

**Behavioural Expectations and Behaviour Change in Pregnancy:
Experiences of Young Single Women**

Jessica Reszel, RN, BScN

Thesis submitted to the Faculty of Graduate and Postdoctoral Studies in
partial fulfillment of the requirements for the Master of Science degree in Nursing

School of Nursing
Faculty of Health Sciences
University of Ottawa

*I'm a woman and I'm young and I'm pregnant, so now I've got all these burdens on my shoulders
and I'm supposed to just walk with my head held high
and not crash and it's really, really hard.*

Participant 3

Acknowledgments

First, I would like to thank my thesis supervisor Dr. Wendy Peterson. I owe her much gratitude for not only her knowledge and encouragement throughout my master's degree, but also her guidance and mentorship which she has offered me since beginning my undergraduate education. Her commitment to my success over the past five years is evident - I feel so fortunate and thankful to have had such a dedicated supervisor throughout this process. I would also like to extend my gratitude to my committee members Dr. Ivy Bourgeault and Dr. Denise Moreau who provided much support and feedback throughout this process. Together, my thesis committee was a constant source of expertise, inspiration, and reassurance and I sincerely thank all three of them for the time and effort they so willingly invested in me.

I am grateful to the nine women who participated in this thesis project. Without the courage and enthusiasm of these women to share their stories with me, I would not have a thesis project. Whenever my thesis project seemed to become overwhelming, I found inspiration in the strength and optimism they showed in overcoming their own challenges.

Finally, thank you to my family and friends for their patience, love, and constant support throughout this process.

Abstract

Background: Pregnancy has been described as a period when women experience heightened behavioural surveillance. Young single women have commonly been described as a population who engage in high risk behaviours during pregnancy (e.g. smoking), yet they are also a population who often has access to fewer resources to make expected behaviour changes during pregnancy. **Purpose:** To explore the experiences of young single pregnant and parenting women regarding behavioural expectations and behaviour change during pregnancy. **Research Questions:** (1) What are the perceived behavioural expectations for young single women during pregnancy? (2) Who or what reinforces the perceived behavioural expectations? (3) To which behavioural expectations do young single women conform (or resist) and why? **Methods:** Nine single pregnant or parenting women between the ages of 15 and 24 were recruited from two urban community health settings between November 2011 and January 2012. Data was collected through individual semi-structured photo-elicitation interviews and analyzed using qualitative content analysis. **Results:** The main findings of the study include: (1) young single pregnant women are subject to a multitude of health and social behavioural expectations, (2) young single women experience internal and external behavioural surveillance during pregnancy, and (3) young single pregnant women experience these behavioural expectations as a tension between the potential for opportunity and oppression. **Implications for Practice:** By understanding young single pregnant women's perceptions of how they are expected to behave, who and what reinforces such expectations, and how young women conform to or resist such expectations, the results of this project will inform the development of effective individual, community, and systemic level interventions and better inform interactions with young pregnant women.

Table of Contents

Acknowledgments	iii
Abstract	iv
Glossary of Terms	viii
Organization of Thesis	ix
Chapter One – Introduction	1
1.1 Research Problem	1
1.2 Research Purpose	3
1.3 Research Questions	3
1.4 Background	3
1.4.1 The context of health care during pregnancy	4
1.4.2 The nature of health risk and young single pregnant women	6
1.4.3 Societal stigma and young single pregnant women	8
1.4.4 Summary	10
1.5 Relevance of Study	10
Chapter Two – Literature Review	13
2.1 Expected Behaviours in Pregnancy	13
2.2 Young Single Pregnant Women and Expected Behaviours in Pregnancy	17
2.3 Young Women’s Experience of Behaviour Change in Pregnancy	20
2.3.1 Prenatal care	20
2.3.2 Smoking	21
2.3.3 Nutrition	22
2.4 Summary	23
Chapter Three – Methodology	25
3.1 Research Design	25
3.2 Theoretical Underpinnings	26
3.2.1 Situating myself within the research process	28
3.3 Recruitment and Sampling	30
3.3.1 Limitations	32
3.4 Data Collection and Procedures	32
3.5 Data Management and Analysis Methods	34
3.5.1 Evolution of data analysis process	36
3.6 Rigour	37
3.7 Ethical Considerations	38
Chapter Four – Results	39
4.1 A Young Single Pregnant Women’s Story	39
4.2 Characteristics of Sample	41
4.2.1 Health and social context of participants	43

4.3 Summary of Themes.....	44
4.4 Theme 1: Expected Behaviours in Pregnancy.....	46
4.4.1 Health behaviours.....	47
4.4.1.1 Drugs and alcohol.....	47
4.4.1.2 Exercise.....	48
4.4.1.3 Nutrition.....	49
4.4.1.4 Service use.....	51
4.4.1.5 Smoking.....	52
4.4.1.6 Weight gain.....	54
4.4.2 Social behaviours.....	54
4.4.2.1 Adoption and abortion.....	55
4.4.2.2 Education.....	55
4.4.2.3 Social Life.....	56
4.5 Theme Two: Experience of Expected Behaviours in Pregnancy.....	58
4.5.1 Behavioural expectations as opportunity.....	58
4.5.1.1 Good mother.....	59
4.5.1.2 Healthy mother and healthy baby.....	60
4.5.1.3 Taking responsibility/making own decisions.....	61
4.5.2 Behavioural expectations as oppressive.....	62
4.5.2.1 Additional behavioural expectations for women (vs. men).....	62
4.5.2.2 Additional behavioural expectations for young women (vs. older women).....	63
4.5.2.3 Loss of identity.....	65
4.5.2.4 Stigma.....	65
4.5.3 Summary of identity constructs and influence on pregnancy experience.....	67
4.5.4 Relationships.....	70
4.6 Theme Three: Surveillance.....	73
4.6.1 Internal surveillance.....	74
4.6.2 External surveillance.....	75
4.7 Summary of Results.....	77
Chapter Five – Discussion.....	78
5.1 Introduction to Discussion of Results.....	78
5.2 Redefining Health in Pregnancy.....	78
5.3 Understanding Behaviours in Young Single Pregnant Women.....	82
5.4 Examining Relevant Identity Constructs in Pregnancy.....	85
5.5 Implications and Recommendations.....	88
5.5.1 Nursing practice.....	88
5.5.2 Nursing education.....	90
5.5.3 Nursing research.....	91
5.6 Study Strengths and Limitations.....	92
5.7 Conclusion.....	94
References.....	95
Appendix A – Letter of Permission.....	110

Appendix B – Recruitment Script	111
Appendix C – Information Sheet for Young Women	112
Appendix D – English Consent Form	113
Appendix E – French Consent Form	116
Appendix F – Demographic Information for Young Women	119
Appendix G – Interview Guide	121
Appendix H – Description of Photographs	123
Appendix I – Example of Data Analysis Process	124
Appendix J – University of Ottawa Ethics Approval	125

List of Table and Figures

Table 1 - Characteristics of Sample	42
Figure 1 - Summary of Themes	45
Table 2 - Opportunities and oppressions of behavioural expectations in pregnancy and corresponding identities	67

Glossary of Terms

Behavioural model of health: A model which focuses on the role of individual behaviours in preventing disease. Health is achieved through making healthy lifestyle choices (Clarke, 2004; Ontario Health Promotion Resource System [OHPRS], n.d.).

Medicalization: Medicalization is a process which involves traditionally non-medical issues and behaviours transitioning under the domain of biomedicine. Medicalization necessitates a use of biomedical language, frameworks, and interventions to describe, understand and manage the issues (Conrad, 1992).

Single woman: An unmarried woman.

Social determinants of health: The social and economic conditions which interact to produce health at an individual and population level. Examples of social determinants include income, gender, education, employment, access to services, among others (National Collaborating Centres for Public Health, 2008).

Social location: Social location is “the relative amount of privilege and oppression that individuals possess on the basis of specific identity constructs” (Hulko, 2009, p.48).

Young woman: A woman between the ages of 15 and 24 inclusive, as per the World Health Organization (2010). The inclusion of women in their early twenties in the category of ‘young women’ is especially appropriate as recent literature has demonstrated that due to the changing demographics of women having children later in life, women in their early twenties may now be experiencing the stigmatization once exclusive to pregnant adolescents (Whitley & Kirmayer, 2008)

Organization of Thesis

This thesis explores the experiences of young single pregnant women regarding dominant behavioural expectations and behaviour change in pregnancy. This thesis is organized into five chapters. Chapter one provides the research purpose and questions, background information for the study and concludes with the significance for nursing. Chapter two provides a review of the literature on expected behaviours in pregnancy, behaviours in young pregnant women, and the experience of behaviour change for young women. Chapter three discusses the methodology used in the study. Chapter four presents the results of the study, followed by chapter five where the results are discussed and recommendations for practice, education, and future research are made.

Chapter One – Introduction

This chapter will present the research problem, research purpose, and research questions. Furthermore, this chapter provides background information on the current health and social context of pregnancy in young women. Lastly, this chapter will explore the relevance of this study.

1.1 Research Problem

In 2007, the number of births to Canadian women ages 15 to 24 was 74,630, which accounts for 19.7% of all live births in Canada (Statistics Canada, 2011a), with up to 73.6% of these women being single (Statistics Canada, 2011b). Young single pregnant women are a group that may experience societal stigmatization based on both their age and their partner status (Hyde, 2000; Macvarish, 2010; Wiemann, Rickert, Berenson, & Volk, 2005). Such stigmatization may be further reinforced by current discourses surrounding the high-risk nature of the behaviours of young single women during pregnancy. Examples of young single women's high risk behaviours during pregnancy have included higher rates of smoking, alcohol use, poor dietary intake, and late contact with prenatal health services (Baker et al., 2009; Heaman, 2009; Heaman, Lindsay & Kaczorowski, 2009; Kaiser & Hays, 2005; Millar & Hill, 2004; Moran, 2007; Public Health Agency of Canada [PHAC], 2006; Wahn & Nissen, 2008). While this literature has provided a thorough description of the types of behaviours young single women engage in (and do not engage in) throughout pregnancy, these descriptions have failed to situate such behaviours within the individual and social context of the young women experiencing pregnancy, which ultimately has the potential to lead to further problematizing and stigmatization of this population.

While there exists several studies that have situated behaviours during pregnancy within the social context of pregnancy and the context of the pregnant woman, such studies have not

been specific to young single women, but rather have been inclusive of the general pregnant population (Baric & MacArthur, 1977; Bessett, 2010; Bondas & Eriksson, 2001; Fox, Heffernan, & Nicolson, 2009; Kennison, 2009; Nash, 2011). Considering the challenges often faced by young single pregnant women such as lower social support (Hanna, 2001; Statistics Canada, 2008), poverty (National Council of Welfare as cited in Best Start Resource Centre, 2003), violence (Covington, Justason, & Wright, 2001), low education (Fessler, 2003), stigmatization (Berman, Silver, & Wilson, 2007; Ekstrand, Larsson, Von Essen, & Tyden, 2005; Hanna, 2001), high mobility and high stress levels (Best Start Resource Centre, n.d.), young single women's experience of behavioural expectations and behaviour change in pregnancy may differ from that of the general pregnant population.

Often, the ability to make the expected behaviour changes during pregnancy requires resources and paradoxically, those who can benefit the most from behaviour changes often lack the resources to effectively make such changes (Biro, 2011). Thus, for groups of pregnant women with less access to resources, such as young single women, conforming to the dominant behavioural expectations may present a challenge and lead to social consequences such as further stigmatization. Including women from varying backgrounds, such as young single pregnant women, has been recommended as an important area of future research on health expectations, behaviours, and pregnancy (Fox et al., 2009). Thus, an exploration of the experiences of young single pregnant women specifically regarding perceived behavioural expectations and behaviour change is warranted due to this group's relative lack of resources as well as the associated societal problematizing of this group and their health behaviours.

1.2 Research Purpose

Given the limited literature that situates expected behavioural change in pregnancy within the unique context of the young single woman, the purpose of this qualitative study was to understand the experience of behavioural expectations and behaviour change in pregnancy from the perspective of single (unmarried) women between the ages of 15 and 24. To understand the experience of behavioural expectations and behaviour change in pregnancy, this project sought to explore how such expectations are enforced and which expectations are conformed to and which are resisted, with particular attention paid to the individual and societal context in which such experiences occur.

1.3 Research Questions

More specifically, the research questions this project seeks to answer are:

- 1) What are the perceived behavioural expectations for young single women during pregnancy?
- 2) Who or what reinforces the perceived behavioural expectations?
- 3) To which behavioural expectations do young single women conform (or resist) and why?

1.4 Background

To understand the experience of behavioural expectations and behaviour change in young single women it is important to consider the broader context of pregnancy, and more specifically, the nature of risk and the social context of pregnancy in young women. This background section will describe: (1) the context of health care during pregnancy, (2) the current understanding of risk associated with pregnancy at a young age, and (3) the societal context and stigmatization of pregnancy in young single women.

1.4.1 The context of health care during pregnancy. Over the past century care during pregnancy and birth has become increasingly medicalized (Downe, 2008; Wertz & Wertz, 1989). Medicalization is a process which involves traditionally non-medical issues and behaviours transitioning under the domain of biomedicine. Thus, medicalization necessitates a use of biomedical language, frameworks, and interventions to describe, understand and manage the issues (Conrad, 1992). Prenatal care began to fall under the domain of medicine in the early 1900s, with a movement towards the medical profession problematizing pregnancy, increasing the perceived risk, and ultimately necessitating a role for medicine (Barker, 1998). Between 1900 and 1920, it is estimated that less than 5% of women had contact with a physician prior to delivery (Barker, 1998). The biomedical model of prenatal care was developed based on the goal of identifying symptoms of preeclampsia and preventing infection (Alexander & Kotelchuck, 2001; Maloni et al., 1996). Thus, the model of prenatal care known today, including many of the physical assessments and timing of visits, is historically based on the prevention, identification, and treatment of preeclampsia and infection (Alexander & Kotelchuck, 2001). Subsequently, prenatal care has evolved to also include reducing infant mortality, low birth weights, and premature births as priorities (Moos, 2006).

Two services that women may access during pregnancy are prenatal care and prenatal classes, with both of these services representing settings where nurses commonly provide care to pregnant women and their families. The current schedule of prenatal care visits recommended by the Society of Obstetricians and Gynecologists of Canada is “a prenatal visit every 4 to 6 weeks until 30 weeks gestation; every 2 to 3 weeks until 36 weeks gestation; and then every 1 to 2 weeks until delivery” (as cited in Canadian Institute for Health Information [CIHI], 2006, p.4). Data indicates that approximately 97% of Canadian women receive prenatal care (CIHI, 2006).

Of the women that receive prenatal care, it has been estimated that in 2007 approximately 92.3% of women received prenatal care from a physician, with 58.1% of women seeing an obstetrician and 34.1% of women seeing a family physician (Heaman & O'Brien, 2009). While the large majority of women receive prenatal care from a physician, there is a small minority of women who access other models of prenatal care. More specifically, 6.1% of women received prenatal care from a midwife and less than 1% of women received prenatal care from a nurse or nurse practitioner, with the remaining 1% receiving prenatal care from an unspecified provider (Heaman & O'Brien, 2009). The prenatal care visits most commonly entail education on health behaviours as well as screening and management of illness and pregnancy complications (Scarr, 2002).

An additional expected activity during the prenatal period worth noting is attendance at prenatal classes, which provides a group environment for women and families to learn about pregnancy, birth and parenting (Best Start Resource Centre, 2007). Prenatal classes are offered by a variety of professionals at hospitals, clinics, public health units, community centres, and privately (Best Start Resource Centre, 2007; Chalmers & Kingston, 2009). It has been estimated that approximately 33% of pregnant women in Canada attend prenatal classes, with young women between the ages of 15 and 19 representing the age group most likely to attend prenatal classes (Chalmers & Kingston, 2009). It is important to note that the most common place for Canadian women to take prenatal classes is in the hospital environment (Chalmers & Kingston, 2009) and that the content of hospital-based prenatal classes is often related to the types of obstetrical services offered at each hospital site (Best Start Resource Centre, 2007). Thus, with a large percentage of Canadian women accessing both prenatal care and prenatal classes during

pregnancy, the messages reinforced through such health services are influential in shaping dominant behavioural expectations in pregnancy.

As prenatal care has become more medicalized, the state of pregnancy has become subject to “surveillance medicine,” which involves the monitoring of healthy individuals and groups who have the potential to become ill (Armstrong, 1995). The expanded role of medicine in monitoring healthy populations who are at risk of developing illness necessitates the use of screening and health promotion strategies to monitor and manage the level of risk within the population (Armstrong, 1995). Consistent with the current schedule of prenatal care, it has become routine for women to receive such screening and health promotion throughout pregnancy. Further to this increased dominance of surveillance medicine, medicalization has also resulted in the attribution of social inequities to individual behaviours (Conrad, 1992), placing increased responsibility on individuals for behaviours and outcomes. Thus, surveillance medicine and the increased focus on individual behaviours and choices in mitigating the potential risks associated with pregnancy have resulted in women being subject to a myriad of societal expectations, as this project sought to explore.

1.4.2 The nature of health risk and young single pregnant women. In the literature, pregnancy in young women has typically been described as high risk for both the mother and infant. For instance, young pregnant women have been shown to be at increased risk for experiencing anemia, hypertension, and increased risk of postpartum depression (Chalmers & Kimak, 2009; Paranjothy, Broughton, Adappa, & Fone, 2009). Furthermore, infants of young women are at risk for poor health outcomes due to increased risk for preterm labour (Chen et al., 2007; Khashan, Baker, & Kenny, 2010), increased risk of low birth weight infants (Chen et al., 2007), and increased rates of neonatal and infant death (Gilbert, Jandial, Field, Bigelow, &

Danielson, 2004). While there are a myriad of studies that have served to define pregnancy in young women as high risk, the relative importance of the underlying causes of risk in young women, such as biology, poor service access, or social factors, remains debatable (Chen et al., 2007). Although the specific causal mechanisms remain contested, there is evidence to suggest that the health of young pregnant women and their children is shaped by a multitude of social and environmental factors.

Young pregnant women are often socioeconomically disadvantaged, with families headed by a parent under the age of 30 experiencing poverty at a rate twice that of their older counterparts (deGroot-Maggetti, 2002). More specifically, The National Council of Welfare estimates that 85.4% of young single mothers under the age of 25 are living in poverty in Canada (as cited in Best Start Resource Centre, n.d.). Furthermore, many young pregnant women lack access to adequate social support networks. For instance, Statistics Canada (2011b) suggests that up to 94% of pregnant and parenting women between the ages of 15 and 19 are single, while up to 68.1% of women between the ages of 20 and 24 are single. Further to this lack of partner support, many young pregnant women experience abandonment. As highlighted in a study by Hanna (2001), many of these women are “abandoned” by principal support people, including family and friends, upon affirming their pregnancy. Although many of these support people return to the young woman upon the birth of the infant (Hanna, 2001), the concept of abandonment in pregnancy highlights the vulnerability of young women in this period. Young women are also more likely to experience violence prenatally (Covington et al., 2001), have low education (Fessler, 2003), as well as experience high mobility and high stress levels (Best Start Resource Centre, n.d.).

1.4.3 Societal stigma and young single pregnant women. For the purpose of this study, young women are defined as those between the ages of 15 and 24 inclusive, as per the World Health Organization (2010). The inclusion of women in their early twenties in the category of ‘young women’ is especially appropriate as recent literature has demonstrated that due to the changing demographics of women having children later in life, women in their early twenties may now be experiencing the stigmatization once exclusive to pregnant adolescents (Whitley & Kirmayer, 2008). Furthermore, for the purpose of this study ‘single’ is defined as unmarried. A focus on young single women specifically is warranted as further to a lack of partner support, young single mothers experience the greatest depth of poverty (Best Start Resource Centre, n.d.), highlighting this population’s potential lack of resources. Thus, pregnant and parenting women who are young and unmarried are a priority population given their likelihood of experiencing multiple disadvantages.

A further disadvantage commonly experienced by young single pregnant and parenting women is stigmatization. As described by Link and Phelan (2006), stigma occurs through the identification of human differences and a subsequent attribution of negative characteristics to the individuals and groups who possess such differences. Ultimately, this process may result in the loss of status and social exclusion for the labeled individuals and group (Link & Phelan, 2006) and has the potential to impact an individual’s self-esteem, stress levels, and service access (Link & Phelan, 2006; Planned Parenthood of Toronto [PPT], 2005). Applying Link and Phelan’s (2006) conceptualization of stigma to the young single pregnant population facilitates a consideration of what makes this group different and what negative characteristics have been attributed to this group. First, the group of young single pregnant women differs from societal norms regarding sexuality and motherhood (Breheny & Stephens, 2007; PPT, 2005; Shoveller &

Johnson, 2006; E. Whitehead, 2001). Second, there is a multitude of examples of negative physical, behavioural, and social characteristics that have been attributed to this population and their children, as described in the previous section, as well as the negative societal beliefs that young mothers are poor parents and economically dependent on social assistance (Shoveller & Johnson, 2006).

Several studies have explored the concept of stigma in young and single women who are pregnant and parenting. For instance, Wiemann et al. (2005) illustrated how adolescent women's feelings of stigmatization were positively related to not being engaged or married to the father of the baby. This notion is supported by Hyde (2000) who found that young women felt having a partner physically present or making it known to others that they were in a relationship mitigated the negativity associated with being pregnant at a young age. The stigma attached to young single pregnant and parenting women may not only be related to their age and marital status, but also be related to their gender. For instance, a study by DeJean, McGeorge, and Carlson (2012) compared the societal perception of never married parents, finding that there were significant negative perceptions of single mothers compared to single fathers, including the perception that single mothers were less moral, less responsible, and less able to be a good parent (DeJean et al., 2012).

Such examples of stigmatization are further supported by evidence of a current social environment that largely problematizes pregnancy in young women. With the Public Health Agency of Canada (1999) referring to teenage pregnancy as a "major public health problem" (para 1) and a plethora of literature on young pregnancy prevention (see for example de Anda, 2006; Lederman, Chan, & Roberts-Gray, 2008), those young women who do get pregnant and continue with the pregnancy are often stigmatized. Young pregnant women are commonly

blamed for their “misfortunes” and are considered rebellious and promiscuous by society (Berman et al., 2007; Ekstrand et al., 2005; Hanna, 2001). The responsibility and stigmatization of young single pregnancy falls largely on women, with young women perceiving that the public places the blame and pressure on young women rather than men (Herrman, 2008). Thus, with young single pregnant women facing surveillance of their behaviour during pregnancy, often with inadequate social resources and facing societal stigmatization, this study aimed to situate and understand their experiences of behavioural expectations and behaviour change in pregnancy.

1.4.4 Summary. This section provided background information to illustrate the current health care context of pregnancy in general and more specifically, the current health and social context of pregnancy in young women. A consideration of the medicalized context of pregnancy is important to consider as one’s experience of behavioural expectations and behaviour change may be shaped by the dominant medicalized discourses surrounding this period. Furthermore, a consideration of the health and social challenges encountered by young single pregnant women is necessary to understand the multiple challenges and contexts which may shape their experience of behavioural expectations and behaviour change in pregnancy.

1.5 Relevance of Study

This study sought to gain an understanding of young single women’s experiences of behavioural expectations and behaviour change during pregnancy. By understanding what the perceived expectations are, who and what reinforces such expectations, and how young women conform to or resist such expectations, the results of this study will inform the development of effective individual, community, and systemic level interventions.

