

**WHAT FACTORS INFLUENCE THE
BREASTFEEDING PRACTICES OF
YOUNG MOTHERS WHO LIVE OR HAVE LIVED
IN A MATERNITY SHELTER?**

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Abstract

Purpose: The purpose of this study was to inform nursing practice and clinical interventions that support breastfeeding among mothers ≤ 24 years of age who resided in a maternity shelter. *Methods:* Nine young mothers aged 17 to 24, who had initiated breastfeeding, and resided at a maternity shelter, participated in individual semi-structured interviews. This qualitative study was conducted using interpretive description methodology and inductive content analysis. *Findings:* These young mothers took ownership of their choice to breastfeed and found empowerment in this choice and practice. The institutional and social environments that young mothers experienced were critical to their breastfeeding success. Hospital postpartum nurses had a critical role in the establishment of early breastfeeding by providing a combination of practical hands-on and emotional support to the multifaceted needs of these mothers. Ongoing, accessible, and non-judgemental peer, family, and community support were important to breastfeeding initiation and duration. *Conclusion:* A combination of emotional and practical supports from multifaceted trusted sources, including professional and peer supports on an ongoing basis are crucial to young at-risk mothers reaching their breastfeeding goals. *Implications for clinical practice:* Nurses need to focus dually on the practical aspects of breastfeeding while establishing strong therapeutic relationships with this population to successfully provide breastfeeding supports. A combination of accessible and trusted long term professional and peer supports is a key element to designing future breastfeeding support and promotion programs for this population.

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Glossary of Terms

Breastfeeding: Feeding of any human milk to an infant or child.

Breastfeeding duration: Length of time an infant is breastfed any amount.

Breastfeeding initiation: The mother begins breastfeeding.

Complementary food: Use of food or liquid in addition to breastfeeding.

Exclusive breastfeeding: Exclusive breastfeeding refers to exclusive feeding of human milk to infants for any period of time up to 6 months of age, without the addition of water, breast milk substitutes, other liquids and/ or solid foods, with the exception of vitamins, minerals and medications.^{1,2}

Infant feeding: Infant feeding includes any breastfeeding, mixed feeding (breast milk and formula), exclusive formula feeding, and/or solid foods.

Maternal identity: Becoming a mother is a transition into a new phase of life, a “new reality”, and a continuation of a woman’s psychosocial development. How a woman sees herself in this new role is influenced by personal, cultural and socioeconomic factors.³ Spencer argues that exploring experiences related to breastfeeding, or lack of, is central to understanding maternal identity, as “women’s perceptions of themselves as women and mothers” (p. 1823)⁴ is strongly linked to infant feeding practices.⁴

¹ Millar, W.J., & Maclean, H. (2005, March). Breastfeeding practices. In B. Riggs (Ed.) *Health Reports* (Vol.16), Catalogue no. 82-003-XIE, pp. 23-31. Ottawa: Statistics Canada.

² World Health Organization. (2002). *Infant and young child nutrition: Global strategy on infant and young child feeding*. Retrieved from http://apps.who.int/gb/archive/pdf_files/WHA55/es5515.pdf

³ Mercer, R. (2004). Becoming a mother versus maternal role attainment. *Journal of Nursing Scholarship*, 3, 226-234.

⁴ Spencer, R. (2008). Research methodologies to investigate the experience of breastfeeding: A discussion paper. *International Journal of Nursing Studies*, 45(2008), 1823-1830.

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Maternity shelter: A maternity shelter is a specialized homeless shelter with a residential program to serve the needs of pregnant and parenting homeless youth (ages 13-24 years) with complex issues including histories of street involvement, homelessness, addiction, involvement with the criminal justice system, child protection, and mental health.^{5,6}

Community outreach centre: Multi-service centre that provides services to young pregnant women, young mothers and fathers and their children. Examples of services provided by an outreach centre include playgroups, parenting classes, an obstetrical clinic, a well baby drop-in clinic, high school credits, counselling (including mental health and addictions), housing services and a weekly food bank-baby cupboard.⁷

Supplementation: Use of food or liquid to replace breastfeeds, usually under 6 months of age.

Young mother: A pregnant or parenting woman 24 years of age or under.

⁵Dilworth, T. (2006). *Poverty, homelessness and teenage pregnancy* [literature review]. Saint John, NB: First Steps Housing Project., Inc.

⁶Nolte, J. & Allen, B. (2006). *Final Report on the Review of St. Mary's Home residential program*. Retrieved from www.stmaryshome.com/download.php?dts=12699132700f

⁷St. Mary's. (2014). *St. Mary's Home and Young Parents Outreach Centre*. Retrieved from http://stmaryshome.com/en/stmaryshome/Home_p1186.html

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Chapter 1: Introduction

Increasing rates of breastfeeding initiation, exclusivity, and duration are recognized and promoted in Canada and globally as an important population health initiative to increase positive health outcomes for mothers and infants (Breastfeeding Committee for Canada [BCC], 2009; Health Canada [HC], 2002, 2013; Millar & Maclean, 2005; WHO, 2002). In Canada, young mothers aged 15-24 years initiate breastfeeding at comparable rates to other groups, but have the lowest exclusivity and duration rates of any group (Chalmers & Royle, 2009; HC, 2012a).

Young mothers and their infants are vulnerable to negative long term health outcomes due to extenuating social and economic circumstances (Best Start, 2007; UNICEF, 2001). For example, young mothers are more likely to experience challenges to breastfeeding their infants including social stigma and lack of supports (Condon, Rhodes, Warren, Withall, & Tapp, 2012; Noble-Carr & Bell, 2012). In particular, young mothers who access maternity shelters are at increased risk for low breastfeeding rates due to the challenges of being a youth compounded by complex multifaceted economic and social issues, including homelessness and addictions (Dilworth, 2006; Nolte & Allen, 2006).

While the breastfeeding experiences and factors influencing the breastfeeding practices of young mothers are represented in the literature, no studies have addressed the factors unique to young mothers living or who have lived within the context of a maternity shelter. This study adds to the canon of research on young mothers and their breastfeeding experiences by exploring the influences affecting the breastfeeding practices of young mothers who live or have lived in a maternity shelter, and it provides recommendations to improve nursing practice as it relates to breastfeeding promotion and supports for this unique population.

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Background

Clinical Issue

Canadian and international health authorities recommend exclusive breastfeeding for all healthy term infants to 6 months, then continuing breastfeeding along with the introduction of appropriate complementary foods to 2 years and beyond (BCC, 2009; HC, 2002, 2013; Millar & Maclean, 2005; WHO, 2002). Exclusive breastfeeding is recommended by the WHO, and defined as exclusive feeding of human milk for infants up to 6 months of age (including vitamins, minerals and medications), without the addition of water, breast milk substitutes, other liquids and/ or solid foods (Millar & Maclean, 2005; WHO, 2002). As the physiologic norm for mothers and infants, breastfeeding provides optimal nutrition tailored to individual infants' needs and has many health benefits for infants and mothers (Chalmers & Royle, 2009; Schulze & Carlisle, 2010; WHO, 2002).

Breastfeeding provides a wide variety of benefits to infants, mothers and families. For infants, breastfeeding provides immunologic protection through maternal antibodies and is an important factor in positive health outcomes (American Academy of Pediatrics [AAP], 2012; WHO, 2002). For example, breastfeeding is associated with decreased rates of infectious diseases in infants including respiratory tract infections, diarrhea and bacterial meningitis, and with decreased incidence of chronic childhood conditions including diabetes (AAP, 2012; WHO, 2002). The maternal benefits of breastfeeding include more rapid uterine involution, delayed ovulation, and decreased rates of breast and ovarian cancers (Chalmers & Royle, 2009; Schulze & Carlisle, 2010). For families, breastfeeding provides a readily available food source for the infant, a healthier infant is less stress for the family and as there are no wasteful by-products, breastfeeding is ecologically sound (Schulze & Carlisle, 2010; WHO, 2002).

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In 2010, 87.3% of new mothers in Canada initiated breastfeeding, however, only 25.9% of mothers continue to exclusively breastfeed to six months postpartum (HC 2012a). A wide variety of social, cultural and economic factors influence women's infant feeding choices (Chalmers & Royle, 2009). In Canada, the factors that influence women's breastfeeding practices vary widely according to socioeconomic status, ethnicity, social and family support, religion, age, and education levels (Chalmers & Royle, 2009).

In Canada, despite no significant differences in breastfeeding initiation rates amongst mothers within all age groups (HC, 2010), young mothers 24 years of age and under have the lowest breastfeeding duration rates of all women, with only 14.3% of mothers aged 15-24 practicing any breastfeeding at 6 months postpartum compared to 24.6% of mothers aged 25-34 and 31.2% of mothers aged 35-55 (Chalmers & Royle, 2009; HC, 2012a).

In particular, young mothers who access maternity shelters are mothers for whom experiencing complex life circumstances may take precedence over dealing with the emotional and practical challenges of breastfeeding and actively seeking the support needed for breastfeeding success (Nolte & Allen, 2006). Canadian studies have shown young mothers who breastfeed their infants have higher levels of maternal confidence, positive self-identity as a mother, and increased maternal-infant bonding (Brown, Raynor & Lee, 2009; Dennis, Heaman & Mossman, 2011; Hall-Moran, Edwards, Dykes & Downe, 2006; Nelson, 2009; Wambach & Koehn, 2004). Young mothers in the shelter system frequently face multiple risk factors for low breastfeeding rates such as low maternal age, low maternal educational attainment, low family income, and street involvement compounded with complex social and mental health issues (Dilworth, 2006; Nolte & Allen, 2006), and may benefit from the positive effects of increased maternal confidence, increased bonding with their infants and positive maternal identity. In

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Ontario there are seventeen maternity shelters serving this population (Fresh Start Maternity Supports, 2014). Only one is located in Eastern Ontario, this maternity shelter is licensed to provide 24 hour a day support and services to 15 young women and up to 5 infants under the age of 3 months (Nolte & Allen, 2006; St. Mary's, 2014).

Problem Statement

The literature is lacking studies of the factors that influence the breastfeeding practices of at-risk young mothers. Young mothers living in maternity shelters are a unique group in that little is known of the influences in their breastfeeding practices and how the context of living within a shelter affects those practices. Nurses and allied staff who work directly with this population and are in a position to provide programs and education related to breastfeeding promotion and supports would benefit from evidence to inform their practice. Knowledge of the barriers and facilitators to breastfeeding is essential to understanding why approximately 86% of young mothers are formula feeding their infants by six months postpartum (Chalmers & Royle, 2009; HC, 2012a; MacGregor & Hughes, 2010). This knowledge is critical to the creation and implementation of supports and programs that emphasize the facilitators to breastfeeding and mitigate the barriers these young mothers experience to meeting their breastfeeding goals.

Conceptual Framework

This research is informed by the central tenets of the social determinants of health framework (Canadian Public Health Association [CPHA], 2001; Public Health Agency of Canada [PHAC], 2001, 2003, 2011). This upstream view of health postulates that healthcare is more than tertiary health care and curative measures. The key to achieving population health is to effect positive change in each of the 12 interrelated determinants (Table 1). The underlying

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tenet of the determinants of health proposes that the physical, social, and cultural environment people live within shapes their overall health and health potential.

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Table 1

Social Determinants of Health: Twelve Key Determinants

Social Determinant of Health	
1	Income and Social Status
2	Social Support Networks*
3	Education and Literacy
4	Employment/Working Conditions
5	Social Environments*
6	Physical Environments
7	Personal Health Practices and Coping Skills*
8	Healthy Child Development*
9	Biology and Genetic Endowment
10	Health Services*
11	Gender
12	Culture*

Note. *Key determinants of focus for this study

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Study Purpose and Research Question

The evidence indicates that increasing breastfeeding duration rates among mothers aged 15-24 years and helping these mothers identify and reach their individual breastfeeding goals, has the potential to help them shape a more positive, empowered identity, while increasing infant attachment and health status (Karp, Lutenbacher & Deitrich, 2010). The purpose of this study is to inform nursing practice and clinical interventions and to provide insight and a basis on which to design and implement supports and services around breastfeeding for young mothers who are living within the context of a maternity shelter to enable these mothers to reach their individual breastfeeding goals. The research question, “What are the barriers and facilitators influencing breastfeeding practices of young mothers who live or have lived in a maternity shelter?”, was explored in the course of this study.

Organization of Thesis

This thesis is organized as a traditional thesis. The introduction in Chapter 1 provides background to the clinical issue and introduces the research problem and research question “What are the barriers and facilitators influencing breastfeeding practices of young mothers who live or have lived in a maternity shelter?” The literature review, including an overview of current literature on the breastfeeding practices of young mothers, knowledge gaps and limitations is presented in Chapter 2. Chapter 3 describes the methodology, including the interpretive description research design and content analysis methods utilized in this study. The findings of the study conducted from September 2013 to February 2014 are presented in Chapter 4. Chapter 5 presents the discussion of the findings, the relevance of the findings to the body of existing literature, the implications for nursing practice, implications for agency policies,

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recommendations for future nursing research, and the conclusion. References and appendices are included in the last section of the thesis document.

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Chapter 2: Literature Review

A review of the literature spanning 14 years (2000-2014) focusing on young mothers was conducted. The three electronic databases included in the search were CINAHL, PUBMED/MEDLINE and the Cochrane Library (see Appendix A for search terms and search parameters). Online searches were conducted for statistics pertaining to adolescent pregnancy, breastfeeding, and socioeconomic indicators. Canadian data from federal, provincial, and municipal governmental sources were included. Canadian and international non-governmental sources were included. A manual search was conducted of the bibliographies and reference lists of all retrieved articles. Google Scholar was searched using the same inclusion and exclusion criteria as the electronic database searches.

The inclusion criteria were quantitative or qualitative, English language research or systematic reviews focusing on young mothers (prenatal or postpartum) and breastfeeding. The studies examined supports, education, decision making, or experiences of mothers 24 years of age and younger as related to breastfeeding. The exclusion criteria were any study that was published prior to 2000, studies that focused on health care worker experiences with young mothers rather than the mothers themselves, or studies that did not otherwise meet the above inclusion criteria. An overview of the included articles and summary of critical appraisals are presented in Appendix B.

The literature review provides an overview of the dominant themes in the current research on young mothers and their breastfeeding practices. The first section, the 'Context of Young Motherhood in Canada', briefly introduces the socio-economic and cultural context facing young mothers, breastfeeding rates among young mothers compared to the overall

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population, and the benefits of breastfeeding as they relate to the unique needs of mothers under 25 years of age in North America.

The second section, the ‘Predictors of Breastfeeding for Young Mothers’, provides an overview of the research on the breastfeeding practices of young mothers including the influences of family and peer supports, self efficacy, and professional supports. The final section describes the strengths and limitations of the current literature.

Context of Young Motherhood in Canada

Young Mothers in Canada

The birth rate of mothers 15-24 years of age has been steadily declining in Canada since the late 1990s (Best Start, 2007), with young mothers accounting for 66,914 of the 377,636 (17.1%) live births in Canada in 2011 (Better Outcomes Registry and Network [BORN] Ontario, 2011; Ontario Ministry of Health and Long Term Care [OMHLTC], 2009; HC, 2013a). This decline in birth rates may be partially explained by the declining fertility rates and increasing rates of therapeutic abortions (Best Start, 2007; Statistics Canada, 2008).

