swaddle your baby but when you leave the hospital they tell you not to swaddle your baby. So, what do you do? And they say keep your baby on their back, they can't go anywhere else besides their back. But, your baby doesn't like sleeping on their back, they like sleeping on their side. What am I supposed to do?

The safe sleep rules Heather learned about prenatally did not include information about what to do if she encountered difficulties when putting her infant on his back to sleep, and this was frustrating to her. While Heather appeared to value information from a medical discourse, like her physician for example, she believed she couldn't follow the expert recommendation in this situation as her son disliked to sleep on his back, preferring to sleep on his side instead. Ultimately, Heather had to renegotiate her beliefs about safe sleep and chose not follow the expert guideline on infant sleep, believing that in this case, going against the expert guideline was what was best for her son. Heather described this process in the following way:

> So, I listened, I read things and I listened to things but at the same time I kind of just… you get more comfortable as each day goes on and your baby wakes up every morning, they're still there. So, you're like "you know what, if this makes him happy and, you know, I'm not harming him"… You take what they say and you kind of make it your own.

She also said:

> I mean, if you listen to what everybody says you'd be terrified to do anything, you really would. But, you just have to, you know, figure out what he likes and what he's comfortable with and then, you know, adapt to your baby.

Heather described a way of negotiating and renegotiating different beliefs about baby care. Going against expert recommendations was stressful initially, however as each day went on she became more comfortable in her mothering abilities and knowledge, and with her decision to adapt an expert guideline to fit with her baby's needs. Heather's quotes and experience demonstrates a common theme where mothers spoke about how they continued to reassess and re-evaluate some of the decisions they made prenatally about baby care, as they discovered the

75

prenatal information they learned from experts was not always realistic when caring for the

unique needs of their babies. Mothers who participated in the study enacted their agency to

develop and trust their maternal knowledge to negotiate the many differences and similarities in

the prenatal information they received.

For Karen, after she delivered her infant she had to reconsider some of the decisions she

made prenatally about infant sleep practices as she discovered that her infant would only sleep in

the same bed as her and her partner. She looked into the risks and benefits of co-sleeping and

like Heather, also experienced feeling stressed about the possibility of SIDS. Karen said:

> There were some things that changed. We had our minds set up that we weren't going to do co-sleeping, that the baby would sleep in their own room. But, of course that didn't happen because we just needed sleep, so the only way he would sleep is if he was sleeping with us, so that changed. But, I also looked up, you know, the pros and cons of that too, and knowing if there's any risk of doing that, and stuff like that. And I think SIDS is a big thing, so I was researching SIDS and stuff like that. But, there's not really too much on that, it seemed, and that's what I found hard 'cause it basically said "don't do anything" like, for risk of SIDS. But, some things, you know, you have to kind of, you know, if the baby's cold you wanna make sure that they're warm so you have to put more clothes on them or a blanket on them. But, SIDS is like, "No, they have to have the lightest clothes on them and no blankets" and then the poor baby's freezing. Right? Stuff like that. So, yeah, it was, yeah, I don't know… I found that they make SIDS so, like, a big elephant that you don't know, you're just terrified all the time what's going to happen to the baby. So, I found that was the biggest stressor. So, once I could kind of separate from that, it was easier. I wasn't petrified of everything.

There are many guidelines set forth by experts on various aspects of baby care, which mothers

are encouraged to follow as they are evidence based. Karen commented though, that despite her

best intentions to follow the expert and evidence based guidelines on safe sleeping practices, she

believed she was unable to, stating that her baby would only sleep in the same bed as her and her

husband. Her decision to go against expert advice was not an easy decision for Karen, yet she

conveyed that she believed she had no other option. Within a Western socially constructed

discourse on mothering, there is often a belief that mothers should intuitively and naturally know

how to safely take care of their infants. When this discourse is positioned against a health care discourse that posits mothers require support and information it can create tensions through conflicting beliefs. When mothers are faced with contradictory messages, this can be frustrating and perhaps confusing. If their beliefs are different from either of the discourses that they compare themselves to, this could lead to feelings of uncertainty, guilt, and even fear that they are harming their baby. Or it could lead to a desire to challenge discourses that are different from their own. Mothers can also choose to agree with different discourses as they fit with their beliefs and make them feel confident with their practices. In Karen's situation, she did take into consideration the expert knowledge for some medical issues, like hypoglycemia, which she learned from NICU staff where her baby was admitted after birth. She appreciated this information as it was reassuring to her. In this instance, Karen perceived professional advice to be particularly helpful as she indicated that the NICU staff held a specialized body of knowledge about concerning issues like hypoglycemia and therefore influenced her decision to follow their advice. Additionally, because her infant experienced hypoglycemia while in hospital, Karen was exposed to a 'medical gaze' (Foucault, 1976) by the healthcare providers caring for her baby. The institutional involvement in that particular moment lent itself to Karen to engage in self-regulation and abide by NICU practices.

However, as demonstrated in the quotation below, for decisions Karen had to make at home- issues like infant sleeping practices, she enacted her agency to seek out information outside of the traditional health care discourse and make decisions that fit her beliefs and values, which went against healthcare provider advice. Karen said:

> We took what NICU had educated us on into consideration and stuff, but we just kind of went by what felt right for us, so we just, you know, we just went by what worked for us and what didn't work for us. And we're still navigating that, of course. But, yeah, we just went with what felt right.

While it is clear that Karen both accepted and rejected professional expertise, her decision to go against the recommendations of experts was not a simple dismissal. Rather, she sought to re-define the boundaries between circumstances in which professional/expert knowledge was or was not useful (Murphy, 2003, p. 453). When her baby was discharged from the NICU and she returned home, expertise related to baby practices like safe sleep was now based on her own knowledge and expertise of her baby. This knowledge and expertise rested in the people (in this case, Karen and her husband) who had day-to-day care of the baby (Murphy, 2003).

Mavis was a mother who said she often used her intuition to guide decisions in her pregnancy and in the postpartum period. These were decisions she felt comfortable with and instilled in her feelings of assurance that her baby "was okay." It was when she went against her intuition or "gut" feeling that she believed things went wrong. These were Mavis' words:

> Most of the time I listened to my gut about everything and I felt really good about him, I just felt like he was okay. Anytime anything came up I was like "okay, well, you know, as long as he's okay I really don't care, cut off my arm, I don't care." It was when people started making me second guess myself and stopped listening to my gut- that's when things went sideways.

In my interview with Mavis, she provided examples of moments where she experienced pressure from family and healthcare providers to align her mothering practices with dominant health discourses. This created tension for Mavis, as she considered her intuition and personal knowledge as a credible and reliable way of knowing. The evening before she was to be induced, Mavis' mother (an experienced nurse-midwife) and aunt questioned her about fetal movement; their questioning made her doubt herself, to the point where she said: "they basically had me convinced within ten minutes that my baby was dead." While she previously felt her baby moving and felt confident that everything was fine, she was made to feel as though something horrible had happened to her infant so went to the hospital for further assessment. The hospital

confirmed her initial intuition that fetal movement was appropriate and that her infant was healthy. Having her instincts recognized and respected by the healthcare providers at the hospital that evening was empowering for this mother, as she was able to demonstrate to her family that she did have knowledge about what was best for her and her baby.

In the early postpartum period Mavis had a similar experience of feeling caught between two discourses. Mavis reported feeling stressed because her baby wasn't gaining enough weight because her milk didn't "come in" and her baby had jaundice, all of which made breastfeeding difficult. Mavis described receiving conflicting information about how to feed her infant from each healthcare provider she spoke to, which left Mavis feeling confused. This was her experience:

> …I kind of felt like we were getting the hang of it and they told us to start supplementing with formula. Whereas the public health nurse was like "oh, I really think we should come out and do this and do that." And then I was like "ummm." And then when he did start gaining again at the end of the week when my milk finally came in, then she was concerned that he'd gained too much. And I was like "no, now you're just making me second guess myself."

When Mavis initially received the telephone call from the public health nurse who offered breastfeeding support, she thought it would be a helpful resource, however, the advice from the public health nurse went against the advice of the hospital and her maternal knowing. She was comfortable supplementing with formula, and was pleased that her infant was gaining weight. Instead of deferring to the public health nurse, this mother challenged this expert opinion as it was making her "second guess" her instincts that her baby was gaining weight appropriately.

Summary. There is evidence from the participants' stories that mothers were exposed to judgement, conflict, and tension when their decisions went against or opposed dominant discourses about prenatal and mothering practices. While mothers acknowledged and often referred to health professionals as experts, they also resisted their expertise and

79

recommendations if they felt disrespected or their needs weren't being appropriately acknowledged and addressed. Mothers' negotiated decisions using their personal beliefs and values, as well as their intuition. Mothers' subject position as "first-time mothers" played a role in how they navigated their pre- and postpartum experiences, where mothers would often balance information from healthcare providers with their own intuitive knowledge as mothers. Mothers' reliance on their intuitive knowledge was more evident to me when participants spoke of how they negotiated their values, beliefs, and practices in the postpartum period. In the shift from "anticipating" to care for their babies, "to actually doing so", participants relocated the meaning of 'expert', where their maternal knowledge of their baby was legitimate, and sometimes given more weight than the knowledge of healthcare providers (Murphy, 2003, p. 448).

Mothers' Perinatal Choices, Expectations, and Experiences

Globally, mothers are encouraged to seek out information during their pregnancy as the purpose of prenatal information is for expectant women to become knowledgeable about their pregnancy and to help prepare them for childbirth, care of the newborn, and adjustment to life with a baby. When I spoke to mothers about how they prepared for childbirth and early parenting, it was clear they saw themselves as responsible for planning and knowing about birth and baby care practices. Every mother I interviewed reported seeking out prenatal information and education from a variety of sources to prepare for birth and early parenting. From the mothers' descriptions, it was evident that all participants spent considerable effort educating themselves and that most expected to make birthing and parenting choices based on that knowledge. Despite their prenatal planning and research, several mothers reported feeling unprepared for perinatal experiences like childbirth and adjusting to their new role of mother. Recognizing the information they collected prenatally did not prepare them like they had hoped,

some mothers in this study decided to share their experiences in-person with friends and online through Facebook posts so that other soon-to-be mothers could learn from their experience and perhaps be better prepared than they believed they were. In this theme, I present findings that summarize mothers' unanticipated experiences within the context of becoming a mother for the first time. Two subthemes were created to reflect mothers' experiences with prenatal information/education, they are: 1) Expectations versus reality, and 2) Sharing mom truths.

Expectations versus reality. Participants all indicated that they used the months they were pregnant as an opportunity to become more knowledgeable about issues related to pregnancy, childbirth, and postpartum. Two mothers said they paid to attend formal prenatal education classes where they received information over a series of classes in a structured format and the curriculum was created by the healthcare provider who facilitated the class. The other six mothers used a combination of free resources, such as websites, books, friends, family, and healthcare providers to gather the prenatal information they determined would be relevant and helpful to them. All mothers in this study engaged in the practice of seeking prenatal information with the expectation that this knowledge would help prepare them for birth and early parenting. This expectation can be attributed, in part, to commonly held assumptions of both the natural and medical perspective of birth that posit that with prenatal information, mothers will be better prepared for the events that unfold in their labour, delivery, and postpartum. These assumptions are evident in how the 'natural' perspective encourages women to make use of various tools (including birth plans, or using breathing and meditation techniques) to achieve a non-medicalized birth (Aragon et al., 2013; DeBaets, 2017; Malacride & Boulton, 2014, p. 55). The medical perspective on birth assumes that women are medical consumers who can choose, plan, and implement the type of birth they desire- this is evident in many childbirth education

programs encouraging mothers to use a birth plan (Malacrida & Boulton, 2014, p. 55). Despite

the differing underlying assumption of these perspectives, "both the medical and natural

perspective adhere to a discourse of a responsible, capable mother who can choose, plan for and

implement the type of birth she wants to have" (Malacrida & Boulton, 2014, p. 55).

I noted that the majority of mothers commented that there was a disconnect between their

prenatal understandings of what childbirth and being a mother would be like compared to what

actually happened. This raises the important point that it is difficult, indeed impossible, to be

fully prepared for both the experience of childbirth and becoming a mother. Some mothers

believed they were unprepared for childbirth and mothering and would have liked to have

received more information/education in their pregnancy. On the other hand, a few mothers

commented that no amount of anticipatory guidance could have prepared them for what they

experienced, suggesting that some aspects were impossible to prepare for.

Veronica did seek out prenatal information and yet still believed she was unprepared for

childbirth- she reported she didn't know what to expect in the delivery room or even what

medications she could take during her labour. Veronica shared:

> …People don't tell you what to expect in the delivery room or that this is gonna happen
> or, you know, this is what this drug will do to you or this drug or… my plan was
> completely natural. So, I got down there [delivery room] was I was like "maybe I should
> take the gas." And the nurse was again, an older, experienced nurse, said "you know, it's
> not really gonna take the edge off, if you're gonna for natural you might as well just go
> natural." And I'm like "okay, thanks, cool." I valued her advice and her experience.

Commenting on her lack of knowledge, Veronica valued having an "experienced nurse" there to

help guide her in her decision making about things like pain management. The nurse's advice

was consistent with her beliefs and values, and influenced her practices during labour. As

mothers negotiated the decisions they made in their labour, they described the valuable role

health care providers played within these negotiations. Mothers viewed health care providers like

doctors and nurses as a key resource, who were responsible for sharing their expertise and knowledge with mothers. Tiler shared her experience of being unsure her water had broke, as it was unlike what she had read or heard from other mothers and prenatal resources. She said, "The water breaking was not what I expected 'cause I had read and talked to other moms and they said that it was like this big gush and mine just leaked for 24 hours." She went on to say, "but I wasn't sure because it was my first pregnancy, so then I actually called the [hospital]." Her subject position of being a first-time mom positioned her as unknowing, so she used her agency to contact the hospital to see if what she was experiencing was indeed her water breaking. This example illustrates the discourse of health expertise and first-time mothers' dependence on healthcare providers for guidance.

Veronica believed that mothers should have more opportunities to meet with healthcare providers prenatally to receive anticipatory guidance about what to expect in labour and delivery. Veronica shared:

> When I was first seen in the perinatal clinic there was an RN that came in and spent, I'm going to say a good hour with me and talked to me about various things like maternal serum and things like that, which it was great to get that education. If I would've had that again at let's say 28 weeks about…this is what to expect when your water breaks and we bring you in and you are assessed and we admit you and if your water breaks early you go on bedrest… Just as an expectation that people are aware that this is what's happening.

Veronica's belief that healthcare providers should have more of an active role in helping expectant mothers prepare for childbirth may stem from her personal experience of feeling unprepared when her water broke early and she had to go on bedrest. Without free prenatal classes delivered by public health nurses throughout Nova Scotia as it used to be the case until 2014, mothers are expected to seek out prenatal information and education through internet-based platforms on their own. Veronica said she had sought out prenatal information from books

and websites and yet it did not help prepare her for the realities of labour and delivery. It is important to note that Veronica went into labour early, at 35 weeks gestation, so perhaps had she had more time to prepare her childbirth experience may have turned out differently. In any case, Veronica had enough information in her pregnancy to develop a birth plan and was able to follow through with it in her labour, as it included having her husband present, using a birthing ball, and listening to specific music in the delivery room. She also commented that prenatally, she had wanted to have a natural labour with no medication but did not prepare for the possibility that she may change her mind and decide to take medication. As Veronica's labour progressed, she did experience significant pain so her doctor advised her to consider taking morphine to manage her pain. Veronica had not anticipated taking medication in her labour so had to quickly make a decision about something she knew very little about. She stated:

> I didn't know you could take morphine… I sat there and was like, "oh man, I really wanted a natural labour" and my doctor's like "just think about it and then the nurse will come give it to you if that's what you want." So, I had like two minutes to decide.

Veronica reported that she only had a short period of time to decide about taking this medication in her labour and yet she had many concerns. She associated morphine with her mother's palliative pain relief and was unsure about the safety of taking this medication during pregnancy. She said:

> You hear morphine and you're like "narcotic", you know? And it's scary. My mom was on a morphine pump her last two months of life. So, I'm thinking pain, morphine, narcotic- this is my thought pattern. And I have an understanding- a broad understanding- of health, so I'm like "umm, I don't know about this. Is this going to cross the blood brain barrier? Is my baby going to get this? Is my baby going to be born high?" This is what I'm thinking.

Despite having a birth plan in place, Veronica was unprepared for some of the decisions she had to make in her labour. Reflecting on her experience she said, "people don't tell you in labour and delivery it's not gonna go as you plan it." I interpreted Veronica's experience as an example of

how her expectations that prenatal education would prepare her for labour were unrealized. The

intent of prenatal education is not for mothers to prepare and plan for all aspects of labour and

delivery, yet it appeared that Veronica had that expectation. Veronica shared an example of how

having a birth plan promised her a false sense of control and certainty that she could have a

natural birth. It was clear to me that after having her baby, Veronica's perspective about

childbirth preparation changed- she shared with me her belief that expectant mothers should go

into birth "open-minded", acknowledging that things may not go as planned. This is a realistic

expectation for mothers to have, given the unpredictable nature of childbirth, yet it raises

questions about how much choice and control women should expect to have in such an

anticipated and personal moment in their lives.