For instance, an understanding of the perceived behavioural expectations for young pregnant women can illuminate the consistency (or inconsistency) between dominant discourses surrounding pregnancy and perceived behavioural expectations and behaviour changes made by young women. Furthermore, an understanding of who or what young women feel reinforce such expectations can increase knowledge of not only effective channels through which to communicate health messages, but also who or what might be contributing to the systemic surveillance and stigmatization of this group. Lastly, this study has the potential to increase understanding about which expectations young women are able to conform to and which they are not, which may inform understanding about the facilitators and barriers to making expected behaviour changes. Further to such facilitators and barriers, an understanding of young women's motivations to conform and resist dominant health norms in pregnancy may be influential in understanding the unique individual attitudes and societal pressures experienced by the population.

To best understand the aforementioned experiences of young pregnant women, it is important for the voices of this population to be central. There exists a multitude of literature on pregnancy in young women, with many reports focusing on describing young single pregnant women's 'high-risk' behaviours, such as smoking, alcohol use, sexual practices, and late contact with prenatal health services (see for example Kaiser & Hays, 2005; Wahn & Nissen, 2008). While an identification and description of the health behaviour trends of young single pregnant women is important to know, it does not provide a complete picture of this group's pregnancy experience. By omitting the voices of young women themselves in studies that seek to describe health behaviours in pregnancy, such behaviours only come to be understood separate from the social context in which they occur, which may ultimately lead to further stigmatization of this

group. As suggested by Freed (1999), to best understand the self-described experiences of pregnancy one must consider how such experiences are socially influenced. Thus, this study has the potential to increase understanding of the behaviours of young pregnant women through the inclusion of the voices of young women themselves to describe their experiences as situated in their unique social location.

An increased understanding of the pregnancy experiences of young women has the potential to enhance the relationship between health care providers and young pregnant women. This point is supported by Smith Battle (2000) who states that in health care settings relationships that validate the unique social complexities of the lives of young pregnant and parenting women is a crucial aspect of empowerment and support. This project may contribute to facilitating effective relationships between health care providers and young pregnant women by bringing the social context of the young woman to the forefront. Given the disproportionate amount of challenges faced by this population, there is a need for appropriate and sensitive services to not only mitigate potentially negative effects, but to also support and enhance a positive transition into parenthood.

Chapter Two - Literature Review

The purpose of this chapter is to provide a synthesis of the literature related to the study. This review of the literature is divided into three sections. The first section explores the literature on expected behaviours in pregnancy and establishes what the behaviours are and how they are enforced. The second section describes the specific behaviours of young women during pregnancy, with particular attention paid to how such behaviours are developmentally and socially influenced. The third section reviews the literature on the experiences of making expected behaviour changes in pregnancy from the perspective of young women. Finally, the literature is summarized to identify current knowledge gaps.

Four databases were searched: CINAHL, Scopus, PubMed and PsychInfo using key words such as ‘adolescent pregnancy,’ ‘pregnancy,’ ‘health behaviours,’ ‘health norms,’ and specific behaviours such as ‘smoking,’ ‘nutrition,’ and ‘prenatal care,’ among others. Both quantitative and qualitative articles were reviewed but only studies reported in English were included.

2.1 Expected Behaviours in Pregnancy

The literature, including the lay press, is replete with examples of expected behaviours for women during pregnancy. Women experience the pressure to eat more nutritiously (Bondas & Eriksson, 2001), achieve an acceptable level of physical fitness (Bondas & Eriksson, 2001; Nash, 2011), attend prenatal appointments (Bessett, 2010), and eliminate the use of alcohol, tobacco, and drugs (Bondas & Eriksson, 2001). The aforementioned behaviour changes are also reflected in the Public Health Agency of Canada’s (2008) “The Sensible Guide to a Healthy Pregnancy,” which encourages women to make behaviour changes surrounding nutrition, substance use, exercise, oral health, and emotional health. Expected behaviours in pregnancy

have also extended beyond choices to promote health and many women may feel pressure to conform to a “yummy mummy” image of pregnancy as frequently seen in recent media (Nash, 2011). For instance, an online article from “What to Expect” (n.d.) offers women guidance on how to dress during pregnancy, suggesting “clingy tops, body skimming dresses, low-rider jeans, sexy swimsuits, even cropped T-shirts” (“What to Expect”, n.d., para 2). Such examples serve to illustrate how pregnancy is a period with a variety of rules and expectations (Fox et al., 2009) that dictate how pregnant women “should” behave during this period.

Such health and social behaviours that are expected of women in pregnancy may be reinforced through a variety of channels as well as broader societal surveillance of pregnant women. First, health messaging is delivered and reinforced by health care providers (Bessett, 2010), the media (Fox et al., 2009; Nash, 2011), and through popular and experiential knowledge (Toutain, 2010). Furthermore, family members and friends have the potential to also reinforce such health messaging in pregnancy. This is supported by Lee and Grubbs (1993) who found that the majority of young women who initiated prenatal care late received support and guidance on self-care practices from their family members and friends. Thus, despite the emphasis on visits to a physician or midwife as well as participation in prenatal classes as “proper” prenatal care, there is evidence to suggest that even women who do not seek any mainstream prenatal care still make behaviour changes, including changes to nutrition, exercise, sleeping patterns and substance use behaviours (Higgins & Woods, 1999). Such behaviour changes made without the guidance of “expert” health care professionals in formalized prenatal care illustrates the extent to which health and social expectations in pregnancy are embedded and perpetuated through other channels such as the media, family, peers and society to shape the behaviours of pregnant women. A consideration of such behaviour changes made without the guidance of mainstream

prenatal care is especially relevant for young single pregnant women, as this population is more likely to initiate prenatal care after the first trimester (Heaman, 2009). Thus, an exploration of alternate sources and enforcers of health and social expectations during pregnancy is warranted.

A second means by which expected behaviours in pregnancy are reinforced is through surveillance. The power to medically define and manage issues, such as pregnancy, has led to medicalization being described as a form of social control (Conrad, 1992). The current conceptualization of pregnancy as a period with inherent risk (Barker, 1998) has necessitated not only specific actions and behaviours to mitigate such risks, but also societal and personal surveillance to enforce “appropriate” behaviours. Pregnancy is a time period that has become increasingly subject to public scrutiny (Fox et al., 2009), where a woman is held to higher health standards due to her responsibility for not only herself, but also the fetus (Bondas & Eriksson, 2001). The pregnant woman thus becomes subject to the “pregnancy police,” in which society engages in public surveillance of pregnant women for appropriate health and social behaviours and offers advice and guidance on what pregnant women should and should not be doing (Fox et al., 2009; Nicolson, 2010). Furthermore, pregnant women have also been found to engage in self-surveillance and surveillance of other pregnant women (Fox et al., 2009). Such scrutiny of the self and others surrounding ‘appropriate’ health behaviours during pregnancy stems from ideologies of the “good mother,” a woman who conforms to socially acceptable behaviours to benefit her child (Fox et al., 2009). The desire to make behaviour changes for a healthy baby (Bondas & Eriksson, 2001; Higgins & Woods, 1999) is consistent with the concept of *maternal sacrifice*, which maintains that “good mothers” make sacrifices for the good of their child (Bessett, 2010). Pregnant women who expressed having difficulty making such sacrifices during pregnancy report feelings of guilt and judgment (Bessett, 2010), highlighting the pressures

pregnant women experience to conform to health expectations. Furthermore, women are held accountable for their decisions and behaviours during pregnancy and may be blamed for poor infant outcomes (Bessett, 2011; Fox, et al., 2009). As explained by Nicolson (2010), pregnant women have a wealth of health information available to them, but with this increased availability comes increased societal expectations to use the information appropriately to enhance health behaviours.

Such surveillance of ‘appropriate’ health and social behaviours and the social construction of the ‘good mother’ have the potential to create a positive and empowering environment for women by allowing them to use their knowledge and resources to best enhance their own health and the health of their fetus (Bondas & Eriksson, 2001). This notion is reinforced by Fox et al. (2009), who found that women in their study were empowered by their ability to use their resources to conform to the socially acceptable health behaviours during pregnancy, as this classified them as “good mothers.”

Alternately, such surveillance may have the effect of disempowerment (Fox et al., 2009); that is, what was once considered a natural process has become a time period where women are no longer seen as experts of their own bodies and thus need guidance to successfully manage the pregnancy. Furthermore, such surveillance may lead women to experience feelings of failure and guilt when they are unable to conform to societal health expectations during pregnancy (Bondas & Eriksson, 2001). To avoid the associated social consequences (such as stigmatization) of not conforming to dominant behavioural expectations during pregnancy, some women attempt to conceal “inappropriate” health behaviours (Kennison, 2009). For instance, women may perceive a socially sanctioned ‘incompatibility’ between the state of pregnancy and smoking, and thus

attempt to avoid the social consequences by either smoking in non-public places or by concealing their pregnancy (Kennison, 2009).

The aforementioned literature on the content and sources of behavioural expectations in pregnancy illustrates the current emphasis on the individual's conformation to dominant health and social behaviours during this period, which may result in the problematizing of individuals and groups whose behaviour deviates from such expectations, such as young single pregnant women. As will be discussed in the next two sections, young single pregnant women in particular may experience such behavioural expectations and behaviour change differently than the general pregnant population due to their unique individual and social contexts.

2.2 Young Single Pregnant Women and Expected Behaviours in Pregnancy

There are many examples in the literature describing young women's high risk behaviours during pregnancy, including smoking, alcohol use, sexual practices, poor dietary intake, and late contact with prenatal health services (Baker et al., 2009; Kaiser & Hays, 2005; Moran, 2007; Wahn & Nissen, 2008). The findings of such studies resonate with Canadian statistics. For instance, young women, single women, and low income women are most likely to smoke and be exposed to smoke during pregnancy, with approximately one third of women in each of these groups reporting smoking during pregnancy (Millar & Hill, 2004). Furthermore, young pregnant women are more likely to drink alcohol more frequently and more heavily (PHAC, 2006) and are more likely to use street drugs (O'Campo & Johnston, 2009). Young Canadian pregnant women are also more likely to initiate prenatal care after the first trimester and less likely to take folic acid supplements (Heaman, 2009; Kaczorowski & Lee, 2009). While such statistics serve to illustrate priority areas for intervention, they may also contribute to stigmatization of young pregnant women. More specifically, there is the perception that there is

an incompatibility between being young and being a “good mother” (Breheny & Stephens, 2007). The notion that being young means making poor behavioural choices and thus makes young women less able to be a “good mother” validates the social surveillance previously discussed (Breheny & Stephens, 2007).

It is important to consider the experience of behavioural expectations and behaviour change in pregnancy within both the unique developmental and social contexts of young pregnant women. Adolescence and young adulthood represent unique developmental periods. Young adults may be highly influenced by group behavioural expectations, especially those of their peer group (Messer, Shoe, Canady, Sheppard, & Vincus, 2011). That is, youth behaviour is largely influenced by one’s perception of what is “normal” behaviour for their peer group (Messer et al., 2011). For instance, Kingston and Chalmers (2009) found young women differ from older women in that they more commonly identified family and friends as their most important source of information during pregnancy. It is thus important to consider this developmental context along with the social context when exploring the experience of behavioural expectations and change of young pregnant women.

Further to the unique developmental influences on this population, the social context of belonging to a marginalized group may also contribute to their experience of behavioural expectations and behaviour change in pregnancy. For instance, there is evidence to suggest that within marginalized populations, such as young single pregnant women, societal behavioural expectations may be in conflict with those specific to the marginalized group. For example, Bute and Jenson (2010) found that among the subgroup of young low income women in their study early childbearing was considered normal and desirable, yet this behaviour went against the broader societal expectations that childbearing is to be delayed until later. The population of

young single pregnant women may thus be confronted with similar challenges in dealing with pressures to conform to different sets of health and social behavioural expectations; namely, the expectations of their peer group and the societal expectations of pregnant women.

An additional component of the social context is the myriad of social challenges faced by young pregnant women including lower social support (Hanna, 2001; Statistics Canada, 2008), poverty (Best Start Resource Centre, 2003), violence (Covington et al., 2001), low education (Fessler, 2003), stigmatization (Berman, et al., 2007; Ekstrand et al., 2005; Hanna, 2001), as well as high mobility and high stress levels (Best Start Resource Centre, n.d.). Despite the aforementioned challenges encountered by young women, such challenges also have the potential to promote positive health behaviours. For instance, a study by Fulford and Ford-Gilboe (2004) found that felt stigma of young mothers was positively related to increased health responsibility, which involves taking responsibility for one's health, efforts to learn about health, and efforts to seek guidance as necessary (Walker, Sechrist, & Pender, 1987). Contrarily, as will be discussed in the next section, such challenges may also have a negative impact on the experiences of behavioural expectations and behaviour change for young pregnant women. Thus, young women are a priority subgroup of pregnant women due to their lack of access to the same resources as their adult and/or married counterparts, and the potential for subsequent challenges and motivations to conform to the expected behaviours in pregnancy. For this reason, the use of quantitative studies that solely identify and describe the high risk behaviours of young pregnant women alone are not sufficient. Rather, there is a need for further research that employs methods that facilitate an examination of the unique individual and social context of young pregnant women to gain a deeper and more comprehensive understanding of the pregnancy behaviours of this population.

2.3 Young Women's Experience of Behaviour Change in Pregnancy

The purpose of this section is to provide a brief review of the literature on the experience of behaviour change from the perspective of young pregnant women. More specifically, the three main behaviours that were identified in the literature are examined, namely accessing prenatal care, smoking, and nutrition. The studies described below represent the small body of literature that addresses the experience of behaviour changes in pregnancy with young women specifically. Despite the small number of studies found, the few presented below serve to illustrate the unique experiences of young pregnant women regarding behaviour change and illustrate the importance of further studies on this topic to better inform behaviour change interventions with this population.

2.3.1 Prenatal care. An example in the literature of young women's lack of conformity to expected health behaviours is the use of prenatal care, which is commonly conceptualized as a "moral obligation" for pregnant women (Bessett, 2011, p. 370). It has been shown that young pregnant women are less likely to attend the recommended number of prenatal visits (Debiec, Paul, Mitchell, & Hitti, 2010) and that young maternal age is associated with later initiation of prenatal care (Haeri, Guichard, & Saddlemire, 2009). Although the efficacy of prenatal care is debated (Alexander & Kotelchuck, 2001; Barker, 1998; Maloni et al., 1996), young pregnant women are problematized for their lack of conformity to the established sequence and frequency of visits. Such emphasis on the quantity of prenatal care visits ignores the broader social context in which the young pregnant woman is situated and the personal preferences and resources for change accessible to the young woman. Thus, young single pregnant women are confronted with the dilemma of being constantly surveyed for being young and pregnant and the dilemma of being stigmatized for lack of conformity to behavioural expectations in pregnancy due to the

potential lack of resources. Interestingly, research has suggested that despite the late and/or infrequent use of prenatal care by young women, they still engage in health promoting behaviours.

Lee and Grubbs (1993) used a qualitative exploratory design to study the self-care behaviours of pregnant adolescents and found that even young women entering prenatal care in the third trimester had engaged in self-care activities prior to receiving formal care, with the most common behaviours relating to nutrition, exercise, vitamins, sleep, and drugs and alcohol. Such information was communicated through informal sources such as family and friends (Lee & Grubbs, 1993). The aforementioned example of problematizing young pregnant women for their lack of usage of prenatal care is challenged by such evidence which suggests that young pregnant women may seek information from other sources and engage in health behaviours without formal medical guidance. Thus, an exploration of the personal preferences and resources available for conforming to dominant behavioural expectations during pregnancy is especially relevant for this population.

2.3.2 Smoking. A qualitative study by Lawson (1994) examined the experiences of young low income pregnant women who smoked during their pregnancy. For the majority of the participants, smoking during pregnancy was seen as common within their families and social networks, and many women identified other women who had smoked during pregnancy and had healthy infants. Participants also compared their smoking behaviours to the drug use and criminal activity of others, as a way to justify their smoking and make it more favorable than other risky activities (Lawson, 1994). The participants viewed cigarettes as a source of pleasure, stability and security (Lawson, 1994; Wakefield, Reid, Roberts, & Mullins, 1998) and their attempts at cessation were highly influenced by the stress of environmental barriers, such as

unstable living environments and lack of economic and social resources (Lawson, 1994; Wakefield et al., 1998). This notion is supported by Bryce, Butler, Gnich, Sheehy, and Tappin (2009) who state that smoking may be considered “a support that helped clients to cope with daily life” (p. 479). While it can be argued that the social acceptability of smoking has changed since the publication of the aforementioned articles, it remains relevant to illustrate the power of social influences on young women’s behaviours and reinforces the women’s positive perceptions of smoking and environmental barriers encountered which may hinder smoking cessation.

Furthermore, a randomized controlled intervention study by Albrecht and Caruthers (2002) illustrated that of the sample of 142 young pregnant women smoking during pregnancy, over half of them attempted to decrease the number of cigarettes they were smoking while pregnant. This statistic is of importance, as many studies report the high percentage of young women who continue smoking during pregnancy, without an acknowledgment that many of these women have actually reduced the amount they are smoking. McDermott and Graham (2006) identify the need for qualitative studies of the experience of smoking cessation from the perspective of young mothers to inform interventions.

2.3.3 Nutrition. A qualitative study by Burchett and Seeley (2003) found that almost all of the young pregnant women in the sample were aware of what a healthy diet was composed of, and over half of the young pregnant women in their sample attempted to make positive changes to their eating habits during their pregnancy. Several barriers to not making positive changes to their diets during pregnancy were identified, including personal food preferences, limited finances, and limited availability of healthy foods in their homes. It was found that the high cost of healthy foods was the main reason for the young women only being able to follow dietary guidelines sometimes or not at all (Burchett & Seeley, 2003). In fact, due to such financial

constraints a reality for several of the participants was the increased consumption of unhealthy foods to satisfy their increased appetite as cheaply as possible (Burchett & Seeley, 2003).

A qualitative study by Everette (2008) explored the nutrition of pregnant teenagers and showed that the participants' food choices were influenced by their emotional state, culture, and their perception of which foods enhanced the health of the baby. Furthermore, the young women's support networks, including their partners and mothers, were found to be influential in the woman's nutrition habits, which highlight the importance of the young pregnant women's environment on nutrition behaviours (Everette, 2008). The importance of social support networks is reinforced by a study by Tessema, Jefferds, Cogswell, and Carlton (2009) who conducted focus groups and found that minority pregnant women who consistently took prenatal supplements commonly felt their support system expected and reinforced the behaviour. Such studies illustrate the importance of considering the preferences and resources available to the young woman in making positive nutrition changes during pregnancy.

2.4 Summary

This chapter provided a review of the literature on expected behaviour changes for women in pregnancy and how such expectations are reinforced, young women's behaviours during pregnancy, and the current literature on young women's personal experiences of behavioural expectations and changes in pregnancy. Furthermore, this chapter identified knowledge gaps in the literature. While there exists a body of literature that illustrates the multitude of behavioural expectations pregnant women are subject to, many of these studies are not specific to marginalized populations such as young single women. Furthermore, the body of literature specific to young pregnant women commonly uses quantitative measures to describe the behaviours of young women during pregnancy, which commonly highlights the deficits of

this population and leads to the omission of contextual information surrounding such behaviours of this population. Moreover, there are few studies that examine the experience of behavioural expectations and behaviour change from the perspective of young women specifically. The omission of not only the context in which the women are situated but also their voices and perspectives surrounding their behavioural change experiences may limit a consideration of their preferences, resources, and social influences and ultimately lead to further problematizing and stigmatization of this group and their behaviours.

This study sought to fill such gaps in the literature through an exploration of the perceived behavioural expectations and the experience of behaviour change by young single pregnant women. Such an exploration makes the voices of this population central, brings the context of such behaviours to the forefront, facilitates a strength-based approach to understanding their experiences, and will inform interventions for young single pregnant women.

Chapter Three - Methodology

This chapter begins with an overview of the research design used in this study followed by a description of: (1) the use of intersectionality as the theoretical underpinnings for the study, (2) the recruitment and sampling methods, (3) the data collection method of semi-structured photo elicitation interviews, (4) the data management and analysis methods, (5) a discussion of rigour, and lastly (6) ethical considerations.

3.1 Research Design

This study used a qualitative design. The use of a qualitative design has several benefits. First, a qualitative design is consistent with the purpose of project, as qualitative data is collected in the natural context and has the potential to enhance a holistic understanding of a phenomenon (Polit & Beck, 2012). A qualitative design is appropriate to answer the research questions as it allows the participants voices to be central and in their own words (Letvak, 2003) and focuses on the meaning of the experiences for the participants (Creswell, 2009). Furthermore, a qualitative design has the potential to provide a contextually-situated and holistic account of the participant's experiences of behavioural expectations during pregnancy (Creswell, 2009). Lastly, a qualitative design is appropriate to use with youth. The period of adolescence and young adulthood represents a critical developmental period and thus it is important to gain an understanding of the unique social context in which youth experience health (Rich & Ginsburg, 1999). A qualitative design has the potential to facilitate such an understanding of the socially-situated health experiences of youth by making their own experiences, thoughts, and values central to the research (Rich & Ginsburg, 1999). Such a youth-centered approach is consistent with recommendations from the Registered Nurses Association of Ontario (RNAO) (2010), who support the inclusion of the voices of youth in matters that affect their lives. Thus, a qualitative

approach to the project allowed for a youth-centered approach by making their voices central and considering the unique social context in which each participant is situated.

More specifically, this study used a descriptive qualitative design which aims to present a comprehensive and accurate summary of what the participants are saying (Polit & Beck, 2012; Sandelowski, 2000). A descriptive qualitative design facilitated an examination of what the participants experienced and the meanings attributed to those experiences (Sandelowski, 2000). Given that this study aimed to understand the experiences of the participants, a descriptive qualitative design was appropriate as it promoted the development of a comprehensive and accurate summary of the participants experiences (Sandelowski, 2000). Furthermore, given that the researcher aimed to keep the women's voices central in this study, the use of qualitative description allowed the researcher to stay close to the data throughout data analysis and in the presentation of the results (Sandelowski, 2000).

3.2 Theoretical Underpinnings

This study uses an intersectionality perspective. Intersectionality recognizes the existence of categories of difference that interact to "influence political access, equality, and the potential for any form of justice" (Hancock, 2007, p. 64). Thus, rather than focusing on a single category of difference, intersectionality facilitates an examination of multiple identities or categories of difference and thus encourages understanding of the experiences of those who live at the intersection of multiple marginalizations (McCall, 2005).

The use of an intersectionality lens in this study served two purposes. First, in combination with the knowledge gaps identified in the literature, an intersectionality lens directed the selection of young and single pregnant women as a relevant population to study considering their potential for experiencing multiple marginalizations. Furthermore, the use of an

intersectionality lens facilitated the recognition of the unique social locations of the young single pregnant women who participated in the study. As described by Hulko (2009), social location is “the relative amount of privilege and oppression that individuals possess on the basis of specific identity constructs” (p.48). The participants in the study represent a diverse group who may experience multiple identity constructs based on (but not limited to) their age, gender, pregnancy status, ethnicity, relationship status, and economic status. The aforementioned identity constructs are equally important and interact with not only other categories, but also societal institutions, to produce unique social locations (Hancock, 2007; Hulko, 2009). Thus, as described by Clow, Pederson, Haworth-Brockman, and Bernier (2009), intersectionality posits that “people’s experiences are simultaneously the product of how they identify themselves, how they are seen by others, and how they interact with others” (p. 163).