While the number of births to women 24 years and under is declining, a greater percentage of young mothers live with conditions of risk such as poverty, minimal social support, feelings of social exclusion, and low maternal educational attainment (Best Start, 2007; BORN Ontario, 2011; MHLTC, 2009; Mossman, Heaman, Dennis & Morris, 2008; Statistics Canada, 2005; UNICEF, 2001). UNICEF (2001) and Best Start (2007) identify that pregnancy and birth in young mothers itself is not an issue because it is perceived as normal and welcomed in many cultures. The issue is the socio-economic circumstances in which a growing number of these mothers are living and the subsequent social and economic exclusion they and their infants face (Best Start, 2007; UNICEF, 2001). These extenuating circumstances leave this group of

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women and infants especially vulnerable to negative health and social outcomes (Best Start, 2007; UNICEF, 2001). This trend is so prevalent in developed nations including Canada that WHO and UNICEF use the rates of pregnancy, regardless of pregnancy outcomes, in young women as key indicators of social and economic inequities. Among Organisation for Economic Co-operation and Development (OECD) countries Canada is ranked 8th highest of 28 countries for prevalence of these indicators (Best Start, 2007; BORN Ontario, 2011; UNICEF, 2001).

In Ontario, the 2007 collaborative report by Best Start and the Sex Information and Education Council of Canada on teen pregnancy prevention profiles Toronto as an example of how the birthrate amongst youth varies according to socioeconomic indicators in Canada's urban centres (Best Start, 2007). In Toronto, the birth rate amongst youth from high income neighbourhoods was 2.5/1000 and in the low income neighbourhoods it was as high as 35/1000 (Best Start, 2007). The Ottawa Public Health (OPH) "Enhanced Street Youth Surveillance" report cites 58% of street youth had been pregnant (OPH, 2011). Of those pregnancies, the outcome in 32% of the cases was abortion, 30% reported miscarriages, and 21% of those in 2009 culminated in a live birth (OPH, 2011). This statistic is significant as street involved youth are one of the main groups served by the maternity shelter system (Nolte & Allen, 2006).

Breastfeeding Rates among Young Mothers

Young mothers are least likely to breastfeed for any amount of time (BCC, 2009; Chalmers & Royle, 2009; Dennis et al., 2011; Feldman-Winter & Shaikh, 2007; Hall-Moran et al., 2006; HC 2010, 2012b; Millar & Maclean, 2005; Simard et al., 2005; UNICEF, 2005; Wambach & Cohen, 2009). The rate at which young mothers initiate breastfeeding in Canada does not significantly differ from the initiation rates of older mothers. Millar and Maclean (2005) found that 81% of young mothers (24 years of age and under) initiating breastfeeding,

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compared to 85% of mothers 25 years of age and older. The primary difference is found in the breastfeeding duration rates (Millar & Maclean, 2005). At 6 months postpartum 15-21% of mothers over 25 continued to breastfeed, compared to 8% of mothers under 25 (Millar & Maclean, 2005). It has been noted that breastfeeding initiation rates fall as family income levels, maternal educational attainment, and maternal age decrease (HC, 2010, 2012a; Millar & Maclean, 2005; UNICEF, 2005). The young mothers accessing maternity shelters generally have limited incomes, have low levels of educational attainment, and are amongst the youngest of maternal age groupings being under 25 years of age (Dilworth, 2006; Nolte & Allen, 2006).

Benefits of Breastfeeding for Young Mothers

The physiological benefits of breastfeeding include decreased postpartum bleeding, more efficient uterine involution, increased release of serotonin, improved maternal mood, and reduced risk of ovarian, breast, and cervical cancer later in life (BCC, 2002, 2009; PHAC, 2003; Millar & Maclean, 2005; Savio-Beers & Hollo, 2009; UNICEF, 2005; WHO, 2002). For young mothers, there are also psychological and maturational benefits unique to their life stage, for example the possibility of increasing self efficacy as a parent (Sipsma, Magriples et al., 2013). Young mothers are transitioning to the stages of parenthood and adulthood simultaneously (Mann, Harmoni & Power, 1989; Sipsma, Magriples et al., 2013), which may impose challenges to parenting practices, such as breastfeeding, not encountered by their older peers. Young mothers who access maternity shelters often have complex issues that may affect their transition to parenthood including a history of street involvement, mental health and addictions issues (Nolte & Allen, 2006; OPH, 2011; St Mary's, 2014).

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Predictors of Breastfeeding for Young Mothers

The six primary predictors of breastfeeding behaviour and practices in young mothers identified from the literature are: believing in the benefits of breastfeeding, the perception of breastfeeding as normal, the effects of early breastfeeding success, the ability to breastfeed in public, the availability of accessible and appropriate supports, and the use of formal and informal support networks. These factors have been identified from studies examining young mothers as a group, no studies were found that focused on young mothers in maternity shelters.

Belief in the Benefits of Breastfeeding

In the studies reviewed, the young mothers who chose to breastfeed and did so for any length of time shared the key belief that breastfeeding was the healthiest option for their infants (Dennis et al., 2011; Goulet, Lampron, Marcil & Ross, 2003; Nelson & Sethi, 2005; Simard et al., 2005; Sipsma, Diveny et al., 2013; Vaaler, Stagg, Parks, Erikson & Castrucci, 2010; Wambach & Cohen, 2009). Mothers who held this belief were prepared to confront critics and were more comfortable breastfeeding in public (Dennis et al., 2011; Goulet et al., 2003; Nelson & Sethi, 2005; Simard et al., 2005; Vaaler et al., 2010; Wambach & Cohen, 2009). Health benefits to the infant were almost universally cited as the main reason for continuing with breastfeeding despite difficulties (Dennis et al., 2011; Nelson & Sethi, 2005; Simard et al., 2005; Vaaler et al., 2010; Wambach & Cohen, 2009; Wambach et al., 2011). These mothers were typically already motivated to access services and possessed intrinsic and extrinsic motivators to continue breastfeeding when faced with challenges (Dennis et al., 2011).

The unique bond and relationship with their infant was cited as a primary motivator to initiate breastfeeding by young mothers and a secondary aspect to the health benefits for the infant (Nesbitt et al., 2102; Sipsma, Diveny et al., 2013). The increased attachment to their

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infants through the breastfeeding relationship was influential in the initial decision whether to breast or bottle feed, but it is not clear as to the effect on breastfeeding duration (Nesbitt et al., 2012; Sipsma, Diveny et al., 2013).

In several Canadian studies with young mothers, breastfeeding was correlated with increased feelings of maternal confidence, increased feelings of control over life circumstances, helping to form an emerging self-identity as a woman and a mother, providing increased social support through connections with other breastfeeding mothers and facilitating mother-infant bonding (BCC, 2002; Savio- Beers & Hollo, 2009). It is unclear if these positive outcomes were a result of being a breastfeeding mother or if they already possessed these traits which were favourable to breastfeeding duration.

Perception of Breastfeeding as Being the Norm

Another primary predictor of both breastfeeding initiation and duration among young mothers is the attitude of their own mothers towards breastfeeding (Dykes, Hall-Moran, Burt & Edwards, 2003; HC, 2002; Noble-Carr & Bell, 2012; Smetana, Campione-Barr & Metzger, 2006; Vaaler et al., 2010). A significantly higher proportion of the young mothers who chose to breastfeed were breastfed themselves as infants, and, as such, they had grown up in environments where breastfeeding was the norm (Vaaler et al., 2010). The social environment in which these young mothers were raised imprinted the normalcy of breastfeeding and the support of the mother's mother was tied to increased initiation and duration rates (Dykes et al., 2003; HC, 2002; Nesbitt et al., 2012). The reverse was also found; social and family supports could act as barriers to breastfeeding if the network of family and friends were not supportive of breastfeeding or breastfeeding was perceived as physically challenging or even painful (Nesbitt et al., 2012; Sipsma, Magriples et al., 2013). Nesbitt et al. (2012) found that young mothers with

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family members who had formula fed or had difficulties breastfeeding their infants “focused on sharing their negative experiences” (p. 6) going so far in some cases as to predict these same problems for the young mothers in question. At-risk young mothers within the context of the shelter system may not have the benefit of supportive relationships from their own mothers or the positive modelling related to breastfeeding while growing up.

Early Breastfeeding Success

In the early postpartum period both health care professionals and mothers have a tendency to equate successful feeds and infant weight gain with successful parenting (Holub et al., 2007; Nelson & Sethi, 2005; PHAC, 2003; Volpe & Bear, 2000; Smetana et al., 2006; Wambach et al., 2011). Research has shown that increased feelings of maternal competence, translate into increased time spent on infant care, which is crucial to early social development and attachment to the primary caregiver (Holub et al., 2007). Of the young mothers who initiate breastfeeding, those who have early issues with slow infant weight gain, compounded by feelings of being judged as an incompetent mother, low self-efficacy and confidence, and lack of appropriate support are more likely to switch to formula feeding (Holub et al., 2007; Wambach et al., 2011). Because they have to deal simultaneously with many of the above-mentioned factors, adolescent mothers are at a greater risk of discontinuing breastfeeding and viewing formula feeding as less risky to their infant and their maternal self esteem (Holub et al., 2007; Wambach et al., 2011). For young mothers in the shelter system potential issues of low self efficacy may be compounded by multiple stressors including homelessness, addictions and mental health issues (Dilworth, 2006; Nolte & Allen, 2006).

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Ability to Breastfeed in Public

Young mothers report high levels of embarrassment and anxiety related to breastfeeding in public (Best Start, 2007; Brown et al., 2009; Condon et al., 2012; Dennis et al., 2011; HC, 2002; Wambach et al., 2011). One factor influencing this anxiety is the perception or reality that they are being negatively judged by the adults around them no matter what the setting (Condon et al., 2012; Wambach et al., 2011). This awareness that others may be watching and judging, combined with feeling unprepared for the practical aspects of breastfeeding in public, is cited as a contributing factor to the bottle feeding culture associated with young mothers (HC, 2002; Smetana et al., 2006). Young mothers report feeling stigmatized when out in public with their infants due to their age, and breastfeeding in public may add to these feelings of stigmatization and being watched and judged by older adults (Nesbitt et al., 2012; Noble-Carr & Bell, 2012). Noble-Carr and Bell (2012) found that this discomfort extended to interactions with healthcare professionals where young mothers experienced these same feelings of being watched and judged as they did in public spaces.

Availability of Accessible and Appropriate Supports

Over the past decade, North American studies have shown a combination of family support, peer support, and health care providers to be effective at increasing breastfeeding duration rates (Brown, et al., 2009; Feldman-Winter & Shaikh, 2007; HC, 2002; Simard et al., 2005; Smetana et al., 2006; Wambach et al., 2011). One of the key features of successful ‘youth friendly’ breastfeeding promotion and support programs are the attitudes of the health care providers. Programs where the adults were perceived as non-threatening, non-judgemental, caring, patient, trustworthy, and consistent were more successful than the same programs where the adults were not perceived this way (Best Start, 2007; Brown et al., 2009; Dennis et al., 2011;

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HC, 2002; Mann et al., 1989; Nelson & Sethi, 2005; Simard et al., 2005; Smetana et al., 2006; Wambach, 2011). The content seems to matter less than the long-term relationships built by the staff. A non-fragmented approach with realistic expectations (for example, bottle feeding may be the optimal choice for an individual mother) and a focus on building maternal self-esteem were crucial components to successful programs (Brown et al., 2009; Simard et al., 2005).

The peer support component also was essential to the success of programs (Feldman-Winter & Shaikh, 2007; Mossman et al., 2008; Savio-Beers & Hollo, 2009; Vaaler et al., 2010; Wambach et al., 2011). Peer support provided a form of group identity and positive peer models (Brown et al., 2009; Mossman et al., 2008; Savio-Beers & Hollo, 2009; Vaaler et al., 2010; Wambach et al., 2011). Peer supports were seen as understanding the life circumstances of the young mothers, and fulfilled the needs for strong social and functional support (Savio-Beers & Hollo, 2009). The modelling aspect helped to normalize breastfeeding within the culture of young mothers and may offset the lack of modelling related to breastfeeding from the mothers' upbringing and provide a group identity important to normal development (Noble-Carr & Bell, 2012; Savio-Beers & Hollo, 2009).

Young mothers reported wanting practical information, including: information on expressing breast milk, how to breastfeed discretely in public, how to challenge negative attitudes, how to have a social life and breastfeed, and how to wean (Condon et al., 2012; Dykes et al., 2003; Feldman-Winter & Shaikh, 2007; Noble-Carr & Bell, 2012). The programs that reported high success rates not only used strength based approaches with a combination of trustworthy reliable adults and a strong peer support component but also provided practical support and information based on the needs and goals of the individual mother and infant (Dykes

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et al., 2003; Feldman-Winter & Shaikh, 2007). These programs need to be easily accessible and readily offered to the mothers (Dykes et al., 2003; Feldman-Winter & Shaikh, 2007).

Two examples that successfully use all of these elements are the web based “Be a Star” campaign from the United Kingdom and the American Breastfeeding Educated and Supported Teen (BEST) programs (Be a Star, 2014; Volpe & Bear, 2000). As with the studies examining self efficacy and breastfeeding success in young mothers, there is a self selection bias present in the programs represented in the literature about breastfeeding support targeting young mothers when only the successful programs are represented. Those programs that are failing to reach their intended populations are missing from the literature. As some of the findings from the above programs may be transferable to other programs and centres (for example cultural, urban-rural) it is not clear how context dependant the findings are and what other factors may be influencing the outcomes (for example cultural practices, socioeconomic circumstances). All of the programs represented in the literature were outreach based, there were no programs based in a residential context such as a maternity shelter.

Informal versus Formal Support Networks

Noble-Carr and Bell (2012) found young mothers in their focus groups identified informal peer supports as their primary means of obtaining information and creating networks with other young breastfeeding mothers. This group did not turn to professional or organized peer networks; rather they relied on friends, family, and online informal supports such as blogs, social network pages (Nesbitt et al., 2012; Noble-Carr & Bell, 2012; Wolynn, 2012). There was a desire by these young mothers to be treated as normal moms and they found youth specific programs on breastfeeding condescending, perhaps due to the perception of stigma as young

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mothers (Noble-Carr & Bell, 2012, p. 5). These mothers reported wanting practical, timely information over immense quantities of information (Noble-Carr & Bell, 2012).

In contrast, formal support networks were found in some studies to be perceived by young mothers as inconsistent and overly authoritarian (Noble-Carr & Bell, 2012). Those who benefitted from formal supports in the early postpartum period, found the lack of ongoing easily accessible supports a hindrance to breastfeeding success (Condon et al., 2012). Young mothers were found to not actively seek out professional supports or self identify as needing help even when these mothers knew how and where to access these supports in the community (Nesbitt et al., 2012; Sipsma Magriples et al., 2013).

Limitations of the Literature Review

Of the studies examined in this literature review, the main limitations were the use of convenience samples or the use of the most readily available participants (Polit & Beck, 2012) and potential self selection bias. These limitations are significant due to the fact that the young mothers in the samples were already self-selecting by accessing the clinics and supports in the community, and the studies cannot account for the effects of social desirability bias, or the mothers reporting behaviours they believe to be viewed as positive by the researcher.