Sonia shared that in her childbirth "things did get a bit hairy" and did not go as expected;

her advice to new mothers was this:

> Go in open minded, that's all you can do. Whatever's going to happen is going to happen, as long as you're alive, be happy. As long as she [baby] gets here and she's alive and you're alive, be happy. And be thankful… You can't go in and be like "I'm going to have a natural vaginal birth in a tub with birds chirping on this speaker…"

Like Veronica, she believed that mothers should go into childbirth "open minded" to save

themselves disappointment if their experience does not go per their birth plan. She also said:

> Going in open-minded is the best thing you can do, 'cause if you go in with a typed plan step-by-step and then you deviate from that you're going to feel insecure and you're going to be freaked out and you're not going to know what's going to happen. But, you know, as long as your end goal is getting him [baby] out and being alive, I think you're in pretty good shape.

Because Sonia had the personal experience of feeling unprepared for some aspects of her

childbirth, she responded by sharing the advice that mothers must be aware that even the most

carefully prepared plans can go wrong. Further, she believed the only expectation mothers

should have is for mom and baby to survive childbirth and if that occurs they should be

"thankful". I interpreted Sonia's statement as her belief that women have very little control in the childbirth encounter and that by creating a birth plan they are only setting themselves up to feel insecure when they have to deviate from their birth plan. As far as prenatal expectations of childbirth, Sonia's believed mothers should only anticipate surviving and having a healthy baby.

In my interview with Mavis, she explained that despite her efforts of planning and readying herself for labour and delivery, nothing could have prepared her for that experience. She was upfront with her belief that childbirth is difficult to prepare for, saying: "no matter what you do, you can't really prepare to pop out a nine point five baby." Mavis provided an example of how her preparations did not assist her in labour:

> I knew it was going to be [painful] and I knew it was going to be like contractions- I didn't have contractions, it just didn't stop. There was no break... I just kept saying to my husband "I just need a minute, I just need a minute, I just need a break. I need a break, I need a break." And that's what I kept saying to the nurse, was "I just need a minute, I can't breathe..." So, anything I that I thought like "oh, look at me doing yoga and pilates and breathing and relaxing and different positions"- right out the window.

Prenatally, women are encouraged to learn about pain management strategies they can employ in their labour. In her pregnancy, Mavis watched YouTube videos about yoga, pilates, and breathing techniques with the expectation they would assist with pain management in labour. Upon reflection of her experience, Mavis seemed to indicate that it was ignorant or naïve of her to think that yoga or pilates would be of any benefit to her during such a painful experience. In labour, Mavis discovered that some of the prenatal advice she received about pain management was not appropriate for her. Knowing her options wasn't a bad thing, but it demonstrates that not all prenatal education is relevant to each mother, however mothers may not be able to determine what's relevant and what's not until they actually experience childbirth.

When I asked Karen if the information or support she received prenatally impacted her birth experience, she said:

No, no… I guess you kind of don't know what to expect, but you expect the worst, so of course I was terrified. I just want the baby to stay in here, or I don't want it coming out because I'm terrified of how it's going to come out. But, it was totally different than anything I was expecting and it was great. It was a really positive experience… So, I guess nothing prepared us for that, but it was in a good way, so it all worked out very well in the end.

In the first theme, mothers' prenatal experiences of and exposure to a discourse of fear were examined. You may recall that Karen heard many "bad" stories about childbirth and understandably expected "the worst" about her own labour and delivery. She was pleasantly surprised when her expectations were not realized, as her childbirth experience turned out to be better than she anticipated. While childbirth was a positive experience for Karen, she had to experience unnecessary feelings of fear in her pregnancy as she worried about childbirth.

Anna was a mother who reported that her expectations of childbirth were met, stating she felt adequately prepared for the childbirth experience. Anna had sought out several resources in her pregnancy, including private classes and workshops that she and her partner paid to attend. She believed that even before going to the formal education classes she was quite knowledgeable about childbirth, having learned quite a bit from her two sisters' experiences. In talking about how she prepared for childbirth, Anna said: "Not having done it before, I would do it all the same again and I don't think there was anything missing. I got there and I felt mentally I was ready to go." The in-person prenatal classes Anna and her partner attended were facilitated by a public health nurse who used to work on a neonatal intensive care unit (plus used to teach prenatal classes before the province discontinued that program), and a sleep consultant. This mother believed that these facilitators had excellent credentials (expert knowledge) which aligned well with her beliefs and values rooted in a medical/science based discourse. She appreciated the anticipatory guidance she received in these classes, such as information on

87

medical terminology mothers may hear, when to go to the hospital, and possible interventions, including medications and machines. Anna said:

> …Seems a little brutal sometimes, the labour and delivery, but it was great 'cause, you know, they went from all the phases of labour. So, they talked about what you might feel or this is what some people feel in this phase… So, they would start to explain certain terminology that you might hear while you're at the hospital or at home... And they talked about all the interventions that could possibly happen, so any meds, um, machines that they might use, or if you go and they send you home why that might happen…

While she noted that information about labour and delivery can seem "a little brutal", Anna did appreciate when others were honest about the realities of labour and delivery. In her interview, she said she was pleased when her friends and sisters were "candid" in answering her questions about what pregnancy and birth are really like. Anna shared:

> And people… if you ask questions they'll tell you honestly, which is great. They'll tell you the truth of what happened and "this is what tore", "this is what going to get the diabetes test done is like."

Anna wanted to know other women's authentic experiences as a way to anticipate and plan for her own birth. Additionally, in the childbirth classes she appreciated the instructor's transparency of what childbirth can be like by showing the class a video of a vaginal delivery and a Caesarian section.

Anna noted that the private resources she accessed in her pregnancy, while helpful for her, were not "very accessible for people." She recognized that many mothers are not in a position to attend these classes, stating "I'm just lucky and I know I am." She also noted that it was a "privilege" to have sisters who are mothers and have a background in health as additional resources to support her in her pregnancy.

Some mothers in this study provided examples of how their prenatal education did not prepare them for their experience of childbirth. This experience of feeling unprepared cause some mothers to feel misled by their prenatal education and from their birth plan. Prenatally it

appeared that mothers had the expectation that prenatal information should prepare them for childbirth, however after having gone through childbirth, it was common for mothers to realize that it is impossible to prepare for all aspects, and that mothers should instead adopt an "open mind" attitude in case their childbirth does not go as they hope.

Sharing mom truths. While all participants in this study reported they sought out prenatal information and education, believing that it would prepare them for their birth and postpartum experiences, it was a common experience for mothers to realize that their prenatal information did not prepare them like they had hoped. Because I interviewed mothers after they had their babies, participants were able to articulate what aspects of childbirth and becoming a mother were unanticipated and how they chose to address their perceived shortcomings of prenatal information/education. After having their babies, mothers quickly recognized there is a lack of 'mom truths' being shared with expectant mothers, in other words, information about what to really expect when they're expecting. This subtheme will show how mothers chose to honestly share the less talked about aspects of becoming a mother with others.

Sonia stated that in her pregnancy, because she wanted to know "real life things, things that can happen and what to kind of be prepared for" she sought out information from expert and scientific sources, as she believed it was credible information and would best prepare her for childbirth and postpartum. When I interviewed Sonia as a new mom, she acknowledged that there were some things she was completely unprepared for, perhaps indicating that prenatal information/education does not discuss or prepare women for some aspects of mothering. She shared: "Yeah, I didn't know I'd come home in diapers. Chrissy Teigen said it the best, ""No one told me I'd come home in diapers." No one told me I'd lose my hair." Sonia's quote demonstrates how some of the common struggles mothers face in their day-to-day lives are

invisible and not talked about in society or within the context of prenatal information/education. Sonia noticed that there was a lack of real stories being shared with expectant women and mothers so she took it upon herself to create a blog in an effort to expose what is "real". She told me that this blog is based on her pregnancy and her life as a mother. As Sonia said, "[the blog's] real in the experience side that I don't sugar coat it." Sonia's reaction to the limits of the prenatal information she received about postpartum preparation was to create a blog to share her reality and 'mom truths' with others, which may offer some anticipatory guidance to expectant women, or support to others mothers also experiencing the common and normal challenges of being a first-time mother. Her blog was about the practical, day-to-day realities of being a mom. It was born out of her experience of not feeling prepared for the fact that she would have to leave the hospital in diapers or that her hair would fall out. This was important information that she would have liked to have known in her pregnancy. However, just because it was information that Sonia would have liked to have known, does not mean it is information that all expectant woman would want to know beforehand. This highlights the fact that women's prenatal information and support needs and preferences are individual- some advice will resonate with some mothers, and some advice won't.

Veronica was another mother who also commented on the lack of information provided to her while she was pregnant about the less talked about, negative aspects of becoming a new mom, like the serious condition of postpartum depression. Veronica shared:

> …Postpartum depression is a thing and people don't talk about it. There's a whole black cloud around it… It happens, it happened to a friend of mine and, you know, her husband said to me, "[mother], make sure you're getting out 'cause postpartum depression is a thing." And this is a big tough guy, mechanic, you know, builds hot rods for a living in his garage. When you hear a big tough guy saying to you "postpartum depression is a thing" and you're not hearing it from Public Health. Or, the [hospital] provided no… they're like, "if you have thoughts of committing suicide call this number."

90

Veronica valued that her friends shared their experience with her, as she believed it was information missing from the main messages of prenatal information and education. The telephone number provided seemed to be a last resort, as it came with the instruction to call it if she had "thoughts of committing suicide." While Veronica was grateful to have the information from her parent friends, she believed more could be done by institutions and organizations for women prenatally to spread awareness about postpartum depression. She said:

> Again, at 28 weeks they told you, you know, this is what to expect at labour and delivery, then maybe they should follow up with you at 32 and say, "you know, postpartum depression is a thing, this happens to women all the time and baby blues are for real and you need to be aware of this… And get help if you need it, or these are resources available to you if you find yourself in this situation." I found that support wasn't provided to me, like anything like that. I received more support about postpartum depression from my friends than I did from any public service of any type, like whether it be hospital or health clinic, or even the internet. People don't talk about postpartum depression, you know? It's not talked about.

The messages Veronica received from the hospital provided no insight into the symptoms of baby blues or postpartum depression, or even the resources available to new mothers. Therefore, she believed hospitals/institutions should do more prenatally, before postpartum depression even occurs. Veronica reported that her main source of information about postpartum depression was from her parent friends, who advised her to ensure she was taking care of herself after she had her baby, as "postpartum depression is a thing." Veronica's example shows that in the absence of support and information from health institutions about the very serious and real condition of postpartum depression, her parent friends took it upon themselves to share their knowledge and their reality with her so that she might be able to prevent it from happening to her.

For Heather, she shared with me that she was unprepared for how emotional she would feel in the postpartum period. Heather spoke candidly about her experience bringing her infant home and described that what she was feeling did not match societal and cultural expectations of

how a new mother should feel, or how even how she thought she would feel. Here is Heather's experience:

> I just thought it would be this emptiness filled in me because we were trying for so long and then when we came home I was so emotional because, I mean, your emotions, hormones are everywhere. And I'm just looking at him, like "did we make the wrong decision? Should we not have had him?" I wasn't happy in that moment.

Prenatally, Heather thought that a baby would fill an emotional void and when this feeling did not materialize after birth, it was difficult for her. She was not overcome with happiness, and her new baby did not fill the "emptiness" like she anticipated. Heather recognized the feelings she had were not in alignment with how new mothers were 'suppose' to feel after having their first baby. In the initial days and weeks of being a mother she questioned whether she and her partner should have even had a baby- a concern she voiced to her husband. Heather shared:

> For a good two or three weeks, I said to my husband "are we sure we should've done this?" And he'd get mad at me because he's like "of course we should've, what are you talking about?" But, I mean, he also didn't just deliver a baby and have a lot of his hormones go every which way. But once that started to even out and I was… and you just got to get into a routine. And I'm sure once the second one- if we have another one- it'll be easier again. But, yeah, it's just, it's a whole different world now.

While Heather's husband's response likely stems from concern and worry over the fact that his wife was feeling that way, it does perpetuate the dominate discourse of motherhood as always being an easy and happy experience. Because of the social and cultural construction of mothering, women who have 'negative' emotions may be reluctant to put their feelings into words because it goes against the dominant discourse. For Heather, however, instead of internalizing and succumbing to her feelings, she negotiated in her own mind what was going on and sought out support from a friend. In the interview, Heather talked about how one of her friends, who was also a mother, proved to be a good source of support in the initial postpartum

period. While she was experiencing the confusing feelings of unhappiness in a time that has been socially constructed to be very happy, her friend told her that she had felt similarly. Heather said:

> I had a friend who I saw over the summer and she's like, "you know, when I first came home with the baby I questioned it. I said to my husband 'should we have done this?'" But it's just, you know, a learning experience for everybody- baby and mom and dad.

Heather said that hearing her friend's experience affirmed her own feelings, instilling in her a sense of solidarity, and helping her feel less alone in her experience. In her interview, Heather said, "It felt good to be like "I'm not the only person who was very upset bringing this baby home, and crying every night."" This mother and her mother-friend challenged the dominant stereotypes of mothering. They first recognized that the realities of mothering are quite invisible in society and together shared the less talked about but very true aspects of mothering. Perhaps it was having another mother who willingly shared how she was feeling during the initial days and weeks of motherhood that encouraged this mother to use her agency to also speak about her imperfect reality.

Summary. Participants' descriptions of the events that occurred in childbirth and early postpartum period revealed that their experiences were not as they had envisioned prenatally. In part, this can be attributed to the expectations and assumptions participants had prenatally, where if they sought out information in their pregnancy they would be ready for the events that unfold in their labour, delivery, and postpartum. While many mothers held that assumption prenatally, as evidenced by their creation of birth plans and disappointment when their birth didn't go the way they envisioned, in the postpartum, mothers often came to the realization that preparing for birth includes being "open minded" about their expectations.

Mothers in this study recognized the lack of mother truths about childbirth and postpartum, which had the effect of hiding the real aspects of becoming a mom. Some mothers

responded to the lack of 'mom truths' by honestly sharing their true feelings, recognizing how they were feeling was different than how mothers are 'supposed' to feel after having a baby. A clear demonstration of mothers' power and agency was how mothers chose to share their true feelings with their mother friends, whether that was by having informal conversations, or more publically, by creating a blog to expose common and normal realities of becoming a mother.

First-Time Mothers' Need for Social Support

This theme is about how and why participants sought out support in the prenatal period. All mothers expressed the importance of having support in their pregnancy and in the postpartum period. Support came in different ways for participants; for many, support came from connecting socially with other women who were pregnant or who had recently had a baby; however, for others, support came from traditional sources, like healthcare providers or their own mothers. All mothers shared the belief that social support is valuable and used their personal power to seek out the support they needed, in both online and offline formats. Bogossian (2007) distinguished four subtypes of social support: emotional, informational, tangible, and comparison support. In this study, mothers emphasized the importance of receiving social emotional support- such as reassurance, validation, and normalization from other mothers in social and in-person settings, but also from healthcare providers. Participants also mentioned the need for social informational support, but this seemed to be less prominent, given the wealth of information mothers found online or through pregnancy books. Three subthemes emerged from the analysis of their experiences: 1) Mothers' personal constructions of support, 2) Mothers' programmatic preferences for accessing support, and 3) Mothers create the social support they need.

Mothers' personal constructions of support. This subtheme explores the participants' understandings of prenatal support. Through the analysis of the interviews, it became evident to

me that mothers had constructed their understanding of support based on their beliefs and values, but also on circumstantial factors, such as life events and health conditions in their pregnancy. I have chosen several examples from mothers' interviews to highlight how their unique experience determined from where or from whom they sought support as well as why and how.

Sonia also provided an example of turning to a moms' Facebook group for support and reassurance after an experience at the hospital left her feeling as though important information about the health of her baby was being "diluted". Because of a medical condition she experienced during her pregnancy, Sonia had to have weekly ultrasounds to check for infant movement. At each appointment, the ultrasounds were perfectly normal, so she started to question if there was something else the health care providers were looking for and not telling her. Sonia explained why she reached out to a Facebook group for support:

> So, it was just one of those things where it's like, no big deal. So, what I was getting concerned about that, I was "is this, you know, are they are not telling me something?" And another one of the moms was like, "you know what, they did that to me too, don't worry about it. It's completely okay."

She went on to say:

> So, I was just worried that something was being not withheld, but kind of I guess diluted. So, I wouldn't, you know, the 'new mom' wouldn't freak out… So, talking to moms about stuff like that was really nice 'cause, you know, "we had that experience, everything turned out fine, don't worry about it." You know? There was one night I had- I was having a lot, like consistent cramping and I didn't know what it was, so, you know, instead of calling 411 or, like, calling the Prenatal Line or whatever, you just kind of fire off messages, like "hey, does anybody else have this? Is this normal?" That stuff I really liked because they didn't make you think the worst and freak out right away.

Sonia did not want to be "the new mom" who "freaked out". She believed that first-time mothers are perceived to be anxious and more likely to "freak out" than multiparous women. Social and institutional discourses perpetuate the belief that first-time mothers are overly concerned, so, to avoid unnecessary stress or worry for the mother, health care providers decide how much or how

little information to share. In this regard, healthcare providers are viewed as gatekeepers of information where they hold power and control over what they choose to share with first-time mothers. Sonia responded to this relation of power by choosing not to express her concerns to the health care providers at the hospital, she instead used her agency to send messages to mothers on social media for their opinion. Sonia reported that she had a positive relationship with her physician and did not report of any previous experiences of feeling judged by healthcare providers because she was a first-time mom. As Sonia's belief was not informed by previous experience, it demonstrates how first-time mothers are keenly aware of how their subject position has been socially constructed. In an effort to resist being characterized as "the new mom" who "freaked out", she sought information and support from other first-time moms, believing they would be less likely to judge her for feeling concerned. She was able to quickly get reassurance from others who have been in a similar situation. Facebook provided this mother with peer support that helped calm her and ease her anxieties so that she would not automatically assume the worse. Sonia's example shows how she sought out support in a particular way that took into consideration the socially constructed subject position of being a first-time mom.