The benefits of an intersectionality approach to this study are many. Primarily, intersectionality promotes a holistic view of the participants’ experiences by privileging an examination of the interaction between multiple identity constructs and between identity constructs and broader societal systems and processes rather than relying on an analysis of one single category in isolation to describe complex experiences (Clow et al., 2009). Given that a young, single, pregnant woman’s experience of behavioural expectations are influenced by her intersecting identity constructs (e.g. age, gender, pregnancy status, socioeconomic status) as well as by an interaction between such identity constructs and broader social systems (e.g. health care system) and processes (e.g. medicalization of pregnancy, societal stigmatization and expectations) an intersectional approach is helpful in understanding the context of her complex social experience including behavioural expectations during pregnancy.

Furthermore, intersectionality facilitates recognition that participants experience both oppression and power based on their social location and this oppression and power may change based on the social context (Hulko, 2009). An examination of the experience of behavioural expectations during the period of pregnancy specifically can benefit from an acknowledgment of the potential for changing social locations of participants during this unique period. That is, an understanding of the oppression and power inherent in social locations can facilitate an understanding of how and why participants experience behavioural expectations and behaviour change during pregnancy in certain ways.

Lastly, an intersectional approach to understanding human experience has applications for nursing practice as well as for other health and social service providers. More specifically, by facilitating a deeper and more holistic understanding of the intersecting identities of young single women during the period of pregnancy and the subsequent influence on the experience of behavioural expectations and behaviour change, an intersectionality approach will help to inform clinical practice with this population in practice by promoting awareness of the unique social context of the participants.

3.2.1 Situating myself within the research process. In qualitative research the researcher is influential in the data collected and the results of the analysis, thus it is critical to engage in reflexive analysis to identify how the researcher influences the research process (Finlay, 2002). Although engaging in reflexive analysis ‘outs’ the researcher and leaves them vulnerable to scrutiny, it is an important means of increasing the integrity of the research (Finlay, 2002), as this section sought to achieve. More specifically, given that this study used an intersectionality lens and particular attention was paid to the identity constructs and related social

locations of the participants, it was imperative that I consider my own social location and how this may have influenced the research process.

My decision to work with young single pregnant women throughout this project was not based on my own personal experience with being young, single, and pregnant, nor was it based on my own experiences of marginalization. In fact, I have largely occupied a privileged social location. I am white, middle-class, Canadian-born, English-speaking, married, and educated. I have largely followed an ‘expected’ life trajectory for a woman of my age and have encountered very few societal barriers related to my social location. Rather, my interest in working with this population stemmed from my interest in the medicalization of pregnancy and my interest in marginalized groups who are often most subjected to and further marginalized by such medicalization.

It is also important to acknowledge that prior to starting this project and throughout this research process I did not personally conceptualize young pregnant and parenting women as problematic nor did I feel that they are less capable or less deserving of having children. Given that during this experience I identified as a youth myself, I recognized that judging ability and deservingness on age alone is a common bias that needs to be challenged. My past experience working within youth engagement models was influential, where it is acknowledged that the knowledge and skills of young people are often under-recognized and under-utilized based strictly on their age. This approach largely influenced my interactions with the women as I never assumed there was a deficit; rather, my assumption was that each young woman had her own knowledge, skills, and resources to be recognized and mobilized.

Throughout the research process it was my identity as a youth that was highly influential, both during recruitment and the interview process. When attending the community centres for

recruitment, I was frequently handed the ‘participants’ sign-in sheet rather than the ‘professionals’ sign-in sheet. When sitting in the groups at the centres waiting for my time to speak to the women about participating in the study I was sometimes approached by centre staff and volunteers as a participant in the program rather than as a researcher recruiting for a study. My young age allowed me to blend in with the other women at the centres and often resulted in me being perceived as one of the young mothers accessing resources at the centres. While this experience made me feel more comfortable since I felt like I was being less intrusive at the programs, my young age and young appearance nevertheless would impact how the women participating in the study would relate to me and what they would talk about in the interviews. Furthermore, despite having age in common, my experience in a different social location than these women would also influence the types of questions I would ask. Having never been young, single, and pregnant my questions and discussion with these women may have been very different than another researcher who may have shared more common experiences with the participants.

3.3 Recruitment and Sampling

Convenience sampling was used to recruit young single mothers. Convenience sampling is used when the most readily available participants are approached (Polit & Beck, 2012). For the purpose of this study, convenience sample was especially appropriate as the recruitment location was very closely aligned with the inclusion criteria for the study. Young women were recruited from two sites of a program funded by the Canada Prenatal Nutrition Program (CPNP). The program provides peer support, education, and healthy food to young pregnant women throughout pregnancy and up to six months postpartum (PHAC, 2002). The two participating sites were located in the same mid-sized city, and serve women under the age of 25 who are

pregnant and parenting. Prior to commencing recruitment the investigator met with the CPNP manager and approval was obtained to recruit women from the two sites (see Appendix A for letter of permission). Upon initiation of recruitment, the investigator attended a maximum of two programs per week at each site between the months of November 2011 and January 2012. At each group, the group facilitator introduced the investigator to the group of young women, followed by an explanation by the investigator regarding the purpose of the study and an invitation for the women to participate (see Appendix B for verbal recruitment script). The investigator stayed for the duration of each group to allow for interested women to individually approach the investigator and ask questions about the study. This approach of having the investigator stay for the entire session was recommended as being the preferred method of recruitment by the CPNP project manager. When a woman expressed interested in participating, the investigator scheduled an interview at a time and location convenient for the participant, collected the woman's contact information to provide a confirmation phone call, and provided the woman with the information sheet (see Appendix C). Information sheets were also put out at each group the investigator attended for women to take.

A list of inclusion criteria was developed to ensure that the participants represented the population of interest (Polit & Beck, 2012). To participate in the study, young women were required to 1) be between the ages of 15 and 24 inclusive; 2) be unmarried; and 3) be pregnant or a parent to a child under the age of six months. Recruiting participants from the program was an effective and efficient means of recruiting the study sample as all participants in the program were women that fit the first and third inclusion criteria. Recruitment continued until data saturation was achieved; that is, when no new themes emerged from the data (Bowen, 2008). Data saturation was continually assessed throughout recruitment, data collection, and data

analysis (Bowen, 2008). Upon reaching data saturation, that is, when the researcher did not hear anything new from the participants being interviewed, no new participants were recruited. The achievement of data saturation was facilitated by (1) interviewing knowledgeable participants who were either currently experiencing or had recently experienced the topic of interest, and (2) the amount of rich and usable data from participants (Morse, 1995; Morse, 2000).

3.3.1 Limitations. The sampling and recruitment strategies used may be a potential study limitation for two reasons. First, the women who volunteered to participate in an interview may differ from those who chose not to participate (Polit & Beck, 2012). Second, recruitment occurred through a community-based service all participants were accessing services. While the purpose of qualitative research is not to generalize findings, it is nonetheless important to acknowledge that the findings from this study may not be transferable to settings where young pregnant women are not accessing services. In an attempt to address this limitation the investigator phrased interview questions to elicit “shadowed data,” which is second hand information about the population of interest (Morse, 2000, p. 4). More specifically, during the interviews the investigator used images and specific interview questions to elicit information about the general experiences of the population of interest which may help to make the information more applicable to young women who did not participate in the study.

3.4 Data Collection and Procedures

Data was collected through semi-structured individual interviews using photo elicitation. Prior to starting the interview, the investigator reviewed the consent form (see Appendix D and E for English and French versions, respectively) with the participant in its entirety and written consent was obtained. At this point each participant was given a \$20 grocery store gift certificate

as a token of appreciation. Next, demographic information was collected (see to Appendix F). Each interview was audio-recorded and written notes were also taken by the investigator. Six open ended questions were asked about the woman's experience with behavioural expectations and behaviour change during pregnancy (see Appendix G for interview guide). The average length of the interviews was 46 minutes (range of 18 minutes to 86 minutes). The interviews were all conducted at a time and place convenient for the woman. Two of the women chose to have the interview conducted at their home and the remaining seven interviews were conducted in private rooms at centers where the women were receiving services. Semi-structured interviews presented an appealing option to elicit information on predefined topics while allowing the flexibility for respondents to speak freely on the subject (Barriball & While, 1994; Polit & Beck, 2012). The questions in the interview guide evolved and new probes were developed as the interviews progressed and new themes emerged. For instance, as the initial participants discussed the concept of the "good mother" and the additional expectations on young pregnant women (versus older women and men), probes were added to the interview guide to explore whether other women had similar experiences.

The interviews also involved the use of photo elicitation, which uses images as a basis for discussion in the interview (Close, 2007). This project used a total of 17 images (see appendix H for photographs) collected by the investigator from the internet. Initially, 15 images of dominant health messages in pregnancy were selected by the investigator based on the literature review, messages detailed in current pregnancy magazines, internet searches, and pregnancy books. During the interview the 4x6 inch color images were laid on the table or floor for the participant to see. As the interview questions were asked each woman was given the opportunity to examine the images and use them to help her answer the questions. The opportunity to select whether or

not to use the images and to select which ones to focus on allowed the participant increased control in the interview process (Close, 2007). At the end of each interview the participant was asked if she could think of any images to add for future interviews. Each suggested image was added for subsequent interviews. This technique facilitated the use of images that were relevant to the population of interest.

While the majority of photo elicitation research has used photographs, it has been suggested that any visual image may be used to encourage in depth reflection and discussion (Harper, 2002). The use of images in this project was especially appropriate as the concept of ‘behavioural expectations’ may be abstract and difficult to understand and articulate. As discussed by Harper (2002), the use of images can prevent misunderstandings that may occur and facilitate a more clear and in depth exploration of the experience by the participant. Furthermore, considering that some participants completed this interview at six months after pregnancy, the images were useful in stimulating their memories of the experience (Harper, 2002).

3.5 Data Management and Analysis Methods

Following each interview, audio-recordings were transcribed verbatim by the investigator. The participant’s names were removed from each transcript. The transcripts were subsequently verified by the investigator by listening to the recording while reading the transcript to identify errors. Furthermore, following each interview field notes were written to provide information about the context of the interview and the impressions of the investigator (Polit & Beck, 2012). The data sources including the audio recordings, transcripts, field notes and demographic forms are all kept in the locked office of the thesis supervisor at the University of Ottawa. Consistent with the University of Ottawa Research Ethics Board, these data sources

will be kept in this location for five years after publication of the data. To assist with data management the investigator used NVivo 9 software.

The interview transcripts were analyzed using conventional qualitative content analysis (Hsieh & Shannon, 2005). Conventional content analysis was an appropriate data analysis strategy as it is useful when describing a phenomenon, in this case the experience of behavioural expectations and behaviour change in pregnancy. The unit of analysis was the interview transcript, allowing for a consideration of the context in which patterns are emerging (Graneheim & Lundman, 2004). Consistent with the method described by Hsieh and Shannon (2005) the procedure used to analyze the transcripts is as follows: (1) all transcripts in their entirety were read, (2) transcripts were reread and key words and phrases were highlighted and notes were made in the margins as a preliminary analysis, (3) the preliminary coding scheme was developed using the highlighted words and phrases and the researchers preliminary analysis notes, (4) related codes were grouped into broader categories and themes. More specifically, codes were grouped into categories to answer the question “what?” to describe what the participants were saying (Graneheim & Lundman, 2004). Then codes and categories were grouped into themes to answer the question “how?” to interpret the experience of the participants (Graneheim & Lundman, 2004). For an example of how this data analysis process was applied, refer to Appendix I for a sample segment of a transcript. Throughout the data analysis process, notes were written on each transcript to document impressions and decisions. The coding template and data analysis was reviewed by the thesis committee.

Intersectionality was used as an interpretive lens throughout the analysis of the data. More specifically, to apply an intersectionality lens during data analysis the researcher was mindful of the following questions: (1) What identity constructs do the women implicitly and

explicitly talk about? (2) What privileges and oppressions (social location) come with the discussed identity constructs? A consideration of these questions as the interview transcripts were analyzed privileged an examination of the multiple identities or categories of difference experienced by the participants and the related changes in their social location. Together, an understanding of such identity constructs and social locations facilitated a more holistic understanding of the women's pregnancy experiences.

3.5.1 Evolution of data analysis process. It is important to acknowledge the evolution of the data analysis process utilized in this thesis project and to provide transparency in the data analysis process. Upon conception of the project, it was planned that directed content analysis would be used as the data analysis method. Directed content analysis involves the use of a theory to develop an initial coding template through the identification of key concepts (Hsieh & Shannon, 2005). More specifically, the directed content analysis was to utilize The Theory of Planned Behaviour (TPB) (Ajzen, 1988) to identify relevant concepts (behaviour, attitude towards the behaviour, subjective norms, and perceived behavioural control) to be included in the initial coding template for data analysis. During the preliminary analysis this method was used. As data analysis progressed it was clear that there was a tension between the a priori theory and the themes emerging from the data. That is, the use of a directed content analysis using TPB was increasingly restrictive as the data was analyzed and thus the data analysis method evolved to accommodate the nature of the emergent themes. Thus, as previously described the final data analysis method used was a conventional content analysis which allowed the research team increased flexibility to interpret and structure the themes from the data without an a priori theory.

3.6 Rigour

Qualitative rigour is assessed through credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1985). Credibility, or the truth of the findings, was enhanced through the use of triangulation (Lincoln & Guba, 1985), specifically investigator triangulation, by including the thesis supervisor and two committee members in the data analysis process to challenge assumptions of individual investigators and ensure that the interpretations of the data remained true to the participants' experiences (Polit & Beck, 2012). The principal investigator and her thesis supervisor met on a regular basis, approximately one time after every three to four interviews, to review the coding scheme (Polit & Beck, 2012). Furthermore, the preliminary data analysis was presented to the thesis committee as a whole and to individual members at several time points, and the analysis was subsequently revisited after each of these meetings.

Dependability and confirmability, which refer to the stability of the findings and the degree to which the interpretation reflects the data respectively, were enhanced by maintaining an audit trail (Lincoln & Guba, 1985). The audit trail included raw data, notes from data collection and data analysis that document initial impressions, reflections and analytic decisions (Polit & Beck, 2012). Confirmability was further enhanced through the thesis committee's ongoing data analysis discussions to ensure the data reflected the experiences of the participants (Polit & Beck, 2012). Transferability, the potential for the findings to be applied to other groups and contexts, was achieved through the use of thick description (Lincoln & Guba, 1985). A rich and detailed description of the context, demographics, and experiences of the participants allows others to determine the applicability of such research to their own practice.

3.7 Ethical Considerations

Ethical approval for the study was obtained from the University of Ottawa Research Ethics Board (see Appendix J). Upon receiving ethical approval, recruitment began at the two centers.

There were no direct risks to young mothers participating in this study, except for potential discomfort in answering questions. Prior to commencing the interview each participant was reminded that participation was voluntary and she did not need to answer any questions she did not feel comfortable answering and could end the interview at any time. In the event that a participant expressed a need for immediate support (i.e. physical, emotional, social), the name and contact information of the designated contact person at each site was provided on the consent form. Furthermore, during recruitment potential participants were assured that their decision regarding participation in the study would have no impact on the services they receive.

To protect the privacy and confidentiality of the participants, the transcriptions of the audio-recordings had participants' names removed. The consent forms, demographic forms, audio-recordings, electronic transcripts, and paper transcripts are stored in the locked office of the thesis supervisor. The digital audio-recordings and transcripts are individually password protected. Only this author and the three members of the thesis committee have access to the full data.

Chapter Four - Results

The purpose of this chapter is to present the demographics, social context, and results of the analysis. First, this chapter will begin with a story of a young single pregnant woman. While this character and her story are fictitious, this story was written based on the common experiences of the nine women who participated in this study to illustrate the unique context and experiences of this population. Next, the demographics of the participants will be presented, followed by a description of the women's health and social context. Finally, the three main themes of (1) expected behaviours in pregnancy, (2) experience of expected behaviours in pregnancy, and (3) surveillance are presented and described.

4.1 A Young Single Pregnant Women's Story

I became pregnant in my last year of high school. Although nobody else knew yet that I was pregnant, upon finding out I had an immediate sense of impending change and internal pressure. I knew my life would be forever different and I would need to make changes to not only provide a good life for my baby, but also for myself.

When I began telling people I was pregnant, some people encouraged me to get an abortion or place the baby up for adoption. Sometimes people would not tell me outright that I should have an abortion or give the baby up for adoption but I could feel by their stares that they disapproved of my decision to continue on with the pregnancy and keep my baby. Hearing people say things and seeing how people looked at me made me doubt my abilities to care for my baby and my ability to be a good parent. Even though it was very difficult to deal with such comments and stares, I know that this is my body, my baby, and my life. I know that other people do not know how I came to this point and they do not know everything I am doing to prepare for this baby.

Even though I am tired and face judgment every day, I am still enrolled in school trying to finish my high school diploma so I can give my baby the life he or she deserves. I was under a lot of stress when I first became pregnant because of the stares and comments from people at my high school. When the school asked me to leave and return only after delivering my baby my family helped me to find a local school for young pregnant and parenting women where I could continue my courses. Changing schools has also made it difficult for me to maintain friendships. While I have made new friends in similar situations as me, many of my friends from before no longer invite me places or when they do I cannot go because it would not be safe or appropriate for me. Before I was pregnant my friends and I would go out for fast food, go to dances and bars, drink, smoke, and occasionally do drugs. Now that I am pregnant and I am focusing on having a healthy baby, many of the things I used to do with my friends I cannot do anymore. Although sometimes I wish I could go out with my friends, I am afraid of the consequences.

Since becoming pregnant people who never cared about my health behaviours now scrutinize all of my actions. Before becoming pregnant my family, friends, boyfriend, and strangers never paid much attention to my health but now that I am pregnant everyone is worrying about the health of the baby and watching everything I do to make sure I will have a healthy baby. Sometimes I feel overwhelmed by all of the expectations. My boyfriend still eats unhealthy, drinks alcohol, and smokes but he isn't told to make all of the changes I am being told to make. I wish he would make the same changes I am making so that he would help me instead of tempt me.

Even if I do not have all the support to make all of these changes I know it is important for me to do them because I want my baby to be healthy and I feel like a good mother when I make the changes. Sometimes I feel like because I am so young and people think I shouldn't be

having a baby I need to make more changes than the average pregnant woman to prove that I can do this. Sometimes I feel like society expects too much of me – they think I should be finishing my high school diploma, getting a job to earn money for the baby, going to pregnancy and parenting classes to prepare, changing all of my behaviours like eating, smoking, and drinking, all while trying to have a social life like a normal teenager. Sometimes the pressure is too much and I feel like I want to crawl into bed and just sleep. Other times the pressure makes me feel motivated to do it all so I can prove everyone wrong and show them I can be a good mother.

I feel like I can be a good mother when I choose healthy foods, when I decline a cigarette or alcohol, when I choose to stay in and read instead of going to a bar, and when I go to prenatal appointments and classes because I know making these changes shows the world that I love my baby enough to make sacrifices and I am able to care for my baby and provide him or her with the life he or she deserves. Making these changes and sticking to them during pregnancy is an opportunity to prove to myself that I am strong enough to do what I need to do to be the best mother for my child.

4.2 Characteristics of Sample

A total of nine women participated in the study. At the time of the interview, the average age of the women was 19.9 years, ranging from 17 to 24 years old. Of the nine women, four were still currently pregnant (gestational age ranging from 14 weeks to 29 weeks) while the remaining five had a child under the age of six months (age of infant ranging from 3 months to 6 months). Two women were born in the Caribbean and the remainder were born in Canada. The socioeconomic status of the women is reflected in their level of education, employment status,

and number of moves in the past five years. Two women were enrolled in high school and two women were employed. The remaining five women were not enrolled in school nor were they employed. The sample represented a transient group with an average of 5.6 moves in the past five years (range of 0 to over 20 moves). The low level of education and employment and the high number of moves over the past five years is a reflection of the low socioeconomic status of the group of participants. Three women already had other children (range of 1 to 2 previous children). Most of the women had attended prenatal classes and all of them attended the recommended schedule of prenatal appointments. Table 1 summarizes the demographic information of the participants:

Table 1

Demographic information for participants at time of interview

Total number of participants	9
Age – average years (range)	19.9 (17-24)
Pregnant	4
Relationship Status	
Single	2
Dating	2
Engaged	2
Living together	1
Common law	2
Socioeconomic Status	
Education	
Some high school	3
Enrolled in high school	2
Completed high school	3
Some postsecondary	2
Completed postsecondary	1
Employment	
Employed – part-time	1
Employed – sick leave	1
Not employed	7
# of moves in past 5 years – average (range)	5.6 (0-20+)
Born in Canada	7
First child	6

Attended recommended schedule of prenatal care visits	9
Attended prenatal classes	7
Health in pregnancy (1-10) – average (range)	5.8 (1-8)
Support in pregnancy (1-10) – average (range)	7.4 (2-10)

4.2.1 Health and social context of participants. As illustrated in Table 1, participants were also asked to state how healthy they considered themselves during pregnancy and how much support they felt they had during their pregnancy. The average rating for health in pregnancy was 5.8 and the average rating for support in pregnancy was 7.4 (on a scale of 1-10, with 1 meaning not healthy at all/no support at all and 10 meaning very healthy/all the support I need, respectively). To complement these numerical ratings, each woman was also asked how she defines health in pregnancy. When asked to describe health in pregnancy, the women identified behaviours including eating nutritiously, not smoking, monitoring weight gain, and using health services. These behaviours identified by the women suggested that the participants understood health in pregnancy as being achieved through the successful undertaking of specific behaviours. For example, when asked how she defines health in pregnancy one woman explained:

Health during pregnancy is not doing any drugs or alcohol or anything chemical and also cut down on processed foods a lot and trying to eat healthier, like more natural foods more often rather than fast food, even though it is really convenient. Also cut down on caffeine and stuff like that and exercise too (Interview 8)

Similar to the other participants, this definition of health identified several behaviours that are perceived to be important to maintaining the physical health of the mother and baby. Interestingly, this behavioural definition of health was not reflective of the complex social context of the women. For example, all of the women's stories included details of stress, food

insecurity, housing insecurity, abandonment, limited social support, economic hardship, and limited employment opportunities. The same woman who offered the definition of health above lacked social support, had low socioeconomic status, was struggling with employment, was experiencing high levels of stress and had a strong family history of drug and alcohol abuse. Similar to all of the other women interviewed, despite facing a myriad of social issues daily, she did not recognize and/or vocalize these social issues as key to health in pregnancy.

4.3 Summary of Themes

Figure 1 (on following page) illustrates the various themes and their interrelations. The figure illustrates the three main themes: (1) expected behaviours in pregnancy, (2) experience of expected behaviours in pregnancy, and (3) surveillance.