The main limitations of the studies on the belief in benefits of breastfeeding were the use of convenience sampling related to recruitment from settings such a prenatal clinics and possible self selection bias as these were generally mothers who successfully breastfed their infants. The majority of young mothers (approximately 86 % by 6 months postpartum) who formula feed or who practiced mixed feeding are missing from these studies (Chalmers & Royle, 2009; HC, 2012b; MacGregor & Hughes, 2010). Due to the high numbers of young mothers that formula feed or have short breastfeeding duration rates, it could be argued that these studies represent

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only a minority of young mothers and recent studies have identified that young mothers as a demographic, whether they breastfeed or formula feed are well informed about the health benefits of breastfeeding for infants (Condon et al., 2012; Nesbitt et al., 2012), but may be less well informed about the risks of formula feeding (Noble-Carr & Bell, 2012).

Convenience sampling would exclude mothers who were not accessing the targeted clinics and supports. Those mothers who were marginalized or outside of the formal health and social services systems were not included, thus their behaviours, outcomes, and experiences are not represented in the literature. Young mothers, who chose not to breastfeed, whether or not they accessed services, are also not included. By 6 months postpartum approximately 86% of this population are formula feeding their infants (Chalmers & Royle, 2009; HC, 2012a; MacGregor & Hughes, 2010). The influencing factors related to breastfeeding practices of young mothers within the context of maternity shelters is absent from the literature (Nolte & Allen, 2006), as such this study of factors influencing the breastfeeding practices of young mothers in a maternity shelter in eastern Ontario is the first to examine this population.

Knowledge Gaps

The literature represents young mothers who were actively accessing services, held firm beliefs in the benefits of breastfeeding, held a normative view of breastfeeding and had sufficient levels of self efficacy related to their ability to breastfeed to succeed. Young mothers who access services like maternity shelters are young women for whom coping with complex life circumstances take precedence over dealing with the emotional and practical challenges of breastfeeding and actively seeking the support needed for success (Dilworth, 2006; Nolte & Allen, 2006).

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Being a breastfeeding mother also has the potential to provide group identity and peer validation of positive lifestyle choices. The voices of high risk young mothers are absent from the literature on infant feeding. Spencer (2008) argues that as breastfeeding is a phenomenon that occurs within the socio-cultural context of the mother, it “must be examined within her specific context” (p. 1824). Marshall, Godfrey, and Renfrew (2007) further the idea of the socio-cultural context of the mother to include breastfeeding as an integral part of everyday living with a new baby and the transition to motherhood. Therefore breastfeeding practices can only be examined within the “context of everyday living” (p. 2148) of individual mother-infant dyads.

As this review of the literature demonstrates, little is known of the experiences or support needs of young mothers in the maternity shelter system and of the factors influencing the decisions regarding infant feeding practices within the context of a maternity shelter. The purpose of this study is to add to the body of knowledge regarding the needs of this at-risk population with the goal of increasing understanding to inform nursing practice to support these mothers and their infants.

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Chapter 3: Methodology

Research Design

Interpretive Description Design.

The study was conducted using interpretive description design (Thorne, Reimer Kirkham, & MacDonald-Emes, 1997; Thorne, Reimer Kirkham, O'Flynn-Magee, 2004; Thorne, 2008, 2011). Interpretive description was proposed by Thorne et al. (1997) and further developed by Thorne (2008) to address qualitative research questions with clinical relevance while remaining grounded in "Nursing's Epistemological mandate" or within the nature and scope of knowledge used in nursing practice (Thorne et al., 1997). Interpretive description's philosophical alignment with Lincoln and Guba's naturalistic inquiry (CPHA, 2001; Lincoln & Guba, 1985; Oliver, 2009; PHAC, 2003; Thorne et al., 2004) postulates that human experience is constructed and only occurs within the overall context and lived experience of the individual (Thorne et al., 2004).

Thorne (2011) argues that traditional methods of qualitative research including phenomenology, ethnography, and grounded theory do not fulfill the requirements of nursing researchers to bring their research back to the realm of clinical practice to guide improvements to nursing care and patient outcomes. The core tenet of interpretive description is the idea that by understanding the subjective experiences of those who are living the health and/or illness experience (within their own individual context) insights can be gleaned to inform nursing practice with the larger population to which those individuals belong (Thorne et al., 1997).

Interpretive description has the objective of producing findings that will be able to directly inform clinical practice by providing "clinically applicable insight" (Hunt, 2009) by creating a "conceptual description" (Thorne et al., 2004) that provides understanding of the themes and patterns present in the phenomenon under study. Thorne et al. (2004) refers to this

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description as a tentative truth claim that when read by an expert practitioner would make sense and be applicable to the clinical context it was derived from. Ideally these findings can be used to guide the creation and implementation of nursing care (Thorne et al., 2004).

Setting

The study was conducted at a residential maternity shelter in Ontario. The maternity shelter's residential program provides comprehensive services to homeless pregnant and parenting youth (serving youth from 12-24 years of age) in Ontario. The maternity shelter is licensed to provide 24 hour a day support and services to 15 young women and up to 5 infants under the age of 3 months (Nolte & Allen, 2006; St. Mary's, 2014). The target population's profile includes issues of homelessness, addictions, family dysfunction, mental health issues, and street involvement (Nolte & Allen, 2006). The residence has a zero tolerance policy on alcohol and street drug use, and it has a focus on life skills, and healthy life style choices for the young mothers and their infants. The on-site services include counselling, life skills teaching, 24 hour support from on-site staff, and access to public health nurses through the Healthy Babies Healthy Children program of the local health unit through individual visits and an on-site clinic. The maternity shelter is linked to a community outreach centre for young parents within a five minute walking distance where some of the comprehensive services, including prenatal classes, nutrition groups, an obstetrical clinic, a nurse-led infant drop-in clinic, playgroups, a food bank, housing and counselling services and an alternate high school program, are offered to the women at the shelter and the broader community of pregnant and parenting youth.

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Sampling

The inclusion criteria used for this study were young mothers ≤ 24 years of age at the time of recruitment, primary care giver of their infants, residing in or has resided within the residence in the last 6 months, mother of an infant 5 months of age or under at time of recruitment, initiated breastfeeding at least once, and English or French speaking. Young mothers were defined using the criteria utilized by Statistics Canada (Millar & Maclean, 2005) and to include the age groups served by the maternity shelters and community services for youth and young parents in Ontario who define a youth, young mother or parent as being 24 years of age and under (Nolte & Allen, 2006; OPH, 2011; St. Mary's 2014). Convenience sampling was employed using the inclusion criteria (Patton, 1990; Polit & Beck, 2012; Thorne, 2008).

In keeping with Thorne's (2008) assertion that the researcher in a small interpretive description study can set an "arbitrary sample size" (p. 98) as long as the researcher shows "recognition that there will always be more to study" (p. 98), and recognizing that true data saturation within the interpretive description methodology is not truly attainable, the goal of recruitment was set at eight to ten participants. The sample size was also a practical consideration as there are a limited number of potential participants at any given time living within a maternity shelter, and the scope of the master's level study leads to a limited timeframe and resources. The goal for sample size was met with the recruitment and participation of nine young mothers who fit the inclusion criteria for the study. While according to interpretive descriptive design true saturation can never be truly attained, and there will always be new information to glean from unlimited ongoing data collection, the subthemes, and broad themes in the first and last interviews were consistent and no new information was gleaned by the eighth and ninth interviews. Thus, the researcher was confident that the saturation level of the study

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was sufficient to warrant confidence in the relevance of the findings and interpretation thereof to the setting, and the ability of the researcher to draw insights to make recommendations for clinical practice related to the research problem and question.

Recruitment

The following protocol was created in collaboration with the Executive Director of the maternity shelter and community outreach centre and the Residential Director of the maternity shelter. The recruitment protocol was approved by the Research Ethics Board of the University of Ottawa (University of Ottawa Office of Research Ethics and Integrity, 2012) as part of the ethics approval process (see Appendix C for Research Ethics Board approval and letter of support from the maternity shelter). The coordinator of the Baby Basics program at the maternity shelter served as the contact person from the residence for the research team and the Project Manager for the Community Action Plan for Children/Canada Perinatal Nutrition Program served as the contact for the community outreach centre.

The researcher was introduced by the residential director to the residents and staff present and provided an initial 5 minute presentation of the study at the residence following lunch in early September 2013. Recruitment posters/information handouts were distributed to all in attendance and the researcher was available to answer questions. The practice of handing out the recruitment posters/information handouts to all, regardless of interest, decreased the risk of coercion and self identification by potential participants as being interested in the study. The recruitment posters (Appendix D) that explain the aim of the study were also handed out to residents meeting the study inclusion criteria who did not attend the presentations, with an explanation of the study (Appendix E) by the shelter staff. The recruitment posters were also

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displayed in public locations including the women's washroom and quiet offices used by residents for telephone calls at the maternity shelter and the community outreach centre.

The residential director requested that staff determine which residents might potentially be interested in participating in the study in accordance with the residences protocol with past research studies. The Residential Director and Coordinator of the Baby Basics program identified eligible and interested potential participants and the names were forwarded to the researcher approximately every two weeks for the duration of the recruitment period. The researcher then contacted the potential participants to answer questions and arrange interview times, dates, and locations with the understanding that the potential participant could withdraw from the study at any time, for any reason without penalty. The information was reiterated upon the review of the formal consent form with each potential participant by the researcher (see Appendix F). As there is a frequent turnover of residents at the maternity shelter, recruitment was ongoing for the duration of the data collection period via posters, and word of mouth by the residence staff to those residents who were identified as meeting the inclusion criteria from September 2013 to February 2014.

Three additional recruitment presentations were conducted in January of 2014 during day programs at the community outreach centre. The same verbal recruitment script as used at the maternity shelter was used for a 5 minute presentation on the study with time for questions at two weekly prenatal/parenting drop-in programs held at the community outreach centre.

Data Collection

The researcher conducted one semi-structured interview (Appendices G, H and I) with each participant. Participants who were breastfeeding their infant at the time of the first interview and the infant was less than six weeks of age, were eligible for a second in-depth semi-

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structured interview (Appendix H), approximately one month after the first interview. Written, informed consent was obtained prior to each interview, with the researcher reviewing the consent form in detail with each participant and allowing for any questions related to the consent form and study (see Appendix F). A demographic data questionnaire was completed by each participant at the beginning of the initial interview, including questions on relationship status, educational attainment, and age of infant at time of residence at the maternity shelter, and at the time of the interview (Appendix K).

The first five interviews were conducted using version A of the interview guide (Appendix G), upon initial reading and reviewing the transcripts of the first five interviews the interview guide was revised to allow for more open questions, and using a chronological ordering of the questions to allow for an improved narrative flow from the participants (Appendix I). Table 2 summarizes the main questions asked in the interviews.

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Table 2

Summary of Interview Guide Main Questions

Main interview questions		
Prenatal		
Tell me about your pregnancy, what was it like?	When did you start thinking about how you were going to feed your baby?	Did you talk to anyone about feeding your baby before he/she was born...
Hospital (day 1-3 postpartum)		
Tell me about your labour and what happened right after your baby was born...	How did your baby do in hospital, how did the feeds go? Was your baby given any supplements, by whom...	Did you have a favorite nurse, or nurses, what did she do that made her your favorite? Did you have a least favorite...
Hospital discharge to 6 weeks		
Tell me about feeding your baby when you got home...	Who helped you the most with feeding your baby, what did they do that really helped you?	Where to do you usually feed your baby, tell me about that...
Six weeks to 6 months		
Who helped you when your baby was older?	What has been the best thing about feeding your baby since he/she was six weeks old?	Tell me about the hardest part about feeding your baby...
Ending		
If breastfeeding: How long would you like to continue, what is important about this...	What advice would you give others to help with feeding their babies...	

* For the complete interview guide see Appendix J

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Each interview was digitally recorded with the consent of each participant. Directly following the interview observations and notes were recorded by the researcher. The digital recording was downloaded to a password protected laptop, with any identifiers to the participant removed when transcribed (each recording was then assigned a random alphanumeric code, and dated) and kept in the Nursing Best Practice Research Centre at the University of Ottawa in a secure locked office. The digital recordings were transcribed into text by the researcher and downloaded into NVivo® qualitative design software for data management and kept on a password protected, secure laptop. The random alphanumeric code was used to identify the text transcriptions.

Rigour

Lincoln and Guba's (1985) framework to ensure credibility, dependability and transferability was followed to ensure rigour throughout the study (Koch, 2006; Polit & Beck, 2012; Thorne et al. 1997). The criteria of credibility, or the "confidence in the truth of the data" (Polit & Beck, 2012, p. 585) was attained through the consistent keeping of a reflection journal and field journal during the course of the study. Vaismoradi, Turunen, & Bondas (2013) encourage the keeping of a journal by the researcher as a simple and practical method to increase rigour in a qualitative study.

In keeping with Sandelowski and Barroso (2003), dependability was demonstrated by the provision of an audit trail of both methodological and analytic decisions. Both were documented throughout the course of the study as data collection and analysis occurred simultaneously.

Polit and Beck (2012) describe the criterion of transferability as being satisfied through the use of thick description, which must allow for others to recognize the similarities and differences to their own context and make decisions as to whether the findings could have

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relevance to them. The researcher provided adequate description of the original context that readers of the resulting study will be able to assess if they can utilize the findings in their own context and/or experiences.

The initial recruitment period was prolonged to allow for the active recruitment of young mothers of older infants from the affiliated young parent outreach centre. This was done to include the experiences of these mothers with ongoing supports once they had moved out of the shelter. The goal was to increase the transferability of findings into the community context as the young mothers' experiences and breastfeeding support needs changed over time as their infants matured during the first 6 months postpartum.

Vaismoradi et al.'s, (2013) criterion for inter-coder reliability that independent coding of two random interview transcripts and subsequent comparison of the coding results between the researcher and the thesis supervisor was performed to increase credibility of the coding process. The presenting and discussing the findings with the thesis committee, composed of expert clinicians in the areas of breastfeeding and nursing practice with young at-risk mothers, and having this committee review and make suggestions on each draft of the final thesis further served to increase the reliability of the findings.

Reflexivity

Reflexivity, or the critical self-reflection of the researchers' biases and preconceptions related to the subject of the study was practiced through the recognition of the effect of the researcher's presence on the context of the study (Creswell, 2007; Polit & Beck, 2012; Vaismoradi et al., 2013). The researcher practiced ongoing engagement in self reflection to explore her biases and potential effects on the study. The researcher as an experienced public

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health nurse and lactation consultant, who had breastfed two children of her own, acknowledged a pro breastfeeding bias.

Interpretive description begins with the assumption that the researcher, as a practicing professional, brings clinical expertise and experience with the subject matter to the study from the onset and uses this clinical experience in conjunction with the literature and evidence to design and scaffold the research (Thorne, 2008). A research journal was kept from the inception of the study to explore assumptions, biases, personal experiences, and clinical experiences that may have affected the study's emergent design, data analysis and interpretation of results (Vaismoradi et al., 2013). See Appendix L for feasibility and the study timeline.