Anna enacted her agency to ensure the support she sought out was from individuals she knew and could trust, as well as whose beliefs, values, and practices aligned with her own. She shared a story of a time during her pregnancy when she relied on the support of a friend who was a mother of two older children. It was a day when the participant had gone in for a regular check up at the Perinatal Clinic and found out that she had lost weight from her previous appointment. Even though the medical staff at the clinic reassured her that both she and her baby were healthy, she was understandably upset and emotional about the weight loss. Anna shared how she was supported by another mother following her experience at the clinic:

I spoke with another… she's a mom of two and I coach basketball at a university so I went in that day, probably was too upset to probably do anything that day, but I went to practice and I was just in her office beforehand chatting and she's like "you look a little tired today, what's up?" So, and then I told her, and she was like "yeah" she started talking about her pregnancies and how she had a call one day- not out of the blue- it was after she had an ultrasound or something, and they called her to come back in because there was something going on with the baby. And she said she was out walking with a friend, had no expectation that a call like that was going to come. So, she talked to me, she said "you know, it's going to be fine, they said you're fine and you know, maybe you just need to go home and have a bath and relax." So, it was nice to speak with somebody else that, you know… and her situation was, you know, way more stressful than mine, but at the same time she was able to kind of calm me down and say "you know, he's fine and my baby was fine… they like to make sure all the t's are crossed, i's are dotted when it comes to pregnancy."… So, that helped… just to get the support and reassurance.

Anna valued information and support from a medical health discourse so she trusted her healthcare providers' assurance. In this regard, Anna's construction of support was influenced by her reliance and trust in her health care providers, indicating that she valued informational support. However, in this instance, listening to her friend's experience was also beneficial, as it reassured her in a way that was different from how the medical team supported her. She recognized her friend as another mother who had undergone a similar experience in her pregnancy and had a positive outcome. Anna said that by listening to her friend's experience it comforted her and helped her to relax. When Anna experienced stress related to losing weight, she valued emotional support provided to her by her friend who was also a mother. This demonstrates how she attended and negotiated two discourses, one being a medical/health discourse that could provide her with informational support, and the other being a discourse of maternal knowing and experiential knowledge, which provided her with emotional support. While Anna did access healthcare professionals for both information and support, she challenged the notion that healthcare professionals are the only "experts" and recognized other ways of knowing, such as maternal experiential knowledge.

97

These examples demonstrate how some participants were constructing a particular kind of support with others who were also pregnant or who were recent mothers, believing that women who shared the common experience of being pregnant and early mothering were an important source of information and support. This demonstrates the value mothers place on the recent and current experiential knowledge of other mothers. This belief influenced some mothers' practices of seeking out other pregnant mothers, particularly for their 'experience' information.

For other mothers, like Giselle and Veronica, their uncommon prenatal experiences influenced where they received support. Through her entire pregnancy, Giselle suffered from hyperemesis gravidarum, a condition that caused her to have severe nausea and vomiting. On account of her having this illness, it made completing everyday tasks more difficult. One of the challenges Giselle had was the fact that she did not personally know of anyone else who also experienced the same condition. She believed that while some people might say they understand what she was going through, they truly did not appreciate the severity of her illness. Giselle shared:

> …So what was really challenging for me during my pregnancy was that I didn't have anyone who would relate to my condition. Lots of women think they have hyperemesis because they happen to throw up or they have a rough week or that sort of thing. But when you have it as bad as I do, you can't maintain a job outside of the home.

She also said:

> …I had a member of my family (not my parents or my brother, 'cause they're very supportive) say to me "oh, I know how you feel, I went running today and I was a little bit nauseous." And it was like "oh no, you don't know what it's like living with a life-threatening condition when you're growing a child." So, people don't understand even when you try to tell them and so you need to protect yourself from that too because you don't have time to listen to that kind of garbage.

Not only was Giselle in distress over the symptoms she was experiencing, but she also felt as

though she had to grieve the fact that she did not get to enjoy her pregnancy as some mothers do.

Because her pregnancy was not uncomplicated, she felt as though she could not share her true

experience with others who were emotionally invested in the baby as the truth may scare them.

Because she chose not to disclose the reality of her experience, it limited the emotional support

she received. Giselle shared:

> … You have to mourn having this pregnancy that looks good I guess to other people.
> And at the same time too, you don't want to scare them by telling them, you know, "I
> wasn't able to shower yesterday until my husband got home. I laid on the ground crying
> for an hour in front of my toilet because my vomiting was uncontrollable and it was
> extremely scary." So, you don't want to tell people that who are connected to your child
> because you don't also want to scare them… You're almost censoring your information
> and so when you do that too, you can't get the true support that you need..

Social discourses that perpetuate the belief that pregnancy is a happy, healthy time for all

mothers can be isolating for mothers who have a different experience. Fortunately, Giselle

received the necessary support from her medical team at the hospital which helped make her feel

less alone in her pregnancy. What proved to be the most helpful in terms of support was the

validation of the seriousness of her condition. After others trying to normalize her symptoms, it

was a relief for her to get confirmation that what she was going through was much more than

morning sickness, it was hyperemesis gravidarum. It is important that in every interaction, health

care providers, friends, and family listen and respect the experiences of mothers, as feeling heard

and being validated were incredible sources of support for Giselle. Giselle shared her experience:

> And so it was hard for people to understand where I was coming from or provide me with
> emotional support because there's not a lot known about hyperemesis. I'm very fortunate
> that the clinic at the [hospital], as soon as I went in for my first appointment they said
> "no, no, no, you are very sick." And that was really… I cried, but I cried out of happiness
> that someone was saying like "this isn't just morning sickness, you have a serious
> condition."

Despite being very sick with a serious illness in her pregnancy, the support from her partner in addition to the medical support she received at the perinatal clinic at the hospital, reassured Giselle so that she wasn't scared. Through the clinic's care, respect, and attentiveness, she felt supported, saying "I think it's really good when you have a good team you get support, not everyone has that benefit, but I think support can come from information, credible information."

> The clinic was incredible. The clinic at the [hospital]- the prenatal clinic- worked the way healthcare should in the sense that I came in as a very sick patient, they immediately connected me to the nutritionist, they immediately did an ultrasound to make sure it wasn't twins… And then I was connected to the physiotherapist. And so, having a fantastic nurse, and they changed, there was a few nurses, obstetrician, dietician I guess, not a nutritionist, and physiotherapist provided me with the medical support I needed so I wasn't scared in that sense. I felt like they were taking good care of me and they tried to manage me at home and that was what was best for me.

For Giselle, how she constructed support was related to her experience of a rare, yet serious medical condition. While other individuals tried to normalize her symptoms and relate to her, this was not supportive to Giselle as it diminished the severity of her illness. Because other mothers could not relate to her illness, Giselle perceived her best source of support to be from her medical team. The healthcare providers at the prenatal clinic could validate her illness in a way that others couldn't- this was supportive to Giselle.

Veronica also spoke of the support she received from her healthcare providers. During this mother's pregnancy, she was under a significant amount of stress related to the fact that her mother was actively dying from cancer, as well as receiving the news that she was at an increased risk for her infant to be born with Down syndrome (trisomy 21). During this time, while she did turn to books and the internet for information, it was the doctor who followed her during her pregnancy who proved to be the most instrumental source of support for this mother. What was meaningful and important for this mother was the fact that her doctor got to know her on a personal level, making this mother feel listened to and respected. Without the influential

100

support of her doctor, this mother believes that she would have easily become depressed given

the stress of her situation.

> I had books, they were helpful, they were good. I used Google. I, um, my baby doctor was amazing. She spent a lot of time with me where I was having such a unique situation. My brother has Down syndrome so my maternal serum screening came back as a 1 in 55 chance that my child would be born with Down syndrome. So, I was followed on the 7th floor as well throughout my pregnancy. And, with my mom full of cancer and on her deathbed, my doctor was extremely supportive to me and really took the chance to get to know me and listen to me. Where, if I wouldn't have had that support from her, I probably would've became depressed very easily.

This subtheme demonstrated how mothers constructed support based on their unique

circumstance and situation. Participants were able to articulate what support meant to them, and

how they sought out the support to meet their individual needs.

Mothers' programmatic preferences for accessing social support. In this subtheme,

some of the participants described their understanding of how their prenatal experiences of

accessing social support were influenced by institutional and organizational changes to the

delivery of prenatal education. The majority of mothers in this study expressed their

disappointment with not being able to attend in-person group prenatal classes which were once

offered by Public Health Services. With the internet, books, and other resources, mothers

reported having access to prenatal information. However, without the option to attend in-person

classes, some of the participants explained to me that they believed they were missing out on an

opportunity to meet and connect socially with other expectant mothers. For example, Karen

commented on the availability of information online, making it readily accessible to her,

however what she really wanted was an opportunity to connect socially- something that proved

to be much less accessible. When talking about her experience accessing Welcome to Parenting,

Karen said:

> We found more information from talking to people or like, Googling things and stuff like that. And, I guess it just kind of felt impersonal too because it was on the website, so it's kind of like I could get this information anywhere kinda thing…

For Karen, despite accessing the available online social resources, she was left feeling as though she was missing the personal connection that she desired. Our technological world has created a place where we can get immediate access to fairly reliable information, however, it also reminds us that information delivered this way can be impersonal- an issue many mothers commented on in this study.

Throughout her interview, Mavis talked about the importance of first-time mothers having opportunities to connect socially and in-person with other expectant parents in the prenatal period. This was an experience that she did not have in her pregnancy, and now, looking back, she can see how in-person prenatal support could have benefitted her, particularly with meeting other pregnant mothers. The interview began with the participant saying she wished in her pregnancy she had been more involved with other expectant parents. She reported that because most of her friends had babies before she did, she was "really relying" on the in-person prenatal classes as a way to meet other expectant mothers. Mavis said: "I wish I had gotten more involved with other soon-to-be parents, but they took the courses away so I couldn't."

In her search for prenatal information and support, Mavis accessed the online provincial prenatal classes, 'Welcome to Parenting'. She was disappointed with this resource as she already knew much of the content, and the online format made it feel like "homework" at a time when she desired social interaction. This is an example of how Mavis constructed support- for her, support meant interacting socially with other expectant parents, not just prenatal information. 'Welcome to Parenting' was a resource she described as being "totally disconnected" and did not meet her needs as a first-time mother. Although she described her and her husband as "not big

social people", she believed the face to face, group setting would have been helpful to have her

questions answered and to learn from talking with others who have similar experiences. Mavis

said:

> It [Welcome to Parenting] was totally disconnected… It felt like homework at a point when what you really want is to sit around and… we're not big social people- my husband is the opposite of social- and he was probably relieved he didn't have to go to those classes, but especially for people like him. You need someone sitting across from you, answering your questions, having a group discussion, you know? All of the anxiety and getting it out…

In her opinion, in-person prenatal classes were more than educators teaching information; formal

classes provided a space for expectant parents to gather and discuss, share, and support each

other through their common experience of expecting a baby. Mavis did not have the opportunity

to discuss and share as her prenatal classes were delivered through an online, self-directed

learning format. Consequently, because the online classes contained repetitive information and

offered no opportunity for socialization, she and her husband did not end up completing the

modules. Mavis shared:

> It was more the experience of sitting around a group of people, whether he liked it or not, who were about to go through the same thing as us. Maybe they had things they knew that we didn't, maybe we had, you know, similar experiences. You don't get that on an online homework sheet, going through all this stuff. 90% of it was a waste of time so we didn't finish it.

On account of there being no free group prenatal classes available, Mavis found it

difficult to meet other pregnant women and so in the postpartum period, she faced the

consequences. As a result of not meeting many other expectant mothers in her pregnancy, this

mother did not have a large support network of moms and at five months postpartum, she was

trying to meet other parents who have babies of similar age. She stated "I did have a few

girlfriends who had just recently, well, their babies are going to be a year next week." Since her

friends have "all had to go back to work early" she was hoping to connect with other local mothers to establish a friend group for support.

Mavis clearly identified a moment of tension when expressing her beliefs about how mothers are expected to access prenatal support in Nova Scotia, as her beliefs were different from those of the decision makers who implemented Welcome to Parenting. From Mavis' experience we can see that the expected way for mothers to access prenatal support was constructed through a relation of power that expected mothers to be able to get their information and support needs through online prenatal education. Clearly, Mavis did not agree that online was an appropriate method for mothers to get prenatal information and support. Her experience of not meeting other expectant women prenatally is an example of how the decision to eliminate in-person classes affected her ability to create social support networks prenatally.

Mother Veronica shared similar feelings as Karen and Mavis. Veronica believed "there's a lack of education… for expectant moms and dads." She was aware of the "free" supports and services available to her, such as books and online websites, but these resources did not meet her need for social support. Veronica did not access the provincial prenatal education website as she found it "overwhelming" and "intimidating." Veronica said: "With those prenatal things online I didn't even do it 'cause it's overwhelming to sit in front of a computer- it's intimidating." Veronica did search for alternative resources delivered in an in-person format for her and her partner to attend, however she could not find any, stating "there's no free programs that I could find other than the online." While she was aware that parents can pay for in-person programs, she did not want to pay for it, she said "classes or doulas are crazy expensive and I don't want to spend that type of money…"

Several years ago, when Veronica's sister was pregnant, she had attended in-person prenatal classes and enjoyed them very much. Hearing her sister's positive experience, this mother had expected she would be able to access a similar program for her pregnancy and was frustrated to discover that she would have to pay to get that in-person support, stating:

> She [sister] had a rural support group of free prenatal classes at the time- I don't think that program is available anymore. But, she went to this free class in the evenings with her partner and loved it and enjoyed every moment of it. And then, thinking now 12 years has gone by and urban environment that there should be a resource like that available but there was nothing. So, it's kind of frustrating because I couldn't find anything that didn't cost money.

Not only did her desire to have a social, in-person prenatal class stem from her sister's positive experience, but it was also because Veronica described herself as someone who is "very social" and learns through discussion with others. On account of the group setting that prenatal classes and programs occur, they can provide an opportunity for expectant mothers to connect with other expectant mothers to share information and develop supportive relationships with others with similar experiences at similar times. The individualistic, self-directed nature of the online prenatal education website caused this mother to feel overwhelmed and turned her against this method of learning all together. Veronica shared:

> We didn't even do it [Welcome to Parenting] because it's overwhelming. It's overwhelming, I don't want to sit in front of my computer. I'm the type of person- I'm very social- I would rather go and meet people and mingle and see other people's experiences because every pregnancy is different and every parent is different.

> I don't want to sit in front of my computer for however many hours it takes to do that with my partner who works all day. We'd rather go and do something and then go out and get groceries afterwards. If there was something at the Sobeys community room or at the Superstore community room, that would be more something that we would do.

For mother Heather, she described herself as "not a studier", a subject positioning that influenced her beliefs, values, and practices related to prenatal education delivery. This mother associated the Welcome to Parenting website with school- lots of reading and content that had to

be studied- and because intrapersonal learning was not one of her perceived strengths, this method of education did not appeal to her. Self-study through books and online modules was not the best way for her to learn new information because it did not allow for interaction or discussion. Heather had hoped to take in-person prenatal classes because she believed that mode of learning would benefit her as she is a "hands-on kind of person". Heather stated:

> I'm a hands-on kind of person, I'm not a studier. I don't like to sit down and read stuff and then do a test at the end of it… I would rather go into a room with, you know, ten other moms and fathers or whatever the case may be, and have someone up there showing us, you know, and teaching us how to breathe and how to… all that stuff..

Heather recognized that there is a shift in how health programming is being delivered, from in-person to online, however, she still expressed her need for social and in-person information and support prenatally. Heather shared her thoughts in the following two quotes:

> For me, I would've liked to have had classes or something like that. I know online is the way to do things these days, but, yeah, to actually have someone to physically sit down and talk to… Even if you could go to a public health clinic and talk to... talk to somebody, whatever questions that you had.

> You just kind of feel more comfortable knowing that you're not the only one going through whatever the thing is at that moment, you know? It'd be nice to have someone to actually talk to… Public health nurse… other moms too, but definitely a public health nurse.

Heather believed in-person prenatal classes would have provided her and her husband with the information and support they were looking for prenatally. Because she wasn't committed to the books and online courses/websites she accessed, she only "half" completed them. Heather's desire to have had in-person prenatal education stems from how she learns best (interpersonal), but also her belief that it is important for pregnant women to have the opportunity to connect socially with peers and professionals not only for information, but to also get emotional support, encouragement, validation, and normalization.

Analysis of Mavis, Veronica, and Heather's beliefs uncovers the institutional presence in affecting how first-time mothers' needs for prenatal social support were addressed in Nova Scotia through what programs were chosen for prenatal education. Because of programming decisions that were made by the institution of Nova Scotia's Department of Health and Wellness (DHW), mothers were expected to receive both information and support through an online education program. The examples provided by some mothers revealed that 'Welcome to Parenting' did not meet their needs or expectations regarding prenatal social support, with some mothers believing that support is better received face-to-face. Because the DHW had the ability to influence decisions about the provincial delivery of prenatal education programming, a relation of power existed between the DHW and some of the mothers in this study. This study's data analysis revealed that several mothers experienced struggles due to how they believed the changes affected their access to prenatal support. Mavis, for example, reported that without the in-person classes she had less opportunity to meet other expectant mothers in her pregnancy. Many mothers in this study disagreed with the decision made by the province because their beliefs and values about how to access prenatal information and support were different than what 'Welcome to Parenting' could offer. Although no mothers involved in the study overtly challenged the online education program by going to the DHW directly, we can interpret the experiences mothers shared in this study as challenging. For example, many mothers did not hide their disappointment and frustration with the organization that made the changes; this demonstrates their agency to react to the changes and to challenge why these changes were made. As the next subtheme will demonstrate, mothers also displayed their agency in how they created informal support networks in the absence of formal structures.