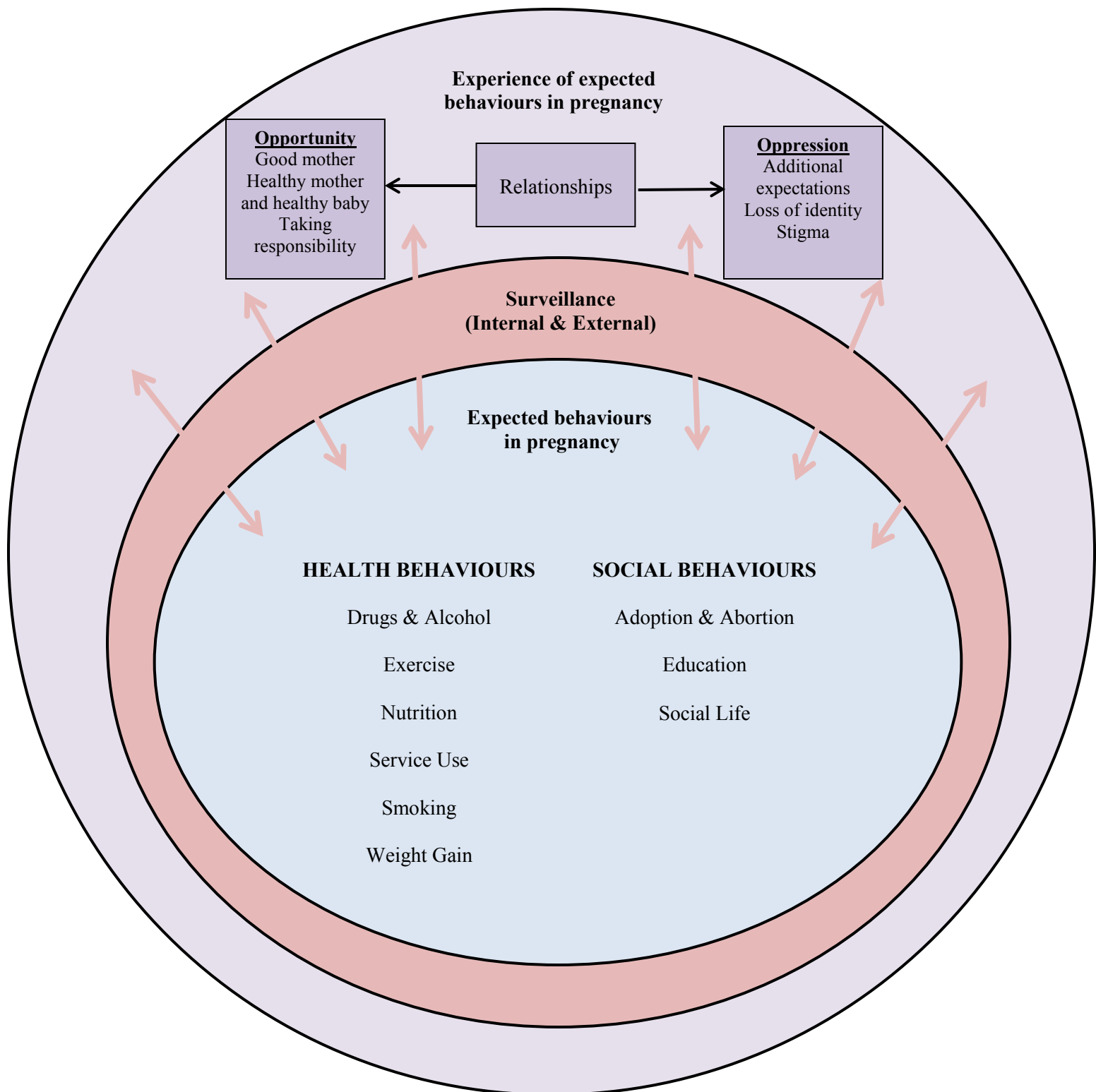


Figure 1. Diagram of themes and interrelations

The first theme of ‘expected behaviours in pregnancy’ encompasses the women’s perceptions of dominant behaviour change expectations in pregnancy. The women identified behaviours that were classified as either health behaviours or social behaviours.

The second theme of ‘experience of expected behaviours in pregnancy’ encompasses *how* the participants experienced the ‘expected behaviours in pregnancy.’ The women’s experience of these expected behaviours was marked by a distinct contrast between ‘opportunity’ and ‘oppression.’ That is, conforming to or resisting each behavioural expectation was experienced as either an opportunity or oppression. The quality of the women’s relationships determined whether they experience behavioural expectations and change as opportunity or oppression.

The third theme of ‘surveillance’ includes both internal surveillance from the women herself monitoring her behaviours and the external surveillance of society, family, friends, and health care providers. The theme of ‘surveillance’ connects the first two themes as: (1) it is through surveillance that the behavioural expectations in theme one are reinforced, and (2) surveillance influences whether the women experience the behavioural expectations as an opportunity or oppression.

As the themes and supporting quotes are presented, numbers in square brackets refer to the photograph the woman was speaking to, as described in Appendix H.

4.4 Theme One: Expected Behaviours in Pregnancy

The women talked about a variety of expected behaviours in pregnancy. The expected behaviours in pregnancy identified by the women were classified as either health behaviours or social behaviours. For the purpose of this study ‘health behaviours’ are those that are consistent with the current health care context of pregnancy and ‘social behaviours’ are those that are consistent with the current social context of pregnancy. More specifically, health behaviours are

those that are reflective of the medicalized and individual-oriented context of pregnancy, and social behaviours are those that are reflective of the social context of pregnancy which defines good motherhood and often problematizes young single pregnant women.

As illustrated in the figure 1 the health behaviours included changes to the women's behaviour related to drugs and alcohol, exercise, nutrition, service use, smoking, and weight gain and social behaviours included behavioural expectations related to abortion and adoption, continuing and completing education, and changes to social lives. The two subthemes of health behaviours and social behaviours are discussed below with examples.

4.4.1 Health behaviours. Health behaviours were the most commonly discussed expected behaviours and behaviour changes in pregnancy. These health behaviours are seen in both the literature and lay press as behaviours that many pregnant women, regardless of age and marital status, are subjected to. When asked how health is defined during pregnancy, all women included examples of health behaviour changes that were necessary for optimal physical health during pregnancy. Among the most commonly discussed health behaviours were: stopping the use of drugs and alcohol, exercising, eating nutritiously, using services, not smoking, and monitoring weight gain, all of which are further explored below.

4.4.1.1 Drugs and alcohol. All of the women discussed drugs and/or alcohol in their interview. Women often discussed alcohol and drugs as something they did before they were pregnant (or before they knew they were pregnant) and something that many other young women do (or have done) before and during pregnancy. Sources of information on drug and alcohol use included women's own research, observing other pregnant women (i.e. passing up alcohol), advertisements, doctors, prenatal classes, and parents. Alcohol was frequently discussed alongside the topic of the women's social lives. Due to this association between their pre-

pregnant social life and alcohol, some women expressed both guilt and judgment related to going out with their friends and being in that environment, despite not actually drinking in such settings when pregnant.

Most women who used drugs and alcohol before being pregnant described quitting the substances ‘cold turkey’ upon learning they were pregnant. The women identified both facilitators and barriers to quitting drugs and alcohol upon confirming their pregnancy. For instance, some women identified a major facilitator to eliminating drugs and alcohol is when their key supports such as partners quit drugs and alcohol as well or avoid usage around the woman. By way of contrast, a barrier to changing drug and alcohol usage is when such key supports continue the substance use around the woman. For example, some women reported friends and family offering them alcohol while pregnant. As described by one woman who quit using marijuana upon finding out she was pregnant, eliminating the use of drugs was motivated by pregnancy and was a source of pride:

Your mind and your body may want it, like you are withdrawing from it. With me I get headaches, I suffered from migraines all my life and now they are worse but I'm happier that I quit because then my pregnancy is more healthier now that I don't have that drug in me all of the time. I'm happy that I can say ‘you know what? I don't need it, I don't want it’, and I don't need it, so pregnancy has helped me with that. (Interview 9)

4.4.1.2 Exercise. The majority of women (8/9) mentioned exercise during pregnancy. Sources for messages surrounding exercise included doctors and prenatal classes, as well as the women’s partners. Exercise was discussed by the women as a way to relieve physical discomfort related to the pregnancy, to physically prepare for childbirth, to manage weight gain during pregnancy, and to stay fit. The women identified a variety of challenges regarding exercising

during pregnancy including having working conditions that promoted sedentary activities rather than physical activities and physical pregnancy complications that limited activity levels. A few women mentioned the challenge of hearing about the importance of exercise in pregnancy but not receiving sufficient information to actually execute the recommended changes, as one woman described:

Nobody actually told me what was safe to do during pregnancy. So I found like the doctor was always saying “make sure you exercise so you don't gain more weight than you are supposed to and you keep the baby healthy,” and I'm sitting there going like okay, but what am I supposed to do? Jog? ...Yoga? Like I don't understand what I am supposed to be doing here? (Interview 3) [13]

4.4.1.3 Nutrition. Nutrition was the most frequently discussed health behaviour and was discussed by all of the women. Sources of nutrition messages included community based programs, doctors, nurses, television, books, parents, and strangers. Most women talked about poor nutrition habits pre-pregnancy and discussed how pregnancy was a motivation to change such habits. Nutrition changes identified included both increasing healthy foods in their diets and reducing unhealthy foods, most commonly trying to cut down on fast food specifically, as one woman describes: “I still went to McDonald's once a week but I stopped going every day so I cut down on things that I thought needed to be cut down on” (Interview 3).

The most frequently mentioned benefits of eating healthy were to have a healthy baby and to manage weight gain, as well as maintaining the women's overall health. As described by one participant, healthy eating has benefits for both mother and baby:

A lot of it was keeping you healthy to keep the baby healthy. So eating well, that's helping you as well as helping the baby and drinking lots of liquid and like taking your

prenatal vitamins. It's not just helping the baby, it's helping you too because the baby is sucking so much calcium out of you that if you do not replenish that then you can lose your teeth and hair and all of these problems for you, but like you are not only taking care of them, you are taking care of yourself as well. (Interview 4) [5]

The women identified a variety of facilitators and challenges to eating healthy during pregnancy. Facilitators included having a support person (parent or partner) purchase and prepare the healthy food, having support persons make the nutrition changes with the woman, as well as having sufficient information to know what to prepare and how to prepare it. Barriers included personal food preferences and cravings, having other children at home to care for, not having sufficient information to execute changes, having support persons that do not follow nutrition recommendations, a work environment not conducive to healthy eating, physical illness limiting appetite, fatigue and affordability of nutritious foods. Despite understanding the benefits of healthy eating during pregnancy, one woman explained how the cost of nutritious foods was a significant barrier to eating them:

When I was living on my own in my apartment money was really tight, like I had to pay rent, I just had no money in the end to get the healthy food. It was whatever was unhealthy that I managed to have money for, so it was hard to get healthy food in the beginning. I would want like carrots and stuff but they were just so expensive and I was like 'oh my God, I cannot afford that this week. Maybe next week...' (Interview 6) [5]

Many women discussed prenatal vitamins. For some women, it was a simple change to take their daily prenatal vitamin, while for others they struggled to remember to take it regularly. One woman discussed how not taking your prenatal vitamins might lead to judgment by others:

Well for sure if you miss a month of prenatal vitamins they [health care providers] would probably be like “why aren’t you taking your prenats?” So for sure they would judge you, but I used to follow my stuff to make sure that everything is okay. (Interview 2) [10]

4.4.1.4 Service use. Most women (8/9) discussed using services. The services mentioned by the women were services such as prenatal visits with a doctor, visiting the dentist, attending prenatal classes, home visits with a public health nurse, telehealth, and community based programs such as nutrition, parenting, and self-esteem courses. When using the identified services the women valued the positive effects on their emotional state, the reassurance about normalcy of physical changes and pregnancy experiences, and felt it helped them to prepare for their baby. All of the women received prenatal care from a physician and many of them discussed the services they received from their physician during pregnancy. For many women going to see their doctor was something that was a clear expectation during pregnancy: “Going to see the doctor was just an automatic. Like there's no doubt about it, you have to do it” (Interview 4). Furthermore, one woman described the value of seeing her doctor throughout pregnancy:

When I go to see my doctor, basically he knows what he's doing. He is able to tell me what I am feeling, if it is natural or unnatural, so it is good to have a stable schedule with your doctor and if you stick to it you are pretty set. (Interview 5)

Some of the women also expressed their perception of additional societal pressure to use services in pregnancy in comparison to their older and married counterparts. The women described this pressure as rooted in the notion that young women are not ready to be pregnant or parenting and thus they must access health and social services to prepare themselves.

4.4.1.5 Smoking. All women discussed the issue of smoking and pregnancy. Messages surrounding smoking during pregnancy came internally, from doctors, strangers, prenatal classes, other pregnant women, parents, friends, partners, and school nurses. Most women (7/9) reported smoking before their pregnancies, with all seven reporting making changes to their smoking habits. More specifically, five of these women reported quitting altogether and two of these women cut back their smoking during pregnancy. A key facilitator discussed by the women was the involvement of support persons in quitting and cutting back the women's cigarettes. For instance, many women discussed the importance of having friends, family members and partners who either quit or cutback with the woman or who smoked away from the pregnant woman. Contrarily, a barrier to making changes to smoking habits was a lack of support from key support persons, as described by one woman: "I was doing as much as I really could and plus I was in a house full of smokers. Like it's not easy to quit when you have people smoking in your face" (Interview 3).

Pregnancy was consistently described as the motivation to either stop smoking or cut back the number of cigarettes. This motivation was linked to both the desire for a healthy baby and mother as well as the desire to avoid judgment from others, as described by two of the participants:

You know all the stories you hear that when you smoke, like every cigarette you smoke is like a minute away from your life, all those things about what happens to your teeth and babies pictures, your brain...yeah all those things like you know, made me think there will be consequences if I do this. (Interview 2) [4]

I don't even have the big belly or whatever, I was just like two weeks pregnant and smoking...people looking at me, and it felt like they are telling me “what are you doing? You're pregnant, stop smoking” and they don't even know nothing or whatever, but I felt like that.... So you know it was like, I stopped smoking pretty quick. It was the same week I stopped smoking. (Interview 1) [4]

A unique subgroup of the women were those who were smoking pre-pregnancy and cut back (rather than quit altogether) upon confirming their pregnancy. Despite understanding the benefits of quitting smoking, these women described stressful lives that were not conducive to quitting smoking altogether. One woman discussed how this stress impacted her readiness to quit:

My doctor told me to just to cut down if I can't quit because first things first, to smoke cigarettes for as long as I've been smoking cigarettes you need to be ready to quit. If you were going to quit smoking cigarettes you need to be ready and there's way too much going on in my life - I am definitely not ready to quit. (Interview 9)

Furthermore, these women were subject to judgment from health care providers, strangers and from their pregnant peers. These women spoke of cutting back their cigarettes as an accomplishment, but as described by one woman, this accomplishment was not always recognized by others:

I just couldn't kick those last 2 to 3 cigarettes. I was stressed, I was 14, I was pregnant, like I just couldn't kick those last two or three and they would harp on me at every doctor's appointment to quit and I was like, you're really not helping me at all, all you're making me want to do is go out and smoke more right now because I'm stressed. Like I've got it down to 2 to 3 cigarettes. I quit everything else I was doing wrong. So that I

found really hard. Like they were constantly nagging me about the smoking. (Interview 3) [4]

4.4.1.6. *Weight gain.* Some women (5/9) talked about the issue of weight gain during pregnancy and postpartum. Messages about weight came from doctors, prenatal classes, friends, family, partners, and the media. The women discussed the importance of gaining the right amount of weight during pregnancy and some expressed concern about gaining too much weight or not enough weight during pregnancy. For instance, one woman discussed her feelings about gaining weight while pregnant:

Doctors have a general weight that you should gain, like between 20 and 30 pounds or something. Like I gained weight over that and I felt so gross about myself. I didn't like it at all and I was trying to forget about gaining all of that weight, it was just like "oh it's just happening, who cares?" But people kept reminding me: "Oh, you are getting so big! Look at you! You are massive! Your clothes don't fit - let's go get a bigger size!" Like I've never had to buy anything bigger than a small and I was buying like large or extra-large and I was like what is happening? (Interview 6) [2]

Furthermore, some of the postpartum women discussed their desire to lose the weight they gained during pregnancy:

You have the weight, you know it's still on you and he's not in you, but the weight is still on you. It's [the priority] to lose weight...I'm not used to, you know, being like that [having weight to lose]....so I would rather you know, lose the weight and get back my shape and go back to where I was. (Interview 1) [2]

4.4.2 Social behaviours. The second subtheme under 'expected behaviours in pregnancy' is social behaviours. These behaviours discussed by the women represent

expectations in pregnancy that are largely unique to the context of being young and single and pregnant. More specifically, the expected behaviours of adoption/abortion, education, and social life are further described below.

4.4.2.1 Adoption and abortion. Some women (5/9) talked about the expectation that young women should either place their baby up for adoption or have an abortion. This is an experience specific to the social context of pregnancy in young and/or single women, consistent with the belief that young and/or single women should not (and cannot) be pregnant or parenting. Such messages came from family, friends, strangers, teachers, and doctors and were reinforced through various channels, including Facebook as explained by one woman:

When I got pregnant that time people are just like, ‘oh well if you want I can drive you to the abortion clinic, you know’ and I am looking at them like, ‘no’...like there were people on my Facebook messaging me telling me how disgusting I am, telling me ‘how come you have CAS [Children’s Aid Society] involved? You can’t even take care of your first one, why would you get pregnant with a second one?’ (Interview 9)

As described by another participant, such messages could be disempowering:

People used to tell me, ‘well maybe you should have an abortion, maybe you should give up the baby, maybe you should put it up for adoption, you are really young you know, it’s not healthy, your body is just not ready to have a baby’.....it was really difficult it made me think and think and think again, I was like ‘is what they are saying true?’ Like what should I believe? (Interview 6)

4.4.2.2 Education. Many of the women (6/9) mentioned both high school and postsecondary education as a priority. While the concept of ‘education’ is not a traditional behavioural expectation for mainstream pregnant women, for this group of young single

pregnant women there was an extremely strong perception that the continuation and completion of education was an essential behaviour in pregnancy and parenthood. The pressure to continue their education was described as being mainly internal, with key people such as partners and family members being supportive in the decision. Education was discussed frequently by the women as a priority behaviour as it was seen as a means to take care of their baby by securing a good life as well as a personal goal and accomplishment:

Seeing a young mom for sure they will be like “oh she is just going to stay home and not go to school, not finish school.” Like I finished my high school and I want to have something later on, that’s why I’m going back to school [college] soon in January so I can be someone and give my daughter whatever she needs. (Interview 2) [14]

Challenges to being enrolled in education and completing their education were physical challenges during pregnancy such as fatigue and physical sickness, being asked to leave the high school they attended pre-pregnancy or feeling uncomfortable remaining in the school. The high school environment was not always supportive or welcoming for young pregnant women:

All I kept thinking was these people don't want me here so why would I want to be here? I am going to get teased in school which is going to affect me emotionally and I'm guessing emotional stress would not be good for the baby at that point. So I was like is this really the safest place for me to be right now, like health-wise? And plus there's no way I'm going to fit in those desks by my ninth month, like there's just no way. Plus I knew that they wouldn't be as accommodating for appointments. (Interview 3)

4.4.2.3 Social life. Most women (7/9) discussed changes related to their social life during pregnancy. While this change in social life may resonate with other subgroups of pregnant women, it was evident that it was the nature of the social interactions and social gatherings of

these young single pregnant women specifically that created a perceived incompatibility between their social life and being 'healthy' in pregnancy. Messages about the women's social lives came internally, as well as from partners and parents. Some women described an incompatibility between their previous social life and being healthy, safe, and taking care of yourself and baby and thus stopped some pre-pregnancy social activities, as described by one woman:

You used to party all the time and stuff like that and your friends are calling you "you should come" and you can't really go out because you know you have to take care of yourself and you know, be somewhere safe and don't smoke. It was hard but it was just okay, I think it was normal. I found other occupations at home like reading, so I went to Chapters and bought some books, baby books, that I read. That passed my time for me.

(Interview 2)

Some women described 'appropriate' social activities during pregnancy which included reading, shopping, and movies. The women who made changes to their social lives saw these changes as a way to prepare for baby, a chance to act like a mom, and an opportunity to develop and maintain new support systems by attending pregnancy groups. As discussed by one participant, a change in her social life was part of her preparation for parenthood: "I have to start staying home more so I will be able to be good at staying at home to take care of my child when she's here" (Interview 5).

Other women felt they were still able to engage in pre-pregnancy social activities such as going out and partying with their friends so long as they did not smoke, use drugs or drink alcohol or stay out too late, although these women often had to endure judgment from others:

I went to [name of community] dances and what not because I still wanted to hang out with some of my friends so I didn't see an issue with it but people were like "oh, you're

pregnant and you're still acting like a teenager!” and I'm like “am I not entitled to a few moments of acting like a teenager?” I'm eating healthy all day, I'm popping prenatal vitamins and iron supplements and going to programs all day long, like I think I'm entitled to one night every two months to go to a dance and be teenager. So I found that like I had to change and act like a complete boring adult to be considered a good mom.

(Interview 3)

4.5 Theme Two: Experience of Expected Behaviours in Pregnancy

This second theme encompasses *how* the women experience the previously discussed expected behaviours in pregnancy. As described below, the women's experience of behavioural expectations and behaviour change in pregnancy is largely defined by a continuous tension between pregnancy as opportunity or pregnancy as oppressive, with relationships as a buffer between the two. Because this study used an intersectionality lens to interpret the data, this section will also include the identity constructs described by the women and introduce how such identity constructs influenced their experiences of behaviours in pregnancy through changing social locations. Consistent with intersectionality, particular attention was paid to how the identity constructs influenced the social location of the participants and shaped the amount of opportunity and oppression possessed by each woman and thus the overall pregnancy experience.

4.5.1 Behavioural expectations as opportunity. All of the women gave examples of how behavioural expectations and behaviour change in pregnancy was positive and led to new opportunities. Conforming to behavioural expectations in pregnancy led to the opportunity to (1) be a good mother, (2) to improve their health and the health of their newborn, and (3) to take responsibility and make their own decisions. Each of these three identified opportunities is

summarized below. As each of the aforementioned opportunities are described, the corresponding identity constructs implicitly and explicitly identified by the women will be introduced.

4.5.1.1 Good mother. Many women talked about how being successful in making behaviour changes in pregnancy increased their confidence in themselves to be a good mother and proved to others their ability to be a good mother. The identity construct of the good mother was especially important for this group of young single women who are continually working against a societal perception that young and/or single women should not and cannot be pregnant and/or parenting. This awareness of societal surveillance and the need to make proper behavioural changes in pregnancy to be a good mother is vocalized by one participant:

I think like there's eating healthy and there's obsessively eating healthy and I think I got to that point with my first pregnancy just because I wanted people to see that I was like doing everything possible to be as good of a mom as I could even before she was coming so that I wouldn't have that risk of people trying to say that I wasn't going to be a good mom due to my actions during my pregnancy. (Interview 3) [5]

Some women determined the degree to which they were good mothers by comparing their health behaviours to the health behaviours of other women. As explained by one woman, good mothers make a choice to conform to behavioural expectations in pregnancy, whereas other mothers may choose to resist:

I felt like a good mother. I felt like, oh I might be [a good mother]. Because you know, I was worried of course at first about being a good mother or not, and what kind of mother am I going to be. But I felt more like a good mother seeing that like wow, you know at

least I can make those changes and I actually made them compared to some people who just don't want to make them. (Interview 1)

Conforming to behavioural expectations in pregnancy gave the women the opportunity to assume the identity of the good mother and the potential to be seen by others as a good mother. This opportunity was described as a positive source of motivation and empowerment.

4.5.1.2 Healthy mother and healthy baby. Many women talked about how pregnancy and the identity of being a pregnant woman made them more aware of their health behaviours and described how pregnancy was the motivation to make behaviour changes. Some women expressed they were aware of their unhealthy behaviours prior to becoming pregnant but it was not until they confirmed their pregnancy that they had the motivation to execute the changes. The women often spoke of the benefits of making behavioural changes as having both immediate and long term benefits for the health of themselves and their children. For instance, one woman quit smoking completely once she became pregnant but also identified long term benefits which served as a source of motivation:

I just did it for the baby's health. Like I don't want the baby seeing me smoking because then they could do it when they are older and think it is all right, or they could get secondhand smoke. I don't want that. (Interview 7) [4]

Many women talked about their own health and the health of the baby in conjunction. The women talked about how the health of the baby was a priority and how behaviour changes made for the health of the baby also improved their own health. As described by one participant, a healthy baby begins with a healthy mom: "I'm not the only person anymore there is someone else growing in me so to make that person grow well you need to help yourself first" (Interview 2).