Data Analysis

The data analysis followed the inductive method of concurrent data collection and content analysis approach (Cole, 1988; Elo & Kyngas, 2008; Hunt, 2009; Thorne et al. 1997; Vaismoradi et al., 2013). The goal of the analysis in interpretive description is to move first to the broad description of the phenomenon, the understanding of the overall picture (Hunt, 2009). This goal was accomplished by asking the broad questions “what is going on here?” and “what am I learning about this?” (Hunt, 2009; Thorne et al., 1997) while seeking themes and patterns that may lead to clinical insight regarding the phenomenon under study (Hunt, 2009). Inductive content analysis was chosen as a compatible method to interpretive description to guide the data analysis process and was used for the coding and reporting stages of this study (Cole, 1988; Elo & Kyngas, 2008; Vaismoradi et al., 2013). The data collection and analysis techniques of inductive content analysis allowed for the emergent nature of interpretive description research design to be maintained. The analytic process followed the three stages of content analysis: the

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preparation, organization, and reporting stages (Elo & Kyngas, 2008; Hsieh & Shannon, 2005; Vaismoradi et al., 2013).

The first stage, the preparation stage, consisted of conducting interviews with participants, transcription of the interviews by the researcher, and making notes on the initial transcripts on initial impressions and thoughts (Elo & Kyngas, 2008; Hsieh & Shannon, 2005; Vaismoradi et al., 2013). Interviews were conducted until the researcher was satisfied that no new information was emerging from the interview process.

The researcher transcribed all of the interviews conducted, satisfying the criteria of repeated immersion in the data and allowing a familiarity with the data as a whole and as well as choosing smaller fragments to be compared with other interviews in search of patterns and commonalities (Thorne, 2008). The repeated immersion first took the form of the researcher conducting and transcribing each individual interview. Then the researcher was immersed in the transcript text through repeated reading and re-reading the material to gain an understanding of the individual and collective transcripts as a whole. While reading and re-reading the transcripts, the researcher was asking the guiding questions of who is speaking, where and when in time and place is this individual within the larger context of the individual's life circumstances, and what is going on here (Elo & Kyngas, 2008; Hsieh & Shannon, 2005; Vaismoradi et al., 2013). The researcher made notes in margins of the transcripts on an ongoing basis during the immersion stage. These notes recorded the researcher's impressions and thoughts on the latent and manifest content of the interviews (Hsieh & Shannon, 2005; Vaismoradi et al., 2013). The interviews (audio file and text transcripts) were then uploaded into NVivo®. The NVivo® software was used to aid in the organization of the data in the subsequent phases of analysis.

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The organization phase consisted of the researcher first open coding all transcripts. Initial codes and notes were written in the transcript texts; they were revised over reading and re-reading of the texts by the researcher (Elo & Kyngas, 2008; Hsieh & Shannon, 2005; Vaismoradi et al., 2013). The initial codes and notes looked at all aspects of the contents of the texts, while creating lists of the barriers and facilitators to breastfeeding that emerged from the texts. This stage corresponded with the interpretive description phase of coding and classifying to find common themes and patterns in the data (Thorne et al., 1997). The open codes were then sorted into codes and then into subthemes (Elo & Kyngas, 2008; Hsieh & Shannon, 2005; Vaismoradi et al., 2013). Definitions for each subtheme and subsequent broad themes were developed (Cole, 1988; Hsieh & Shannon, 2005).

The next step involved broad-based coding (Thorne, 2008) or the merging of categories into broad higher order themes with underlying shared intent (Thorne, 2008). With the goal to describe the phenomena using themes, the subthemes were then grouped in clusters into broad themes (Elo & Kyngas, 2008; Hsieh & Shannon, 2005; Vaismoradi et al., 2013). The broad themes were then used to interpret the results, and thus related back to clinical practice with the goal of informing nursing practice.

Regular meetings between the researcher and her thesis supervisor were held throughout the course of the study to review the progress of the study, design and implementation decisions, data analysis decisions, and interpretation of results. Ongoing consultations with members of the thesis committee and regular meetings were held to review the progress of the project, review design and implementation decisions, review analysis and interpretation with active participation and recommendations of the committee members.

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In the final phase, the reporting phase, the central themes of clinical and contextual relevance were extrapolated and the relationships were explored and utilized in the interpretive description of the data (Thorne, 2008). The results were then described as the contents of the broad themes, namely the subthemes and their definitions (Elo & Kyngas, 2008). The interpretation of broad themes, barriers and facilitators were informed by the method of interpretive description. The relevant findings were compared and contrasted to findings in the literature (Hsieh & Shannon, 2005). The results were related back to the research question including a summary of how findings contributed to clinical nursing practice (Cole, 1988, Elo & Kyngas, 2008; Hsieh & Shannon, 2005; Vaismoradi et al., 2013). This stage culminated in the completion of this Masters thesis, including recommendations for clinical nursing practice, and future nursing research.

Throughout this phase of data collection and analysis, field (analytic) notes with reflections on the data were kept. These were reviewed regularly to help guide the collection and analysis. The thesis supervisor was consulted via regular meetings to review and offer insight into the data collection and analysis process throughout the duration of the study.

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Chapter 4: Findings

The findings from this study highlight the effect that the institutional and social environments have on the young mothers' experiences and how they provide the practical and emotional supports necessary for breastfeeding success. As patients on the hospital postpartum units these young mothers identified the critical role that positive therapeutic relationships with the nurses played in their early breastfeeding success. At the maternity shelter, the young mothers discussed both the positive and negative influences of institutional policies on their breastfeeding practices and those of their peers. The mothers talked about the importance of social supports in the form of an identifiable peer group of other young breastfeeding mothers and the ongoing supports from family. Ongoing institutional supports in the form of public health and community resources were also important to breastfeeding duration. For these young mothers, breastfeeding was an empowering, positive choice they had made for their infants. When that choice was perceived as being taken away by institutional practices, unsupportive professionals, or individual life circumstances, it was described in terms of disempowerment or feelings of lack of control.

Description of Study Participants

Nine participants were recruited over a period of 6 months from a maternity shelter (n=6) and its adjacent community outreach centre for young parents (n=3). At the maternity shelter identification of potential participants was facilitated by a core staff member between September 2013 and January 2014. The researcher conducted three short information sessions with young mothers at core weekly programs at the community outreach centre for young parents. These information sessions were facilitated by the coordinators of each program between January 2014 and February 2014. Recruitment was ongoing from September 2013 though to February 2014.

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The nine participants were interviewed for the study over a period of 5 months from October 2013 to February 2014 (see Table 3). Interviews were held at the maternity shelter (n=4), the community outreach centre for young parents (n=2), or the individual participants' places of residence (n=3). Each participant was interviewed once and was digitally recorded. The two participants who had given consent to be contacted for a second interview were contacted approximately 4 weeks from the date of the initial interview to obtain a more complete picture of their experiences with breastfeeding as their infants grew and matured and as their individual circumstances as new mothers changed over that period of time. Since neither participant returned the researcher's email request for a second interview, no follow-up interviews were conducted. All nine participants were accessing services at the maternity shelter and/or the community outreach centre for young parents at the time of recruitment and being interviewed.

The nine participants ranged in age from 17-24 years old; one participant did not disclose her age. At the time of the interviews, two participants were 17 years of age, one was 18, one was 19, one was 20, two were 21, and one was 24 years of age. The range of ages satisfied the sampling goal to represent the population of the shelter to include both adolescents and young adults as the shelter typically serves young mothers from 13 to 24 years of age, with the average resident being 17 years old. The maternity shelter will also serve younger or older residents on a case-by-case basis (St. Mary's, 2014).

The infants in the study ranged in age at the time of the interviews from 1 week to 6 months of age, with the mean age being 3 months and 1 week. The 6 month old infant did meet the criteria of being 5 months old or younger at the time of recruitment and therefore the mother was included in the study sample.

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Five participants were exclusively breastfeeding at the time of the interview. It is important to note that the definition of exclusively breastfeeding being used by the participants is different than that identified in the literature. In the literature exclusive breastfeeding refers to the feeding of only breast milk to infants (with the exception of vitamins and medications) up to 6 months of age, and then continuing breast milk with the additions of complementary foods at 6 months to 2 years and beyond (Millar & Maclean, 2005; WHO, 2002). The participants reported themselves as exclusively breastfeeding if at the time of the interview they were only feeding their infants from their breasts, regardless of whether they had given their infants formula in the past.

Two participants were exclusively formula feeding at the time of the interview; both had initiated breastfeeding following the birth of their infants and continued for up to 2 months. Two participants were identified as mixed feeding at the time of the interview. One mother was offering formula as a supplement to breastfeeding due to a perceived insufficient milk supply and planned to wean the infant off the formula supplements when her milk supply increased. The other mother had an infant with compromised health, who was on a medically prescribed diet of fortified formula and expressed breast milk; this infant was fed with a combination of nasogastric tube feeds, bottle feeds, and breastfeeds. This mother was parenting twins. Although the other twin was initially formula fed due to low blood glucose levels for the first 3 days in hospital, the baby was exclusively breastfeeding at the time of the interview. The planned breastfeeding duration reported by the participants ranged from 9 months to 3 years.

Of the nine participants, four were residing at the maternity shelter at the time of their interviews. Five of the participants had moved into subsidized housing units. Two of these five had moved in with their partners who were identified as the fathers of their infants and three

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were living alone with their infants. The length of stay at the maternity shelter ranged from 4 months to 9 months, with the average length of residence being 7.5 months (one participant did not disclose her length of residence at the shelter). Prenatally, the mothers lived at the shelter from 1-30 weeks, with an average prenatal residence at the shelter of 15 weeks. The mothers' postpartum length of residence ranged from 1-18 weeks, with an average postpartum residence at the shelter of 9.4 weeks.

Two of the participants had been followed by the local teaching hospital's high risk antenatal team during their pregnancies; both of these mothers had infants who were admitted to neonatal intensive care units (NICU) in Ontario during their first 6 months of life. One participant was parenting twins; the others were all mothers of singleton infants. Six of the nine participants were first time mothers. All of the participants had full custody and were the primary caregivers of their infants at the time of the interview. One infant had been apprehended by local child protection services after birth (upon discharge from hospital), and placed temporarily into foster care.

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Table 3

Participant Demographic Data Summary (9 mothers and 10 infants)

Demographic data	
Maternal age (n=8)*	19.5 years (17 to 24 years)
Age of infant	12.5 weeks (1 week to 5.5 months)
Length of residence at maternity home*	
Prenatal	15 weeks (mean) (1-30 weeks)
Postpartum	9.4 (mean) (1-18 weeks)
Total length of residence	24.5 weeks (mean) (13-34 weeks)
Maternal educational attainment	
Less than grade 8	n=1 (11%)
Some high school	n=4 (44%)
Completed high school	n=2 (22%)
Some college	n=1 (11%)
Maternal relationship status at time of interview	
Single	67%
Dating	11%
Living with father of baby	22%
Method of infant feeding at time of interview	
Exclusively Breastfeeding	56%
Formula feeding	22%
Mixed feeding	22%
Planned breastfeeding duration	
Less than one year	34%
One year	44%
Two years	11%
Three years	11%

*One participant did not disclose her age or length of residence at the maternity shelter (the participant was residing at the shelter at the time of the interview).

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Findings: Broad Themes

The findings are organized according to six broad themes. The focus of the first theme, *Learning to Breastfeed and the Importance of Early Support* highlights the pivotal role that nurses and lactation consultants play in the initiation and establishment of early breastfeeding. The second broad theme, *Choice*, explores the ownership or loss of choice expressed by the mothers. In the third broad theme, *Being Part of the 'In Crowd'*, the mothers describe the practical and social supports that they gained from being with other breastfeeding mothers at the maternity shelter. *Healthy, Special, Cheap, and Easy*, the fourth broad theme, refers to the four benefits the mothers ascribe to breastfeeding. The fifth broad theme, *Mothering the Mother*, describes the importance of emotional support that professionals both in hospital and at the maternity shelter provide to individual mothers. The sixth broad theme, *Importance of Ongoing Supports*, is specific to the breastfeeding mothers of older infants, who identified the importance for them of ongoing supports once moving out of the maternity shelter.

Learning to Breastfeed and the Importance of Early Support

All of the participants talked at length about their early breastfeeding experiences within the first 72 hours postpartum and about the quality of the care and support they received in hospital. These experiences ranged from extremely positive and pivotal to the mothers' early breastfeeding success, to negative and a hindrance to early breastfeeding initiation and maternal confidence. One young mother described a positive hands-on teaching experience as,

“...when my nurse came in and showed me, like with the doll and everything, how to latch...that really helped” (P7).

Another young mother reported the opposite experience.

“They [nurses] didn't really tell me what I need to know even though I asked questions...I didn't know what to do” (P5).

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The majority of the mothers in the study reported receiving prenatal information from diverse sources such as health care providers, formal classes at the maternity shelter, local community agencies, and one on one support from professional and lay prenatal care providers (e.g. public health nurses, physicians, and doulas). But, overwhelmingly the mothers credited the nurses and lactation consultants in hospital as providing the crucial ‘how to’ information on breastfeeding that enabled them to successfully initiate early breastfeeding. Many of the mothers stated the prenatal information did not adequately prepare them for the realities of the mechanics of breastfeeding and resolving early challenges. The mothers’ prenatal perceptions of breastfeeding being natural, and thus easy, or painful and thus difficult were challenged when they were confronted with the realities of breastfeeding.

For some mothers breastfeeding was easier and less painful than expected and, for others it was more challenging than anticipated. The provision of early hands-on support in hospital by healthcare professionals who were accessible, knowledgeable, and supportive created a positive and receptive environment for these mothers to learn about how to breastfeed their infants. As one participant stated,

“...I just thought it would come naturally, you know cause that’s why we have boobs...I didn’t really pay much attention...you don’t think it’s going to be anything hard until you try it...” (P7).

The majority of the mothers who were breastfeeding at the time of the interviews reported having positive experiences in hospital with either a nurse or a lactation consultant. These mothers were emotionally connected to a nurse they described as “special”; a nurse that not only helped with hands-on breastfeeding teaching related to latching, positioning and hunger or satiation cues of the infant, but a nurse also invested time and energy in the emotional support and care of the mother, as described by one woman,

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“The lactation consultant was actually amazing with me...she was really helpful, she like stayed with me the whole day...it was really nice to get a boost from her” (P2).

These ‘special’ nurses and lactation consultants shared common traits and were perceived in common ways by the mothers. These nurses and lactation consultants were described as accessible and consistent; they were there when the mothers needed them and spent sufficient time with the mothers that the mothers felt their needs were being met by someone who genuinely cared for their well being. The mothers described these nurses and lactation consultants as helpful with learning to breastfeed and as going above and beyond for that individual mother and infant. These nurses and lactation consultants were described as non-judgemental and were trusted by the mothers.

“She [the lactation consultant] did everything for me, she bent over backwards and forwards for me” (P8).

Some mothers reported negative experiences with nurses and lactation consultants in hospital following the birth of their infants, or witnessing negative interactions between nurses and other new mothers. These negative experiences hindered any teaching that might have occurred by these nurses as the mothers rejected them as care providers, one mother going so far as to tell the nurse to leave her room.