Mothers create the support they need. In this subtheme, mothers acknowledged that the available supports and services were not sufficient, and so took it upon themselves to create the prenatal social support they needed and desired. Veronica spent some time talking about the support she received from friends and acquaintances online through social media. This mother used her personal Facebook page to give regular updates to her "Facebook friends" about her pregnancy, as well as her dying mother's condition. She said her initial reasoning for why she started updating on Facebook was for its efficiency in sharing information as she was "sick and tired of answering the phone and telling the same story 25 times." These Facebook posts quickly became a mechanism for this mother and her mother-friends to connect and share information and support. Veronica's status updates provided her Facebook friends the opportunity to discuss ideas, beliefs, values, and practices. It allowed them to share and teach and support each other based on each woman's experiential knowledge. Veronica shared this example:

> And I began doing Facebook updates about my pregnancy and my mom and I had… I only have 400 friends on Facebook, but I would have half my Facebook friends follow my posts and 'like' my posts and comment and wait for my next update of what's happening with my pregnancy and what's happening with my mom. So, it became… that social media support that I got from people- people I haven't talked to in 10 years, people I went to high school with that, you know, were like "oh, I had bleeding and it's okay and nothing happened" or "I had a low-lying placenta" or "don't panic, I have a high risk for Down syndrome" or you know "you can handle this." And, just getting that support from… socially without leaving my home.

Veronica did experience some "scares" in her pregnancy, including spontaneous bleeding and having a high risk for her baby to born with Down syndrome. By posting online on her personal Facebook page, she was able to get reassurance from her friends and family members that she could "handle" the challenges she was experiencing in her pregnancy.

Prenatally, women are encouraged to ensure they have support from partners (or another support person) and from healthcare providers. Not often enough is social support from peers

recognized as important for expectant women- something many mothers noted in this study by the lack of information about opportunities for social connection. The following observation made by Karen reflects several other participants' beliefs. Karen said:

> There's so much information for some things, but little information for others. There was little information about pregnancy groups locally, there was no information about it, 'cause I was looking and trying to find pregnancy groups and there weren't any, that I could find anyway.

Karen's experience was familiar to Veronica, as she also struggled to find in-person opportunities to socialize and connect with other expectant mothers. Out of her frustration, this mother used her agency to create her own social support using Facebook. Veronica's words were:

> I had no idea that some of my friends had gone through this, and I have friends from every walk of life. I'm friends with doctors and specialists and lawyers and dentists, and then I'm friends with people that live in north end Dartmouth on Primrose Street and that are on social assistance. Totally different ends of the spectrum. And then, these people would connect together through my Facebook status and talk about their experiences. But, I provided a forum for these people 'cause there's no forum available, locally there's no forum, you can't get out.

Posting on Facebook was her solution to not having the opportunity to meet face-to-face with other expectant mothers to get the support and reassurance she desired. Veronica made it clear to me that while her Facebook posts proved to be helpful to both her and her mother-friends, she still desired an in-person connection with other mothers.

In the postpartum period, Veronica said she was able to get the in-person support she desired prenatally. I have chosen to include her postpartum experiences in this analysis because having had in-person, social support after having her baby strengthened Veronica's belief that she would have benefitted from the same type of support prenatally. In the postpartum period, Veronica he met her mother-friends in a rather unconventional way, first meeting online through the local "Parent Buy, Sell, Trade" Facebook group buying infant clothes. What started online

led to in-person meetings and now the three women are close friends. The emotional support she

has received through her connection with these women has helped her "tremendously." She

valued her friends' experiential knowledge and viewed them as a credible source of information,

turning to them with questions related to baby care. Her friends gave honest advice and

trustworthy information- information she says she wouldn't have otherwise received. Veronica

explained the support she received from her mother friends by providing this example:

> Huge support for me, it's great that their children are older than mine because I have
> somebody to turn to and say "oh, when did you kid start doing this?" or, you know
> "[Baby] didn't have a wet diaper all night last night" and they're like "[Mother], that's
> not a good thing at any age, you know, don't be proud that your kid didn't pee in the
> diaper all night." But then, you know, she gets up and pees. But, you know, I wouldn't
> have known that had they not have told me.

Veronica's mother-friends had their babies before she did and were soon returning to work as

their maternity leave was coming to an end. At the time of the interview, Veronica had yet to

attend a 'Mommy and Me' drop-in group, and was nervous to attend without her mother-friends.

She suggested that if expectant mothers could attend these drop-in groups prenatally, it would

create connections and friendships before the baby comes. She explained further:

> If expectant moms could go to Mommy and Me, which I don't know if they can or not. If
> they could do that I think it would really provide a mentor for somebody, or a connection
> because I connect with people that are either much older than me or younger than me or
> at different steps or places in their lives than I am at… and it helps me figure out what to
> do… And not feel so… I'm nervous… I've not gone to one and we were going to go to
> one today before my friends go back because they know that I'm nervous to go to one.

She also said:

> I don't know anybody and even though I'm a very social person- and I'm very social- so,
> it's just different to, you know, step out on a limb and be like "oh hey, I'm [mother's
> name], do you want to be friends?

Despite her social nature, she still felt nervous about going to her first 'Mommy and Me' group,

as it seemed like she would be going "out on a limb" to make these new friendships. She

believed that if expectant women could go to these drop-in groups prenatally it would make attending in the postpartum period easier. Even though establishing these new friendships with other mothers may not be easy, Veronica recognized that they are important, saying "it's nice to have a different group of people that you can relate to in the moment." This belief informed the value she placed on her relationships with her mother-friends, and led to her practice of seeking out social connections with other mothers. Veronica recognized that in-person prenatal groups with public health nurse facilitators, like 'Mommy and Me' drop-in, are more than just social gatherings for mothers, saying "support, social, information, I think in an atmosphere like that you can hit so many different things." "…Just the social aspect of just talking to people makes such a difference." An example from mother Karen demonstrates this was shared feeling among many of the study participants. In her interview, Karen made the same recommendation as Veronica and Heather did:

> I don't know, it would have been nice to, I guess… 'Cause they have the 'Mommy and Me' groups after you have the baby, and it would kind of be cool if they have had those during pregnancy. I think that would have helped, kind of know more moms and know what people are going through and stuff like that. Because I was on a moms group on Facebook but it's so impersonal. It would have been nice to have that face-to-face with other expectant moms.

Summary. In this theme, the personal experiences of mothers seeking out prenatal support were examined. Mothers shared many examples of their personal constructions of prenatal support, and how this influenced their search for support from other mothers and/or healthcare providers. Relations of power and tensions were uncovered which were related to the changes made to the delivery of provincial Public Health prenatal education programs. While it may appear that mothers had no power in their relationship with the institution who made the decision to implement the Welcome to Parenting program, many mothers did position themselves in a relation of power with the institution. This was evident to me in how they

111

criticised and questioned the online delivery method's capabilities of meeting mothers' need for social and in-person prenatal support. Mothers clearly demonstrated their agency in how they created informal opportunities to receive support, while making suggestions for how mothers could be better supported prenatally through the existing resources of postpartum mommy-baby drop-in groups.

Chapter 5: Discussion

This thesis is an examination of how prenatal education was experienced by eight first-time mothers living in Halifax Regional Municipality, Nova Scotia. This inquiry revealed how mothers' experiences had been constructed and influenced by social and institutional discourses. The descriptions provided by participants demonstrated how discourses intersected and influenced their experiences. While there was diversity in the participants' experiences, their common subject position as being first-time mothers was a critical position from which participants negotiated their expectations and experiences of becoming a mother. It was a subject positioning that influenced their practices of seeking prenatal information and support, as well as their interactions with healthcare providers and their friends and family. Four main findings emerged in this study and were grouped into the following themes: (1) Perceptions of prenatal advice: From fear mongering to empowering, (2) Mothers negotiate beliefs, values, practices: Hot topics in pregnancy and postpartum, (3) Mothers' perinatal choices, expectations, and experiences, and (4) First-time mothers' need for social support. In this final chapter I will discuss each theme and the discourses that emerged within them, and will conclude by identifying possibilities for next steps in research and practice.

The overall question that this thesis sought to address was: **How do first-time mothers experience prenatal education and support in Halifax Regional Municipality, Nova Scotia?** To address this question, I will summarize and discuss the key findings as they relate to the purpose of this research.

Perceptions of Prenatal Advice: From Fear Mongering to Empowering

The first finding from this study focused on understanding mothers' perceptions of prenatal advice, specifically related to childbirth. How participants understood and perceived

prenatal advice from a subject position of "first-time mother" was a critical component to their experience of prenatal information and support. The experiences of mothers demonstrated that prenatal advice can be both fearful and empowering. The intersection of social and institutional discourses constructed the experiences of mothers, and influenced their understanding of prenatal advice. The interplay of the discourses that emerged from participants' experiences will be discussed and compared to the literature.

In today's developed world, the experience of childbirth is associated with minimal risk of an adverse outcome (Geissbuehler & Eberhard, 2002). In this study, however, it emerged that several participants were exposed to and/or experienced a discourse of fear as it relates to prenatal advice about childbirth- a finding that is supported by the literature. A growing body of research demonstrates that there is a high prevalence of fear associated with childbirth (Hildingsson, Nilsson, Karlström, & Lundgren, 2011; Reiger & Dempsey, 2006; Zar, Wijma, & Wijma, 2001). Although up to 80% of women identify common concerns (Saisto & Halmesmäki, 2003), just over 20% (Hofberg & Ward, 2003; Zar et al., 2001) report more specific or intense worries. In Canada, the prevalence of childbirth fear has been estimated at 25% among pregnant nulliparous and multiparous women (Hall et al., 2009). "Fear of childbirth has implications for maternal health because it is a primarily psychological factor that has been shown to contribute to mothers' requests for interventions [during labour], disrupting the physiological process" (Stoll, Hall, Janssen, & Carty, 2014, p. 220). In Western societies, birth fear has been associated with pregnancy complications, increasing childbirth interventions, emergency and elective Caesarean Section, postpartum depression, and Post Traumatic Stress Disorder (PTSD) (Bewley & Cockburn, 2002; Johnson & Slade, 2002; Ryding, Persson, Onell, & Kvist, 2003).

114

To understand why participants in this study perceived prenatal advice about childbirth to be fearful or empowering, it is helpful to explore the underlying discourses that construct childbirth. Many authors have written about the social construction of childbirth (Brubaker & Dillaway, 2009; Davis-Floyd, 2001; Fisher, Hauck, & Fenwick, 2006; Reiger & Dempsey, 2006) and how in every society a dominant discourse becomes a hegemonic truth or accepted societal way of understanding the practice of childbirth. When we look at the practice of childbirth, we can see how the discourses that have dominated this practice have changed over time. The early 20ᵗʰ century witnessed an emerging dichotomy, changing society's view of 'normal birth' (Clews, 2013, para 2). This altered "the concept of 'normal birth' from that of a physiological and social process taking place within the home, to the dominant practice of today, which sees birth as a largely medicalized process within Western society" (Clews, 2013, para 2).

Until the last century, babies were born at home with little support, resulting in tragic complications for mothers and babies alike. Improved living conditions and medical progress have led to a reduction in maternal and neonatal morbidity and mortality (Geissbuehler & Eberhard, 2002). Despite the many medical and technological advances, and the minimal risk associated with childbirth, some mothers in this study still reported experiencing feelings of fear as it related to the information they learned about pregnancy and childbirth. The object of many participants' fears and concerns centered around complications that could occur in pregnancy and birth, such as miscarriage and assisted deliveries and emergency caesarean sections. Despite intrinsic physical characteristics only rarely interfering with mothers' ability to give birth, the use of forceps, vacuum extraction, and emergency caesarean sections are very real complications of labour- the purpose of mainstream prenatal education (healthcare providers, books, reputable websites) is to inform women of the potential of their occurrence. It was evident in this study that

115

the experiences of some mothers demonstrated that within the entirety of prenatal information they received, their focus was on these complications. In light of that discovery, it became important to confer to the literature for possible explanations as to why some participants' focus was on the information they described as "bad" and "scary".

Given that the vast majority of mothers in Western society today give birth in hospitals, attended by medical staff and a woman's partner/support person, most women will not witness a birth prior to becoming pregnant. Consequently, mothers often rely on stories and advice from family, friends, healthcare providers, online websites, and media images to inform their attitudes and perceptions about birth. Fenwick et al. (2015) suggest that without their own personal experience, first-time mothers may be more vulnerable to 'social chatter' and discourses that emphasize risk and risk management (p. 244). The majority of participants in this study had not had previous, direct experiences with childbirth, and so a source of prenatal advice was often vicarious birth stories told by other mothers. An important, yet unsurprising finding was that some mothers said that "bad" birth stories they heard were fear provoking. This finding is reflected in the research literature which supports that 'horror stories' are an important social dimension of childbirth fear among women (Fisher, Hauck, & Fenwick, 2006). Negative stories of birth can have a profound impact on how mothers imagine their own labour and birth (Fenwick et al., 2015). In the present study, participants shared that "bad" stories often originated from online sources, like anonymous Facebook mom groups, blogs, threads, and forums, where participants had no established connection with the mothers who were posting these stories. Participants shared that positive birth stories moderated the strength of their fear; these "good" stories were often shared by family and friends (someone with whom participants had a personal connection).

Some mothers said that even when prenatal advice came from reputable sources, information about unlikely complications instilled in them a sense of fear. For example, even though Tiler's prenatal information from credible books and websites and covered a wide variety of topics (not just the problems) what she focused on in the interview was the "scary" complications. While Tiler did not provide an explanation for why she focused on these complications, I believe the social contextualization of childbirth may offer some rationale for why her focus was on the problems that could occur. For example, there is research to suggest that fear of childbirth can predate pregnancy (Stoll et al., 2014). "Mass-mediated and internalised cultural norms about birth as risky and in need of technological intervention perpetuate a climate of fear about childbirth" (Sakala, 2007; Stoll et al., 2014, p. 224). In Stoll et al.'s (2014) quantitative study of childbirth fear and birth preferences among Canadian university students, it was found that fear of birth was highest in nulliparous women who reported the media shaped their attitudes towards pregnancy and birth, suggesting an important role of the media in contributing to fear of birth.

Media can influence, and even set, health agendas in terms of the coverage and the content of the coverage (Cheek, 2000). Media is shaped by the taken-for-granted understandings of health, that is, by the discursive frames that underpin much of what is written and spoken about in health care. In turn, media can shape taken-for-granted understandings of what health is (Cheek, 2000, p. 45). In relation to women's fear of childbirth, one media analysis research study conducted by Morris and McInerney (2010) found that birthing shows were likely to over-represent the occurrence of obstetric complications and depict birth as a dangerous event. "Such reality shows might have a pervasively negative effect on young adults' attitudes by portraying birth as risky" (Stoll et al., 2014, p. 224).

Trust is paramount to risk communication. As Alaszewski (2005) notes, "individuals give particular credibility to sources that they know, which may include family and friends but also medical professionals with whom they have developed a relationship" (p. 103). This was evident in the present study, as mothers (Heather, Sonia, and Tiler) commented that unregulated sources of prenatal advice- social media websites, Facebook, blogs, forums, and threads- have the potential to contribute to a mother's fear; these mothers believed more weight should be given to scientific or evidence-based sources instead of stories found on anonymous social media websites. This finding is substantiated by Fenwick et al.'s (2015) study, which found that having access to reliable sources of information enabled women to feel informed, more confident and to build expectations and ideals associated with their pregnancy and birth.

Finally, not all mothers in this study believed prenatal advice to be fearful. As mentioned previously, Anna was a mother who felt empowered by the prenatal information she received. Her construction of childbirth was grounded in her first-hand experience of being present for the birth of her sisters' babies, as well as the prenatal information she sought out from a variety of sources. Findings from Stoll and Hall's (2013) quantitative study discovered that factors associated with reduced fear of birth were: "women's confidence in their reproductive/birth knowledge, witnessing a live birth, and learning about pregnancy and birth through friends" (p. 226). Findings from their research study iterated that women's exposure to real- not mass-mediated- birth experiences can decrease fear of birth. The results of Stoll and Hall's (2013) study provide a possible explanation for why Anna did not experience fear in her preparation for childbirth, as her exposure and understanding of childbirth stemmed from her previous experience of attending live births.

Overall, these findings suggest that mothers' perceptions and attitudes of prenatal advice is connected to the broader social context in which mothers are exposed and socialized. Indeed, understandings of health cannot be viewed independently from the social context in which they occur, since "knowledge reflects social, historical, and political phenomena" (Collyer, 1996, p. 1).

Negotiating Beliefs, Values, and Practices: Hot Topics in Pregnancy and Postpartum

The health care discourse of exclusive breastfeeding demonstrates how mothers negotiated conflicting beliefs and values, as it proved to be a discourse familiar to all participants. Not all mothers resisted or challenged the health care discourse of exclusive breastfeeding. For Veronica and Anna, the underlying beliefs and values of this discourse resonated with their own beliefs of breastfeeding, and so this discourse appeared to be an easy and positive fit. For the remaining mothers, the discourse of exclusive breastfeeding uncovered tensions and conflict about what it meant to be a 'good mother.' Mothers reported using moments of conflict, uncertainty, and tension as an opportunity to reflect on their own beliefs and values to make decisions about prenatal and postpartum practices.