Embracing the identity construct of a pregnant woman and conforming to behavioural expectations in pregnancy gave the women the opportunity to make behaviour changes to improve not only the health of their baby and but also their own health. This opportunity was described as having both immediate and long term benefits for the health of their baby and themselves.

4.5.1.3 Taking responsibility/making own decisions. Many women spoke of taking responsibility for their lives and taking control of making their own decisions, which for many women signified the acquisition of an adult identity. The women spoke of taking initiative to seek out information from diverse sources such as the internet, television, books, friends, family, service providers, etc. An alternate source of pregnancy information was observing other women:

I think it is just from observing a lot. Observing how like my friends raise their kids, how my mom raised me, what I have learned at school, what I have seen on TV, what I've read on the Internet. I think it is just observing a lot of different things. (Interview 8)

The women used terms such as 'my life,' 'my pregnancy,' and 'my body' to assert the primary role they had in making their own decisions surrounding their behaviours. The women commonly described making health behaviour decisions by filtering through the constant stream of pregnancy information and applying the information that was consistent with their personal priorities and values. This notion is reinforced by one woman who vocalized her efforts to sort through vast amounts of pregnancy advice and assess their congruence with her personal preferences:

Every time somebody would say something I would go home and just think real long and real hard, 'Does this make sense? Is this for me? Am I already doing it? Why do I need to

do it?'...I couldn't listen to everything people had to say because then that wouldn't have been what I wanted. (Interview 6)

Conforming and resisting behavioural expectations in pregnancy gave the women the opportunity to take responsibility and make their own decisions. While this opportunity was not always without consequences, the women spoke of it as an important component of asserting themselves as knowledgeable and independent adults and mothers.

4.5.2 Behavioural expectations as oppressive. All of the women gave examples of how behavioural expectations and behaviour change were negative and could feel oppressive. The pressures to conform to behavioural expectations in pregnancy led to feelings of oppression related to (1) the additional behavioural expectations put on women compared to men, (2) the additional behavioural expectations put on young women compared to older women, (3) the loss of identity, and (4) the experience of stigma. Each of these four identified oppressions is summarized below. Consistent with intersectionality, as each of the aforementioned oppressions is described the corresponding identity constructs implicitly and explicitly identified by the women will also be introduced.

4.5.2.1 Additional behavioural expectations for women (vs. men). Some women discussed the additional pressures put on the woman for behaviour change compared to men, illustrating the influence of the identity construct of being a woman. The women expressed that their partners did not truly understand their experiences because the men were not subject to the same surveillance and pressures: "I seriously think that some men should undergo that [pregnancy], not to literally have a baby, just to know what it feels like and have everyone harping on them for a change instead of just the women" (Interview 9). This lack of understanding of the women's experience led to some of the men having unrealistic behavioural

expectations of their pregnant partners which led to feelings of further scrutiny and stress for some women. Furthermore, when some men did not change their 'unhealthy' behaviours it presented a significant challenge for their pregnant partners who described the difficulties of making positive behaviour changes in an unsupportive and tempting environment.

There was an acknowledgment that a child's health is not only influenced by the mother's behaviours but also by the father's behaviours. Thus, as suggested by one participant, applying some of the same behavioural standards to fathers could have benefits:

I find they treat the young dads a lot differently. Like I realize they aren't actually pregnant but they should really be kicking the smoking habit too. They should be stopping drinking alcohol - they are about to have a newborn, they shouldn't be drinking alcohol every day. Like they should start eating healthy too because they should be setting a good example for their child. But these expectations are not put on the man during pregnancy. (Interview 3)

4.5.2.2 Additional behavioural expectations for young women (vs. older women). Many women extensively discussed the additional pressures for behaviour change younger pregnant women must endure compared to older pregnant women. The identity of being a youth and thus having additional pressures related to their age was commonly discussed as disempowering, stressful, and unfair. This pressure was described as coming from the general belief that young women are not ready or able to be pregnant or parenting and required increased guidance and surveillance to prepare them for pregnancy and parenthood. Thus, the additional behavioural expectations for young women compared to older women were most commonly connected with the previously identified behavioural expectation of 'service use' as these young women felt increased societal pressure to access health and social services to compensate for the perception

that they lack preparation due to their young age. It is important to note that these women did not express feeling less prepared for pregnancy and motherhood due to their young age. Rather, they felt that all first time mothers would have similar needs regardless of age:

Like if a 30-year-old mother goes into the hospital and doesn't take prenatal classes nobody harps on her... but I was told like, you have to take prenatal classes because I don't know what to do because I am young. But I'm like no first-time mom knows how to give birth! And their exact words were 'you are too young to know what to do, you need to take prenatal classes' and I'm sitting there going so if you are 25 or older you know how to give birth before giving birth? Like that makes no sense! (Interview 3)

It was suggested that many young pregnant and parenting women were highly prepared due to the prevalence and accessibility of services designed specifically to support this population. Despite this, young pregnant women were under increased societal surveillance due to their age alone with no consideration for their level of preparation for pregnancy and parenthood:

There could be 30-year-old parents that know nothing about parenting, never went to a doctor's appointment, never had prenatal care, do not have anything for their baby, and like they get to keep their children. Like they can neglect them all they want and that is behind closed doors because of their age. Whereas there are parents that are 17 and under, have all of the support systems in the world, have everything they could possibly need for their child and still get CAS involvement because of their age. Like it shouldn't be because of their age - it should just be you do it for everybody or you do not do it at all. (Interview 4)

4.5.2.3 Loss of identity. Upon acquiring the identity of a pregnant woman or a mother, some women talked about the experience of losing their personal identity because of the focus on the health of the baby. Many women identified numerous behavioural expectations and behaviour changes in pregnancy that were a priority due to the potential to influence the health outcomes of the baby. This focus on making behavioural changes strictly for the health of the baby led some women to feel selfish when they made decisions for themselves rather than their baby. Furthermore, as described by one woman a sole focus on making behaviour changes for the baby may lead to behaviours that are not always best for the mother:

They are thinking of the baby even though I am the one who is carrying the baby. They should think of both me and the baby, not just the baby. Like stop thinking just of the baby and think of me sometimes and maybe you will be able to figure out what is best for me and my child. (Interview 5)

4.5.2.4 Stigma. Most women mentioned experiencing stigma related to their identities as young women and as single women. The source of societal stigma was frequently discussed as rooted in the notion that young women should not be pregnant or parenting and that young women are not capable of being good mothers. Stigma was consistently discussed as a negative experience and often was identified as a barrier to making behaviour changes due to feelings of disempowerment, stress, and isolation. One woman described how her experiences of stigma from strangers led her to become increasingly isolated:

People always judge people; it was really hard for me to go out. Like 'if you don't have a car, don't ask me to go out'. I used to like not go into a store, my mom used to drive me everywhere and my boyfriend too because I don't want to take the bus to go anywhere

because I don't want to be looked at the way they're looking at me. It was hard that time.

(Interview 2)

Three of the women interviewed had experienced more than one pregnancy. A common experience of these three women was the fear and impact of judgmental attitudes during their first pregnancy and their subsequent indifference to such judgment in their following pregnancies. These women attributed this indifference to their confidence in their own ability to be a good mother that they gained in their first pregnancy and parenthood:

Because it was my first baby I was petrified what people would think of me, what they would think that I am pregnant whereas with this pregnancy I don't care, I don't care.

Think what you want of me, I am pregnant that is it, that is all. (Interview 9)

Women expressed feeling stigma from other mothers, strangers, doctors, CAS workers, hospital staff, and teachers and some attempted to use strategies such as purchasing fake wedding rings to lessen the stigma. Interestingly, some women felt stigmatized by other young mothers and some of the young women made statements during their interviews that indicated judgment towards other young mothers. This judgment from young mothers towards other young mothers was commonly directed at the youngest women and women with inappropriate or unhealthy behaviours. When young mothers judged other mothers it was used as a way to compare the efforts and accomplishments of themselves to those of other mothers who did not make such efforts, and thus elevated the young women to a higher level on the subjective hierarchy of 'good' motherhood as one woman expresses:

"You know before I would see someone smoking and they have a big belly okay, but then when I was pregnant it's almost like I felt "oh my God, poor baby" you know what I

mean, like really poor baby, and I was caressing mine, thinking you're lucky, you know I'm controlling myself and everything.” (Interview 1) [4]

4.5.3 Summary of identity constructs and influence on pregnancy experience. In

summary, throughout the interviews the women expressed feelings of privilege and power through their identities as pregnant women, mothers, and adults. The women also expressed feelings of marginalization in relation to their identities as women, youth, single women, pregnant women, mothers, and their corresponding social class. The purpose of Table 2 below is to provide a summary of the sub-themes of ‘experiences of behavioural expectations in pregnancy’ and the corresponding identities.

Table 2

Opportunities and oppressions of behavioural expectations in pregnancy and corresponding identities.

	Sub-theme	Identity
Opportunity	Good mother	Mother
	Healthy mother/healthy baby	Pregnant woman
	Taking responsibility/making own decision	Adult
Oppression	Additional expectations	Woman, Youth, Pregnant woman
	Loss of identity	Pregnant woman, mother
	Stigma	Youth, unmarried woman, social class

As illustrated above, the results of this study illustrate how young single pregnant women experience multiple identity constructs. The use of an intersectionality lens facilitated an examination of these multiple identities or categories of difference, and encouraged an understanding of the experiences of the young single pregnant women living at the intersection of these multiple marginalizations (McCall, 2005). While an intersectionality lens often privileges an exploration of the impact of race (Hancock, 2007), it is important to note that while

two participants were women of colour, neither of them spoke of the impact of race on their experience. Rather, it was age, gender, marital status, and their identities as pregnant women and mothers that were discussed as most influential. Together, the identities in Table 2 were influential in the women's experience of pregnancy through changing identities and social locations, as will be discussed next.

The women's stories illustrated how pregnancy is a time of changing identities and thus social locations, which ultimately was influential in the women's experiences during pregnancy. Because pregnancy marked a time when the women were either required to assume new identity constructs (i.e. pregnant woman, young woman, single woman) or actively tried to assume new identity constructs (i.e. adult, good mother) there were changes in how the women perceived themselves, how others perceived the women, and changes in the women's interactions. As the women unwillingly or willingly assumed new identity constructs in pregnancy, their social location, that is, "the relative amount of privilege and oppression that individuals possess on the basis of specific identity constructs" (Hulko, 2009, p. 48), changed based on their newly acquired identity constructs. Hulko's definition of social location resonates with the results of this study where the women expressed a constant tension between opportunity and oppression. These experiences of opportunity and oppression were reinforced through the women's perception of herself (self-surveillance), others perceptions (external surveillance), and her interactions with others.

Given that the purpose of this study was to understand young single women's experiences of behavioural expectations and behaviour change in pregnancy, it is important to consider the role that pregnancy behaviours played in the identity constructs and subsequent social location of the women. As previously discussed, the women defined health in pregnancy

through behaviours. With the women defining health in pregnancy through various behaviours, such behaviours served to define the women's identities through the conformation and resistance to such behaviours and thus were influential in the women's corresponding social location. To illustrate the role of pregnancy behaviours and the acquisition of specific identity constructs and changing social locations, an example from the results regarding the identity of the 'good mother' will be used. Many women discussed how by conforming to behavioural expectations in pregnancy (such as quitting smoking, quitting drugs, eating nutritiously) they felt like a good mother. For these women making these expected behaviour changes in pregnancy was a way for the women to assume and *be* the desirable identity of a good mother. Similarly, making the expected behaviour changes in pregnancy allowed the women to resist and challenge the identity of being a young and thus undeserving and unfit mother. Seeing themselves as a good mother and being seen by others as a good mother changed their social location because being a good mother comes with the privilege of deserving and being able to carry and raise a child. The results of this study show that the women used expected behaviours in pregnancy as a means to assume desirable identity constructs and resist undesirable identity constructs.

It is important to note that for many women their social class was described as influential in two ways. First, their *actual* social class was influential as it determined their access (or lack of access) to resources. Second, their *perceived* social class was influential as many women experienced stigma due to the societal perception that young mothers have a low socioeconomic status. As illustrated in table 1, all but one of the women in this study had not completed postsecondary education, most of the women were unemployed, and many had unstable living environments, with an average of 5.6 moves in the past five years. For these women, a lack of education, employment, and stable living environments was often detrimental to the women's

ability to make the expected behavioural changes in pregnancy. As previously presented, some women identified a lack of finances as a barrier to eating nutritiously or the stress of their lives as a barrier to quitting smoking. The lack of resources and resultant stress of living with limited resources was influential in the women's experiences of behavioural expectations and behaviour change in pregnancy.

Furthermore, some women discussed that society commonly perceives young single pregnant women to be of a lower social class, regardless of their actual socioeconomic status. For instance, one woman discussed the experience of using public transportation with her young infant and the assumption made by society that a young mother using public transportation must be unwed, on welfare, and cannot afford her own vehicle. This example illustrates the women's experience that being a young pregnant woman or being a young mother is often equated to being a member of a lower social class and thus these women must contend with the associated stigma of being perceived as having a low socioeconomic status. It is important to note that while most of the women had not completed postsecondary education and most women were unemployed, in many cases this may be common for the general population of youth between the ages of 15 and 24. It is pregnancy and parenthood specifically that brings the socioeconomic status and social class of these women to the forefront as important societal measures of these women's worth and ability for motherhood.

4.5.4 Relationships (as buffer). All of the women talked about their relationships during pregnancy. Often relationships were the buffer between the tensions of opportunity and oppression. That is, positive and supportive relationships enabled the women to experience behavioural expectations and behaviour change as opportunity, whereas negative and

unsupportive relationships often led to women experiencing behavioural expectations and behaviour change as oppressive.

Several women talked about their relationships as key supports in making behaviour changes surrounding nutrition, smoking, alcohol, drugs, and education. Among the most influential relationships were those women had with their partners. For some women, having a partner that supported them in making behavioural changes allowed the women to view such changes as positive experiences:

Every time I would be stressed I would have 3 to 4 cigarettes a day - this is me in grade 7 - so it was like 3 to 4 cigarettes a day I would be doing. So it was pretty hard. And then well, meeting the right guy you are able to stay calm and do it and maintain your goal to have a healthy pregnancy. (Interview 5) [4]

Many women also discussed the important role of female family members such as their mothers, aunts, grandmothers, as well as their fellow pregnant and parenting friends. The women relied on the knowledge, experience, and support of these female family members and friends. One woman described her mother as her central source of information and support in her pregnancy:

Before I had no one to talk to and my mom has been through a lot too so she knows what to say and how to help...like I don't need a doctor [laughs] because she tells me they are going to do this test and this is how they are going to do it before they even tell me. (Interview 7)

Although not without challenges, these women who identified the presence of supportive relationships often discussed their experience with behavioural expectations and behaviour change as positive opportunities in the short- and long-term. Many women also discussed

negative aspects of their relationships during pregnancy. The relationship challenges the young single women in this study experienced may be largely unique to both their current relationship status and their age. These challenges included dealing with the fear of abandonment, managing unstable and unsupportive partnerships, and experiencing changing peer groups, as described next. For instance, most women talked about the fear of abandonment during pregnancy, which led one woman to feel pressure to make behavioural changes so that people would stay with her:

I was doing it [making own health decisions] but I was very scared doing it. I was very scared making my own decisions because what if everybody else decides ‘well, you’re not listening to me so I’m not going to help you’there were a few people that actually said like, ‘I have been trying to help you and you’re not taking it so you know what, I am done [helping you].’ (Interview 6)

Some women talked about stressful relationships, primarily with their boyfriends. The sources of stress in these relationships were related to the men pressuring the women to make expected behaviour changes and the men not offering the women enough support in making such behaviour changes. For instance, one woman described how the stress in her relationship with her boyfriend increased when he began to give her advice on behaviours during pregnancy:

He just he didn’t understand. He tried to take control of the pregnancy, telling me what I had to do, telling me why he wanted me doing it. Like if I ask ‘do I have a choice?’ he said ‘no.’ (Interview 6)

A further challenge encountered by the young women in this study was their changing peer groups since becoming pregnant. While this change in peer groups may be a common experience with older groups of pregnant women, what was unique for the young women in this

study was the loss of their *entire* peer group because they were the only one who was pregnant or parenting:

One important thing is that when you are pregnant you are for sure in your own world and sometimes you don't have any friends because...now you're pregnant and they can't always come to see you, so they spend the night somewhere else (Interview 2)

Some women also talked about the stress and frustration of having others focus on what they are doing wrong rather than commending them for positive changes they have made:

Even if it's not somebody doing it with you but just the support of being told that you were doing a good job alone really helped, and I find that you don't get that a lot, you really don't. I find that they try and focus more on the stuff you are not doing right and try to fix that as opposed to encouraging you to keep doing stuff you are already doing.

(Interview 3)

Such strained relationships often led the women to describe their experience with behavioural expectations and behaviour change as oppressive rather than as a positive experience with the potential for opportunity.

4.6 Theme Three: Surveillance

Almost all of the women (7/9) discussed the experience of surveillance in pregnancy. As illustrated in Figure 1, surveillance is how the 'expected behaviours in pregnancy' are connected with the 'experience of expected behaviours in pregnancy.' That is, surveillance by society, friends, family, health care providers, teachers, and even the women themselves reinforced the myriad of behavioural expectations women are subject to as identified in theme one. Furthermore, such surveillance is also a significant influence in how the women experience the behavioural expectations in theme two. Using an intersectionality lens, the two sub-themes

below describe the women's stories of both internal and external surveillance during pregnancy, with particular attention paid to how the identity constructs previously discussed interact with various social processes and systems to influence such surveillance.

4.6.1 Internal surveillance. When discussing the expected behaviours and behaviour change in pregnancy, many women implicitly suggested that they were constantly monitoring their own actions. Often, this self-surveillance resulted in the woman feeling guilt when she failed to make a needed change:

I kind of blamed myself for all of the problems that my daughter was like prenatally diagnosed with before she came out. I blamed it on not taking the prenatal vitamins. Like it was just the way she was so it wasn't my fault but I put a huge burden over my head because of it. (Interview 4) [10]

This self-surveillance could also lead to feelings of pride when a woman was successful in making behavioural changes. For instance, one woman explained how making sustained behaviour changes made her feel like a good carrier:

I felt like a good mother towards the end because I'm like 'oh my God I held on all this time, I mean I didn't smoke, I am eating healthy, I'm trying my best to you know, do whatever that's good for the baby', so you know I really felt like a good, well a good carrier. (Interview 1)

In the example above it is important to note that the woman made a distinction between being a 'good mother' and being a 'good carrier.' For this woman making behaviour changes in pregnancy allowed her to be a good carrier, but not necessarily a good mother, since being a good mother was equated to actively caring for the baby once it is born. On the other hand, other participants expressed feelings of being a mother (rather than just a carrier) during pregnancy.

Such examples of internal surveillance illustrate how the women themselves are involved in monitoring and reinforcing the behavioural expectations identified in theme one. Furthermore, the resultant feelings of guilt and pride demonstrate how such internal surveillance can contribute to feelings of opportunity (pride) and oppression (guilt).

4.6.2 External surveillance. The women identified a multitude of external sources of surveillance during pregnancy including strangers, family members, partners, friends, teachers, coworkers, and health care providers. Such external surveillance could be stressful and disempowering. Many women expressed that since becoming pregnant they felt increasingly subjected to public scrutiny, both real and imagined. For instance, some women discussed not looking pregnant but still feeling like society was watching them:

They just looked at me really weird like ‘really you are 17? Why are you having a child? Like you don’t even have a job yet.’ I cried for days because people looked at me different... like it didn’t even look like I was pregnant, I had no belly until I was six months. (Interview 6)

Other women gave examples of negative encounters they had with strangers who offered pregnancy advice:

I was going get something to eat and this person was like ‘oh, you shouldn’t be eating that’ and all that and I was like ‘well why not?’ and they said that it was too much fat for my child... I had never experienced that, it was kind of weird. The only other time I experienced a stranger coming up to me was to ask me how to get to this place and that is it. (Interview 5)

Many women described the externally reinforced pressures and expectations for behavioural change during pregnancy, with one woman describing pregnancy as a job. There

was the perception that society expects pregnant women to be perfect: “I’m not dead, I’m pregnant. I know that there are precautions to take but you can only go so far. I am sorry but there is nobody who can have the perfect pregnancy” (Interview 9). This societal pressure to have a perfect pregnancy resulted in feelings of surveillance and scrutiny from multiple sources.

Such external surveillance could also be positive and empowering if it allowed the women to be seen as responsible and good mothers. Some women talked about how other people would judge pregnant women for not conforming to expected behaviours in pregnancy such as taking prenatal vitamins or refraining from smoking but discussed how it was not a concern for them since they always followed such advice. This example demonstrates how the women’s awareness of external surveillance was often a motivator to make behaviour changes. That is, by conforming to the behavioural expectations in pregnancy, these women were able to minimize judgment, prevent CAS involvement, and demonstrate their ability to others to be a good, selfless, responsible mother.

Often, the women’s stories of external surveillance suggested that the intensity and frequency of such external surveillance was intimately tied to the various identity constructs previously discussed, including the identity of being a pregnant woman, being unmarried, being single, and being a mother, among others. Such identity constructs were in constant interaction with societal systems and processes. For instance, many women described the challenges of being a young pregnant woman and a single pregnant woman and the interactions of these identities with the social processes that define ‘good motherhood’ and the social systems that reinforce this definition and exclude those who do not fit such societal norms. A further example from the data is the women’s implicit explanations of the challenges in being a pregnant woman

and being subject to the social process of medicalization of pregnancy and the health care system that subjects women to increased behavioural expectations to achieve a ‘healthy’ pregnancy.

Such examples of external surveillance illustrate how a multitude of sources such as family, friends, partners, health care providers and society are involved in monitoring and reinforcing the behavioural expectations identified in theme one. Furthermore, the resultant feelings of disempowerment and empowerment demonstrate how such external surveillance can contribute to feelings of opportunity (empowerment) and oppression (disempowerment).

4.7 Summary of Results

The purpose of this chapter was to provide an overview of the demographics of the participants and to present the main findings of the study. A diagram was presented to show the various themes and subthemes and their relationships to one another. The three main themes of *expected behaviours in pregnancy*, *experiences of expected behaviours in pregnancy*, and *surveillance* were subsequently summarized and supported with examples from the interviews with the women. Consistent with the three aforementioned themes, the main findings of the study include: (1) young single pregnant women are subject to a multitude of health and social behavioural expectations, (2) young single pregnant women experience these behavioural expectations as a tension between the potential for opportunity and oppression, and (3) young single women experience internal and external behavioural surveillance during pregnancy, which serves to reinforce the behavioural expectations identified in theme one and influences the experiences of opportunity and oppression identified in theme two.

Chapter 5 - Discussion

The purpose of this chapter is to situate the findings presented in chapter four in the current literature. Next, the implications and recommendations for practice, education, and research will be identified and explored. Lastly, strengths and limitations of the study will be discussed.