“She [the nurse] was just judging everything I did...she didn’t like anything I did and I told her to get out of my room...I told her to get out after all the judging...she was rude” (P8).

The mothers with the most negative portrayals of early hospital breastfeeding supports had the least favorable outcomes in their own opinions and expressed regret over the early loss of breastfeeding.

“I wish I could feed him from the breast...I can’t and I really wish I could (breastfeed)...I wish someone would have given me advice on how I could” (P1).

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Choice

All of the participants spoke about choice in relation to their own infant feeding practices and those of other young mothers. While the majority of the mothers acknowledged some influence of care providers and family members on their decision to breastfeed, they all talked about how breastfeeding was ultimately their choice.

“I had already made the decision to breastfeed so it [prenatal teaching] didn’t change my decision at all...I knew from the start” (P5).

The mothers who viewed themselves as successfully breastfeeding all expressed ownership of the choice to breastfeed; it was their choice.

“I always knew...there was always going to be breastfeeding...” (P7)
 “I choose to do it [breastfeed]” (P4).

These mothers were proud of their good decisions and ability to choose to overcome the challenges of early breastfeeding. They used descriptors such as:

“That’s your choice if you’re gonna do it or not” (P3), breastfeeding as “a good choice” (P4), and “I’m proud of them, especially being young mom, it’s hard... it’s worth it” (P5).

This autonomy of choice was an important part of how the mothers described themselves, and viewed their maternal identity in relation to other breastfeeding and non breastfeeding mothers.

“I know what kind of mother I want to be and nothing else influences my own thoughts” (P2).

The participants also recognized the power of choice, and made value judgements about the choices of other young mothers. Mothers who were breastfeeding their babies were described as “...she’s a good mom” (P4) and “...that’s a good mom” (P2). Breastfeeding mothers were viewed as inspirational role models by many of the mothers in the study. Witnessing other young mothers breastfeeding, whether that was at the shelter or in public, was reported as helping the participants feel more confident that they too could breastfeed.

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“I’m just happy, I’m glad she’s breastfeeding...I saw my friends, some of them, I just thought I’m proud you’re doing it [breastfeeding]” (P3).

Several of the mothers in the study described formula feeding mothers as:

“...they give up too easy and just go to formula” (P7).

These mothers postulated that some practices at the maternity shelter facilitated this ease of switching to formula feeding. For example, the mandatory section of the infant care course taught to all expectant mothers at the shelter includes formula preparation, and requires all residents have formula and bottles as part of the necessary items to have for the baby before the birth. These mothers felt this sent the message that breastfeeding was going to be difficult and the mothers to be had to have formula ready as a backup plan to feed their infants.

“...they’re able to, because people [shelter staff] are offering formula, and because they are made to buy bottles...I feel like if it wasn’t, formula was not so there...the girls would be more likely to breastfeed” (P7).

Some participants felt that young mothers who formula feed were choosing their body over their baby’s best interests, as breastfeeding was viewed as diminishing the sexiness of breasts, and breastfeeding mothers as having less attractive or older looking bodies. One mother stated,

“...you only bottle feed your baby if he or she was sick...or something but not over choice of wanting to...people who do it’s superficial” (P2).

Other mothers in the study simply viewed formula feeding as the other choice mothers could make.

“...she has her own reason as to why she choose to bottle feed, so I’m not gonna judge anyone, that’s her choice” (P3).

The mothers who were exclusively formula feeding (n=2), and the mothers who were mixed feeding (n=2) their infants expressed feelings of disempowerment or lack of control regarding choices that were made related to feeding their infants. The two formula feeding

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mothers expressed regret over losing the breastfeeding relationship, and cautioned other mothers not to allow others to make choices for them that would interfere with continuing the breastfeeding relationship with their babies.

“I would say keep with the breastfeeding...I know women out there can do it no matter the judging, no matter what keep up the good work...don’t let anybody get between you and your baby...don’t give up” (P8).

One mother reported feeling a loss of choice related to feeding her infant in hospital following the birth. She reported that her infant was to be apprehended by local child protection services and placed in foster care following discharge from hospital, and the hospital staff was aware of this plan. This mother reported that she wanted to breastfeed, and barring that possibility, to provide expressed breast milk for her infant, but this decision was taken out of her control once the infant was apprehended.

“The foster mother kind of didn’t want to feed my child breast milk” (P1).

The other participant expressed that physicians in the NICU initially made the decision to formula feed her infant. Later she felt her baby had made the choice not to breastfeed due to what she perceived as the strong bond baby had with his father and not with her.

“It made me feel like maybe he [the baby] doesn’t want that bond...he wants to be constantly with his dad...” (P8).

Being Part of the ‘In Crowd’

The mothers reported that for the first 2 weeks postpartum, or until the shelter staff were assured that breastfeeding was well established and the mother was responding appropriately to the infant’s feeding cues, all infants had to be breastfed in the dedicated breastfeeding room on the first floor of the residence. Formula fed infants also had to be fed on the first floor of the residence, though not in the dedicated breastfeeding room. Mothers who were pumping their milk also reported they were required to pump in another separate room, as there is only one dual

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electric pump shared amongst the residents. The requirement to breastfeed in a dedicated room was described by mothers as both a facilitator and a barrier to early breastfeeding at the shelter.

The breastfeeding mothers in the study reported identifying with other breastfeeding mothers residing at the maternity shelter and feeling included with their peer group. This peer group was identified as providing practical supports related to breastfeeding and positive social supports for these mothers. Of mothers in the study who were formula feeding, only one was formula feeding when she resided at the maternity shelter and she expressed feelings of isolation and exclusion from other mothers at the maternity shelter due to her situation of not having her infant with her at the shelter and having to pump in isolation from other mothers.

The breastfeeding mothers described the social atmosphere of the dedicated breastfeeding room as a positive experience, providing them with peer support and camaraderie.

“It’s [breastfeeding with other mothers] like strength in numbers” (P5).

“It’s [the breastfeeding room] fun too, because it’s like a bunch of people breastfeeding...talking...socializing, it’s fun” (P3).

The peer support and social atmosphere helped to increase feelings of confidence in their choice to breastfeed, and provided other mothers as role models to identify with.

“Like with their boob out and breastfeed anywhere...I wasn’t really used to breastfeeding...so it was nice...it made me feel a bit more comfortable breastfeeding, knowing they’re confident doing it, I’m gonna be like that too” (P7).

The mothers also reported that the group atmosphere helped to mitigate the lack of staff support as other mothers were able to provide practical help with issues such as positioning, latching and fussy infants where and when the mothers needed it, for instance in the middle of the night.

“He [the baby] had some really big cluster feeds...there was a lot of support around me, other breastfeeding mothers around me...who were going through the same thing, so like, I wasn’t alone, wasn’t the only one who had to do it” (P5).

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The practice of having to go to the dedicated room for every feed was also described as a barrier to breastfeeding in that it was tiring in the middle of the night for the mothers to have to get up with their infants and go downstairs to the room (the bedrooms are on the second floor of the residence).

“Even in the middle of the night I was constantly making trips downstairs...taking the stairs up and down, up and down, I was so sleep deprived” (P7).

The inconvenience of having to get up and go downstairs to feed their infant was shared by formula feeding mothers who would have to go downstairs to the kitchen to prepare the formula. As such having to go to the first level of the residence for feeds was a logistics issue shared by all of the mothers in the residence. Although, by the time their infants were over 2 weeks old, many of the breastfeeding mothers were allowed to breastfeed in their bedrooms making breastfeeding the easier night time option.

Healthy, Special, Cheap, and Easy

The four reasons to breastfeed consistently expressed by the young mothers in the study was that breastfeeding was healthier than formula, breastfeeding provided a unique bond between mother and baby, breast milk was free, unlike infant formula which was known to be expensive, and once the baby was older, breastfeeding was easier than having to prepare bottles of formula or expressed breast milk.

The mothers knew breast milk was healthier for their infants, but were generally unable to express why (despite reporting being given prenatal information on the benefits of breastfeeding).

“Cause people keep telling me that to breastfeed is making the baby more healthy than formula” (P4).

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Every mother in the study expressed that breast milk was the healthiest option for feeding their infants.

“It’s the most healthiest thing for my baby...it’s all natural” (P2).
 “She [the baby] hasn’t been sick once, so I think like the antibodies and stuff like that” (P5).

Both of the formula feeding mothers expressed regret that their infants were no longer reaping the health benefits of their breast milk.

“I still wanted him to at least have a little bit of breast milk...so that way he could have that and the formula, cause I know the breast milk is best for babies” (P1).

None of the mothers were able to give a concise description of why breast milk was healthier; some were able to list one or two reasons, but most simply stated that it was healthier.

Although the mothers (with one exception) in the study did not expressly state that breastfeeding also had health benefits for them, they did indirectly acknowledge the mental health benefits that they as mothers derived from breastfeeding. The mothers expressed the mental health benefits in statements such as:

“It’s [breastfeeding] fun, it’s good” (P2), “I liked it [breastfeeding]” (P9), “it feel good, to breastfeed, seriously, it does” (P4) and “I really enjoy it [breastfeeding]” (P5).

The breastfeeding mothers all expressed joy and pleasure in breastfeeding their infants, especially as the babies grew older and the early challenges of breastfeeding had resolved.

The majority of mothers in the study reported that breastfeeding created a unique bond or attachment between mother and baby.

“It’s a close bond...he’s [the baby] just, it’s you, you, you...it’s like mom, he wants you and it’s really nice” (P2).

The relationship between a mother and a breastfed baby was viewed as different and stronger than that of a formula fed baby, and cited as an important reason to continue to breastfeed an older infant.

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“When I see people in the mall breastfeeding their kids, I’m like, that’s a special attachment...if you’re giving your baby the bottle...I find it’s not really attachment, it’s just like, okay, here’s a fake nipple in your mouth” (P8).

One mother in the study had formula fed her first child, but was breastfeeding her second baby. This mother reported that breastfeeding was the only difference between how she cared for her two children and she felt the breastfed baby was closer to her and there was stronger attachment to this infant because of the breastfeeding relationship.

“There’s more of a bond there...with the breastfeeding because, there’s, nothing else has been different” (P5).

The mothers of the formula fed babies described having lost the unique relationship that comes with breastfeeding, and expressed a desire to regain this bond, or to breastfeed future infants to have this relationship with subsequent children.

“I don’t like it [formula feeding]...because I wish I could and still breastfeed him because there is that special bond between a mother and a baby [pauses] when you’re breastfeeding” (P1).

The mothers in the study also reported the cost savings as a reason to continue breastfeeding. Breast milk was simply free and formula expensive, especially for young mothers with limited financial means.

“It [formula] be a whole lotta money out of my pocket” (P9).

The cost savings were seen as a long term benefit and motivator to continuing breastfeeding an older infant and toddler.

“It’s [breast milk] a whole lot cheaper, whole, lot, cheaper” (P9)

“It’s [breast milk] free” (P2).

The mothers in the study who were breastfeeding older infants consistently wanted to send the message to other mothers to persevere through the early difficulties of establishing breastfeeding as breastfeeding an older infant was considerably easier than formula feeding. The

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mothers who were breastfeeding older infants felt that mothers were not well informed of how breastfeeding changes as an infant grows and matures and only hear about the early difficulties of breastfeeding. They needed exposure to other mothers who were breastfeeding older infants to see that it is worth the effort to overcome the early challenges.

Mothering the Mother

The mothers in the study who expressed satisfaction with their feeding choices and outcomes discussed at length their positive experiences and relationships with their health care providers in hospital and the staff at the maternity shelter. The mothers expressed strong feelings of being emotionally supported, and connecting with the special staff members who they reported as helping them the most with breastfeeding and provided emotional support in all aspects of the transition to motherhood. These staff members freely invested their time in the mothers, and were consistently available.

“She [the nurse] was always there...I told them I didn’t want any other nurse...and I never got any other nurse” (P8).

The mothers in the study who were formula feeding by the time of the interview reported overall negative interactions with staff at the respective hospitals where they had delivered or gone for medical care of their infants. These mothers reported feelings of being left alone and isolated.

“The ones [nurses] in the hospital, I decided I wanted to breastfeed and they [the nurses] just kinda left me and walked out of the room” (P1).

The women discussed how although they wanted practical hands-on and emotional supports, they either were not offered the supports they needed or the staff offered in a judgemental and demeaning manner, thus the mother refused the help. Staff who were viewed as judgemental,

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rude, hard and authoritarian were not seen as being helpful, or offering any useful breastfeeding supports.

“The staff are constantly bugging you, if you don’t do this right, there’s consequences...and I don’t like that” (P8).

Once at the maternity shelter the mothers who were successfully breastfeeding reported the staff went out of their way to take care of the mother (allowing her to sleep, bringing water, listening when upset). The emotional aspect of the support continued upon discharge for these mothers.

“She [shelter staff member] gave me a lot of tips and she would watch him the longest while I slept...she was really great...I came down one morning like crying and she like helped me, she was supportive” (P7)

“[she] kept me calm...[she] was there to help me...she guided me” (P8).

The mother who returned to the maternity shelter without her infant (due to apprehension before hospital discharge by local child protection services) reported that while there was staff support, she felt staff were not sensitive to her needs, and did not act in an enabling role to help her provide expressed breast milk for her infant.

“It would have been nice to have had help to figure out how to pump...cause I was just kinda given it...So I kinda had to figure it out a little bit on my own...that was kind of discouraging” (P1).

Importance of Ongoing Supports

The mothers of older infants in the study identified easily accessible ongoing supports as important to their continuing success with breastfeeding. Although not as intensive or emotionally charged as the early supports at either the hospital or the maternity shelter, the ongoing supports were a familiar avenue to ask questions related to infant feeding and care as they arose. Several of the mothers recounted stories of friends who had stopped breastfeeding

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when their babies reached milestones such as teething because they didn't know how to solve issues related to breastfeeding an older infant.

The three mothers in the study who discussed their ongoing supports had all moved into their own housing units and were still accessing services at the local outreach centre for young parents affiliated with the maternity shelter. These mothers identified their public health nurse and their own mothers as the two main sources of ongoing support available to answer questions related to breastfeeding an older infant.

“I still see my nurse...she comes here and I ask her all the questions I have when she gets here...she's great” (P7).

“They're [public health nurses] not tight, they're just loose and really talk to you” (P2).

The mothers of older infants had mothers who were experienced with breastfeeding their own children and available to answer questions. These three young mothers also still received home visits approximately every two weeks from their public health nurse from the local health unit and reported the home visiting program as a useful source of available and predictable ongoing support surrounding infant feeding.

Facilitators and Barriers to Breastfeeding within the Context of a Maternity Shelter

Both the facilitators and barriers to the breastfeeding practices of young mothers who live or have lived within the context of a maternity shelter are present in the broad themes discussed. To provide practical and specific recommendations to guide nursing practice and to improve outcomes for this population of young mothers, the details and items that emerged from the interviews are further categorized as potential facilitators and barriers (see Table 4 for summary).