Given that the exclusive breastfeeding discourse originates from healthcare, the emphasis is on the nutritional and health risks and benefits of various infant food sources. However, it is also one that subtly "positions breastfeeding as the proper and 'moral' choice of mothers" (Knaak, 2010, p. 346). Giselle commented on how the exclusive breastfeeding discourse is connected to the "broader ideologies of what it means to be a 'good' mother in Western society today" (Knaak, 2010, p. 347), indicating that infant feeding decisions are a highly accountable matter for expectant women and mothers. It is clear that the way prenatal advice addresses infant feeding practices (that is, the conventionalized practices and assumptions that underpin the

shaping of the practice itself) is as of much interest as what the prenatal advice actually describes (Cheek, 2000).

In this study, mothers indicated that advice influenced by a health care discourse of exclusive breastfeeding can cause non-breastfeeding mothers to feel judged and criticised. In a study about breastfeeding messages discussed in an antenatal education program in Australia, it was revealed that the languages and practices used by the midwives who facilitated the program were often limited to convincing women to breastfeed rather than engaging with them in conversations that facilitated exploration and discovery of how breastfeeding is experienced (Fenwick, Burns, Sheehan, & Schmied, 2013, p. 425). In that study, the facilitator's "own passion and personal beliefs for 'teaching' breastfeeding was often framed within institutional policies promoting and supporting breast feeding, which resulted in only information about breastfeeding to be discussed" (p. 432). The researchers of that study highlighted the need for facilitators of prenatal education to acknowledge the social, emotional, and individual nature of infant feeding decisions (2013). The comments made by several participants in the present study reinforce Fenwick et al.'s recommendations, believing that much of the prenatal advice about breastfeeding they were exposed to was "values-based". It is suggested that healthcare providers integrate new discursive frames that capture women's embodied knowledge and understanding about breastfeeding (Fenwick et al., 2013, p. 432) as it may convey information about infant feeding practices in a more supportive way.

Mothers deconstructed the message "breast is best" adopted by the health care discourse of exclusive breastfeeding they were exposed to prenatally. Participants (Giselle, Sonia, Karen, Mavis) conveyed that the concept of 'best' shifted from being a mainly objective construct to a highly subjective one; demonstrating how a mother's infant feeding decision is based on multiple

120

factors. In the case of Giselle and Karen, "the concepts embedded within the notion of breast feeding as an individual, social, and emotional experience" (Fenwick et al., 2013, p. 431) were not part of their exposure to the health care's discourse about exclusive breastfeeding. Instead of succumbing to the pressures of the dominant breastfeeding discourse, mothers in this study used their agency to feed their babies in a way that resonated with their personal beliefs, values, and ultimately practices.

Mothers' subject position as first-time mothers played an interesting role in how they navigated their pre- and postpartum experiences. I noted that participants constituted themselves as unknowing and in need of guidance from expert healthcare providers in some instances (mainly in the prenatal period), and yet demonstrated having their own expert maternal knowledge about what was best for their infant in other moments. It was unsurprising that healthcare providers were positioned as experts by the participants within this study, as they have been institutionally and socially constructed as such in our Western society. What was interesting to me was the fact that as participants transitioned from being pregnant to actually having their baby, it provided personal context that was empowering for decision making. In this transition, the constitution of 'expert' shifted from those who had professional knowledge, to those who had relevant maternal knowledge of their baby- which was the mothers themselves.

Murphy's (2003) research on mothers' infant feeding practices provide comparative findings, in that after the birth of participants' babies, "they defined the expertise relevant to infant feeding as that to which they, as the babies' mothers and everyday carers, had privileged access" (p. 456). In Murphy's study, mothers established themselves, rather than health professionals, as the primary agents of knowledge of their babies. Murphy noted that given the force of medical expert discourses, mothers' deviations from expert rules risk characterisation of

their practices as irresponsible and illegitimate (p. 447). She noted that participants in her study resisted such characterization, and so offered a counter discourse which simultaneously endorses the centrality of expertise, yet at the same time, relocates it, so that mothers were the experts (Murphy, 2003, p. 447).

Expert knowledge and guidelines are an important channel through which "the State seeks to regulate the choices of individuals" (Murphy, 2003, p. 458). "Such expert knowledge has a powerful influence upon the choices that mothers make" (Murphy, 2003, p. 458). However, as demonstrated in this study, recipients of such expert advice are not mere 'docile bodies' (Foucault, 1977). If, for whatever reason, mothers choose to go against expert and evidence based guidelines, they can and do develop creative strategies for resisting the characterization of 'bad mother' (Murphy, 2003, p. 458). "In so doing, mothers turn the discourse of expertise to their own advantage, re-establishing some freedom" in their role as mother (Murphy, 2003, p. 459). As such, adopting Foucault's understanding of power as relational, is well-suited to explore mothers' resistance to medical expertise. Instead of being helpless and passive to medical dominance, mothers challenge and resist in thoughtful and sophisticated ways (Murphy, 2003).

Mothers' Perinatal Choices, Expectations, and Experiences

The third finding of the study focused on mothers' choices, expectations, and experiences of childbirth and becoming a mother. Participants spoke of preparing for birth using a variety of sources, like pregnancy books and websites, advice from family and friends, private prenatal education classes, and information from their healthcare providers. This active preparation for birth represented to me participants' desire to be involved in making informed decisions about their labour and delivery. In some cases, this translated to participants' decision to create a birth plan. Birth plans were developed in the 1970s in response to pregnant women's sense of loss of

agency in childbirth (Lothian, 2006). "The aim of a birth plan is to improve women's satisfaction with labour and delivery by promoting participation, informed decision making, and empowerment" (Aragon et al., 2013, p. 980). "Women who make birth plans often desire to have their experiences of birth reflect their values and to exert reasonable control over what happens to their bodies" in the process of childbirth (DeBaets, 2017, p. 31).

The stories that some participants shared with me revealed a disconnect between their expectations of childbirth and their actual experience, which did not always go according to their birth plan. In Veronica's case, her plan to have a natural birth was not fulfilled, causing her to feel misled. Veronica's experience is reflected in other literature which also found that women believed their birth plans to be superficial, and they "did not enable women to be more in control in labour" (Too, 1996, p. 35). Healthcare providers have also shared their criticism of birth plans, believing that some mother's plans are "rigid and unrealistic" (Lothian, 2006, p. 296). One study found that birth plans often provoked some degree of annoyance for healthcare providers, mainly because "the requests were sometimes believed to be inappropriate." (Jones et al., 1998).

The purpose of birth plans, or prenatal education for that matter, is not so that mothers can prepare and plan for all aspects of childbirth. "The birth plan is not intended to be a list of requests but rather a tool to facilitate communication between women and those who will care for them in labour" (Lothian, 2006, p. 297). When mothers have the expectation that they can and will be able to control their birth it is obvious that challenges will arise, given the unpredictable nature of childbirth in the medical setting. This was the case for Veronica, however she should not- indeed, cannot- be blamed for wanting to shape her birth experience. In reviewing the literature, I discovered that women often receive little to no guidance about how to have their beliefs and values reflected in their birth plan (DeBaets, 2017, p. 31). In the absence of

meaningful guidance from healthcare providers about what constitutes reasonable expectations as far as choice and control in childbirth, expectant women may unknowingly create plans and expectations that are not feasible. "Rather than providing women an empowered capacity to choose, plan, and control their births", the discourse of 'birth planning' can be viewed "as a form of governmentality" (Malacrida & Boulton, 2014, p. 55). Women's attempts to plan and manage their childbirth experience, "occur within a set of institutional and social conditions" (Malacrida & Boulton, 2014, p. 45). In Western society, birth is an experience that often occurs "within an institution that may privilege medicalized births and within an increasingly "technocratic" model of medicine/childbirth" (Davis-Floyd, 2001, p. S5; Malacrida & Boulton, 2014, p. 45). These factors, along with the fact that childbirth is not a predictable experience in the medical setting, can mean that mothers' choices, expectations, and birth plans "can become irrelevant" in the process of labour and delivery (Malacrida & Boulton, 2014, p. 46).

Just as the empirical research exploring the value of birth plans has shown conflicting evidence about whether birth plans have a positive or negative effect on labour and delivery experiences, so too did the results of this study. Like Veronica, Anna had also prepared a birth plan, yet she described it as "loosely" planning her "ideal" labour, indicating to me that while she knew what interventions she did and did not want, her plan was flexible in case it had to change. Anna reported that she was able to follow her birth plan, which contributed to her perceptions that her labour was a positive experience. This finding indicates that birth plans can enhance the experience of labour and delivery, if there is an understanding that unexpected circumstances can arise during labour that may not be in line with the birth plan. Further, the success of a birth plan depends on honest communication between expectant women and healthcare providers and an environment/institution that empowers and respects women to make informed choices. A birth

124

plan should include acceptance of the unpredictable nature of childbirth, and that women's preferences should be flexible (Aragon et al., 2013). Participants in the present study also commented that mothers should go into birth "open minded"- mothers came to realize this after having their births that did not go 'according to plan'.

Becoming a parent forms a major transition period in a new mother's life (Deave, Johnson, & Ingram, 2008). Like previous studies, this inquiry revealed that new mothers feel unprepared and uninformed for the transition to be a mother, including childbirth, "the practical aspects of caring for a baby, and the change in themselves on becoming mothers" (Deave, Johnson, & Ingram, 2008, p. 8; Wilkins, 2006). Darvill, Skirton, and Farrand (2010) found that having unrealistic expectations about pregnancy, childbirth, and the postpartum period does not facilitate mothers' passage through the phases of the maternal transition. This suggests the need for a proactive approach with the goal to create realistic expectations of the birth and postpartum period (Seefat-van Teeffelen, Nieuwenhuijze, & Korstjens, 2011). One research study suggested that prenatal education should offer expectant women opportunities to learn from more experienced mothers in an "apprentice-style way" (Wilkins, 2006, p. 178). In the present study, there is evidence that after participants became mothers, they engaged in this apprentice-style practice in a way, as mothers indicated that they wanted to pass on some of their experiential knowledge to pregnant women. Within this theme it was found that when mothers experienced unanticipated moments in their transition to being a mother, some participants in this study decided to share this information with other expectant women through in-person conversations, Facebook posts, and blogs. These mothers believed that it was important information that they would have liked to have known themselves. In this manner, participants demonstrated that they,

125

as first-time mothers, had relevant knowledge and could contribute to supporting other expectant women.

First-Time Mothers' Need for Social Support

Becoming a mother can cause stress and anxiety because of the role change from being a non-parent to having responsibilities for caring for a new baby (Warren, 2005). Social support has been found to lessen expectant women's concerns and needs caused by the transition to becoming mothers (Warren, 2005). The final theme demonstrated how social support was a critical aspect of participants' prenatal experience. Through the websites, books, and healthcare providers, mothers indicated that they had access to informational support. What participants indicated as lacking, however, was the opportunity to meet face-to-face with other expectant women prenatally to obtain social emotional support. Most mothers believed connecting and socializing with other women was an important part of the prenatal experience, but noted that because of program changes it was difficult to establish meaningful connections with other expectant women.

Participants' construction of prenatal support revealed that for many mothers, support meant interacting socially with other expectant parents, it did not just mean prenatal information. It was a common belief among participants that if they would have had access to in-person classes, they would have had more opportunity to meet other expectant parents. Because mothers did not have access to in-person classes, some participants believed their social support networks were limited (Mavis, Heather, Veronica).

This inquiry demonstrated that the shift from in-person prenatal education to online methods has implications for women who need and desire reassurance and support from social and face-to-face interaction. In this study, some mothers believe the online education classes

126

(Welcome to Parenting) offered by Public Health to be "overwhelming" and "intimidating" and not reflective of their needs for in-person support. Other research has demonstrated the value of social, in-person support for mothers in the pre- and post-partum periods. Nolan et al.'s (2012) study found that when prenatal classes "were successful in providing a support network, women found friendships stemming from pregnancy were powerful in helping them grow in confidence and competence as new mothers following the birth of their babies" (p. 183). This indicates that opportunities for social connection in the prenatal period are important for mothers to develop self-efficacy and confidence.

However, the stories of the mothers in this study demonstrated they searched for and created solutions to the lack of in-person prenatal classes. Mothers were not victims of the relation of power they had with the Department of Health and Wellness who implemented the change to the delivery of prenatal education in Nova Scotia. Mothers' agency emerged in their creation of informal social support networks in the absence of formal structures. Participants conveyed that while online support networks with personal acquaintances were helpful in some instances prenatally, as they provided women with an opportunity to receive emotional support and encouragement, mothers were still missing the in-person connection. Participants' belief in the value of prenatal in-person social support was only strengthened after the birth of their babies, as participants shared that in the postpartum period, there were more opportunities for social gathering with other new moms, including mommy-baby drop in groups.

Implications

This study highlights that while pregnancy and birth are universal phenomena, women in Western societies have very limited exposure to birthing practices within their own family context. Thus, mothers often rely on other women's birth stories, media, pregnancy books and

websites, and healthcare providers to prepare for the experience of childbirth. The first theme demonstrates the importance of childbearing women's social learning about pregnancy and birth, and how different types of exposure to vicarious childbirth experiences can affect women's perceptions of these experiences (Stoll & Hall, 2013).

Findings from this inquiry indicate that mothers' perceptions of prenatal information can be connected to the broader social context. Healthcare providers who deliver prenatal information about pregnancy, childbirth, and postpartum should recognize and acknowledge the underlying discourses that construct perinatal experiences that include relations of power between mothers, friends, family members, and health care professionals. This may include efforts to uncover and counter socially constructed norms and expectations about pregnancy, childbirth, and mothering.

"Unpacking the dimensions of women's fears", and exploring "the nature of relationships as mediating women's fear provides important information on which to base potential intervention strategies and give direction on how to support women in ways that lessen rather than intensify fear" (Fisher et al., 2006, p. 74). The present study contributes to the unpacking of women's fears by demonstrating that *how* prenatal information is conveyed and talked about socially is just as important as the content of prenatal information itself. The practice of sharing positive birth stories and their contribution to the development of women's confidence in birth has not been well-researched to-date (Stoll & Hall, 2013). However, the power of sharing positive birth stories has been noted by well-known American midwife Ina May Gaskin. The first half of her book, *Ina May's Guide to Childbirth,* is a collection of women's positive birth stories. These stories are meant to empower expectant women, and give insight into the inner power and wisdom that comes from "ecstatic birth" (Gaskin, 2003, p. xiii). Gaskin provides the

following advice: "If you are pregnant or plan a pregnancy in the near future, you may want to return to these birth stories again and again to strengthen your own spirit in preparation for giving birth" (2003, p. xiii). It is recommended that future studies focus on the type of information about pregnancy and birth that is shared among women and how it impacts their own understanding, attitude, and perceptions of childbirth.

Additionally, this inquiry highlights the need for models of maternity care that encourage healthcare providers and expectant women to engage with each other in an authentic manner so that trusting relationships can be developed (Fenwick et al., 2015, p. 245). Nurses and healthcare providers must "listen carefully to a woman's concerns" and respond "in a way that validates her feelings and expectations", as this will provide an opportunity for sensitive, honest, and realistic discussions around labour and birth, with the goal to lessen childbirth fear (Fenwick et al., 2015, p. 245). This kind of honest, caring discussion is less optimal in an online prenatal education format.

The second theme explored how mothers negotiated beliefs, values, and practices related to 'hot topics' in their pregnancy and postpartum. Findings emerged that suggest a health care discourse plays a dominant role in how women and mothers understand exclusive breastfeeding practices. Healthcare providers who provide prenatal information and support must explore how best to address the multiple contextual realities of infant feeding during the perinatal period to ensure inclusiveness and valuing of the diverse experiences and viewpoints of mothers. Women can and do engage in multiple ways of being 'good' mothers and how they decide to feed their infants is not reflective of their mothering skill. An important first step for healthcare providers and nurses working with expectant women and new mothers is to consider the diverse viewpoints and discursive frames that exist about breastfeeding (Fenwick et al., 2013), and how

129

these discourses either challenge or support mothers' infant feeding practices. Pregnant women and new mothers should have access to practical, objective information about infant feeding, and should be respected to make an informed decision about how to feed their baby.

From the third theme, appropriate preparation for the childbirth experience may be the key to ensuring that mothers have expectations that enable women to have a satisfying and positive experience. Healthcare providers should take time to discuss women's expectations and birth plans to collaboratively ensure they can be addressed within the birthing context of their choice whether that be at home or in the hospital, with a doctor, midwife, or doula. In addition, providers should be aware of the non-regulated sources of information new mothers use, like blogs, Facebook pages, and forums (and recognize their potential to contribute to fear of birth) and offer validated and accessible resources as necessary.

Prenatal education groups, programs, and services made up solely of first-time mothers will not "lift the veil of secrecy surrounding motherhood" (Wilkins, 2006, p. 178). Perhaps prenatal education should involve women who are already mothers to enable expectant women to learn from them and "identify issues that are specific concerns in the early days" (Wilkins, 2006, p. 178). This is a recommendation made not only by the participants of this study, but by other researchers as well (Barnes et al., 2008; Deave, Johnson, & Ingram, 2008; Wilkins, 2006).

A primary institutional and social assumption about prenatal education is that challenges experienced by mothers in pregnancy, childbirth, and postpartum period are because of a "knowledge deficit" (Gilmer et al., 2016, p. 119). This leads to the expectation that prenatal education "will help to resolve this lack of knowledge" (Gilmer et al., 2016, p. 119). Further, it is assumed that "when parents are equipped with this new information, it will reduce their distress and promote positive changes in parental attitudes and behaviour" (Gilmer et al., 2016, p. 119). It

is also important to understand who delivers prenatal education and how power is negotiated with mothers.