5.1 Introduction to Discussion of Results

This descriptive qualitative study found that young single women feel subjected to many health and social behavioural expectations in pregnancy and that they experience these expectations as a constant tension between the opportunities and oppressions associated with conformity or resistance to each behaviour. This discussion section will situate these findings within the current literature and be organized according to three arguments: (1) redefining health in pregnancy, (2) understanding health behaviours in young single pregnant women, and (3) examining pregnancy experiences using intersectionality.

5.2 Redefining Health in Pregnancy

As introduced in chapter four, the young women defined health in pregnancy as largely behavioural in nature, despite their complex social needs. This incongruence between the dominant behavioural definition of health and the complex social issues faced by the women in this study illustrates the need to redefine health in pregnancy to better encompass their social context. This section will first compare the women's descriptions of health in pregnancy with current national and provincial recommendations as well as current literature. Next, the findings from this study will be used alongside other research findings to illustrate the benefits of redefining health in pregnancy to more fully encompass the women's social context.

The behavioural explanations of health in pregnancy offered by the women are consistent with the current broader landscape of health and health care, which have often privileged lifestyle interventions. The behavioural nature of the women's discussions of health in pregnancy is consistent with recommendations made by the Public Health Agency of Canada (2012) who state that "a healthy pregnancy is in your hands" (para 1) and makes recommendations regarding behaviours such as smoking, nutrition, alcohol use, and physical activity, all of which were identified by the women participating in this study. The statement that "a healthy pregnancy is in your hands" resonates with the women's descriptions of health and how the achievement of health is dependent on their personal willingness and ability to conform to dominant behavioural expectations and recommendations.

All of the women who participated in this study reported attending the recommended number of prenatal care appointments and almost all of the women had completed prenatal classes at the time of the interview. The behaviours identified by the women as being necessary for health in pregnancy are also consistent with current content of prenatal care and prenatal classes. Given that approximately 97% of Canadian women receive prenatal care (CIHI, 2006) and approximately half of young women attend prenatal classes (Chalmers & Kingston, 2009), the content of this care is influential in how women define and experience health in pregnancy. Similar to the behaviours identified by the women in this study, White, Fraser-Lee, Tough, and Newburn-Cook (2006) found that most women reported receiving health behaviour advice from their prenatal care providers on nutrition, smoking, drugs, alcohol, and physical activity, among others, demonstrating the similarities in health expectations for both the young women in this study and pregnant women in general. Such topics are also reinforced in prenatal classes (Province of New Brunswick, 2008). Interestingly, the health behaviour topic least discussed was

stress and coping in pregnancy, with less than half of the women reporting this being discussed at prenatal appointments (White et al., 2006). Similarly, the young women interviewed for this study rarely mentioned psychological or social components of health in pregnancy, with only two women out of nine stating that minimizing stress levels was important in pregnancy.

What is largely absent from both the participant's descriptions of health in pregnancy and from the content of prenatal care is the influence of the social context in pregnancy. It is important to note that the omission of the social context in their definition of health by the women interviewed does not reflect poorly on their knowledge or ability as pregnant women. Rather, the women's inclination to discuss behavioural aspects of health is consistent with accounts of the medicalization of pregnancy and childbirth. More specifically, as suggested by Barker (1998), the medicalization of pregnancy has the power to "structure viable understandings and experiences" (p. 1074). Thus, the women's descriptions of health and behaviours in pregnancy are largely consistent with the prevailing medicalized understanding of pregnancy, which has structured society's understanding and experience of pregnancy. Despite the women's daily struggles with complex social issues, these were not included in their definition of health in pregnancy, nor are these social issues brought to the forefront of prenatal care services as previously discussed. Rather, the women often spoke of these social issues as barriers to making expected behaviour changes in pregnancy, rather than as stand-alone priority issues to be addressed to achieve health in pregnancy.

Although the women spoke of the complex social issues they encountered in pregnancy as secondary to the behavioural aspects of health, there is evidence in the literature to suggest that other young pregnant and parenting women may identify such social issues as priorities. For instance, literature suggests that despite government set targets to decrease smoking and increase

breastfeeding, young women identified broader social indicators, consistent with the social determinants of health, such as housing, employment, education, and food security as critical (Austerberry & Wiggins, 2007; Cox et al., 2005). The importance of redefining health care to be inclusive of the broader social context should not be underestimated. For socially marginalized groups such as young pregnant women, the social complexities they encounter are both critical issues in themselves that impact health and also the underlying cause for many of the behaviours that traditional prenatal care attempts to change. For instance, Austerberry and Wiggins (2007) identify that there are often other underlying issues that lead young women to smoke. The notion that many of the behaviours that need to be changed during pregnancy stem from broader social issues resonates with some of the participants' stories from this study. One woman talked about how she could not quit smoking because of the stress in her life, while other women talked about their difficulties achieving good nutrition due to limited finances. These examples illustrate how by bringing the broader social context to the forefront in prenatal health care the root causes of behaviours may be addressed and improved.

Two strategies may be used to bring the broader social context to the forefront in prenatal health care and the care of young mothers and their children. First, as was done during this study, engaging young women in discussions about the importance of social factors during pregnancy may encourage the women to reflect on, recognize, and vocalize the role of their social context in health during pregnancy. This process may facilitate an enhanced contextual understanding by both the interviewer and the young women. Second, an intersectionality approach is a means of bringing the broader social context to the forefront in prenatal health care and the care of young mothers and their children. As was illustrated in the results of this study and in the literature, young single pregnant and parenting women may experience multiple marginalizations (such as

gender and economic status) which are in continual interaction with each other and with broader societal systems and processes (Clow et al., 2009). While traditionally such social issues have been conceptualized as single isolated categories, intersectionality promotes understanding of the interrelated and fluid nature of these social issues and their impact on health outcomes (Hankivsky & Christoffersen, 2008).

5.3 Understanding Behaviours in Young Single Pregnant Women

The women in this study provided rich descriptions about what behavioural expectations they were commonly subjected to in pregnancy and how they experienced these expectations. The participants were able to identify many behavioural expectations during pregnancy that were consistent with current recommendations. Thus, although the behaviours of young pregnant women have commonly been conceptualized as high-risk, such as higher rates of smoking, alcohol use, poor dietary intake, and late contact with prenatal health services (Baker et al., 2009; Heaman, 2009; Heaman et al., 2009; Kaiser & Hays, 2005; Millar & Hill, 2004; Moran, 2007; PHAC, 2006; Wahn & Nissen, 2008), the findings of this study suggest that such high risk behaviours may not necessarily be attributed to a lack of awareness or effort. Rather, all of the women identified an awareness of recommended behavioural changes and discussed their attempts at making such changes. Using an intersectionality approach, this study identified that the young women experienced multiple and converging marginalizations which often presented barriers in making the recommended changes, illustrating the role of each woman's unique social context in influencing her ability to conform to dominant behavioural recommendations in pregnancy.

As discussed in the previous section, young single women are subject to many of the same behavioural expectations in pregnancy as other pregnant women in general. One of the key

differences for young single pregnant women is their relative lack of resources and increased social challenges including lower social support (Hanna, 2001; Statistics Canada, 2008), poverty (Best Start Resource Centre, 2003), violence (Covington et al., 2001), low education (Fessler, 2003), stigmatization (Berman, et al., 2007; Ekstrand et al., 2005; Hanna, 2001), high mobility and high stress levels (Best Start Resource Centre, n.d.). Thus, this section will discuss similar barriers discussed by women in conforming to behavioural expectations in pregnancy and relate them to current literature and argue for the importance of considering the broader social context in understanding young single women's pregnancy behaviours.

The women identified many factors which influenced their ability to make recommended behaviour changes in pregnancy. Such factors included those related to their current support system, and economic and social resources, among others. For instance, some women discussed challenges related to the level of support they were receiving from key people such as family members, friends, and partners. These women provided clear examples of the benefits of receiving support from such people in facilitating their behaviour change and discussed the challenges when such people were not supportive or not participating in the women's behaviour changes. The impact of support (or lack of support) from key people in the young women's life in making recommended behavioural changes is also seen in the literature. For instance, findings by Everette (2008) reinforce the role of social support in young women's behaviour changes in pregnancy as it was found that the women's partners and mothers were found to be influential in the woman's nutrition habits. The role of social support in behaviour change is also applicable to the broader pregnant population as illustrated by Tessema et al. (2009) who found that minority pregnant women who consistently took prenatal supplements commonly felt their support system expected and reinforced the behaviour.

Furthermore, a lack of social and economic resources sometimes prevented the women in this study from making expected behavioural changes in pregnancy. For instance, some women discussed the challenge of having insufficient money to purchase healthy foods, which resonates with findings from Burchett and Seeley (2003) who found the high cost of healthy foods was the main reason for the young women only being able to follow dietary guidelines sometimes or not at all (Burchett & Seeley, 2003). Another example of the impact of the limited social and economic resources was the resultant stress experienced by the women. Many women discussed feeling so stressed that it prevented them from doing daily activities. One woman specifically discussed the impact of such stress on her willingness to quit smoking, which is similar to findings by others who found that young women's attempts at smoking cessation were highly influenced by the stress of environmental barriers, such as unstable living environments and lack of economic and social resources (Lawson, 1994; Wakefield et al., 1998) and the fact that smoking may be used as a coping mechanism (Bryce et al., 2009).

While health education is one component of health promotion and behaviour change (D. Whitehead, 2001), a strong focus on health education may exclude the role of the broader environment on behaviours. As illustrated by D. Whitehead (2001), presenting a patient with the appropriate health information to generate a change in behaviour is often insufficient. That is, the provision of relevant health teaching and information is rarely sufficient to induce and maintain behaviour change by the patient (D. Whitehead, 2001). Rather, a critical factor in behaviour change is the "characteristics of the social environmental context of the behaviour" (McQueen, 1996, p. 31), highlighting the interconnectedness between the person and the broader social determinants of health. This is similar to the results of this study which found that young women did indeed have an awareness of necessary behaviour changes in pregnancy (as described in

chapter four, theme one), yet this awareness of expected changes and communication of such expectations did not necessarily lead to full and sustained behaviour change. Again, this is similar to Burchett and Seeley (2003) who found that most young women were aware of the components of healthy nutrition in pregnancy, but encountered social and economic barriers in actually executing such changes. Thus, it is important to consider the broader context of each woman in influencing their ability to make recommended changes.

5.4 Examining Relevant Identity Constructs in Pregnancy

Given that pregnancy represents a time with the potential for changing social locations, that is, a change in the amount of power and oppression held by the woman, intersectionality represented an appropriate lens to use to interpret such experiences. This section explores the various identity constructs introduced in chapter four and compares this to current research.

The women implicitly discussed experiencing multiple identity constructs when describing their pregnancy experience, as previously summarized in Chapter 4, Table 2. The young women's pregnancy experiences were influenced by their identities as women, youth, single women, pregnant women, mothers, and adults. The role of the aforementioned identity constructs have also been identified in previous research with pregnant women. In this study, the women identified the privilege of taking responsibility and making their own decisions once becoming pregnant, which ultimately transitioned them into the identity of an adult and the privileges associated with being an adult. The acquisition of the identity construct of adulthood resonates with other studies with young mothers where they felt that childbearing showed society that they are grown up and it was a time to start making more responsible decisions (Herrman, 2008). Similarly, as illustrated by Brubaker (2007), some young pregnant women may resist medicalized prenatal care as a way of asserting their independence and decision making power.

For the women in this study pregnancy and motherhood also became an opportunity for the women to make their own health and the health of their baby priority, which resonates with findings from Bondas and Eriksson (2001) who found that pregnancy was a motivator to live a healthy life.

Contrary to the privileged identity constructs discussed above, the women also implicitly suggested experiencing identity constructs that led to oppression, namely, the identities of being a woman, being young, being pregnant, being a mother and being single. The women expressed feelings of having additional expectations placed on them during pregnancy in comparison to their male partners. These feelings of additional societal pressure on women are consistent with a study by Herrman (2008) who found that young women felt society made them endure more responsibility and stigma for young childbearing compared to the men. Similarly, there is evidence to suggest that society also holds a more negative perception of single female parents compared to single male parents. For example, a study by DeJean et al. (2012) revealed that society perceives the characteristics and abilities of single mothers less favorably than single fathers. Furthermore, the results of this study demonstrated that the women felt subject to additional expectations and stigma during pregnancy due to their young age, with such stigma having a negative influence on the young women's ability to make behaviour changes due to feelings of disempowerment, stress, and isolation. The experience of stigma during pregnancy related to being young is a commonly reported experience in the literature, where it has been documented that women experience age-related stigma from people in public places (Hanna, 2001; Herrman, 2008).

Moreover, the identity construct of being pregnant was discussed as being oppressive for many women due to the increase in behavioural expectations and surveillance. These additional

behavioural expectations and increased surveillance experienced during pregnancy are a common experience shared with pregnant women in other age groups. For instance, studies by Bessett (2010), Fox et al. (2009), and Kennison (2009) offer examples of how women in general experience an increase in surveillance over behaviours in pregnancy. A potential difference in the experience of the identity construct of pregnancy between a marginalized group such as young single women and pregnant women in general may be their power to resist the dominant norms reinforced by societal surveillance. This is reinforced by Middleton (2006) who discusses the challenges encountered by mothers with fewer resources and who experience social challenges in developing and executing the “agency, authority, autonomy and authenticity” (p. 74) to resist the social construction of good motherhood. Similarly, Weinberg (2004) describes the need for young pregnant and parenting women to continually prove to society their fitness to be a mother which begins during pregnancy through the proper management of behaviours. Similar to the young women in this study, all of whom accessed medical prenatal services, Brubaker (2007) found that young pregnant women may embrace medicalized prenatal care as it is an opportunity to normalize their pregnancy and access a service that other ‘good mothers’ also use.

Lastly, some of the women described their identity as a single woman specifically as an influential identity construct. This is similar to findings by Wiemann et al. (2005) who found that there was an association between young women feeling stigmatized by their pregnancy and not being married or engaged to the father of the baby. This resonates with interviews from this study when women described the pressure to purchase fake wedding rings to avoid judgment for being unmarried. Thus, given that a young, single, pregnant woman’s experience of behavioural expectations is influenced by her intersecting identity constructs, as well as by an interaction

between such identity constructs and broader social systems and processes, an intersectional approach is helpful in understanding the context of her complex social experience of behavioural expectations during pregnancy.

5.5 Implications and Recommendations

5.5.1 Nursing practice. The findings of this study lead to three main recommendations for nursing practice including (1) incorporating the social context of health in nursing care of young pregnant and parenting women by employing a social determinants of health approach, (2) taking a strength-based approach to working with young pregnant and parenting women, and (3) assessing the women's relationships and involving key support persons in the care of young pregnant women. The three recommendations are elaborated on below.

First, there is a need for nurses to bring the social context of each young pregnant woman to the forefront of nursing care. It is important to note that within nursing the concept of the 'social determinants of health' has commonly been used to encompass the multiple components of the social context identified in this study. Consistent with the Canadian Nurses Association's (2009) position statement on the social determinants of health, which identifies the determinants as a "a foundational element of nursing education and nursing practice" (p. 4), it is recommended that nursing practice incorporates the social determinants of health (i.e. the social context) into all components of care. This study found that when discussing health in pregnancy the young women discussed elements of health that are commonly reinforced through medicalized prenatal care, despite their complex social needs and challenges. Given that the efficacy of medicalized prenatal care is debated (Alexander & Kotelchuck, 2001; Barker, 1998; Maloni et al., 1996) and there is evidence to suggest that the social determinants of health have significant influence over health outcomes (Lightman, Mitchell, & Wilson, 2008; Wilkinson & Marmot, 2003),

incorporating the determinants of health in nursing practice could increase health equity. By incorporating the social context into all aspects of nursing care with young women during pregnancy, the priority issues of housing, food security, economic stability, and social support could be brought to the forefront. Considering that a social determinants of health perspective is consistent with the scope of public health and community health nursing (Canadian Public Health Association, 2010) and there is literature to support the benefits of public health nursing for young pregnant and parenting women (Flynn, Budd & Modelski, 2008; Koniak-Griffin et al., 2002), it is recommended that the strengths of this field of nursing are built upon. This recommendation to make the social context of each young pregnant woman central is further reinforced by the RNAO (2010) who states that assessments should be comprehensive to identify and understand not only the high risk behaviours but also the broader context of such behaviours (p. 30). A further means of incorporating the social context into nursing practice is through political advocacy. It is important for nurses to engage in sociopolitical activities including advocating for healthy public policy and contributing to program development, among others (Whitehead, 2003). Such sociopolitical activities have the potential to address the social inequities experienced by young pregnant women.

Furthermore, consistent with the RNAO's (2010) Best Practice Guideline on *Enhancing Healthy Adolescent Development*, it is recommended based on the findings of this study that nurses use a strength-based approach in all interactions with young pregnant and parenting women. Some of the young women in this study expressed feeling scrutinized, judged, and disempowered by their encounters with health care providers and the health care system, leading to increased levels of stress. This experience is not uncommon as often young single women perceive that they are seen as deficient and in need of guidance to alter such deficiencies

(Peterson, Sword, Charles & DiCenso, 2007; Weinberg, 2004). Thus, a strength-based approach calls for health care providers who recognize the power of surveillance to influence a woman's experience of pregnancy as an opportunity or oppression and to use surveillance to recognize and reinforce existing positive health behaviours. Thus, rather than solely focusing on the deficiencies of the young woman, a strength-based approach that builds on each woman's existing individual, family, and community assets is recommended.

Lastly, the findings of this study highlight the importance of assessing the quality of the young women's relationships and including key support persons in caring for young pregnant women, as appropriate. Relationships were found to be highly influential in the women's experience of pregnancy as opportunity or oppression, thus nurses should be attentive to key relationships that women discuss and the role that each relationship plays in women's behaviour changes and pregnancy experience. Many women in the study discussed the benefits of having a support person, most notably their partners, mothers, and friends make behaviour changes as well and the barriers when support persons did not make changes. Given that there is evidence to suggest that partners, families and friends are influential in health behaviour changes (Lewis et al., 2006; Tessema et al., 2009; Vander Wal, 2012), an important role for nursing could be to facilitate participation of key support persons in behaviour change in pregnancy, as appropriate.

5.5.2 Nursing education. The recommendations for education follow from the recommendations for nursing practice. That is, for nurses to effectively implement the aforementioned recommendations for practice, it is essential that such knowledge and skills become further incorporated into nursing education. First, there is a need to increase education surrounding the social determinants of health. The nursing profession operates largely from a biomedical and lifestyle perspective (Whitehead, 2003) and it is thus necessary to expand this

view to include the social determinants of health. As suggested by Reutter and Kushner (2010), nursing education needs to more fully encompass determinants of health outside of health care and develop nursing student's knowledge and skills surrounding policy and advocacy.

Furthermore, it is recommended that a health equity and policy lens is incorporated throughout all nursing education (Reutter & Kushner, 2010).

Next, the findings of this study illustrate the need to educate and prepare nurses to best utilize a strength-based approach. As described by the RNAO (2006), providing strength-based care requires a reconceptualization of traditional nursing practices by shifting the focus from deficits to strengths (p.29). Thus, this reconceptualization of nursing practices needs to be integrated throughout nursing courses and practicums.

5.5.3 Nursing research. The findings of this study reveal several areas for future research. First, this study found that the young women largely defined health in pregnancy as behavioural in nature. The women identified many behaviours that they were expected to conform to and their resources and challenges in achieving their behavioural definition of health. Given that there is evidence to suggest that young pregnant women encounter a multitude of social challenges, future research could explore young women's perceptions of economic and social resources in shaping health in pregnancy along with their perception of their access to the social determinants of health in pregnancy.

Next, the women discussed the role of their relationships, most often their relationships with their partner, in both their experience of behavioural expectations in pregnancy as well as in making behaviour changes. Often, their relationship with their partner was the buffer between whether the woman experienced behavioural expectations as an opportunity or oppression. Furthermore, the support (or lack of support) from their partner serves as a significant facilitator

or barrier for making behaviour changes in pregnancy. It is thus recommended that future research further explores the role of this relationship in young pregnant women's choices and experiences. Furthermore, future research could explore the perspective of the male partners in experiencing behavioural expectations and behaviour change in pregnancy.

Lastly, this study utilized photo elicitation during the interviews. Given that the use of photographs was received positively by the participants, future research could explore the use photovoice to further engage young pregnant women in the process of using photography to explore their experiences.

5.6 Study Strengths and Limitations

This study had several strengths. This study incorporated intersectionality as a theoretical lens from the design of the study through to analysis. The use of a theoretical lens was influential in selecting a relevant population of interest and providing a general orientation which influenced data collection and analysis (Creswell, 2009). Furthermore, intersectionality promoted a holistic view of the participants' experiences by privileging an examination of the interaction between multiple identity constructs and between identity constructs and broader societal systems and processes rather than relying on an analysis of one single category in isolation to describe complex experiences (Clow et al., 2009). Furthermore, the use of intersectionality privileged the use of qualitative methods that allowed the women to express their experiences in their own words and allowed the context of their experiences to be explored. Lastly, this study used photo elicitation during the interview to stimulate discussion, facilitate recall of previous experiences, and allow the women to have increased control over the interviews (Close, 2007; Harper, 2002). The use of photo elicitation was also seen as a strength as it was received positively by the participants. At the end of the interview, each woman was asked whether she

found the use of photographs during the interview helpful. All of the women agreed that the photographs were helpful. The main reasons given for the usefulness of the photographs were triggering thoughts and memories, facilitating conversation, and helping participants to express themselves.

There also exist several limitations. First, some interviews were conducted after the woman was no longer pregnant and thus some women had to recall experiences that happened up to six months prior to the interview. Because these young women continue to be subjected to behavioral expectations beyond pregnancy and into parenthood (for example breastfeeding), these women were likely to talk about their current behavioural expectation experiences in parenthood. Thus, these interviews required additional time and probing to gain an understanding of these women's *pregnancy* experiences. The use of photo elicitation was key in minimizing this limitation as the use of photographs helped in recalling information and experiences. All of the women who participated in this study were recruited from community-based services, thus each woman was currently accessing health and/or social services during pregnancy and/or postpartum. While the purpose of qualitative research is not to generalize findings, it is nonetheless important to acknowledge that the results of this study may not necessarily be transferable to settings where young pregnant women are not accessing services. the experiences of young single women who are not accessing services was beneficial to have participants who could speak to their experience using services and the behavioural expectations communicated through such services, it is nonetheless important to consider that the results of this study may not reflect the experiences of young single women who are not accessing services. Moreover, while the use of pictures was an overall strength in the facilitation of the interviews, the images may have influenced some of the women's answers when discussing

health and behaviour change in pregnancy. To minimize this potential limitation each woman was asked to suggest photographs to utilize in future interviews to ensure that the images were relevant to the population of young single pregnant women. Furthermore, at the beginning of the interview each woman was reminded she did not need to use the photographs to describe her experiences. Lastly, the researcher is a registered nurse and the participants may have perceived that certain answers to the interview questions about health and behaviours in pregnancy might be more appropriate than others. To minimize this potential limitation the researcher reminded each woman that all information would remain confidential and the researcher maintained a non-judgmental approach throughout the interviews.

5.7 Conclusion

The purpose of this study was to explore the experiences of young single women of behavioural expectations and behaviour change during pregnancy. The findings of this study suggest that young single pregnant women are subject to a multitude of health and social behavioural expectations. Young single women experience these behavioral expectations and behavior changes in pregnancy as a tension between the potential for opportunity and oppression as each behavior change comes with benefits and risks. While these young single women may be subject to many of the same behavioural expectations in pregnancy as the general pregnant population, their experiences differ due to the intensity and frequency of internal and external surveillance and stigmatization, as well as their relative lack of resources and the related challenges in making behaviour changes. Thus, the findings of this study illustrate the importance of understanding the experiences of young single pregnant women in making behavior changes and suggests the importance of considering the social context of these women.