Facilitators

While the prenatal facilitators to breastfeeding were not reported by most of the mothers who participated in the study as major factors influencing their breastfeeding practice they were

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nonetheless present in the majority of the interviews. The mothers reported receiving information prenatally from their physicians, public health nurses, staff at the maternity shelter and doula. This information on the benefits of breastfeeding included the cost savings, that breastfeeding was the healthiest option for the infant, and that breastfeeding provided bonding and attachment opportunities with their infants. Mothers reported being given free breastfeeding items such as nipple cream, breast pumps, and in one case a breastfeeding pillow. This information and the free items came from the maternity shelter, the public health nurses and prenatal classes and groups the mothers attended.

Some of the mothers reported being influenced by their own mother's breastfeeding practice, or the practices in the communities that they grew up in. Some of the mothers stated they had positive memories of watching their own mothers breastfeed their younger siblings, and breastfeeding was the normative method to feed infants in their families. One of the mothers recounted how in her country of origin breastfeeding was the norm, and mothers would routinely breastfeed infants of extended family members. The mothers who had been exposed to breastfeeding as the normal way to feed infants in their families or communities held positive views on breastfeeding in the prenatal period due to early exposure to family members successfully breastfeeding.

In the hospital early and easy access to a lactation consultant or knowledgeable nurse was common to most of the mothers who were breastfeeding at the time of the interviews. The professional supports who were helpful were perceived as approachable, accessible, non-judgemental, caring, genuinely interested in the mother, and easy to relate to. These nurses and lactation consultants provided the mothers with a combination of both the practical, how to, and

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hands-on teaching of breastfeeding and also provided emotional and practical support of the mother and her immediate postpartum needs, thus enabling early breastfeeding initiation.

Once mothers were discharged to the maternity shelter with their infants the staff at the maternity shelter continued to provide both the hands on and emotional support to the mothers who were successfully breastfeeding. Peer supports and feelings of inclusion and identification with other breastfeeding mothers at the shelter were also identified as major facilitators to continuing breastfeeding after hospital discharge. Having other young mothers as role models helped shape the perception that breastfeeding, once well established, was easier than formula feeding. The dedicated parenting room helped to facilitate these interactions between the breastfeeding mothers residing at the shelter by providing a safe and social environment to feed their infants and provide peer support to each other. Hearing ongoing positive messages about breastfeeding helped to reinforce the mother's motivation to continue breastfeeding.

“Everybody breastfeed, like, it just makes me feel like you should breastfeed too” (P3).
“Just telling me things like, you know, it's get better...just to hear that once or twice, to know it's going to get easier eventually” (P7).

Ongoing professional and family supports were identified as facilitators to breastfeeding duration once mothers moved out of the maternity shelter. These included home visits from public health nurses, access to community based parenting programs, and extended family support.

Barriers

Many of the barriers to breastfeeding mirror the facilitators. The majority of the barriers were in the form of services and supports that were perceived as lacking by individual mothers, rather than negative information about breastfeeding or strong promotion of infant formula. The mothers did report that there were some negatives they associated with breastfeeding prenatally,

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including; the predominant perceptions were that breastfeeding would be painful and difficult. Some of the mothers postulated that this perception was being reinforced by the staff at the maternity shelter and the public health nurses who followed the mothers in the prenatal period. Two of the mothers talked about the mandatory lessons on formula preparation at the maternity shelter. All of the residents must learn how to prepare and give formula, as well as have formula and bottles in their layettes before the birth of their baby. The lessons on formula preparation was felt by one of the mothers to reinforce the perception that breastfeeding would be hard, painful, and mothers must have a backup plan to formula feed their infants in place. Other mothers discussed feeling overwhelmed by all of the prenatal focus on breastfeeding by their public health nurses, with some mothers even resorting to ignoring information when it was being presented.

Some of the mothers reported a lack of early hands-on support in hospital, and wanting to learn to breastfeed but the nurses not taking the time to teach them. The professional supports who were perceived by the young mothers as authoritarian, harsh or judgemental in their approach to care and teaching were not seen as being helpful with breastfeeding support, and in one case outright rejected by the young mother. One mother reported a nurse did come to provide breastfeeding teaching but the mother felt the nurse was judgemental and hard on her, focusing on what she was doing wrong. This mother rejected the nurse as a care provider telling her to leave her room. The two mothers who had infants who had been admitted to the local children's hospital reported a lack of support for breastfeeding and providing expressed breast milk for their compromised infants. They both stated that there wasn't a lactation consultant on staff, and the nursing staff seemed to lack the knowledge to help them with feeding their infants or maintaining their milk supplies.

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The mothers who were exclusively formula feeding and mixed feeding by the time of the interviews reported feelings of disempowerment related to infant feeding choices. They reported that others, including physicians, social workers, foster parents, and in one case the infant, were making decisions related to infant feeding without consultation of the mother.

Lack of privacy was widely cited as a barrier to both breastfeeding and pumping of breast milk. Mothers in the study reported feeling uncomfortable breastfeeding in public spaces, stating they felt judged and stared at especially by older adults. Interestingly, one of the mothers who was formula feeding her infant reported feeling negatively viewed by others when bottle feeding in public. Several mothers did state that simply by being young mothers people would probably stare at them in public regardless of whether or not they were breastfeeding.

“...I find that a lot of people look at me differently because I am feeding him from a bottle and not from the breast...but I’m also thinking like the people are looking at me just because I am a young mother too” (P1).

The mothers in the study who had used breast pumps while residing at the maternity shelter reported feeling uncomfortable and isolated as they had to pump in a separate room from the other mothers. In addition, this room had a large window and the mothers felt others would stare at them as they walked by.

Some of the mothers talked about how they had to get over the idea of their breasts as sexual to breastfeed. They stated that many of their peers did not breastfeed due to the view of their breasts as sexual, or that they would lose their sex appeal as breastfeeding would make their body look older.

“You lose the sexiness, to the breasts, so some people they don’t like breastfeeding...I look so old when I stop breastfeeding” (P4).

“They [mothers who use formula] think their boobs are gonna drop” (P2).

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Several of the mothers perceived others looking at their breasts in a sexual manner, both at the maternity shelter and in public, thus making the mother feel uncomfortable breastfeeding except in safe, private locations.

“Some people pass by you and try looking at your boobs” (P3).

This study finds that young mothers find the choice to breastfeed empowering, respond best to nursing interventions that meet both their emotional and practical hands-on needs, value the benefits of breastfeeding, and feel a sense of connection and solidarity with their breastfeeding peers. The breastfeeding practices of the young mothers in this study were both negatively and positively affected by both social support and institutional/agency policies. The findings of this study support the need to provide supports simultaneously at multiple levels including peer supports, professional supports, and between agencies and health services. These findings add to the body of existing literature on the support needs of young mothers to meet their breastfeeding goals. These findings also provide a base to begin to tailor more effective nursing interventions to support breastfeeding in at-risk young mothers who use the maternity shelter system.

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Table 4

Facilitators and Barriers to Breastfeeding Practices for Young Mothers Who Live or Have Lived Within the Context of a Maternity Shelter in Ontario.

Facilitators to breastfeeding	Barriers to breastfeeding
Prenatal knowledge of benefits of breastfeeding	Prenatal perception of breastfeeding as hard, painful, must have 'back up plan'
Family norm was to breastfeed- previous positive exposure to breastfeeding	Mandatory prenatal knowledge of how to prepare and give formula and need to purchase formula before baby born at maternity shelter
Saw lactation consultant or knowledgeable nurse in hospital	Feeling of nurses judging mother, not interested in helping mother while in hospital
Perception of breastfeeding as easier	Lack of knowledge about how to breastfeed older baby
Peer supports and feeling of inclusion at with other breastfeeding mothers at the maternity shelter	Feeling isolated, not part of peer group at maternity shelter
Professional supports that were perceived as approachable, accessible, non-judgmental, easy to relate to, and genuinely interested in the mother	Feelings of disempowerment related to infant feeding choices
Professional supports included both hands on 'how to' of breastfeeding and emotional support	Lacked hands on breastfeeding supports in hospital, at shelter, and in NICUs
Ongoing, accessible supports at shelter and in community	Lack of privacy in public to breastfeed, and at shelter to pump. Sexualisation of breasts
Hearing ongoing positive messages about breastfeeding and reinforcing mothers abilities	Feeling judged as a young mother

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Chapter 5: Discussion

In previous studies, the young mothers predominately represented are mothers who were actively accessing services, held firm beliefs in the benefits of breastfeeding, held a normative view of breastfeeding, and had sufficient levels of self efficacy related to their ability to succeed at breastfeeding (Dennis et al., 2011; Goulet et al., 2003; Hall-Moran et al., 2006; Nelson & Sethi, 2005; Vaaler et al., 2010). None of the mothers in previous studies self identified as being homeless, or using the shelter system.

This research study provides unique knowledge in that it focuses on young mothers who either were residing or had resided with their infants in a maternity shelter in eastern Ontario. This group of young mothers was identified at increased risk of adverse outcomes related to instability in their social and economic circumstances, including dealing with issues of homelessness, addictions, and mental illness (Nolte & Allen, 2006).

The Canadian breastfeeding initiation rate in 2010 was 80-90% for mothers 15-24 years of age. As breastfeeding initiation was part of the inclusion criteria for this study, 100% of participants had initiated some breastfeeding. However, at the time of the interviews, with their infants ranging in age from 1 week to 5.5 months of age, five of the mothers were exclusively breastfeeding, two were mixed feeding (offering both breast milk and formula), and two were formula feeding. As there are no published breastfeeding initiation or duration rates for mothers who have resided at a maternity shelter, the researcher cannot draw conclusions as to whether the breastfeeding rates reported in this study are typical of mothers who have resided at a maternity shelter.

Anecdotally, the staff at the maternity shelter report that there tends to be alternating periods when either the majority of mothers are breastfeeding or the majority of mothers are

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formula feeding at any given time. The participants' rates of duration, exclusive breastfeeding (56%), and practicing any breastfeeding (76%) at 5 months postpartum are higher than those reported for the age group by Health Canada and the Public Health Agency of Canada (Chalmers & Royle, 2009; HC 2012b). Health Canada (2010) reports 14.3% of mothers ages 15-24 years exclusively breastfeeding at six months postpartum, and the Public Health Agency of Canada reports 40-55% of mothers ages 15-24 are practicing any breastfeeding by three months postpartum (Chalmers & Royle, 2009).

Using the social determinants of health framework (PHAC, 2011), the six key determinants of health identified corresponding to the broad themes were 1) health services, 2) personal health practices and coping skills, 3) social support networks, 4) culture, 5) social environments, and 6) healthy child development. The discussion points and the broad themes map onto these six key determinants (see Table 5).

None of the areas identified by the young mothers in this study occur in isolation of the others. It is important for the young mothers to have supports on multiple levels and on an ongoing basis including peer supports, trusting relationships with professionals, community links and resources, health education, and the fostering of a consistent breastfeeding friendly culture across the services used by young mothers including at the hospital, maternity shelter and community services.

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Table 5

Social Determinants of Health: Key Determinants and Corresponding Discussion Points and Broad Themes.

Key Determinant of Health	Discussion Point	Broad Theme
Health Services	Professional Supports	Learning to Breastfeed and the Importance of Early Supports Importance of Ongoing Supports
Personal Health Practice and Coping Skills	Empowerment of Choice	Choice
Social Support Networks	Peer Supports and Modelling of Positive Breastfeeding Practices	Part of the 'In Crowd' Ongoing Supports
Culture	Culture Breastfeeding in Public Agency Policies	Learning to Breastfeed and the Importance of Early Supports Importance of Ongoing Supports
Social Environment	Influence of Family and Community Culture towards Breastfeeding	Mothering the Mother Importance of Ongoing Supports
Healthy Child Development	Positive Aspects of Breastfeeding Health Benefits for Baby Maternal-Infant Bonding Maternal Mental Health	Healthy, Special, Cheap and Easy

Note. *The discussion points come from the literature review.

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Health Services: Professional Supports

Health services as a key determinant of health are integral to individual and population health. Appropriate and accessible primary health care services are crucial to both short term and long term positive health outcomes (Federal, Provincial, Territorial Advisory Committee on Population Health [FPTACPH], 1994; PHAC, 2011). Access to appropriate health services is especially important for members of vulnerable groups, such as the young mothers who access maternity shelters and their infants, due to the multifaceted risk factors for poor health outcomes including low income, low educational attainment levels, and lack of social supports. In this study professional supports were found to be an important factor to a young mothers' breastfeeding success, thus increasing the health status of herself and her infant.

Consistent with the literature, this study found that formal breastfeeding supports could have either a profound positive or negative effect on breastfeeding initiation and duration. Numerous North American studies have shown that professional supports that are perceived by young mothers as non-threatening, non-judgmental, caring, patient, trustworthy, and consistent were successful at building relationships with the mothers and having a positive impact on breastfeeding practices (Best Start, 2007; Brown et al., 2009; Dennis et al., 2011; HC, 2002, 2008; Mann et al., 1989; Nelson & Sethi, 2005; Peterson, Sword, Charles, & Dicenso, 2007; Simard et al., 2005; Smetana et al., 2006; Wambach et al., 2011). It was the relationships built by the professionals with the mothers in these studies that was critical to programs and services to be received and be effective to build maternal self esteem was (Brown et al., 2009; Peterson et al., 2007; Peterson, Davies, Rashotte, Salvador, & Trepanier, 2012; Simard et al., 2005). The young mothers in this study talked at length about their experiences with special healthcare providers who met the mothers' immediate needs for hands on breastfeeding teaching, and their

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emotional needs as new mothers. This study identified the critical nature of early positive hands on and emotional support by nurses and lactation consultants in hospital of the mothers who were successfully breastfeeding following the birth of their infants.

As found in the wider literature, when professional supports were perceived by the young mothers as judgemental, not interested in the mother, or overly authoritarian, such approaches to care were barriers to receiving breastfeeding support (Condon et al., 2012; Noble-Carr & Bell, 2012). When the mothers in this study perceived the professionals in this manner they did not accept help that was offered to them.

In previous studies young mothers did not actively seek out professional supports or self identify as needing help even when these mothers knew how and where to access these supports in the community (Nesbitt et al., 2012; Sipsma, Magriples et al., 2013). The young mothers in this study continued, even months after moving out of the maternity shelter, to access community supports and services in the form of ongoing home visits from public health nurses and accessing programs at the young parent outreach centre affiliated with the maternity shelter. It is important to note that these mothers were generally the ones who had reported overall positive interactions with formal supports such as nurses and staff at the shelter.

Two of the young mothers had infants who were admitted to a children's hospital that did not have lactation consultants, and these mothers expressed that they lacked support from the nursing staff surrounding providing expressed breast milk or how to breastfeed their infants when they were admitted to the NICUs. One of the mothers had an infant admitted to a children's hospital that did have a lactation consultant and found the service helpful. Mothers of infants admitted to NICUs report inadequate breastfeeding supports and negative attitudes from staff towards their efforts to provide breast milk for their compromised infants (Cricco-Lizza,

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2009; Siddell, Marinelli, Froman & Burke, 2003). Breastfeeding mothers of infants admitted to the NICUs are associated with lower breastfeeding duration rates, with a significant percentage switching to formula feeds by the time of their infants are discharged home (Nyqvist et al., 2012; Siddell et al., 2003). This lack of on-site breastfeeding support at the local NICU is significant as it is well established that breast milk is important to the long term health outcome of all infants, including preterm and compromised infants (AAP, 2012).