Exploring first-time mothers' experiences of prenatal information and support revealed the complexities of the discourse of prenatal education including the reasons why and how mothers accessed prenatal information and support from a wide variety of sources. There were some participants who appreciated online prenatal information, and there were other participants who reported that they would rather learn prenatal information through group discussion in a face to face setting. Where participants sought prenatal information/education/advice depended upon their personal preferences and unique needs. Therefore, "it is unlikely that a single, standardized format or prenatal program could be sufficiently flexible" to meet the diverse needs of expectant women (Gilmer et al., 2016, p. 131). Public Health, Family Resource Centres, community agencies, and other healthcare providers who work to support pregnant women need to create opportunities that will allow expectant parents to access information, advice, and support "at a time and format that suits them" (Gilmer et al., 2016, p. 131). Nurses should be "challenged to think critically, question the status quo, actively collaborate with community-based organizations and the research community, and influence future programs to truly reflect what will work, for whom, under what conditions" (Gilmer et al., 2016, p. 131). The following questions have been adapted from Gilmer et al.'s 2016 (p. 131) realist review of parent education interventions and may be useful to guide future work on prenatal education: What do pregnant women already know about pregnancy, childbirth, and early baby care? Are women interested in traditional models of acquiring information and support? Do women desire education or simply information? Is there sufficient evidence to support which delivery method (face to face and/or

online) of prenatal information is better? Who can be involved in the delivery of prenatal education/information and support (i.e. interprofessional collaboration)?

The final theme identified social support as a factor that may influence the way in which transition from pregnancy to early mothering is experienced. All mothers demonstrated their ability to join and/or form social support networks in online formats, however their participation in these groups ranged from "voyeur" to actively posting and engaging in conversations on Facebook/blogs with other mothers. For most participants, online groups were helpful to know what was "normal" and to receive reassurance so long as the group consisted of peers who had similar beliefs and values. Overall, the mothers in this study conveyed that pregnant women want and need more opportunities to socially connect with other expectant women and new mothers. Some participants believed that without face-to-face prenatal classes their ability to create social connections in the prenatal period was negatively affected. Provincial governments, health care institutions, community organizations, and researchers need to collaborate to shift relations of power and create opportunities for expectant mothers to connect socially to acquire information and support. Inviting expectant mothers to mommy-baby drop-in groups offered through Public Health was a suggestion offered by several participants.

Implications for future research. In this study, participants were asked retrospectively about their experience of prenatal information and support. This was a purposeful decision, as I wanted to explore how mothers felt their prenatal information and support did or did not prepare them for childbirth and postpartum experiences after they had experienced birth and the early postpartum period. In making this decision, I discovered that the influence of participants' experience of childbirth and early parenting had an impact on the types of experiences mothers decided to share with me and how they told their stories; as previously discussed, during the

interviews, not only did participants talk about their prenatal experience, they also shared how this influenced their childbirth and postpartum experiences. If instead I had recruited expectant women and interviewed them prenatally for their prospective views about their informational and support needs in relation to becoming a mother, it would probably have been different as they would only be able to comment on the prenatal period and how they may or may not have felt prepared, educated, informed, or supported prior to the experiences. While this type of focus on experiences would provide interesting findings, the direct links through the continuum or pre- and postnatal experiences would not have emerged as important findings. It is recommended that future studies could explore both the prospective and retrospective views of pregnant women and mothers to develop different accounts of the kinds of prenatal support, advice, and information women might find helpful.

Findings from this study demonstrate that expectant women and mothers should have more opportunities to engage with each other to share information and receive support. "Centering Pregnancy" is one example of a program that is changing the way women receive their prenatal care (Centering Healthcare Institute, 2018). This program combines clinical care provided by a physician, nurse, or midwife with group discussion (facilitated by either a healthcare provider or support person, such as a doula) about important and timely health topics while leaving room to discuss what is important and of interest to the group of expectant women. This approach provides parents with the opportunity to experience primary prenatal care, information, and to develop social connections with other pregnant families, their peers, and healthcare providers simultaneously (Bennett et al., 2017). This program is a promising practice, shown to improve outcomes by increasing access to prenatal information/advice, developing a community of support, and empowering women to take an active role in their prenatal care.

Future research should be conducted to explore the experiences of women involved in local "Centering Pregnancy" programs and how this has impacted women's experiences of transitioning to becoming mothers.

Strengths and Limitations

A strength of the study was the methodological approach of feminist poststructuralism and the use of discourse analysis, as it enabled an in-depth exploration of individual mother's experiences. By using the methodology of feminist poststructuralism, different discourses were identified which uncovered new insights about the practice of prenatal education and support in the Nova Scotia context. The sample size of eight provided significant, rich data for analysis in this qualitative study. While not generalizable, the main findings can be transferred to understanding prenatal education practices in Halifax Regional Municipality.

The limitations of this study must be considered for their implications in the transferability of findings. The demographic characteristics of the study participants may have influenced the findings of this study. The majority of participants identified as Caucasian, and one participant identified as First Nations. This cultural homogeneity does not address the experiences and perspectives from other social and cultural groups. Additionally, all participants were in heterosexual relationships with the father of the baby. I recommend that in future studies, sampling and recruitment should be more inclusive of other diversities such as race, culture, and lesbian, gay, bisexual, transgender, queer (LGBTQ).

While the study was advertised using online and offline formats, all participants reported they became aware of the study from the poster that was uploaded to the IWK's Facebook and Twitter sites. Given that participants all had access to internet and social media they did not indicate that they had trouble accessing prenatal information from online formats. Recruiting

simultaneously through offline and online posters proved to have both positive and negative implications. Uploading recruitment posters to the IWK social media websites enabled me to quickly reach and advertise to my target population of first-time mothers. This method of advertising enabled quick recruitment of participants; however, the implications of having mothers recruited from just social media as opposed to waiting for potential participants to respond to hard copies of the posters are such that I may have missed mothers who did not have access to internet. For example, one mother did contact me to participate in the study after hearing about it from the posters, unfortunately, however, I had already recruited the full sample size of participants and could not recruit this mother for this study. In a future study, recruitment should be more inclusive of the mothers who do not have access to online resources (i.e. other non-online recruitment).

Conclusion

In my endeavour to explore first-time mothers' experiences of prenatal education, I discovered that mothers wanted to discuss more than just their prenatal experience. As each mother spoke of her individual experience preparing and becoming a mother, she drew upon important and meaningful interactions and encounters that occurred in the 'pre', 'intra' and 'post' partum periods. I soon realized that despite the language used to attempt to compartmentalize these perinatal experiences, these boundaries are often blurred. Indicating to me that becoming a mother can be an overwhelming experience in general, highlighting the interconnectedness of the different elements and experiences in our lives.

American author, Rubin (1984), has explored the complex changes involved in becoming a mother, a process she has called 'maternal role attainment.' She described that this process begins during pregnancy and continues to change and evolve as women go through the stages of

childbirth and postpartum (Wilkins, 2006). Since Rubin, other authors have continued to develop understandings of how women experience the transition of becoming mothers. American author Mercer (2004) (a student of Rubin) proposed changing the term 'maternal role attainment' with the phrase 'becoming a mother', which she believes better reflects the dynamic process that women experience (Wilkins, 2006, p. 170). Findings from this research study support the notion that 'becoming a mother' is an ongoing and evolving experience. In my attempt to focus on the prenatal experiences of women, I discovered that isolating these distinct moments (pre, intra, and post-partum) in a woman's journey of 'becoming a mother' is difficult.

Presently in Nova Scotia, information and support services for pre- and postpartum mothers are separated into 'before birth' (e.g. Welcome to Parenting) and 'after birth' (e.g. Mommy and Me drop-in groups, etc.) which is sensible in some ways- some information is more relevant and applicable to women depending on if she is five months pregnant or has a five-month-old infant, for example. Yet this segregation of before birth and after birth fails to reflect the continuity and overlap in the experiences of preparing and becoming a mother which was revealed in this study. The findings of the study suggest that we, as healthcare providers, nurses, researchers, and policy makers, must think about the structure of maternity programs and services differently. To more accurately reflect the notion that women's transition and journey of 'becoming a mother' is an ongoing process, beginning in pregnancy and continuing well into the postpartum period, women and mothers need opportunities to engage with others who are in both the prenatal and postpartum periods.

The recent change to the delivery method of universal prenatal classes in Nova Scotia from in-person to online, provided the stimulus for this research study. The recent change provided an opportune time to explore the current practices of prenatal education in greater

detail. This qualitative research study draws attention to the discourses that constructed mothers' experiences of prenatal education and support. It has implications for developing new practices as it provided a deeper understanding of how mothers negotiated relations of power in their everyday experiences of preparing and becoming a mother.

This inquiry identifies social support as a factor that may influence the way in which women experience the transition to becoming a mother. For example, the findings suggest that social connections with other mothers during pregnancy may influence the experience of early mothering. Lack of social support in the prenatal period led some mothers to feel isolated, whereas mothers who felt supported seemed to facilitate confidence. Contact with other pregnant women and new mothers has been shown to be a vital source of support for women, but this inquiry revealed that opportunities for prenatal in-person support are not always readily accessible in HRM. Without free prenatal education classes, healthcare providers must think of creative ways to facilitate in-person social networking using existing programs and services. A feasible suggestion made by several participants was to invite expectant women to the postpartum mommy-baby drop in groups offered by Public Health. Additionally, instead of asking women and mothers to come to Public Health for information and support, perhaps Public Health should consider meeting expectant women and new mothers where they gather socially- at local coffee shops, swimming pools, and libraries- for example.

The intent of this research study was to provide a deeper understanding of first-time mothers' experiences of prenatal education and support with the potential to create change to tailor prenatal education and support programs to meet the health needs of women in Nova Scotia. I plan to use my privileged position with connections to both the academic and public health communities to broadly disseminate the findings of the study. This will be achieved

through publishing the findings in peer reviewed journals, and presenting at conferences, workshops, and/or seminars. Additionally, I intend to share the key findings with key stakeholders, like Public Health and the IWK Health Centre, to continue to improve current prenatal education and support practices in Nova Scotia.

References

Agger, B. (1991). Critical theory, poststructuralism, postmodernism: Their sociological
 relevance. *Annual Review of Sociology, (17)*, 105-131.
 doi:10.1146/annurev.so.17.080191.000541

Ahlemeyer, J., & Mahon, S. (2015). Doulas for childbearing women. *The American Journal of
 Maternal/Child Nursing, 40*(2), 122-127. doi:10.1097/NMC.0000000000000111

Alaszewski, A. (2005). Risk communication: Identifying the importance of social context.
 Health, Risk & Society, 7(2), 101-105. doi:10.1080/13698570500148905

Aragon, M., Chhoa, E., Dayan, R., Kluftinger, A., Lohn, A., & Buhler, K. (2013). Perspectives
 of expectant women and health care providers on birth plans. *JOGC, 35*(11), 979-
 985. doi:10.1016/S1701-2163(15)30785-4

Association of Nova Scotia Midwives. (2018). *About midwifery.* Retrieved from
 http://www.novascotiamidwives.ca/about-midwifery/

Aston, M. (2016). Teaching feminist poststructuralism. Founding scholars still relevant today.
 Creative Education, 7, 2251-2267. doi:10.4236/ce.2016.715220

Aston, M., Etowa, J., Price, S., Vukic, A., Hart, C., MacLeod, E., & Randel, P. (2016). Public
 health nurses and mothers challenge and shift the meaning of health outcomes. *Global
 Qualitative Nursing Research, 3*, 1-10. doi:10.1177/2333393616632126

Aston, M., Price, S., Etowa, J., Vukic, A., Young, L., Hart, C., MacLeod, E., & Randel, P.
 (2014). The power of relationships: Exploring how public health nurses support mothers
 and families during postpartum home visits. *Journal of Family Nursing, 21*(1), 11-34.

Aston, M., Price, S., Etowa, J., Vukic, A., Young, L., Hart, C., MacLeod, E., & Randel, P. (2014a). Universal and Targeted Early Home Visiting: Perspectives of Public Health Nurses and Mothers. *Nursing Reports, 4*(1), 12-18.

Aston, M., Price, S., Kirk, S. F. L., & Penney, T. (2011). More than meets the eye. Feminist poststructuralism as a lens towards understanding obesity. *Journal of advanced nursing, 68*(5), 1187–94.

Ateah, C. A. (2013). Prenatal parent education for first-time expectant parents: "Making it through labor is just the beginning…" *Journal of Pediatric Health Care, 27*(2), 91-97. http://dx.doi.org/10.1016/j.pedhc.2011.06.019

BabyCenter. (2017). *My pregnancy & baby today.* Retrieved from https://www.babycenter.ca/mobile-apps

Barnes, M., Pratt, J., Finlayson, K., Courtney, M., Pitt, B., & Knight, C. (2008). Learning about baby: What new mothers would like to know. *Journal of Perinatal Education, 17*(3), 33-41. 33-41, doi: 10.1624/105812408X3

Bennett, C. T., Buchan, J. L., Letourneau, N., Shanker, S. G., Fenwick, A., Smith-Chant, B., & Gilmer, C. (2017). A realist synthesis of social connectivity interventions during transition to parenthood: The value of relationships. *Applied Nursing Research, 34*, 12-23. doi:10.1016/j.apnr.2016.11.004

Best Start Resource Centre. (2013). *Prenatal education in Ontario – Better Practices.* Retrieved from http://www.beststart.org/resources/rep_health/prenatal_education_June2013.pdf

Best Start Resource Centre. (2014). *The delivery of prenatal education in Ontario: A summary of research findings.* Toronto, ON: Author.

Bewley, S., & Cockburn, J. (2002). Responding to fear of childbirth. *The Lancet, 359*(9324), 2128-2129. doi:10.1016/S0140-6736(02)09113-4

Bogossian, F. E. (2007). Social support: Proposing a conceptual model for application to midwifery practice. *Women and Birth, 20*(4), 169-173. doi:10.1016/j.wombi.2007.08.003

Brixval, C. S., Axelsen, S. F., Andersen, S. K., Due, P., & Koushede, V. (2014). The effect of antenatal education in small classes on obstetric and psycho-social outcomes: A systematic review and meta-analysis protocol. *Systematic Reviews, 3*(12). doi:10.1186/2046-4053-3-12

Brubaker, S. J., & Dillaway, H. E. (2009). Medicalization, natural childbirth and birthing experiences. *Sociology Compass, 3*(1), 31-48. doi:10.1111/j.1751-9020.2008.00183.x

Butler, J. (1992). Contingent Foundations: Feminism and the Question of "Postmodernism". In J. Butler, & J. Scott (Eds.) *Feminists theorize the political* (pp. 3-21). New York and London: Routledge, Chapman and Hall, Inc.

Callister, L. C. (1995). Cultural meanings of childbirth. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 24*(4), 327-331.

Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada. 2010. *Tri-Council policy statement: Ethical conduct for research involving humans*. Retrieved from http://www.pre.ethics.gc.ca/pdf/eng/tcps2/TCPS_2_FINAL_Web.pdf

Canadian Internet Registration Authority. (2017). *Canada's internet factbook 2017*. Retrieved from: https://cira.ca/sites/default/files/public/CIRA-Internet-Factbook-2017-EN.pdf

Capital Health. (n.d.) *Public health: Family resource centres*. Retrieved from http://www.cdha.nshealth.ca/public-health/family-resource-centres

Centering Healthcare Institute. (2018). *CenteringPregnancy.* Retrieved from

    https://www.centeringhealthcare.org/what-we-do/centering-pregnancy

Chedid, R. A., Terrell, R. M., & Phillips, K. P. (in press). Best practices for online Canadian

    prenatal health promotion: A public health approach. *Women and Birth.* Retrieved from

    http://www.womenandbirth.org/article/S1871-5192(17)30291-3/fulltext

Cheek, J. (2000). *Postmodern and poststructural approaches to nursing research.* Thousand

    Oaks, CA: Sage Publications.

Clews, C. (2013). Normal birthing and its meaning: A discussion paper. *Evidence*

    Based Midwifery, 11(1), 16-20.

Collyer, F. M. (1996). Understanding ulcers: Medical knowledge, social constructionism, and

    helicobacter pylori. *Annual Review of Health Social Sciences, 6*, 1-39. Retrieved from:

    https://ses.library.usyd.edu.au/bitstream/2123/1106/1/Collyer%201996%20Ulcers

    %20ARHSS.pdf

Creswell, J. W. (2013). *Qualitative inquiry & research design. Choosing among five approaches*

    (3rd ed.). Los Angeles, CA: Sage Publications Inc.

Darvill, R., Skirton, H., & Farrand, P. (2010). Psychological factors that impact on women's

    experiences of first-time motherhood: A qualitative study of the transition. *Midwifery,*

    26(3), 357-366. doi:10.1016/j.midw.2008.07.006

Davis-Floyd, R. (2001). The technocratic, humanistic, and holistic paradigms of

    childbirth. *International Journal of Gynecology & Obstetrics, 75*, S5-S23.

Deave, T., Johnson, D., Ingram, J. (2008). Transition to parenthood: The needs of parents in

    pregnancy and early parenthood. *BMC Pregnancy and Childbirth, 8*(30).

    doi:10.1186/1471-2393-8-30

DeBaets, A. M. (2017). From birth plan to birth partnership: Enhancing communication in

childbirth. *American Journal of Obstetrics & Gynecology, 216*(1), 31-

33. doi:10.1016/j.ajog.2016.09.087

Denzin, N. K., & Lincoln, Y. S. (2000). *Handbook of Qualitative Research*. Thousand Oaks, CA:

SAGE Publications, Inc.