References

- Ajzen, I. (1988). *Attitudes, personality, and behaviour*. Chicago: Dorsey Press.
- Albrecht, S. A. & Caruthers, D. (2002). Characteristics of inner-city pregnant smoking teenagers. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, 31(4), 462-469.
- Alexander, G. R. & Kotelchuck, M. (2001). Assessing the role and effectiveness of prenatal care: History, challenges, and directions for future research. *Public Health Reports*, 116(4), 306-317.
- Armstrong, D. (1995). The rise of surveillance medicine. *Sociology of Health & Illness*, 17(3), 393-404.
- Austerberry, H., & Wiggins, M. (2007). Taking a pro-choice perspective on promoting inclusion of teenage mothers: Lessons from an evaluation of the Sure Start Plus Programme. *Critical Public Health*, 17(1), 3-15. doi: 10.1080/09581590601045246
- Baker, P. N., Wheeler, S. K., Sanders, T. A., Thomas, J. E., Hutchinson, C. J., Clarke, K., & Berry, J. L. (2009). A prospective study of micronutrient status in adolescent pregnancy. *The American Journal of Clinical Nutrition*, 89(4), 1114-1124.
- Baric, L. & MacArthur, C. (1977). Health norms in pregnancy. *British Journal of Preventive and Social Medicine*, 31, 30-38.
- Barker, K. K. (1998). A ship upon a stormy sea: The medicalization of pregnancy. *Social Science & Medicine*, 47(8), 1067-1076.
- Barriball, K. L. & While, A. (1994). Collecting data using a semi-structured interview: A discussion paper. *Journal of Advanced Nursing*, 19, 328-335.
- Berman, R. C., Silver, S., & Wilson, S. (2007). "Don't look down on me because I have one":

- Young mothers empowerment in a context of support. *Journal of the Association for Research on Mothering*, 9(1), 42-52.
- Bessett, D. (2010). Negotiating normalization: The perils of producing pregnancy symptoms in prenatal care. *Social Science & Medicine*, 71, 370-377. doi: 10.1016/j.socscimed.2010.04.007
- Best Start Resource Centre. (2003). The impact of poverty on pregnant women: A guide for program managers. Retrieved from http://www.beststart.org/resources/anti_poverty/pdf/prog_mgr_guide.pdf
- Best Start Resource Centre. (2007). Prenatal education in Ontario: Better practices. Retrieved from http://www.beststart.org/resources/rep_health/pdf/prenatal_education_web.pdf
- Best Start Resource Centre. (n.d.). Reducing the impact: Working with pregnant women who live in difficult life situations. Retrieved from http://www.beststart.org/resources/anti_poverty/pdf/REDUCE.pdf
- Biro, M. A. (2011). What has public health got to do with midwifery? Midwives' role in securing better health outcomes for mothers and babies. *Women and Birth*, 24, 17-23. doi:10.1016/j.wombi.2010.06.001
- Bondas, T. & Eriksson, K. (2001). Women's lived experiences of pregnancy: A tapestry of joy and suffering. *Qualitative Health Research*, 11, 824-840. doi: 10.1177/104973201129119415
- Bowen, G. A. (2008). Naturalistic inquiry and the saturation concept: A research note. *Qualitative Research*, 8(1), 137-152. doi: 10.1177/1468794107085301

- Breheny, M. & Stephens, C. (2007). Irreconcilable differences: Health professionals' constructions of adolescence and motherhood. *Social Science and Medicine*, 64, 112-124. doi:10.1016/j.socscimed.2006.08.026
- Brubaker, S. J. (2007). Denied, embracing, and resisting medicalization: African American teen mothers' perceptions of formal pregnancy and childbirth care. *Gender and Society*, 21(4), 528-552. doi: 10.1177/0891243207304972
- Bryce, A., Butler, C., Gnich, W., Sheehy, C., & Tappin, D. M. (2009). CATCH: Development of a home-based midwifery intervention to support young pregnant smokers to quit. *Midwifery*, 25, 273-482. doi:10.1016/j.midw.2007.10.006
- Burchett, H. & Seeley, A. (2003). Good enough to eat? The diet of pregnant teenagers. Retrieved from http://www.foodcomm.org.uk/pdfs/Too_good_to_eat.PDF
- Bute, J. J. & Jensen, R. E. (2010). Low-income women describe fertility-related expectations: Descriptive norms, injunctive norms, and behaviour. *Health Communication*, 25(8), 681-691. doi: 10.1080/10410236.2010.521909
- Canadian Institute for Health Information. (2006). *Giving birth in Canada: The costs*. Ottawa, ON: Author.
- Canadian Nurses Association. (2009). *Position statement: Determinants of health*. Ottawa, ON: Author.
- Canadian Public Health Association. (2010). *Public health/community health nursing practice in Canada: Roles and activities (4th ed.)*. Ottawa, ON: Author.
- Chalmers, B. & Kimak, C. (2009). Postpartum depression, previous depression, and support. In B. Chalmers & S. Dzakpasu (Eds.), *What Mothers Say: The Canadian Maternity Experiences Survey* (pp. 206-211). Ottawa, ON: Public Health Agency of Canada.

- Chalmers, B. & Kingston, D. (2009). Prenatal classes. In B. Chalmers & S. Dzakpasu (Eds.), *What Mothers Say: The Canadian Maternity Experiences Survey* (pp. 47-50). Ottawa, ON: Public Health Agency of Canada.
- Chen, X. K., Wen, S. W., Fleming, N., Demissie, K., Rhoads, G. G., & Walker, M. (2007). Teenage pregnancy and adverse birth outcomes: A large population based retrospective cohort study. *International Journal of Epidemiology*, 36, 368–373. Retrieved from <http://ije.oxfordjournals.org/>
- Clarke, J. N. (2004). *Health, Illness, and Medicine in Canada* (4th ed.). Toronto, ON: Oxford University Press.
- Close, H. (2007). The use of photography as a qualitative research tool. *Nurse Researcher*, 15(1), 27-36.
- Clow, B., Pederson, A., Haworth-Brockman, M., & Bernier, J. (2009). *Rising to the challenge: Sex and gender-based analysis for health planning, policy, and research in Canada*. Halifax, NS: Atlantic Centre of Excellence for Women's Health.
- Conrad, P. (1992). Medicalization and social control. *Annual Review of Sociology*, 18, 209-232.
- Covington, D. L., Justason, B. J., & Wright, L. N. (2001). Severity, manifestations, and consequences of violence among pregnant adolescents. *Journal of Adolescent Health*, 28, 55-61.
- Cox, J. E., Bevill, L., Forsyth, J., Missal, S., Sherry, M., & Woods, E. R. (2005). Youth preferences for prenatal and parenting teen services. *Journal of Pediatric and Adolescent Gynecology*, 18(3), 167-174. doi:10.1016/j.jpag.2005.03.003
- Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd ed.). Thousand Oaks, CA: SAGE Publications

- de Anda, D. (2006). Baby think it over: Evaluation of an infant simulation intervention for adolescent pregnancy prevention. *Health & Social Work, 31*(1), 26-35.
- Debiec, K. E., Paul, K.J., Mitchell, C. M., & Hitti, J. E. (2010). Inadequate prenatal care and risk of preterm delivery among adolescents: A retrospective study over 10 years. *American Journal of Obstetrics & Gynecology, 203*(122), e1-6. doi: 10.1016/j.ajog.2010.03.001
- deGroot-Maggetti, G. (2002). A measure of poverty in Canada: A guide to the debate about poverty lines. Retrieved from http://action.web.ca/home/cpj/attach/A_measure_of_poverty.pdf
- DeJean, S. L., McGeorge, C. R., and Carlson, T. S. (2012). Attitudes toward never-married single mothers and fathers: Does gender matter? *Journal of Feminist Family Therapy, 24*(2), 121-138. doi: 10.1080/08952833.2012.648121
- Downe, S. (2008). *Normal childbirth: Evidence and debate* (2nd ed.). Oxford, UK: Elsevier.
- Ekstrand, M., Larsson, M., Von Essen, L., & Tyden, T. (2005). Swedish teenager perceptions of teenage pregnancy, abortion, sexual behaviour, and contraceptive habits: A focus group study among 17-year-old female high-school students. *Acta Obstetrica et Gynecologica Scandinavica, 84*(10), 980-986.
- Everette, M. (2008). Gestational weight and dietary intake during pregnancy: Perspectives of African American women. *Maternal and Child Health Journal, 12*, 718-724. doi: 10.1007/s10995-007-0301-5
- Fessler, K. B. (2003). Social outcomes of early childbearing: Important considerations for the provision of clinical care. *Journal of Midwifery & Women's Health, 48*(3), 178-185. doi:10.1016/S1526-9523(03)00063-1

Finlay, L. (2002). "Outing" the researcher: The provenance, process, and practice of reflexivity.

Qualitative Health Research, 12(4), 531-545.

Flynn, L., Budd, M., & Modelski, J. (2008). Enhancing resource utilization among

pregnant adolescents. *Public Health Nursing*, 25(2), 140-148. doi: 10.1111/j.1525-1446.2008.00690.x

Fox, R., Heffernan, K., & Nicolson, P. (2009). 'I don't think it was such an issue back then':

Changing experiences of pregnancy across two generations of women in south-east England. *Gender, Place, and Culture*, 16(5), 553-568. doi: 10.1080/09663690903148424

Freed, A. F. (1999). Communities of practice and pregnant women: Is there a connection?

Language in Society, 28, 257-271.

Fulford, A. & Ford-Gilboe, M. (2004). An exploration of the relationships between health

promotion practices, health work, and felt stigma in families headed by adolescent mothers. *Canadian Journal of Nursing Research*, 36(4), 46-72.

Gilbert, W. M., Jandial, D., Field, N. T., Bigelow, P., & Danielson, B. (2004). Birth outcomes in

teenage pregnancies. *The Journal of Maternal-Fetal and Neonatal Medicine*, 16, 265-270. doi: 10.1080/14767050400018064

Graneheim, U., & Lundman, B. (2004). Qualitative content analysis in nursing research:

Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, 24(2), 105-112.

Haeri, S., Guichard, I., & Saddlemire, S. (2009). Maternal characteristics and outcomes

associated with late enrolment for care in teenage pregnancies. *Southern Medical Journal*, 102(3), 265-268.

- Hancock, A. (2007). When multiplication doesn't equal quick addition: Examining intersectionality as a research paradigm. *Perspectives on Politics*, 5(1), 63-79. doi: 10.1017/S1537592707070065
- Hankivsky, O. & Christoffersen, A. (2008). Intersectionality and the determinants of health: A Canadian perspective. *Critical Public Health*, 18(3), 271-283. doi: 10.1080/09581590802294296
- Hanna, B. (2001). Negotiating motherhood: The struggles of teenage mothers. *Journal of Advanced Nursing*, 34(4), 456-464
- Harper, D. (2002). Talking about pictures: A case for photo elicitation. *Visual Studies*, 17(1), 13-26. doi: 10.1080/1472586022013734 5
- Heaman, M. (2009). Prenatal care. In B. Chalmers & S. Dzakupasu (Eds.), *What Mothers Say: The Canadian Maternity Experiences Survey* (pp. 42-46). Ottawa, ON: Public Health Agency of Canada.
- Heaman, M., Lindsay, J., & Kaczorowski, J. (2009). Smoking. In B. Chalmers & S. Dzakupasu (Eds.), *What Mothers Say: The Canadian Maternity Experiences Survey* (pp. 79- 83). Ottawa, ON: Public Health Agency of Canada.
- Heaman, M. & O'Brien, B. (2009). Prenatal care provider. In B. Chalmers & S. Dzakupasu (Eds.), *What Mothers Say: The Canadian Maternity Experiences Survey* (pp. 37-41). Ottawa, ON: Public Health Agency of Canada.
- Herrman, J. W. (2008). Adolescent perceptions of teen births. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 37, 42-50. doi: 10.1111/J.1552-6909.2007.00201.x
- Higgins, P. G. & Woods, P. J. (1999). Reasons, health behaviours, and outcomes of no prenatal care: Research that changed practice. *Health Care for Women International*, 20, 127-136.

- Hsieh, H. & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, 15(9), 1277-1288. doi: 10.1177/1049732305276687
- Hulko, W. (2009). The time- and context-contingent nature of intersectionality and interlocking oppressions. *Affilia: Journal of Women and Social Work*, 24(1), 44-55. doi: 10.1177/0886109908326814
- Hyde, A. (2000). Age and partnership as public symbols: Stigma and non-marital motherhood in an Irish context. *The European Journal of Women's Studies*, 7(1), 71-89.
- Kaczorowski, J. & Lee, L. (2009). Folic acid supplementation. In B. Chalmers & S. Dzakpasu (Eds.), *What Mothers Say: The Canadian Maternity Experiences Survey* (pp. 57-62). Ottawa, ON: Public Health Agency of Canada.
- Kaiser, M. M. & Hays, B. J. (2005). Health-risk behaviours in a sample of first-time pregnant adolescents. *Public Health Nursing*, 22(6), 483-493.
- Kennison, L. H. (2009). Smoking and pregnancy: Reconciling incompatibilities. *Holistic Nursing Practice*, 23(1), 32-38.
- Khashan, A. S., Baker, P. N., Kenny, L. C. (2010). Preterm birth and reduced birthweight in first and second teenage pregnancies: A register-based cohort study. *BMC Pregnancy & Childbirth*, 10(36). Retrieved from <http://www.biomedcentral.com/1471-2393/10/36>
- Kingston, D. & Chalmers, B. (2009). Prenatal information. In B. Chalmers & S. Dzakpasu (Eds.), *What Mothers Say: The Canadian Maternity Experiences Survey* (pp. 51-56). Ottawa, ON: Public Health Agency of Canada.
- Klein, J. D. (2005). Adolescent pregnancy: Current trends and issues. *Pediatrics*, 116, 281-286. doi: 10.1542/peds.2005-0999
- Koniak-Griffin, D., Anderson, N., Brecht, M., Verzemnieks, I., Lesser, J., & Kim, S. (2002).

- Public health nursing care for adolescent mothers: Impact on infant health and selected maternal outcomes at 1 year postbirth. *Journal of Adolescent Health*, 30(1), 44-54. doi: 10.1016/S1054-139X(01)00330-5
- Lawson, E. J. (1994). The role of smoking in the lives of low-income pregnant adolescents: A field study. *Adolescence*, 29(113), 61- 80.
- Lederman, R. P., Chan, W., & Roberts-Gray, C. (2008). Parent–adolescent relationship education (PARE): Program delivery to reduce risks for adolescent Pregnancy and STDs. *Behavioural Medicine*, 33, 137-143.
- Lee, S. H. & Grubbs, L. M. (1993). A comparison of self-reported self-care practices of pregnant adolescents. *Nurse Practitioner*, 18(9), 25-29.
- Letvak, S. (2003). The experience of being an older staff nurse. *Western Journal of Nursing Research*, 25(1), 45-56. doi: 10.1177/0193945902238835
- Lewis, M. A., McBride, C. M., Pollak, K. I., Puleo, E., Butterfield, R. M., & Emmons, K. M. (2006). Understanding health behaviour change among couples: An interdependence and communal coping approach. *Social Science & Medicine*, 62, 1369-1380. doi: 10.1016/j.socscimed.2005.08.006
- Lightman, E., Mitchell, A., & Wilson, B. (2008). *Poverty is making us sick: A comprehensive survey of income and health in Canada*. Toronto, ON: Community Social Planning Council of Toronto and the Wellesley Institute.
- Lincoln, Y. S. & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage Publications.
- Link, B. G. & Phelan, J. C. (2006). Stigma and its public health implications. *Lancet*, 367, 528-529.

- Macvarish, J. (2010). The effect of 'risk-thinking' on the contemporary construction of teenage motherhood. *Health, Risk, & Society*, 12(4), 313-322. doi : 10.1080/13698571003789724
- Maloni, J. A., Cheng, C. Y., Liebl, C. P., & Maier, J. S. (1996). Transforming prenatal care: Reflections on the past and present with implication for the future. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 25, 17-23.
- McCall, L. (2005). The complexity of intersectionality. *Signs: Journal of Women in Culture and Society*, 30(3), 1771-1800.
- McDermott, E. & Graham, H. (2006). Young mothers and smoking: Evidence of an evidence gap. *Social Science & Medicine*, 63, 1546-1549. doi:10.1016/j.socscimed.2006.03.025
- McQueen, D. V. (1996). The search for theory in health behaviour and health promotion. *Health Promotion International*, 11, 27-32. doi: 10.1093/heapro/11.1.27
- Messer, L. C., Shoe, E., Canady, M., Sheppard, B. K., & Vincus, A. (2011). Reported adolescent sexual norms and the development of a social marketing campaign to correct youth misperceptions. *Journal of Children and Poverty*, 17(1), 45-63. doi: 10.1080/10796126.2011.539197
- Middleton, A. (2006). Mothering under duress: Examining the inclusiveness of feminist mothering theory. *Journal of the Association for Research on Mothering*, 8(1,2), 72-82.
- Millar, W. J. & Hill, G. (2004). Pregnancy and smoking. *Health Reports*, 15(4), 53-56. Retrieved from <http://www.statcan.gc.ca/pub/82-003-x/82-003-x2003004-eng.pdf>
- Moos, M. K. (2006). Prenatal care: Limitations and opportunities. *The Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 35, 278-285. doi: 10.1111/J.1552-6909.2006.00039.x
- Moran, V. H. (2007). A systematic review of dietary assessments of pregnant adolescents in

- industrialised countries. *British Journal of Nutrition*, 97, 411-425. doi: 10.1017/S0007114507381373
- Morse, J.M. (1995). The significance of saturation. *Qualitative Health Research*, 5(2), 147-149.
- Morse, J.M. (2000). Determining sample size. *Qualitative Health Research*, 10(1), 3-5.
- Nash, M. (2011). "You don't train for a marathon sitting on the couch": Performances of pregnancy 'fitness' and 'good' motherhood in Melbourne, Australia. *Women's Studies International Forum*, 34, 50-65. doi:10.1016/j.wsif.2010.10.004
- National Collaborating Centres for Public Health. (2008). Social determinants of health fact sheet. Retrieved from http://nccph.netedit.info/docs/DoH_eng_PRESS_M.pdf
- Nicolson, P. (2010). Sources of pregnancy advice for 21st century women: Does (grand)mother still know best? *Expert Review of Obstetrics & Gynecology*, 5.6, 637-640.
- O'Campo, P. & Johnston, M. (2009). Street drug use. In B. Chalmers & S. Dzakpasu (Eds.), *What Mothers Say: The Canadian Maternity Experiences Survey* (pp. 90-93). Ottawa, ON: Public Health Agency of Canada.
- Ontario Health Promotion Resource System. (n.d.). Module 4: Theories. Retrieved from <http://www.ohprs.ca/hp101/print/module3.pdf>
- Paranjothy, S., Broughton, H., Adappa, R., & Fone, D. (2009). Teenage pregnancy: Who suffers? *Archives of Disease in Childhood*, 94, 239-245. doi:10.1136/adc.2007.115915
- Peterson, W. E., Sword, W., Charles, C., & DiCenso, A. (2007). Adolescents' perception of inpatient postpartum nursing care. *Qualitative Health Research*, 17(2), 201-212. doi: 10.1177/1049732306297414
- Planned Parenthood of Toronto. (2005). Young parents' sexual health consultation report. Retrieved from <http://www.ppt.on.ca/pdf/reports/YoungParentsreport.pdf>

- Polit, D. F. & Beck, C. T. (2012). *Nursing Research: Generating and assessing evidence for nursing practice* (9th ed.). Philadelphia, PA: Lippincott Williams & Wilkins
- Province of New Brunswick. (2008). Healthy pregnancy—healthy baby: A new life. Retrieved from <http://www2.gnb.ca/content/dam/gnb/Departments/h-s/pdf/en/HealthyPeople/BFI/HealthyPregnancyHealthyBaby.pdf>
- Public Health Agency of Canada. (1999). Teen pregnancy. Retrieved from http://www.phac-aspc.gc.ca/publicat/meas-haut/mu_ee-eng.php
- Public Health Agency of Canada. (2002). Buns in the Oven, Ottawa, Ontario. Retrieved from http://www.phac-aspc.gc.ca/hp-ps/dca-dea/prog-ini/cnpn-pcnp/buns-oven_ca-mijote/index-eng.php
- Public Health Agency of Canada. (2006). Alcohol use and pregnancy: An important Canadian public health and social issue. Retrieved from http://www.phac-aspc.gc.ca/publicat/fasd-ru-ectaf-pr-06/pdf/fasd-ru-ectaf-pr-06_e.pdf
- Public Health Agency of Canada. (2008). The sensible guide to a healthy pregnancy. Ottawa, ON: Author. Retrieved from <http://www.phac-aspc.gc.ca/hp-gs/pdf/hpguide-eng.pdf>
- Public Health Agency of Canada. (2012). A healthy pregnancy is in your hands. Retrieved from <http://www.phac-aspc.gc.ca/hp-gs/index-eng.php>
- Registered Nurses Association of Ontario. (2006). *Supporting and strengthening families through expected and unexpected life events (revised 2006)*. Toronto, ON: Author.
- Registered Nurses Association of Ontario. (2010). *Enhancing healthy adolescent development (revised 2010)*. Toronto, ON: Author.
- Reutter, L. & Kushner, K. E. (2010). Health equity through action on the social determinants of health': Taking up the challenge in nursing. *Nursing Inquiry*, 17(3), 269-280.