Personal Health Practices and Coping Skills: Empowerment of Choice

The key determinant of personal health practices and coping skills recognizes that in order to make and sustain healthy choices individuals must have the “knowledge, intention, and coping skills” (p. 22) to deal with challenges to practicing healthy behaviours (FPTACPH, 1994). In this study the healthy choice for the young mothers and their infants was to choose to breastfeed. The young mothers chose to breastfeed and developed the coping skills and supports necessary to maintain this healthy practice for themselves and their infants. Similar to the findings in Nesbitt et al.’s (2012) study, the young mothers in this study took ownership of the choices they had made in relation to feeding their infants while downplaying the influence of others. Some would state the choice was theirs alone, with no external influences, then talk at length about family members who had breastfed or being raised in communities where breastfeeding was the norm. Other mothers, when asked about who influenced their decision to breastfeed their infant would simply reply “me”, or “no one, just myself”. All of the mothers in this study referred to choices related to infant feeding; their choices, choices made by other mothers, and in three of the interviews, the loss of choice.

Three of the formula or mixed feeding infants in this study were either admitted in the early postpartum to NICUs or had health issues affecting feeding. All of these mothers talked

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about others making choices for them, without consulting them, and feeling disempowered by this. The literature review does not explore the effects of either maternal-infant separation, or compromised infant health on the ability of young mothers to make choices related to infant feeding, this is important as these mothers and infants are especially challenged to breastfeed and may require greater supports to maintain a breastfeeding relationship.

The choice to breastfeed empowered some of the mothers in this study, they knew the baby needed them, no one else could provide the breastfeeding relationship. For example, one mother stated that breastfeeding was a good way to limit the time her infant's father could spend with the baby, ensuring that she remained as the full time primary caregiver.

“He [the baby's father] actually wanted me to stop breastfeeding because he wanted, wants to take the baby, we're not together...and I just told him no, like, I'm not stopping, so you're just going to have to wait” (P5).

Social Support Networks: Peer Supports and Modelling of Positive Breastfeeding Practices

The social determinants of health framework postulates that social supports, whether they be from family, peer groups, or communities are an important component of health and having the ability to make and maintain healthy lifestyle choices (FPTACPH, 1994; PHAC, 2011). In this study, the young mothers identified peer supports, family support, and the support of professionals as important to their success and confidence to breastfeed.

The findings from this study support previous studies that have found the importance young mothers placed on peer support. The social determinants of health postulates that social supports, inclusion into social groups, and supportive environments are crucial to the making and sustaining of positive lifestyle choices (PHAC, 2011). As found in the literature (Brown et al., 2009; Mossman et al., 2008; Savio-Beers & Hollo, 2009; Vaaler et al., 2010; Wambach et al., 2011), peer support provided a form of group identity and positive role models. At the maternity

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shelter this peer support took the form of the social nature of the dedicated breastfeeding room where mothers were able to connect and learn from their breastfeeding peers. As in the 2009 study by Savio-Beers et al., the communal nature of the dedicated breastfeeding room and the group identity provided by it fulfilled mother's needs for ongoing social and practical support surrounding breastfeeding.

The mothers in this study who reported overall positive breastfeeding experiences had the benefit of both professional supports that tended to the mother's individual practical hands on breastfeeding needs and the mother's broader emotional needs. These mothers reported more positive experiences adjusting to new motherhood, had positive peer to peer experiences and continued to access ongoing professional, family, and peer supports once they had moved into the community.

Culture

The prevalent cultural values of either a social group or an institution can have an effect on health practices of individuals (PHAC, 2011). The young mothers in this study discussed how cultural ideas of sexuality related to breasts and breastfeeding when talking about breastfeeding in public and how some young mothers choose not to breastfeed due to sexualisation and body image concerns. The young mothers also talked about the institutional culture at the maternity shelter, and how practices at the shelter had the potential to undermine breastfeeding.

Breastfeeding in Public

The inability to breastfeed in public, while a primary reason to cease breastfeeding in the literature (HC, 2002; Smetana, et al., 2006), was not cited as a reason to stop breastfeeding, only as an obstacle that the mothers in this study had to overcome. The mothers in this study also

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talked about how they or other young mothers had to work past the view of their breasts as sexual objects in order to breastfeed. None of the mothers in this study cited this as a reason to stop breastfeeding but did recount stories of other young mothers who did not breastfeed for this reason.

Agency Policies

The Condon et al. (2012) study found that mothers who try breastfeeding, but are not committed to it, tend to fall back on formula if it is available and they lack early supports. This lack of commitment is consistent with observations of some of the young mothers in this study. These mothers talked about how practices at the maternity shelter make it too easy to use formula if challenges arise with the breastfeeding. They postulated that mothers at the maternity shelter gave up too easily on breastfeeding because they can; it was an accepted practice within the institutional culture of the shelter. They felt this is due to the prenatal practice of requiring teaching of formula preparation, and the requirement that all mothers purchase formula and bottles as a backup plan in case breastfeeding is not successful. This policy at the shelter is seen to be undermining the confidence of mothers to breastfeed in the prenatal period and is contrary to a culture of breastfeeding as the norm at the shelter.

Social Environments: Influence of Family and Community Culture towards Breastfeeding

Social environments are recognized as a key determinant of health. The social environments in which individuals are raised and exposed to (including family and cultural ideas and norms) influence lifestyle choices and add resources on which to draw when challenges arise (PHAC, 2011). The young mothers in this study talked about the influence of the family and cultural environments in which they were raised and how the practices surrounding breastfeeding informed their choices with feeding their infants.

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The literature identified the social environment that young mothers grew up in as being influential in their decision to breastfeed (Dykes et al., 2003; HC, 2002; Nesbitt et al., 2012; Vaaler et al., 2010). While the mothers in the Nesbitt et al. (2012) study reported their mothers and partners as being influential in deciding to breastfeed, the mothers in this study, by the very nature of being at the maternity shelter may lack those stable family support networks. Despite the breakdown in, or lack of family supports that may lead a pregnant or parenting youth to access a maternity shelter, several of the mothers in this study did discuss the influence of their own mothers and extended communities on their knowing they would also breastfeed their infants, but still insisted that the decision to breastfeed was their own. These mothers perceived breastfeeding as the normal way to feed an infant, and saw the positive relationship breastfeeding gave their own mothers with their younger siblings. The social and cultural environments that these mothers were exposed to provided a foundation for their decision to breastfeed.

None of the mothers in this study cited the fathers of their infants or their partners as being influential on their initial decision to breastfeed. Only one mother in the study stated her partner was helpful, her partner would allow her to rest and have energy to breastfeed. Furthermore, one mother in the study placed some of the blame on her partner for her loss of the breastfeeding relationship as the baby was perceived by the mother as choosing the partner over her as the favored parent.

Healthy Child Development: Positive Aspects of Breastfeeding

Healthy child development is recognized as central to long term population health (FPTACPH, 1994; PHAC, 2011). Healthy early development lays the foundation for health throughout the lifespan, and it is an important focus for primary healthcare initiatives (FPTACPH, 1994; PHAC, 2011). The mothers in this study overwhelmingly cited the health

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benefits provided by breastfeeding as their primary motivator to breastfeed. Maternal health and mental health benefits and increased bonding with their infants were also important health benefits described by these breastfeeding mothers and infants.

The young mothers' primary reason for initiating any breastfeeding was the health benefits to the infant. The mothers consistently described breastfeeding, once well established, as enjoyable and an activity they did with their baby. The mothers described breastfeeding as an activity that made them happy, although they did not identify this positive aspect of breastfeeding as a benefit to themselves, or their mental health. The majority of the mothers viewed breastfed infants as having a stronger bond with their mothers, and cited this bond as a motivating factor to continue breastfeeding or something they deeply regretted losing once they had stopped breastfeeding.

Health Benefits for Baby

The mothers in this study did believe in the health benefits of breastfeeding for their infants, with these health benefits being cited as the primary reason to breastfeed in this study and in the literature (Condon et al., 2012; Dennis et al., 2011; Goulet et al., 2003; Nelson et al., 2005; Nesbitt et al., 2012; Simard et al., 2005; Sipsma, Diveny et al., 2013; Vaaler et al., 2010; Wambach et al., 2009). A focus on teaching the positive benefits of breastfeeding for infants, as opposed to a focus on the negative impacts of formula feeding, in the prenatal period and reinforcing these positive messages of breastfeeding being the healthiest option for infants to toddlerhood and beyond may help to motivate young mothers to continue breastfeeding. This positive focus may encourage young mothers to seek out ongoing supports to deal with new challenges that can arise with breastfeeding older infants.

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Maternal-Infant Bonding

Several recent studies (Condon et al., 2012; Nesbitt et al, 2012; Sipmsa, Diveny et al., 2013) cite bonding and attachment with their infant as a primary motivator for young mothers to initiate breastfeeding. Early and positive maternal-infant bonding and attachment are recognized as being important to infant mental health and subsequent child development (AAP, 2012; Sullivan, Perry, Sloan, Klienhaus & Burtchen, 2011). The mothers in this study valued the unique bond between mother and baby that they associated with breastfeeding. This relationship was viewed as different and as stronger than with that of a formula fed baby, and was cited as an important reason to continue to breastfeed an older infant. The mothers of the formula fed infants in this study expressed profound regret at losing that special relationship with their infants when they ceased breastfeeding. Condon et al. (2012) found the same phenomena amongst young mothers in the United Kingdom, where young mothers regretted stopping breastfeeding due to the perceived loss of the unique bond with their infants that came with the breastfeeding relationship.

Benefits of Breastfeeding to Maternal Mental Health

Positive maternal mental health is important to infant and child cognitive and behavioural development (Grace, Evindar, & Stewart, 2003). Compromised maternal mental health has the potential to negatively affect maternal-infant bonding and attachment, and increase adverse long term developmental outcomes in children (Glasheen, Richardson, & Fabio, 2010). A recent Canadian study noted young mothers did not identify maternal benefits as a motivator to breastfeed (Nesbitt et.al, 2012). The young mothers in this study did talk indirectly about maternal benefits of breastfeeding to their mental health and maternal enjoyment of breastfeeding as a motivating factor to continue the breastfeeding relationship with their infant.

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While only one mother expressly discussed the health benefits for her, as well as her infant as a reason to breastfeed, the majority of the breastfeeding mothers described breastfeeding in terms of personal enjoyment. They liked breastfeeding and they felt good when they breastfed their infants. These mothers had an overall more positive view of their experiences with infant feeding and supports. They described their infant feeding practices in terms of empowered decision making and related more positive portrayals of themselves as mothers during the interviews.

The young mothers in this study focused predominately on the practical and emotional aspects of breastfeeding as related to their own and their infants' unique needs and circumstances, rather than reasons for formula feeding or the challenges with breastfeeding in public. The discussions centered on how their needs had either been met or not met in the moment, how they felt in the moment, and their views of themselves as mothers through the lens of whether they were breastfeeding or not. These young mothers took ownership of their choices when they were meeting their goals, and felt profound disempowerment and loss of attachment to their infants when they were not. They highly valued both professional practical hands on support and emotional support related to breastfeeding and their needs as new mothers. In addition, the mothers found comfort, social networking and identity within their peer group of young breastfeeding mothers.

Strengths and Limitations

Strengths

This study adds valuable insight into the needs of a specific population of young mothers. This study adds the voices of young mothers who live or have lived in the context of a maternity shelter in a Canadian city to the literature of the facilitators and barriers to their breastfeeding

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practices. By adding these voices and experiences, this study provides a basis on which to begin to examine current nursing practices both in hospital and the wider community to better serve these mothers and their infants. The study sample included a mix of both older adolescents and young adults, representing a broad range of ages served by the maternity shelter at any given time. Saturation was achieved; as evidenced by the consistency of themes that emerged throughout all nine interviews, despite using two different versions of the interview guide. The broad themes and insights into the effects of positive therapeutic nurse patient interactions on early breastfeeding initiation and accessible, ongoing peer and community health care supports in breastfeeding duration gleaned from this study are consistent with what is found in the wider literature on breastfeeding and young mothers outside of the context of a maternity shelter, contributing to the transferability of the findings in order to inform nursing practice to support young mothers with breastfeeding their infants in other hospital and community settings with similar demographics.

Limitations

The study does have some notable limitations, mainly the use of convenience sampling and the small sample size with nine participants in total. The sample size was limited due to the small number of potential participants at any given time who are living or have lived at the maternity shelter within the past 6 months. The shelter can only provide accommodation for up to 15 expectant and new mothers and 5 infants under the age of 3 months at any one time (St. Mary's, 2014). Of those potential participants, not all will have initiated any breastfeeding, and not all would have resided at the shelter postpartum, thus not all would have met the study inclusion criteria. The total number of potential participants was further constrained by time limitations of a Master's level research study. Therefore convenience sampling was used as

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these were the mothers who were either living at the shelter during the recruitment period or had lived there with their infants in the past 6 months with their infants and could be contacted by the shelter staff. The study was conducted at a time when most mothers residing at the maternity shelter had initiated breastfeeding. It is possible if the sample had been taken at a different period in time many of the mothers might have been formula feeding, and focused on different aspects of their experiences with healthcare providers and the shelter staff as being important to their experiences feeding their infants.

Similar to the limitations of previous studies, the young mothers who participated in this study were mothers who were motivated to volunteer for a study, were still accessing services from either the maternity shelter or the affiliated young parents outreach centre. These young mothers had primarily positive or beneficial experiences with the services, or would not continue to access them. The study participants only included those who self identified as breastfeeding for any amount of time. The voices of the mothers who chose not to initiate any breastfeeding are not represented in this study.

The researcher attempted to mitigate the effects of the above limitations by including mothers who had initiated breastfeeding even once in the inclusion criteria, thus allowing for mothers whose primary experiences with infant feeding had been with formula feeding. Recruitment was expanded to include actively recruiting from the affiliated young parent outreach centre to increase the potential pool of participants with older infants (3 to 5.5 months of age) in order to include representation from mothers with experience feeding older infants once they had moved out of the maternity shelter. This allowed for the inclusion of their experiences with ongoing supports in the wider community context, and to include their

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experiences, or lack thereof, with the continuity of care and services as their needs changed over time.

Implications for Practice, Policy, and Research

Implications for Nursing Practice

The young mothers in this study strongly identified the need for early, positive interactions with nursing staff in hospital in the hours and days directly following the birth of their infants. This early postpartum time is a pivotal period for the opportunities it presents for hospital nursing staff to positively influence breastfeeding initiation and to foster maternal confidence in healthcare providers and services through positive in-hospital experiences and therapeutic relationships. The mothers in this study talked at length about nurses and lactation consultants who approached their care with an essential mixture of practical hands on and empathetic emotional support that extended beyond their breastfeeding needs.

In McIntyre's (2002) WHO report "Adolescent friendly health services: An agenda for change" key characteristics of youth friendly health services included health care providers who "have interpersonal and communication skills...non-judgemental and considerate, easy to relate to and trustworthy...devote adequate time to clients or patients...and provide information and education materials" (p. 27). Recent Canadian studies have found that there is a need to improve the quality of nursing care young mothers receive in hospital in the early postpartum period (Peterson et al., 2007; Peterson et al., 2012). Young mothers respond well to care that is delivered in a friendly, respectful, patient, and personal manner; they need to feel that the nurse is genuinely interested in their well-being (Peterson et al., 2007). Peterson et al. (2012) found that nurses who are "skilled in establishing relationships and placing mothers "at ease" in their presence..." (p. 365) were able to provide effective care that was accepted by the mothers.