Eisler, R. T. (1988). *The chalice and the blade: Our history, our future.* San Francisco, CA:

Harper & Row

Ernst, E. K. (1994). Health care reform as an ongoing process. *JOGNN, 23,* 129-138.

Ernzen, M. A. (1997). Prenatal education programs can reduce a woman's risk of acquiring

toxoplasmosis. *International Journal of Childlbirth Education, 12*(3),

Fenwick, J., Burns, E., Sheehan, A., Schmied, V. (2013). We only talk about breast feeding: A

discourse analysis of infant feeding messages in antenatal group-based education.

Midwifery, 29(5), 425-433. doi:10.1016/j.midw.2012.02.006

Fenwick, J., Toohill, J., Creedy, D. K., Smith, J., & Gamble, J. (2015). Sources, responses and

moderators of childbirth fear in Australian women: A qualitative

investigation. *Midwifery, 31*, 239-246. doi:10.1016/j.midw.2014.09.003

Ferguson, S., Davis, D., & Browne, J. (2013). Does antenatal education affects labour and birth?

A structured review of the literature. *Women and Birth, 26*, e5-e8.

doi:10.1016/j.wombi.2012.09.003

Fisher, C., Hauck, Y., & Fenwick, J. (2006). How social context impacts on women's fears of

childbirth: A Western Australian example. *Social Science & Medicine, 63*, 64-75.

doi:10.1016/j.socscimed.2005.11.065

Foucault, M. (1976). *The birth of the clinic: An archaeology of medical perception.* Taylor &

    Francis Group. Retrieved

    from: https://monoskop.org/images/9/92/Foucault_Michel_The_Birth_of_the_Clinic_197

    6.pdf

Foucault, M. (1977). *Discipline and punish: The birth of the prison.* New York, NY: Vintage

    Books. Retrieved

    from: https://monoskop.org/images/4/43/Foucault_Michel_Discipline_and_Punish_The_

    Birth_of_the_Prison_1977_1995.pdf

Foucault, M. (1982). The subject and power. *Critical Inquiry, 8*(4), 777-795. Retrieved from

    http://www.unisa.edu.au/Global/EASS/HRI/foucault_-_the_subject_and_power.pdf

Gagnon, A. J., & Sandall, J. (2007). Individual or group antenatal education for childbirth or

    parenthood, or both. *Cochrane Database of Systematic Reviews, 3.* Art. No.: CD002869.

    doi:10.1002/14651858.CD002869.pub2

Gao, L., Larsson, M., & Luo, S. (2013). Internet use by Chinese women seeking pregnancy-

    related information. *Midwifery, 29*(7), 730-735. doi:10.1016/j.midw.2012.07.003

Gaskin, I. M. (2003). *Ina May's guide to childbirth.* New York, NY: Bantam Books Trade

    Paperbacks.

Geissbuehler, V., & Eberhard, J. (2002). Fear of childbirth during pregnancy: A study of more

    than 8000 pregnant women. *Journal of Psychosomatic Obstetrics & Gynecology, 23*(4),

    229-235. doi:10.3109/01674820209074677

Gilliland, A. L. (2011). After praise and encouragement: Emotional support strategies used by

    birth doulas in the USA and Canada. *Midwifery, 27*(4), 525-531.

    doi:10.1016/j.midw.2010.04.006

Gillis, A., & Jackson, W. (2002). *Research for nurses. Methods and interpretation.* Philadelphia, PA: F. A. Davis Company

Gilmer, C., Buchan, J. L., Letourneau, N., Bennett, C. T., Shanker, S. G., Fenwick, A., & Smith-Chant, B. (2016). Parent education interventions designed to support the transition to parenthood: A realist review. *International Journal of Nursing Studies, 59*, 118-133. doi:10.1016/j.ijnurstu.2016.03.015

Godin, K., Blue, S., Bourdages, N., Edwards, S., Horan, M., MacDougall, R., Mill, C., Procter, T. D., Schieck, A., & Alton, G. D. (2014). *Assessing public health prenatal education knowledge: Findings from the LDCP Healthy Pregnancies project*. Woodstock, ON. Retrieved from https://www.publichealthontario.ca/en/ServicesAndTools/Documents/LDCP/ LDCP_Healthy_Pregnancies_Knowledge_Survey_Report_2014.pdf

Graceful Beginnings Birth Services. (2015). *Childbirth preparation classes.* Retrieved from http://www.gracefulbeginnings.ca/childbirth-preparation-classes.html

Guyon, A., Hancock, T., Kirk, M., MacDonald, M., Neudorf, C., Sutcliffe, P., & Talbot, J. (2017). The weakening of public health: A threat to population health and health care system sustainability [Editorial]. *Canadian Journal of Public Health, 108*(1), e1-e6. doi:10.17269/CJPH.108.6243

Hall, W. A., Hauck, Y. L., Carty, E. M., Hutton, E. K., Fenwick, J., & Stoll, K. (2009). Childbirth fear, anxiety, fatigue, and sleep deprivation in pregnant women. *JOGNN, 38*, 567-576. doi:10.1111/j.1552-6909.2009.01054.x

Hall, J. M., & Stevens, P. E. (1991). Rigor in feminist research. *Advances in Nursing Science, 13*(3), 16-29. doi:10.1097/00012272-199103000-00005

Harding, S. (1987). *Feminism and methodology: Social sciences issues.* Bloomington, Indiana: Indiana University Press.

Hekman, S. (1997). Truth and method: Feminist standpoint theory revisited. *Signs, 22*(2), 341-365. Retrieved from: http://www.jstor.org/stable/3175275

Hesse-Biber, S., & Piatelli, D. (2007). Holistic reflexivity: The feminist practice of reflexivity. In S. N. Hesse-Biber (Ed.), *Handbook of feminist research, theory & praxis* (pp. 493–515). Thousand Oaks, CA: Sage Publications.

Hildingsson, I., Nilsson, C., Karlström, A., & Lundgren, I. (2011). A longitudinal survey of childbirth-related fear and associated factors. *JOGNN, 40*, 532-543. doi:10.1111/j.1552-6909.2011.01274.x

Hofberg, K., & Ward, M. R. (2003). Fear of pregnancy and childbirth. *Postgraduate Medical Journal, 79*(935), 505-510. doi:10.1136/pmj.79.935.505

hooks, B. (2000). *Feminism is for everybody: Passionate politics.* Cambridge, MA: South End Press.

Ickovics, J. R., Kershaw, T. S., Westdahl, C., Magriples, U., Massey, Z., Reynolds, H., & Rising, S. S. (2007). Group prenatal care and perinatal outcomes: A randomized controlled trial. *Obstet Gynecol, 110*(2), 330-339. doi:10.1097/01.AOG.0000275284.24298.23

Johanson, R., Newburn, M., & Macfarlane, A. (2002). Has the medicalization of childbirth gone too far? *BMJ, 324*(7342), 892-895.

Johnson, K. C., & Daviss, B.-A. (2006). Outcomes of planned home births with certified professional midwives: Large prospective study in North America. *British Medical Journal, 330*(7505), 1416-1419.

Johnson, R., & Slade, P. (2002). Does fear of childbirth during pregnancy predict emergency

caesarean section? *BJOG: an International Journal of Obstetrics and Gynaecology,*

109(11), 1213-1221. doi:10.1046/j.1471-0528.2002.01351.x

Jones, M. H., Barik, S., Mangune, H. H., Jones, P., Gregory, S. J., & Spring, J. E. (1998). Do

birth plans adversely affect the outcome of labour? *British Journal of Midwifery, 6*(1),

38-41. doi:10.12968/bjom.1998.6.1.38

Knaak, S. J. (2010). Contextualising risk, constructing choice: Breastfeeding and good mothering

in risk society. *Health, Risk, & Society, 12*(4), 345-355.

doi:10.1080/13698571003789666

Koehn, M. L. (2002). Childbirth education outcomes: An integrative review of the literature.

Journal of Perinatal Education, 11(3), 10-19.

Lagan, B. M., Sinclair, M., & Kernohan, W. G. (2010). Internet use in pregnancy informs

women's decision making: A web-based survey. *BIRTH, 37*(2), 106-115.

doi:10.1111/j.1523-536X.2010.00390.x

Lather, P. (1991). *Getting smart. Feminist research and pedagogy with/in the postmodern.* New

York, NY: Routledge

Lee, A. S., & Kirkman, M. (2008). Disciplinary discourses: Rates of cesarean section explained

by medicine, midwifery, and feminism. *Health Care for Women International, 29*(5),

448-467. doi:10.1080/07399330801949574

Lima-Pereira, P., Bermúdez-Tamayo, C., & Jasienska, G. (2011). Use of the Internet as a source

of health information amongst participants of antenatal classes. *Journal of Clinical*

Nursing, 21(3-4), 322-330. doi:10.1111/j.1365-2702.2011.03910.x

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* Beverly Hills, CA: Sage Publications.

Liverani, M., Hawkins, B., Parkhurst, J. O. (2013). Political and institutional influences on the use of evidence in public health policy. A systematic review. *PLOS ONE, 8*(10), e77404. doi:10.1371/journal.pone.0077404

Lothian, J. (2006). Birth plans: The good, the bad, and the future. *JOGNN, 35*(2), 295-303. doi:10.1111/j.1552-6909.2006.00042.x

Lothian, J. A. (2008). Childbirth education at the crossroads. *Journal of Perinatal Education, 17*(2), 45-49. doi:10.1624/105812408X298381

Lupton, D. A. (1999). 'The best thing for the baby': Mothers' concepts and experiences related to promoting their infants' health and development. *Health, Risk & Society. 13*(7-8), 637-651. doi:10.1080/13698575.2011.624179

Macdonald, M. (2006). Gender expectations: Natural bodies and natural births in the new midwifery in Canada. *Medical Anthropology Quarterly, 20*(2), 235-256. doi:10.1525/maq.2006.20.2.235

Malacrida, C., & Boulton, T. (2014). The best laid plans? Women's choices, expectations, and experiences in childbirth. *Health, 18*(1), 41-59. doi:10.1177/1363459313476964

McQueen, A., & Mander, R. (2003). Tiredness and fatigue in the postnatal period. *Journal of Advanced Nursing, 42*(5), 463-469. doi:10.1046/j.1365-2648.2003.02645.x

McVeigh, C. (2000). Investigating the relationship between satisfaction with social support and functional status about childbirth. *The American Journal of Maternal/Child Nursing, 25*(1), 25-30. Retrieved from: http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&AN=00005721-200001000-00006&D=ovft&PDF=y

Mercer, R. T. (2004). Becoming a mother versus maternal role attainment. *Journal of Nursing*

  Scholarship, 36(3), 226-232. doi:10.1111/j.1547-5069.2004.04042.x

Morris, T., & McInerney, K. (2010). Media representations of pregnancy and childbirth: An

  anlysis of reality television programs in the United States. *Birth, 37*(2), 134-140.

  doi:10.1111/j.1523-536X.2010.00393.x

Morton, C. H. & Hsu, C. (2007). Contemporary dilemmas in American childbirth education:

  Findings from a comparative ethnographic study. *Journal of Perinatal Education, 16*(4),

  25-37. doi:10.1624/105812407X245614

Muhajarine, N., Ng, J., Bowen, A., Cushon, J., & Johnson, S. (2012). Understanding the impact

  of the Canada prenatal nutrition program: A quantitative evaluation. *Canadian Journal of*

  Public Health, 103(Suppl. 1), S26-S31.

Murphy, E. (2003). Expertise and forms of knowledge in the government of families. *The*

  Sociological Review, 51(4), 433-462. doi:10.1111/j.1467-954X.2003.00430.x

Narasimhulu, D. M., Karakash, S., Weedon, J., & Minkoff, H. (2016). Patterns of internet use by

  pregnant women, and reliability of pregnancy-related searches. *Maternal and Child*

  Health Journal, 20(12), 2502-2509. doi:10.1007/s10995-016-2075-0

National Collaborating Centre for Methods and Tools. (2012). *A model for evidence-informed*

  decision making in public health. [fact sheet]. Retrieved from

  http://www.nccmt.ca/uploads/media/media/0001/01/9e2175871f00e790a936193e98f4607

  313a58c84.pdf

Nelson, A. (2003). Transition to motherhood. Journal of Obstetric, Gynecologic, and Neonatal

  Nursing, 32, 465-477.

Neuhauser, L., & Kreps, G. L. (2003). Rethinking communication in the e-health era. *Journal of Health Psychology, 8*(1), 7-23. doi:10.1177/1359105303008001426

Nicholls, L., & Webb, C. (2006). What makes a good midwife? An integrative review of methodologically-diverse research. *Journal of Advanced Nursing, 56*(4), 414-429. doi:10.1111/j.1365-2648.2006.04026.x/epdf

Nichols, M. R. (1995). Adjustment to new parenthood: Attenders versus nonattenders at prenatal education classes. *BIRTH, 22*(1), 21-26.

Nolan, M. (1998). *Antenatal education: A dynamic approach.* London, UK: Baillière Tindall.

Nolan, M. L., Mason, V., Snow, S., Messenger, W., Catling, J., & Upton, P. (2012). Making friends at antenatal classes: A qualitative exploration of friendship across the transition to motherhood. *The Journal of Perinatal Education, 21*(3), 178-185. doi:10.1891/1058-1243.21.3.178

Nova Scotia. (2012). *Giving children the best start: The early years: Discussion paper*. Halifax, N.S. Retrieved from http://www.ednet.ns.ca/earlyyears/documents/Early%20 Years_Discussio%20Paper_EN.pdf

Nova Scotia Health Promotion and Protection. (2008). *Prenatal education and support needs in Nova Scotia.* Retrieved from http://novascotia.ca/dhw/healthy-development/documents/Prenatal-Education-and-Support-Needs-in-Nova-Scotia.pdf

Nova Scotia Public Health. (2011). *Nova Scotia public health standards 2011-2016.* Retrieved from http://novascotia.ca/dhw/publichealth/documents/Public_Health_Standards_EN.pdf

O'Sullivan, C., O'Connell, R., & Devane, D. (2014). A descriptive survey of the educational preparation and practices of antenatal educators in Ireland. *The Journal of Perinatal*

Education, 23(1), 33-40. doi:10.1891/1058-1243.23.1.33

Patton, M. (1990). *Qualitative evaluation and research methods (pp. 169-186).* Beverly Hills,

CA: Sage.

Perry, S. E., Hockenberry, M. J., Lowdermilk, D. L., & Wilson, D. (2010). Nursing care during

pregnancy. In R. Carter (Ed.), *Maternal child nursing care* (4th ed., pp. 229-272).

Maryland Heights, MO: Mosby Elsevier Inc.

Pinnegar, S., & Daynes, J. G. (2007). Locating narrative inquiry historically: Thematics in the

turn to narrative. In D. J. Clandinin (Ed.), *Handbook of narrative inquiry: Mapping a*

methodology (pp. 3-34). Thousand Oaks, CA: Sage Publications

Province of Nova Scotia. (2014). *Healthy development.* Retrieved from http://novascotia.ca/dhw/

healthy-development/pregnancy.asp

Province of Nova Scotia. (2014). *Online prenatal and parenting program launched* [News

Release]. Retrieved from http://novascotia.ca/news/release/?id=20140916002

Province of Nova Scotia. (2015). *Nova Scotia Health Authority.* Retrieved from

https://novascotia.ca/dhw/about/nova-scotia-health-authority.asp

Public Health Agency of Canada. (2000). Organization of services. In Author, *Family-Centered*

Maternity and Newborn Care: National Guidelines. Retrieved from

http://www.lhsc.on.ca/About_Us/SPL/projects/completed/SWOPP/guidelin.pdf

Public Health Agency of Canada. (2009). *What mothers say: The Canadian maternity*

experiences survey. Retrieved from http://www.publichealth.gc.ca/mes

Public Health Agency of Canada. (2013). *Perinatal health indicators for Canada 2013: A report*

from the Canadian perinatal surveillance system. Ottawa, ON: Author.

Public Health Agency of Canada. (2016). *Healthy pregnancy.* Retrieved from http://www.phac-aspc.gc.ca/hp-gs/prof-eng.php

Reiger, K., & Dempsey, R. (2006). Performing birth in a culture of fear: An embodied crisis of late modernity. *Health Sociology Review, 15*(4), 364-373.

Rogan, F., Shmied, V., Barclay, L., Everitt, L., & Wyllie, A. (1997). 'Becoming a mother'—Developing a new theory of early motherhood. *Journal of Advanced Nursing, 25*, 877-885.

Rubin, H. J., & Rubin, I. S. (2005). *Qualitative interviewing: The art of hearing data* (2nd ed.). Thousand Oaks, CA: Sage Publications

Rubin, R. (1967). Attainment of the maternal role: Part 1. Processes. *Nursing Research, 16*(3), 237-245.

Ryding, E. L., Persson, A., Onell, C., & Kvist, L. (2003). An evaluation of midwives' counseling of pregnant women in fear of childbirth. *Acta Obstetricia et Gynecologica Scandinavica, 82*(1), 10-17. doi:10.1034/j.1600-0412.2003.820102.x

Scott, J. W. (1992). Experience. In J. Butler & J. W. Scott (Eds.), *Feminists Theorize the Political* (pp. 22-40). New York, NY: Routledge, Chapman and Hall, Inc.

Saisto, T. & Halmesmäki, E. (2003). Fear of childbirth: A neglected dilemma. *Acta Obstet Gynecol Scand, 82*, 201-208.