- Rich, M. & Ginsburg, K. R. (1999). The reason and rhyme of qualitative research: Why, when, and how to use qualitative methods in the study of adolescent health. *Journal of Adolescent Health, 25*(6), 371-378.
- Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health, 23*, 334-340.
- Scarr, E. M. (2002). Effective prenatal care for adolescent girls. *The Nursing Clinics of North America, 37*, 513-521.
- Shoveller, J. A. & Johnson, J. L. (2006). Risky groups, risky behaviour, and risky persons: Dominating discourses on youth sexual health. *Critical Public Health, 16*(1), 47-60. doi: 10.1080/09581590600680621
- Smith Battle, L. (2000). The vulnerabilities of teenage mothers: Challenging prevailing assumptions. *Advance in Nursing Science, 23*(1), 29-40. Retrieved from <http://journals.lww.com/advancesinnursingscience/pages/default.aspx>
- Statistics Canada. (2008). Births. Catalogue no. 84F0210X. Retrieved from <http://www.statcan.gc.ca/pub/84f0210x/84f0210x2008000-eng.pdf>
- Statistics Canada. (2011a). Live births, by age and parity of mother, Canada, annual – Table 102-4508. Retrieved from <http://www5.statcan.gc.ca/cansim/a01?lang=eng>
- Statistics Canada. (2011b). Live births, by age and marital status of mother, Canada - Table 102-4507. Retrieved from <http://www5.statcan.gc.ca/cansim/a05?lang=eng&id=1024507>
- Tessema, J., Jefferds, M. E., Cogswell, M., & Carlton, E. (2009). Motivators and barriers to prenatal supplementation use among minority women in the United States. *Journal of the American Dietetic Association, 109*, 102-108. doi: 10.1016/j.jada.2008.10.013

- Toutain, S. (2010). What women in France say about alcohol abstinence during pregnancy. *Drug and Alcohol Review*, 29, 184-188. doi: 10.1111/j.1465-3362.2009.00136.x
- Vander Wal, J. S. (2012). The relationship between body mass index and unhealthy weight control behaviors among adolescents: The role of family and peer social support. *Economics and Human Biology*, 10, 395-404. doi: <http://dx.doi.org/10.1016/j.ehb.2012.04.011>
- Wahn, E. H. & Nissen, E. (2008). Sociodemographic background, lifestyle and psychosocial conditions of Swedish teenage mothers and their perception of health and social support during pregnancy and childbirth. *Scandinavian Journal of Public Health*, 36, 415-423. doi: 10.1177/1403494807085315
- Wakefield, M., Reid, Y., Roberts, L., & Mullins, R. (1998). Results of a qualitative study of smoking among pregnant adolescents. *Journal of Adolescent Health*, 22, 2-3.
- Walker, S. N., Sechrist, K. R., & Pender, N. J. (1987). The health-promoting lifestyle profile: Development and psychometric characteristics. *Nursing Research*, 36(2), 76-81.
- Weinberg, M. (2004). Young single mothers: The work of proving fitness for parenting. *Journal of the Association for Research on Mothering*, 6(2), 79-89.
- Wertz, R.W. & Wertz, D.C. (1989). *Lying-in: A history of childbirth in America* (expanded edition). New Haven, CT: Yale University Press.
- What to expect. (n.d.). What to wear during pregnancy. Retrieved from <http://www.whattoexpect.com/pregnancy/looking-good/what-to-wear.aspx#comments>
- White, D. E., Fraser-Lee, N. J., Tough, S., & Newburn-Cook, C. V. (2006). The content of prenatal care and its relationship to preterm birth in Alberta, Canada. *Health Care for Women International*, 27, 777-792. doi: 10.1080/07399330600880335

- Whitehead, D. (2001). Health education, behavioural change and social psychology: Nursing's contribution to health promotion? *Journal of Advanced Nursing*, 34(6), 822-832. doi: 10.1046/j.1365-2648.2001.01813.x
- Whitehead, E. (2001). Teenage pregnancy: On the road to social death. *International Journal of Nursing Studies*, 38, 437-446.
- Whitehead, D. (2003). Incorporating socio-political health promotion activities in clinical practice. *Journal of Clinical Nursing*, 12, 668-677.
- Whitley, R. & Kirmayer, L. J. (2008). Perceived stigmatization of young mothers: An exploratory study of psychological and social experience. *Social Science & Medicine*, 66, 339-348. doi:10.1016/j.socscimed.2007.09.014
- Wiemann, C. M., Rickert, V. I., Berenson, A. B., & Volk, R. J. (2005). Are pregnant adolescents stigmatized by pregnancy? *Journal of Adolescent Health*, 36, 352e1-352e7. doi:10.1016/j.jadohealth.2004.06.006
- Wilkinson, R. & Marmot, M. (Eds.). (2003). *Social determinants of health: The solid facts* (2nd ed.). Copenhagen: World Health Organization.
- World Health Organization. (2010). Young people: Health risks and solutions. Retrieved from <http://www.who.int/mediacentre/factsheets/fs345/en/index.html>

Appendix A – Letter of Permission

Office of Research Ethics and Integrity



July 21, 2011

Dear Members of the Research Ethics Committee,

On behalf of the Canada Prenatal Nutrition Program (CPNP), Buns in the Oven program, it is my pleasure to provide a letter of support for the research project *Health Norms in Pregnancy: Experiences of Young Women*, being conducted by Jessica Reszel.

The details of this study have been discussed with the principal investigator, Jessica Reszel, and her thesis supervisor, Wendy Peterson, and we support the research. We support Jessica Reszel in her recruitment of young women from two CPNP sites: [REDACTED] and [REDACTED].

Sincerely,



Project Manager
CAPC/CPNP Ottawa

Appendix B - Recruitment Script

My name is Jessica and I am currently a student at the University of Ottawa in the Masters of Science in Nursing program. For my program I am completing a project on young women's experiences of expected health behaviours during pregnancy. I am inviting you to participate in this study.

To participate in the study, you must be between the ages of 15 and 24, not be married, and either currently be pregnant or have a child under the age of six months.

If you choose to participate in this study, you will have a discussion with me that will last between 30 and 90 minutes. I will bring a collection of images from magazines, the internet, etc. that show some types and sources of health behaviour messages. During the interview, you may choose images that speak to your experiences to facilitate our discussion. You do not need to use the images I bring. We will talk about how you feel others think you should behave to stay healthy during pregnancy, who or what makes you feel this way, and which expectations you follow and do not follow.

You do not need to participate in this study. It is your choice to participate or not. Your decision to participate will not impact any of the services you receive here. If you would like to participate, I will be interviewing participants on a first come, first served basis.

Do you have any questions at this time?

[Answer questions]

I will be here for the rest of the group, so please feel free to talk to me if you would like more information or would like to participate in the study.

Appendix C - Information Sheet for Young Women**THANK YOU FOR YOUR INTEREST!**

The purpose of this study is to understand young women's thoughts and feelings of expected health behaviours during pregnancy.

To learn more about your thoughts and feelings of expected health behaviours during pregnancy, we invite you to participate in an interview to share your experiences.

What will we talk about in the interview?

- How you feel people think you should behave during pregnancy to be healthy
- Who or what expects you to behave a certain way during pregnancy to be healthy
- How you felt about these new expectations while you were pregnant

Jessica will bring a collection of images (from magazines, the internet, and so forth) to the interview that show some types and sources of health behaviour messages. You may choose whether to use these images to help you talk about your experiences.

If you have any questions, please call Jessica Reszel at [REDACTED]-[REDACTED]-[REDACTED] or e-mail her at [REDACTED]

Appendix D – Consent Form for Young Women

Title of study: Health Norms in Pregnancy: Experiences of Young Women



Université d'Ottawa
Faculté des sciences
de la santé
École des sciences
infirmières

University of Ottawa
Faculty of Health
Sciences
School of Nursing

Researchers: Jessica Reszel RN, BScN
Master of Science in Nursing Student
School of Nursing
University of Ottawa
[REDACTED]

Wendy Peterson RN, PhD
Assistant Professor
School of Nursing
University of Ottawa
[REDACTED]

INVITATION TO PARTICIPATE:

I am asked to take part in this study lead by Jessica Reszel and Wendy Peterson because I am a young single mother (or pregnant woman) attending the Buns in the Oven Program at [REDACTED] or [REDACTED] in Ottawa.

PURPOSE OF THE STUDY:

The purpose of this study is to understand young women's thoughts and feelings about expected behaviours while pregnant.

ELIGIBILITY:

To take part in this study I must be:

- 1) between 15 and 24 years old; AND
- 2) not married; AND
- 3) pregnant or the mother of an infant aged 6 months or less

PARTICIPATION:

If I agree to take part in this study:

- I will take part in one interview with Jessica Reszel. It will last between 30 and 90 minutes. The interview will be held at a time and place suited for me. The interview will be taped and the researcher may take some notes.

- During the interview Jessica will provide a selection of images (from magazines, the internet, and so forth) showing types and sources of health behaviour messages which may be used to guide the discussion. If I do not want to discuss the images, I can still participate in the interview. I will be asked to talk about my experience being pregnant, and my understanding and experience of expected health behaviours while pregnant.

RISKS:

There are no major risks associated with participating in this study. My involvement in this study will mean that I share personal experiences, which may cause me to feel discomfort. If I require further support, I may contact [REDACTED], Buns in the Oven program coordinator, [REDACTED], Tel.: [REDACTED], E-mail: [REDACTED]. I understand that I can refuse to answer any question and can choose to end the interview at any time.

BENEFITS:

I will not directly benefit from my participation in this research. This research may help to improve services offered to young pregnant women and their families.

CONFIDENTIALITY AND CONSERVATION OF DATA:

I have been promised by the researcher that the information I will share will be kept confidential. The information gathered from me in the interview will be used only for the purposes of this research.

I understand that the interviewer must, by law, report concerns about child safety. For example, if she has serious concerns about the safety of a child, she will have to report these concerns. In this situation confidentiality cannot be maintained.

The consent forms, demographic forms, recordings, and transcripts will be kept in a locked filing cabinet in Wendy Peterson's office at the University of Ottawa [REDACTED] for 5 years after the publication of the data. Only Jessica Reszel and Wendy Peterson will have access to the recordings. My name will be removed from the transcripts and replaced with a pseudonym.

ANONYMITY:

Reports and presentations of this study may include quotes of what I have said. However, my name will not be used in any reports or presentations. I cannot be identified from the content in any report(s) or presentations.

COMPENSATION:

At the beginning of the interview, I will be given a \$20.00 grocery store coupon as thanks for taking part.

VOLUNTARY PARTICIPATION:

My participation in this study is voluntary. I can refuse to take part. If I choose to withdraw from the study my data will be destroyed. If I choose to participate, I can stop at any time for any reason. I can also refuse to answer any questions that I do not wish to answer. My choice to take part or not will not affect the care that I receive from [REDACTED] or [REDACTED].

INFORMATION ABOUT THE STUDY RESULTS:

I may contact the researchers at the numbers above to get a report of the study results.

FURTHER INFORMATION:

If I have any questions about the study, I may contact Jessica Reszel or her supervisor, Wendy Peterson. Contact information is at beginning of this consent form.

If I have any questions about the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, [REDACTED]
[REDACTED], Tel.: [REDACTED]

I, _____, agree to participate in the above research study conducted by Jessica Reszel RN, of the School of Nursing at the University of Ottawa. This research is under the supervision of Wendy Peterson RN, PhD.

There are two copies of the consent form, one of which is mine to keep.

Participant's signature: _____ Date: _____

Researcher's signature: _____ Date: _____

I agree to be audio-recorded during the interview:

- ☐ Yes
- ☐ No

Participant's signature: _____ Date: _____

Appendix E - Formulaire de consentement pour jeunes femmes

Université d'Ottawa
Faculté des sciences
de la santé
École des sciences
infirmières

University of Ottawa
Faculty of Health
Sciences
School of Nursing

613 562-5473
613 562-5443
451 Smyth
Ottawa ON K1H 8M5 Canada
www.uOttawa.ca

Titre de l'étude : Normes de santé durant la
grossesse : Expériences de jeunes femmes

Chercheuses: Jessica Reszel IA, B.Sc.Inf.
Étudiante en maîtrise, Sciences infirmières
École des sciences infirmières
Université d'Ottawa
[REDACTED]

Wendy Peterson IA, Ph.D.
Professeure adjointe
École des sciences infirmières
Université d'Ottawa
[REDACTED]

INVITATION À PARTICIPER :

Je suis invitée à participer à cette étude menée par Jessica Reszel et Wendy Peterson parce que je suis une jeune mère célibataire (ou jeune femme enceinte) inscrite au programme Ça mijote à la [REDACTED] ou au [REDACTED] à Ottawa.

BUT DE L'ÉTUDE :

Cette étude a pour but de mieux comprendre les pensées et les sentiments à l'égard des comportements escomptés durant la grossesse.

ADMISSIBILITÉ :

Pour participer à cette étude, je dois :

- 1) être âgée de 15 à 24 ans; ET
- 2) ne pas être mariée; ET
- 3) être enceinte ou mère d'un enfant âgé de moins de six mois.

PARTICIPATION :

Si j'accepte de participer à cette étude :

- J'accorderai une entrevue à Jessica Reszel. Cette entrevue se déroulera en anglais. Elle sera d'une durée de 30 à 90 minutes et se tiendra à un endroit et à un moment qui me conviennent. L'entrevue sera enregistrée et la chercheuse pourra prendre des notes.

- Au cours de l'entrevue, Jessica montrera une sélection d'images (tirées de périodiques, d'Internet, etc.) illustrant des types et des sources de messages sur des

comportements liés à la santé qui pourraient servir à orienter la discussion. Si je ne veux pas commenter les images, je pourrai quand même accorder l'entrevue. On me demandera de parler de mon expérience de grossesse, et de ma compréhension et de mon expérience des comportements escomptés sur le plan de la santé durant la grossesse.

RISQUES :

Il n'y a aucun risque important à participer à cette étude. Ma participation à cette étude signifie que je partagerai des expériences personnelles, ce qui pourrait susciter chez moi un certain malaise. Si j'éprouve un besoin de soutien, je peux communiquer avec [REDACTED], coordonnatrice du programme Ça mijote, [REDACTED], au [REDACTED], ou par courriel à [REDACTED]. Je comprends que je peux refuser de répondre à toute question et que je peux décider de mettre fin à l'entrevue à tout moment.

AVANTAGES :

Je ne tirerai aucun avantage direct de ma participation à cette recherche. Les résultats de cette recherche pourraient aider à améliorer les services offerts aux jeunes femmes enceintes et à leurs familles.

CONFIDENTIALITÉ ET CONSERVATION DES DONNÉES :

La chercheuse m'a promis que l'information que je partagerai demeurera confidentielle. Les renseignements recueillis lors de mon entrevue ne serviront qu'aux fins de cette recherche.

Je comprends qu'en vertu de la loi, l'intervieweuse doit signaler toute préoccupation relative à la sécurité d'enfants. Par exemple, si elle a de sérieuses inquiétudes sur la sécurité d'un enfant, elle devra le signaler. Dans une situation comme celle-là, la confidentialité ne peut être respectée.

Les formulaires de consentement, les formulaires démographiques, et les transcriptions d'entrevues seront conservés dans un classeur verrouillé au bureau de Wendy Peterson à l'Université d'Ottawa [REDACTED] pour cinq ans après la publication des données. Seules Jessica Reszel et Wendy Peterson auront accès aux enregistrements. Mon nom sera retiré des transcriptions et remplacé par un pseudonyme.

ANONYMAT :

Les rapports et les présentations issus de cette étude pourraient contenir des citations de mon témoignage. Cependant, mon nom ne figurera dans aucun rapport ni dans aucune présentation. Je ne pourrai être identifiée à partir du contenu d'aucun rapport ni d'aucune présentation.

DÉDOMMAGEMENT :

Au début de l'entrevue, on me remettra un bon d'achat d'une valeur de 20 \$ valide dans un marché d'alimentation.

PARTICIPATION VOLONTAIRE :

Ma participation à cette étude est volontaire. Je peux refuser d'y prendre part. Si je décide de me retirer de l'étude, mes données seront détruites. Si je choisis d'y participer, je pourrai mettre un terme à ma participation à tout moment pour quelque raison que ce soit. Je peux aussi refuser de répondre à des questions si je le souhaite. Ma décision de participer ou non à l'étude n'aura

aucune incidence sur les soins que je reçois de la [REDACTED] ou du [REDACTED]
[REDACTED]

INFORMATION CONCERNANT LES RÉSULTATS DE L'ÉTUDE :

Je pourrai communiquer avec les chercheuses aux numéros de téléphone ci-dessus pour obtenir un rapport des résultats de l'étude.

RENSEIGNEMENTS ADDITIONNELS :

Si j'ai des questions au sujet de l'étude, je peux communiquer avec Jessica Reszel ou sa directrice Wendy Peterson. Les coordonnées figurent au début du présent formulaire de consentement.

Si j'ai des questions concernant l'éthique de cette étude, je peux communiquer avec le responsable de la déontologie de la recherche à l'Université d'Ottawa, [REDACTED]
[REDACTED], tél. : [REDACTED].

Je, _____, consent à participer à l'étude décrite ci-dessus menée par Jessica Reszel IA de l'École des sciences infirmières de l'Université d'Ottawa. Cette étude est menée sous la supervision de Wendy Peterson IA, Ph.D.

Il y a deux copies du présent formulaire de consentement, dont une que je peux conserver.

Signature de la participante : _____ Date: _____

Signature de la chercheuse : _____ Date: _____

Je consens à un enregistrement sonore de mon entrevue :

- ☐ Oui
- ☐ Non

Signature de la participante : _____ Date: _____

Study ID: _____

Question	Answer
Age	
Relationship Status	☐ Single ☐ Dating ☐ Living together ☐ Engaged ☐ Common law ☐ Other (describe):
Education completed	☐ Some High School ☐ Completed High School ☐ Some Post-secondary ☐ Completed College ☐ Completed University Baccalaureate
Education in progress	☐ Yes ☐ No If yes, what level? _____ Part-time or full-time? _____
Are you currently employed?	☐ Yes Part-time Full-time On maternity leave ☐ No
Who do you currently live with?	☐ Family ☐ Partner ☐ Friends ☐ Other: _____
How many years have you lived in Canada?	
How many times have you moved in the past 5 years?	
If pregnant, number of weeks	
If not pregnant, age of baby and date of birth	
How many children do you have?	
How healthy do you (or did you) consider yourself to be during pregnancy?	1 Not healthy at all 2 3 4 5 6 7 8 9 10 Very healthy

How much support do (or did you) you feel you have (had) during pregnancy?	1 No support at all	2	3	4	5	6	7	8	9	10 All the support I need
Who offers you this support?										
During your pregnancy, did you attend:	Prenatal care appointments		Yes (how often?)						No	
	Prenatal classes		Yes (how many?)						No	

Appendix G - Interview Guide

Topic	Interview Questions	Probes	How to use images
General	Tell me about how you define health during pregnancy	What does it mean to be healthy during pregnancy? Emphasis on mom, baby or both? Biological, social, emotional? How easy is it for you to be healthy during pregnancy?	N/A
What are the perceived behavioural expectations?	Since becoming pregnant, tell me about what messages you have heard or felt about what you should and should not be doing to stay healthy during pregnancy.	Not just people saying things, but also feeling watched or judged	Ask the women to identify which images show how she feels people think she should act during pregnancy to be healthy. The women will be asked what each of those images means to her and how she has experienced it in her pregnancy
Who reinforces behavioural expectations?	Since becoming pregnant, tell me about who or what has made you feel like you should be doing certain things and not doing other things to stay healthy during pregnancy.	Examples: health care providers, teachers, books, internet, friends, family, media, strangers, television shows	Ask the women to identify which images show who or what she feels tells her how to act during pregnancy to be healthy. The women will be asked what each of those images means to her and how she has experienced it in her pregnancy
Which behavioural expectations are conformed to?	Tell me about which changes you made during pregnancy to try and stay healthy. Tell me about why you decided to make these changes and how easy or difficult it was for you.	Examples include resources, values, rewards or consequences (i.e. social acceptance versus stigmatization)	Ask the women to identify any images that represent health changes she decided to make and any pictures that represent who or what enabled or influenced her to make such changes.
Which behavioural expectations are resisted?	Tell me about which changes you did not make during pregnancy.	Examples include resources, values, rewards or consequences (i.e.	Ask the women to identify any images that represent health changes she did not make and any images that

	Tell me about the reasons for not making such changes.	social acceptance versus stigmatization)	represent who or what made such changes difficult or undesirable.
Effectiveness of images	Tell me about the usefulness of having images to stimulate discussion today.	Why did the images work well? Or, why did the images not work well? Do you have any suggestions for additional images that should be added to the collection for future interviews? Do you have any suggestions for how the images could be used differently/more effectively?	N/A

Appendix H – Description of Photographs

Photographs Used in Interviews	
<i>*Actual photographs not included to respect copyright laws</i>	
#	Description of Photograph
1	A woman has her hands holding her pregnant belly. The hand and white sleeve of a health care provider is visible and they are placing a stethoscope on the women's belly.
2	A pregnant woman standing on a scale to weigh herself
3	A young woman receiving an injection in her left arm
4	A pregnant woman breaking a cigarette in half
5	A pregnant woman holding a large plate full of a variety of fruits
6	A pregnant woman lying down on her side resting
7	A variety of bottles and glasses of different types of alcohol
<i>*An image of alcohol was suggested by participants</i>	
8	A group of four young pregnant women walking down the street together
9	A pregnant woman sitting on the floor using a laptop
10	A pregnant woman with a variety of pills (or vitamins) and a glass of water in her hands
11	A middle-aged woman sitting at a table engaged in conversation with a young woman
12	A pregnant woman sitting reading a book
13	A pregnant woman doing stretches
14	A stack of books (with no titles)
15	Four health care providers standing together – two in scrubs and two in white coats
16	A woman's back as she is receiving an epidural
<i>*An image of an epidural was suggested by a participant</i>	
17	Four women sitting in chairs at a prenatal group with some taking notes

Appendix I – Example of Data Analysis Process

Interviewer (I): Tell me about any messages you heard directly or even felt, so maybe someone didn't say it but you just felt it, about what you should and shouldn't be doing while you're pregnant.

Participant (P): Well I know the cigarette smoking was a big one. I quit so it wasn't an issue for me but my entire family smokes in their houses and the whole no second hand smoke made it very difficult for me because I didn't want to expose my child to that while it was pregnant, but at the same time that was making me lack can support because I couldn't go see my family. They weren't very keen on smoking outside, they don't believe all the stuff that's been proven so I just tried to avoid going to see them. But then I had almost no support and that lack of support made it a lot harder through the pregnancy than it would have like you would have getting secondhand smoke once or twice a month... So I don't regret it because like he's healthier but at the same time just the lack of support during the pregnancy was really hard

...

P: Yeah, you get looks if you are smoking and pregnant...really nasty looks

I: Who do those looks come from?

P: Mostly strangers I find most of the looks I've gotten have been from women around 40 to 50 years old, actually a lot of the comments and looks you get period are from women about that age so you get really nasty looks for smoking during pregnancy or a little snare whatever people walking away rolling their eyes so yeah definitely and I knew what I was doing was wrong but I couldn't stop

....

P: I find they treat the young dads a lot differently like I realize they aren't actually pregnant but they should really be kicking the smoking habit too they should be stopping drinking alcohol they are about to have a newborn they shouldn't be drinking alcohol every day like they should start eating healthy to because they should be setting a good example for their child but these expectations are not put on the man during pregnancy

What?	How?	Identity Constructs
<i>What the woman is saying</i>	<i>How the woman experiences behaviour change in pregnancy</i>	<i>Influence of identity on experience</i>
Smoking: It is important to decrease exposure to tobacco for health of baby Social support: It is important to have social support in pregnancy	This woman is experiencing the tension between: The opportunity to improve the health of her baby by decreasing exposure to tobacco yet is experiencing oppression from a lack of support due to her decision to decrease exposure to tobacco by avoiding family members who smoke	Identity of being pregnant: Additional stigma for smoking while pregnant Identity of woman: Additional expectations for women to quit compared to men

Appendix J – University of Ottawa Ethics Approval

File Number: H 08-11-09

Date (mm/dd/yyyy): 10/31/2011



Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

Ethics Approval Notice

Health Sciences and Science REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Wendy	Peterson	Health Sciences / Nursing	Supervisor
Jessica	Reszel	Health Sciences / Nursing	Student Researcher

File Number: H 08-11-09

Type of Project: Master's Thesis

Title: Health Norms in Pregnancy: Experiences of Young Women

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
10/31/2011	10/30/2012	Ia

(Ia: Approval, Ib: Approval for initial stage only)

Special Conditions / Comments:

N/A

File Number: h08-11-09

Date (mm/dd/yyyy): 10/31/2011



Université d'Ottawa

Bureau d'éthique et d'intégrité de la recherche

University of Ottawa

Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed the section above entitled "Special Conditions / Comments".

During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove subjects from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g. change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information/consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the "Modification to research project" form available at: http://www.rges.uottawa.ca/ethics/application_dwn.asp

Please submit an annual status report to the Protocol Officer 4 weeks before the above-referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at: http://www.rges.uottawa.ca/ethics/application_dwn.asp

If you have any questions, please do not hesitate to contact the Ethics Office at [REDACTED] or by e-mail at: [REDACTED]