Sakala, C. (2007). Letter from North America: Understanding and minimizing nocebo effects in childbearing women. *BIRTH, 34*(4), 348-350. doi:10.1111/j.1523-536X.2007.00196.x

Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. *Adv Nurs Sci, 16*(2), 1-8.

Seefat-van Teeffelen, A., Nieuwenhuijze, M., & Korstjens, I. (2011). Women want proactive psychological support from midwives during transition to motherhood: A qualitative study. *Midwifery, 27*(1), e122-e127. doi:10.1016/j.midw.2009.09.006

Sjöö, M., & Mor, B. (1987). *The great cosmic mother: Rediscovering the religion of the earth* (2nd ed). San Francisco, CA: Harper & Row.

Smith, A. (2005). Why education for birth is important. In M. L. Nolan & J. Foster (Eds.), *Birth and Parenting Skills. New directions in antenatal education* (pp. 33- 49). London, UK: Elsevier Ltd.

Stamler, L. L., & Yiu, L. (2012). *Community health nursing. A Canadian perspective* (3rd ed.). Toronto, ON: Pearson Canada.

Stoll, K. H., & Hall, W. (2012). Childbirth education and obstetric interventions among low-risk Canadian women: Is there a connection? *The Journal of Perinatal Education, 21*(4), 229-237. doi:10.1891/1058-1243.21.4.229

Stoll, K., & Hall, W. (2013). Vicarious birth experiences and childbirth fear: Does it matter how young Canadian women learn about birth? *The Journal of Perinatal Education, 22*(4), 226-233. doi:10.1891/1058-1243.22.4.226

Stoll, K., Hall, W., Janssen, P., & Carty, E. (2014). Why are young Canadians afraid of birth? A survey study of childbirth fear and birth preferences among Canadian university students. *Midwifery, 30*, 220-226. doi:10.1016/j.midw.2013.07.017

Strega, S., & Brown, L. (2005). *Research as resistance: Critical, indigenous and anti-oppressive approaches to research*. Toronto, ON: Canadian Scholars Press.

Su, L.-L., Chong, Y.-S., Chan, Y.-H., Chan, Y.-S., Fok, D., Tun, K.-T., Ng, F. S. P., & Rauff, M. (2007). Antenatal education and postnatal support strategies for improving rates of

exclusive breast feeding: Randomised controlled trial. *BMJ: British Medical Journal,*
335(7620), 596-599. doi:10.1136/bmj.39279.656343.55

Sullivan, P. (2002). Canada's public heath system beset by problems: Report. *Canadian Medical*
Association Journal, 166(10), 1319. Retrieved from
http://search.proquest.com.ezproxy.library.dal.ca/docview/204794877/fulltextPDF/
F12C491E11CA49C3PQ/1?accountid=10406

Svensson, J., Barclay, L., & Cooke, M. (2008). Effective antenatal education: Strategies
recommended by expectant and new parents. *Journal of Perinatal Education, 17*(4), 33-
42. doi:10.1624/105812408X364152

The Society of Obstetricians and Gynaecologists of Canada. (2008). *A National birthing*
initiative for Canada. Retrieved from
https://sogc.org/wp-content/uploads/2012/09/BirthingStrategyVersioncJan2008.pdf

Too, S.-K. (1996). Do birth plans empower women? A study of their views. *Nursing Standard,*
10, 33-37.

Toohill, J., Fenwick, J., Gamble, J., & Creedy, D. K. (2014). Prevalence of childbirth fear in an
Australian sample of pregnant women. *BMC Pregnancy and Childbirth, 14*(275). https://
doi.org/10.1186/1471-2393-14-275

Varner, C. A. (2015). Comparison of the Bradley Method and HypnoBirthing childbirth
education classes. *The Journal of Perinatal Education, 24*(2), 128-136.
doi:10.1891/1946-6560.24.2.128

Waldenström, U., Brown, S., McLachlan, H., Forster, D., & Brennecke, S. (2000). Does team

   midwife care increase satisfaction with antenatal, intrapartum, and postpartum care? A

   Randomized controlled trial. *BIRTH, 27*(3), 156-167. doi:10.1046/j.1523-

   536x.2000.00156.x/epdf

Walker, D. S., Visger, J. M., & Rossie, D. (2009). Contemporary childbirth education models.

   Journal of Midwifery & Women's Health, 54(6), 469-476.

   doi:10.1016/j.jmwh.2009.02.013

Warren, P. L. (2005). First-time mothers: Social support and confidence in infant care. *Journal

   of Advanced Nursing, 50*(5), 479-488. doi:10.1111/j.1365-2648.2005.03425.x

Weedon, C. (1997). *Feminist practice & poststructuralist theory* (2nd ed.). Oxford, UK:

   Blackwell Publishers Ltd.

Wickham, S., & Davies, L. (2005). Are midwives empowered enough to offer empowering

   education?. In M. L. Nolan & J. Foster (Eds.), *Birth and Parenting Skills. New

   Directions in Antenatal Education* (pp. 69- 84). London, UK: Elsevier Ltd.

Wilkins, C. (2006). A qualitative study exploring the support needs of first-time mothers on their

   journey towards intuitive parenting. *Midwifery, 22*, 169-180.

   doi:10.1016/j.midw.2005.07.001

World Health Organization. (2004). *World report on knowledge for better health: Strengthening

   health systems*. Retrieved from

   http://www.who.int/rpc/meetings/en/world_report_on_knowledge_for_better_health2.pdf

World Health Organization. (2016). *WHO recommendations on antenatal care for a positive

   pregnancy experience*. Retrieved from

   http://apps.who.int/iris/bitstream/10665/250796/1/9789241549912-eng.pdf?ua=1

Zar, M., Wijma, K., Wijma, B. (2001). Pre- and postpartum fear of childbirth in nulliparous and

parous women. *Scandinavian Journal of Behaviour Therapy, 30*(2), 75-

84. doi:10.1080/02845710121310

Zwelling, E., (1996). Childbirth Education in the 1990s and Beyond. Journal of Obstetric,
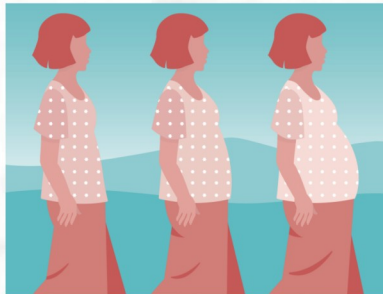
Gynecologic, & Neonatal Nursing, 25 (5), 425-432.

Appendix A

August 16, 2017

To Whom It May Concern:

My name is Victoria Little and I am a graduate student at Dalhousie University. I am writing you to let you know about a research study exploring first-time mother's experiences of prenatal education and support in Halifax Regional Municipality (HRM). I am contacting you because you have contact with pregnant women and first-time mothers. I am also asking for you to consider promoting this study in your practice.

This research is being done to learn more about how first-time mothers in HRM experience prenatal education and support. In Canada, mothers have a variety of options for prenatal education and support including for example, family, friends, blogs, chat spaces, family resource centres, midwives, doulas, doctors, and nurse practitioners. The shift in the delivery of universal prenatal education in Nova Scotia from face to face to online is potentially creating new and different experiences for mothers, that have not yet been fully examined. Presently, we do not know what supports mothers prefer to access and what they find most helpful. We need to explore what prenatal information and support mothers need. Exploring the experiences of first-time mothers as they navigate the prenatal and early postpartum period will offer new ways of understanding how healthcare providers and communities can best support expectant mothers.

I am seeking your help to promote this study among your patient population to aid in recruitment. Specifically, I am requesting that you consider placing the enclosed advertisements for this study in a location that is accessible to potential participants – perhaps a patient/family waiting area, washroom, or private assessment rooms.

The study has received ethical approval by the IWK Health Centre. Please do not hesitate to contact me if you have any questions as you read over this material. I can be reached by phone: (902) 890-1471 or by email: victoria.little@dal.ca. Dr. Megan Aston, Associate Professor at the School of Nursing, Dalhousie University, will be supervising this study, and she can be reached at 902-494-6376 or by email: megan.aston@dal.ca

Thank you for your time and for your consideration of support.

Kindly,

Victoria Little, RN, BScN
Master's of Science in Nursing Student
School of Nursing, Dalhousie University

Appendix C

Pre-Screen Questionnaire

Thank you for your interest in participating in this study. We are conducting a study with first-time mothers in Halifax Regional Municipality about their experiences with prenatal education and support. Exploring the experiences of first-time mothers as they navigate the prenatal and early postpartum period will offer new ways of understanding how healthcare providers and communities can best support expectant mothers. Now that you have some more information, are you still interested in participating? *(yes – proceed to next section; no – thank them for their time and interest)*

Before you are able to be in this study, you will have to answer some questions to see if you can take part. This is called pre-screening. This is an important step in the study so that we know we are including mothers who can speak about the issues that we are exploring. The pre-screen will take just a few minutes of your time.

It is possible that the questions will show that you can't be in the study. Your responses to the questions will be kept private. Your responses to these questions will not impact the standard, usual care you will receive from any health care facility, personnel, or community agency, and will not be known to anyone other than myself.

At this point, do you have any questions? (*answer any questions*)Would you like to continue with the pre-screen? (*yes – proceed to pre-screen questions; no – thank them for their time and for their interest*)

1.Are you a resident of Halifax Regional Municipality, Nova Scotia? _____ (*yes, inclusion*)

2. Are you 18 years of age or older? _____ (*yes, inclusion*)

3. In the past 12 months, have you birthed or adopted a baby (or babies)? _____ (*yes, inclusion*)

Thank you for your time in answering these pre-screening questions. Based on your responses, you are (eligible to be enrolled in the study, not eligible to be enrolled in the study).

If eligible to be enrolled:

Are you still interested in participating in this study? (if yes, schedule a time for the review of informed consent and the interview)

If not eligible to be enrolled:Thank you very much for your interest and time.

Appendix D

Information and Consent Form: Interviews with mothers

Research Title
Women's Experiences of Prenatal Education and Support in Nova Scotia

Researcher(s)
Victoria Little, RN, BScN, Master's of Science in Nursing Student
School of Nursing, Dalhousie University

Supervisor
Dr. Megan Aston RN PhD School of Nursing Dalhousie University

Thesis Committee
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Dr. Andrea Chircop RN PhD School of Nursing Dalhousie University
Dr. Debbie Sheppard-LeMoine RN PhD Rankin School of Nursing, St. Francis Xavier
University

Introduction and Purpose
The health of mothers and babies is of national and international concern. Antenatal care and health services need to be accesible to all pregnant women. The purpose of providing antenatal care is to ensure that women and their families receive prenatal education and support to assist them to make informed, safe decisions throughout their pregnancy and into early parenthood. For many years, Public Health Services in Nova Scotia provided in-person education and support classes to pregnant women. Although prenatal classes were meant to be available to all pregnant women, not all women chose to use these services. Due to declining enrolment, in 2014 the Nova Scotia Department of Health and Wellness introduced a free prenatal education website, "Welcome to Parenting," to replace the in-person classes. In Canada, mothers have a variety of options for prenatal education and support including for example, family, friends, blogs, chat spaces, family resource centres, midwives, doulas, doctors, and nurse practitioners. The shift in the delivery of universal prenatal education in Nova Scotia from face to face to online is potentially creating new and different experiences for mothers, that have not yet been fully examined. Presently, we do not know what supports mothers prefer to access and what they find most helpful. We need to explore what prenatal information and support mothers need.
Purpose: The purpose of the proposed study is to explore first-time mother's experiences of prenatal education and support in Halifax Regional Municipality, Nova Scotia.
How will the researchers do the study?
This research study will explore mothers' experiences of prenatal information and support. We will collect data/information through face-to-face interviews. The researcher intends to interview six to eight first-time mothers who have birthed or adopted a baby (or babies) within 12 months prior to participating in the interview. We will ask these mothers to share their experiences of prenatal education and support.

What will I be asked to do?
You will be asked to participate in a face-to-face interview led by the student researcher. You will be asked to participate in an open-ended discussion that will be audio taped. The discussion will last 60-90 minutes. You will be asked to talk about your personal experiences of accessing information and support before you gave birth or adopted your baby (or babies). Audiotapes will then be transcribed by the student researcher word for word. During the interview, you will be encouraged to share your experiences through speaking.

What are the burdens, harms, and potential harms?
We do not anticipate that you will experience any potential harm. However, if you find the interview upsetting or distressing, we would suggest you follow up with a health care provider with whom you are comfortable speaking to discuss this issue. We can provide you with a telephone number for resources available at the IWK.

What are the possible benefits?
There are no direct benefits to you from participating in the interview. However, you might enjoy the discussion and exchange of ideas with the researcher. It is hoped that what is learned will be of future benefit to others.

Can I withdraw from the study?
You can withdraw from the study at anytime before or during the interview. All of your contact and demographic information will be destroyed and we will not include the information we gathered from your interview in the study. Withdrawal from the study will not affect the care you receive from any health care facility, personnel or community agency.

Will the study cost me anything and, if so, how will I be reimbursed?
The study will not cost you anything. You will be given a $25 gift certificate to a local grocery store at the end of the interview to thank you for your time.

What about possible profit from commercialization of the study results?
Neither the researcher, nor her research committee, will profit from any commercialization of the results of the research.

Are there any conflicts of interest?
There are no actual, perceived or potential conflicts of interest (including financial conflicts) on the part of the researchers and/ or the institutions.

How will my privacy be protected?
Any information that is learned about you will be kept private. What you discuss during the interviews will be kept confidential.
Your consent form and demographic information will be locked in a filing cabinet and will be destroyed five (5) years after the completion of the study. All names used in the interview discussion will be removed and all identifying information will be removed. Your name will not be connected to any information we use in the study. Only the researcher and her supervisor, Dr. Megan Aston, will have access to the original audiotape of the interview and written transcript. Names and identifying information will be removed before other research committee members

see the data. No names or other identifiable information will be included in any publications. The IWK REB Audit committee may have access to study records for audit purposes

What if I have study questions or problems?
If you have any questions or concerns about the study please contact Dr. Megan Aston, who will be supervising the study, at the School of Nursing Dalhousie University: megan.aston@dal.ca or 902-494-6376

What are my Research Rights?
Participating in the interview indicates that you have agreed to take part in this research and for your responses to be used. In no way does this waive your legal rights nor release the investigator(s), sponsors, or involved institution(s) from their legal and professional responsibilities. If you have any questions at any time during or after the study about research in general you may contact the Research Office of the IWK Health Centre at (902) 470-8520, Monday to Friday between 9 a.m. and 5 p.m.

How will I be informed of study results?
If you would like a copy of the final research report please sign the consent form below indicating you would like a hard copy mailed to you or an electronic copy emailed to you

Study Title: Women's Experiences of Prenatal Education and Support in Nova Scotia

Participant Consent

I have read or had read to me this information and consent form and have had the chance to ask questions which have been answered to my satisfaction before signing my name. I understand the nature of the study and I understand the potential risks. I understand that I have the right to withdraw from the study during the interview at any time. I agree to have my words from the interview used in reports, publications, and conferences. I have received a copy of the Information and Consent Form for future reference. I freely agree to participate in this research study.

Name of Participant: (Print) _____

_____

Participant Signature: _____ -

_____

Date: _____ Time:_____ _____

____

Statement by person providing information on study and obtaining consent

I have explained the nature and demands of the research study and judge that the participant named above understands the nature and demands of the study. I have explained the nature of the consent process to the participant and judge that they understand that participation is voluntary and that they may withdraw during the interview at any time.

Name: (Print)_____

_____

Signature: _____ Position: _____ __

_____

Date:_____ Time: _____ __

_____

Date: _____Time: _____ _

_____

How will I be informed of study results?

Would you like to receive a hard copy or electronic copy of the final research report?
Hard copy Yes ____ No ____Electronic Copy Yes ___ No ____

If you indicated yes to either a hard copy or electronic copy, please provide your mailing address or email address:

Appendix E

Semi-Structured Interview Guide

1. The period leading up to childbirth or adoption is a time of great change as mothers prepare physically and emotionally for birth/adoption and early parenting. As a first-time mother, what issues (needs, desires, concerns, or problems) did you experience? Issues might be physical, social, emotional, psychological, etc. Issues might include feeling nervous about becoming a mother for the first time or a desire to connect with other expectant mothers. Issues can be positive, negative, or neutral. I want to know what was meaningful and important to you.

2. Did you want to seek out any supports or education/information to address any of the issues you raised in question 1?

    a. If no,
        i. Tell me why you chose not to seek out support or education/information for the various issues you were experiencing?
        ii. Tell me how you worked through the issues on your own?

    b. If yes,
        i. Tell me why you chose to seek out support or education/information for the various issues you were experiencing?
        ii. Where did you look? Tell me about your experience looking for support and information.

3. Did you find the support or education/information you were looking for?
    a. If yes,
        i. Tell me about your experience looking for the support or education/information
        ii. Tell me about your experience receiving support for each issue.
    b. If no,
        i. Tell me about your experience not being able to find the support or education/information you were looking for.

4. Did the support or education/information you received prenatally impact your birth experience?
    a. If no,
        i. Tell me why the support or education/information did not impact your birth experience.
    b. If yes,
        i. How did the support or education/information you received prenatally impact your birth experience?

5. Did the support or education/information you received prenatally impact your parenting practices?

      a. If no,
          i. Tell me why the education/information did not impact your parenting practices?
      b. If yes,
          i. How did the support or education/information you received prenatally impact your parenting practices?

6. Tell me where you would like to access education/information prenatally and why. (online, in person, print, video, FAQ, peers, professionals etc.)

7. Tell me where you would like to access support prenatally and why (virtual, in person, group, one-on-one, peer, family, friend, professional etc.