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Similar to the findings from the Peterson et al. (2007, 2012) studies, the current study found that nursing care that was perceived as judgemental or rushed was rejected by the mothers, eliminating any opportunities to establish a therapeutic nurse-patient relationship allowing for the provision of care and teaching. This study reinforces the findings of previous studies, that to meet the needs of the most vulnerable young mothers and their infants related to early breastfeeding initiation, hospital nursing staff and lactation consultants need further training in the care of young mothers. The early establishment of positive nurse-patient interactions to facilitate the teaching of early hands on breastfeeding supports while increasing the confidence of the mother is essential. This study adds to the findings of earlier studies as the findings suggest breastfeeding outcomes are related to the quality of the therapeutic relationship young mothers experience with nurses while in hospital in the early postpartum period.

This study identified the need for specialized lactation supports in NICUs, as three of the participants who were either mixed feeding or formula feeding reported a lack of breastfeeding support at the local children's hospital. This issue raises questions related to the effects of the lack of lactation consultant services at children's hospitals on the breastfeeding duration rates of young mothers whose infants are admitted for treatment. However, due to the small number of mothers involved in this study further research is required to determine if their experiences in the NICU are a common phenomenon.

In the context of this study, the need for skilled and empathetic supports extends beyond the hospital into the maternity shelter and later into community supports. In keeping with the WHO's 2002 recommendations, services must continue into the community context (McIntyre, 2002). Accessible and positive breastfeeding and emotional supports must extend from the hospital to the maternity shelter, and to the broader community once the mothers move to their

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own residences. These supports and services are especially important for breastfeeding support and duration as the mothers' and infants' needs change as the context changes and the infant matures. The links the young mothers have at the shelter to public health nurses from the prenatal period onwards and the services at the young parent outreach centre are excellent examples of this continuation of services.

In keeping with the breastfeeding literature, specific youth friendly services (Best Start, 2007; Brown et al., 2009; Dennis et al., 2011; Nelson & Sethi, 2005; Simard et al., 2005; Smetana et al., 2006; Wambach et al., 2011) and the importance of peer to peer supports identified by the mothers in this study, there is a need for the establishment of peer to peer breastfeeding supports within the maternity shelter and in the wider community for young mothers. These supports would help to normalize breastfeeding within the culture of the maternity shelter and the young parent outreach centre, allowing young mothers to see breastfeeding peers as role models in the prenatal and postpartum periods, and to provide a peer group for the mothers to identify with as they are building their own identities as new mothers.

Implications for Policy

The institutional environments and culture related to breastfeeding was found to have an impact on the breastfeeding practice of young mothers in this study. There is a need for the hospitals, shelter, and affiliated young parent outreach centre to provide consistent and seamless breastfeeding services and supports to this group of at-risk young mothers. A common framework and philosophy of breastfeeding support would facilitate the transitions between services for the young mothers, and allow the shelter, outreach centre, and hospital to provide services that compliment and build on the others.

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The adoption of the WHO's Baby Friendly Initiative (BFI) by the hospitals, the maternity shelter, and the affiliated young parents outreach centre would provide a common framework and philosophy for the institutions in regards to breastfeeding support (BCC, 2012; UNICEF, 2011; WHO, 2009). Adopting the BFI principles into practice would also ensure consistency in messaging from staff and a consistent minimal level of competence in providing practical hands-on breastfeeding help (BCC, 2012; UNICEF, 2011; WHO, 2009). The BFI initiative grew out of the WHO/ UNICEF's Baby Friendly Hospital Initiative in the 1990's: the goal was to ensure the uniform implementation of best practices to increase maternal and infant health outcomes worldwide in hospital maternity wards (BCC, 2012; UNICEF, 2011; WHO, 2009). The WHO targeted increasing breastfeeding rates as key factor in increasing positive maternal and infant health outcomes and increasing food security for low income families (WHO, 2009). As part of the 2012 provincial initiative entitled "Ontario's Healthy Kids Strategy" the government of Ontario is providing support with training and resources to hospitals and community health agencies to achieve WHO BFI designation (Government of Ontario, 2014). The goal is to increase breastfeeding rates in Ontario by increasing the number of hospitals and community health centres that provide breastfeeding support and services utilizing clinical best practices (Government of Ontario, 2014; Provincial Council for Maternal and Child Health, 2014).

Both the ten steps for the Baby Friendly Hospital Initiative and the seven steps for the Baby Friendly Community Initiative include training of all staff involved with mothers and infants to support informed decision making about infant feeding, supporting mothers to initiate and maintain breastfeeding as well as supporting mothers who choose not to, in an equal and non-judgemental manner, and providing a welcoming atmosphere for breastfeeding families (BCC, 2012). Adopting the principles and recommendations of the BFI into everyday practice

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would also provide a common ground and framework to promote cooperation between the shelter, hospitals, local breastfeeding supports and the broader community resources to provide breastfeeding supports and services for the young mothers prenatally, postpartum at the shelter and in the broader community once they had obtained housing for themselves and their infants (BCC, 2012; UNICEF, 2011; WHO, 2009). Using the BFI as best practice would provide legitimacy to the staff in the view of the residents and quality assurance as the hospitals and shelter would have to adhere to regional policies and practice guidelines as well as inspections for the hospitals (BCC, 2012; UNICEF, 2011; WHO, 2009). Practices, such as the mandatory inclusion of formula in the layettes of the mothers would be revisited, and discontinued if deemed to be counter to the promotion of breastfeeding as the norm for infant feeding.

The shelter and young parent outreach centre have the capacity to provide a culture of breastfeeding support and facilitate peer supports for the breastfeeding mothers who access the maternity shelter, while they reside at the shelter, and once they have moved into the community. As young mothers benefit from feeling part of a peer group and having strong and consistent social support networks, it is recommended that the peer support begin prenatally, and continue through the outreach centre once the mother and her infant have moved into the community.

Having a lactation consultant on staff at the maternity shelter and young parent outreach centre would be an invaluable asset to provide consistent breastfeeding support. To provide seamless care through prenatal to postpartum, it is recommended that the lactation consultant act as liaison and advocate for the mothers when in hospital. Working with the hospital nurses and lactation consultants to care manage would allow the unique needs of the young mothers to be better met, and facilitate early breastfeeding support.

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It is recommended that the local hospitals establish liaisons with the shelter, and the shelter provide in-services for the front line hospital staff on this unique at-risk population. It is also recommended that all residents of the maternity shelter have a consultation with the lactation consultant while in hospital and a plan of care regarding breastfeeding be sent to the shelter with the mother on hospital discharge, including where to seek supports and pre-arranged contacts for breastfeeding support in the community.

Implications for Nursing Research

This study has identified several knowledge gaps related to supports and programs to help young mothers living within the context of a maternity shelter reach their breastfeeding goals. This study lacks the voices of the young mothers who choose not to initiate breastfeeding while living within the context of a maternity shelter. This group would be valuable to study to compare the nursing support needs of breastfeeding and non-breastfeeding mothers in relation to the design and implementation of infant nutrition programs at the shelter and in the community.

The mothers who had stopped breastfeeding in this study expressed grief and regret over the loss of breastfeeding. These mothers expressed a desire to regain the perceived lost bond with their infants. This study identifies a need for nurses to explore whether (and how) mothers regain this perceived lost bond with non-breastfed babies, in order to provide support and guidance to non-breastfeeding mothers. Maternal-infant bonding has been shown in the literature to have major implications for maternal mental health and infant mental health, and infant growth and development (AAP, 2012; Figueiredo, Costa, Pacheco & Pais, 2009; Johnson, 2013; Sullivan et al., 2011). This is an important area of research especially with at-risk young mothers for whom the risk factors of compromised maternal-infant bonding and negative

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maternal and infant outcomes is higher than the general population (Figueiredo et al., 2009; Johnson, 2013; Nolte & Allen, 2006).

Further research is needed into the effects of modelling positive breastfeeding experiences from peers and the availability of peer to peer supports on the decision making process of young mothers related to breastfeeding initiation and duration. While the mothers in this study discussed their choices around feeding their infants as highly autonomous, the mothers also talked at length about identifying and drawing inspiration from other breastfeeding mothers. The effects of modelling and peer-to-peer supports require further exploration at various stages (including prenatally to increase positive modelling of breastfeeding and provide positive peer role models, postpartum groups (e.g. 0-6 months) and ongoing (6 months and beyond). This identification with breastfeeding peers is necessary for designing and implementing accessible and appropriate breastfeeding peer supports in contexts such as maternity shelters and in the broader community.

Conclusion

This study adds the voices of some of the most marginalized young mothers in our society, those who access the maternity shelter system, to the cannon of research on young mothers and breastfeeding. Those voices were found to be absent from the existing literature on young mothers and breastfeeding practices. This knowledge is valuable as working to help young mothers achieve success with breastfeeding, and in turn increase breastfeeding duration rates, is a tangible intervention that nurses can provide to help mitigate some of the negative long term health outcomes for at-risk young mothers and their infants by increasing self efficacy, confidence, group belonging and providing successes from which to build future successes.

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The young mothers in this study found breastfeeding to be empowering and found value for both themselves and their infants in their breastfeeding practices. The main findings focus on the institutional and social environments that these young mothers experience in terms of practical and emotional supports. As inpatients on the postpartum units these young mothers identified the critical role positive therapeutic relationships with the nurses played in their early breastfeeding successes. At the maternity shelter the young mothers discussed both positive and negative influences of institutional policies on their breastfeeding practices and those of their peers at the shelter. The mothers talked about the importance of social supports in the form of an identifiable peer group of other young breastfeeding mothers, and the ongoing supports from family. Ongoing institutional supports in the form of public health and community resources were also important to breastfeeding duration. For these young mothers breastfeeding is an empowering, positive choice they had made for their infants, and disempowering when that choice was perceived as being taken away by institutional practices, unsupportive professionals and individual life circumstances.

Further research is needed into the factors influencing the infant feeding practices of young mothers who choose not to initiate any breastfeeding. This study identified a need for further research into how nurses can support young mothers who do not achieve their breastfeeding goals, in terms of positive maternal mental health and maternal-infant bonding. Lastly, further research is also needed into the effects of positive modelling of breastfeeding behaviours by peers and the effects of positive peer supports.

This study is a first step towards gaining the necessary knowledge about factors that influence the breastfeeding choices and practices of adolescent mothers living within the

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maternity shelter system. In due course, the goal is to create appropriate and accessible nursing and community supports to aid these mothers in reaching their breastfeeding goals.

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Appendix A: Search Strategy

Databases:

CINAHL (Limited to 2002-2012-10 yr search, English, research papers)	Breastfeeding*, Adolescent*	OR
	AND	
	Support*, Education*, Attitudes*, Identity*, Experiences*	OR
MEDLINE/PUBMED (Limited to 2002-2012-10 yr search, English, research papers)	Breastfeeding (MeSH), Adolescent (MeSH)	OR
	AND	
	Support tx, Education tx, Attitudes tx, Maternal Identity tx, Experiences tx	OR
COCHRANE (Limited to 2002-2012-10 yr search, English, research papers)	Breastfeeding, Adolescent	OR
	AND	
	Support, Attitudes, Experiences	OR
GOOGLE SCHOLAR (Limited to 2002-2012, Peer Reviewed Articles)	Breastfeeding, Adolescent	OR

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	AND	
	Support, Education, Attitudes, Maternal Identity, Experiences	OR
tx=text MeSH=mapped subject heading *denotes explode		

Keywords and Results

PUBMED: Breastfeeding and Adolescents (3212 results)

Breastfeeding and Adolescents and Experiences (86 results, 13 included, 73 excluded)

Breastfeeding and Adolescents and Identity (10 results, 0 included, 10 excluded)

Breastfeeding and Adolescents and Support (1528 results- added and attitudes 266 results, 12 included, 255 excluded)

Breastfeeding and, Homelessness, and Adolescents (0 results)

CINAHL: Breastfeeding and Adolescents (7 results, 3 incl., 4 excluded- all duplicates to PUBMED)

Breastfeeding and Adolescents and Experiences (0 results)

Breastfeeding and Adolescents and Identity (0 results)

Breastfeeding and, Adolescents and, Support and, Attitudes (5 results, 4 included, 1 excluded- all duplicates to PUBMED)

Cochrane: Breastfeeding and adolescents (26 results, 0 included, 26 excluded)

Breastfeeding and Adolescents and Experiences (4 results, 0 included, 4 excluded)

Breastfeeding and Adolescents and Support (17 results, 0 included, 17 excluded)

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***Inclusion criteria:** Qualitative or quantitative studies, and systemic reviews. Age range of participants/subjects: 13-24yrs of age. Key words/concepts including: breastfeeding, adolescents, supports, education, experiences, initiation and duration, attitudes, and barriers. Peer reviewed and published in the ten year period of 2002-2012 inclusive.

Internet search (using Google search engine):

-Statistics Canada: adolescent pregnancy, pregnancy, breastfeeding (initiation and duration), birth rates (by maternal age, parity, education level, and income).

-Government of Ontario: birth rates (by maternal age, education, and income level), breastfeeding (initiation and duration).

-Champlain Local Integrated Health Network (LIHN): birth rates (by maternal age, education and income level), breastfeeding (initiation and duration).

-Ottawa Public Health: teen pregnancy, street youth, and breastfeeding

-Eastern Ontario maternity shelter system: St. Mary's Home/Center (Ottawa)

-Teens and breastfeeding ('Be a star' website)

Manual Search: References and Bibliographies of found articles (limited to 2002-2012).

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Appendix B: Summary Tables of Individual Primary and Secondary Sources**Summary of Qualitative and Quantitative Studies**

Author (year) & Country	Aim/Primary Concept Studied/ Term Used for Research Use	Methods	Setting/Sample	Key Findings	Notes on Quality
Nelson, A., and Sethi, S. (2005) Canada	Grounded theory study. To discover the phenomenon of breastfeeding as experienced by teenage mothers.	Interviews and demographic questionnaire.	Mostly home visits. First time breastfeeding mothers between the ages of 15-19 years.	Emergent key concept: Continuously committing to breastfeeding, within the four categories: deciding to, learning to, adjusting to and ending breastfeeding	Strengths: Purposive sampling, clear explanation of grounded theory, rigour and saturation satisfied. Potential for transferability of findings. Limitations: Only studied mothers who successfully breastfed.
MacGregor, E., and Hughes, M. (2010) United Kingdom	Literature review. To provide an understanding of mothers justifications for not or stopping breastfeeding (both adolescent mothers and those from low income households).	Literature review using Critical Appraisal Skills Program (CASP).	N/A. Appraised nine qualitative studies.	Six themes: Benefits, barriers, feeding in public, myths, support and influence and experiences of breastfeeding.	Strengths: Clear, easily reproducible search strategies. Limitations: Limited number of studies coded (n=9).

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Moran, V., Edwards, J., Dykes, F., and Downe, S. (2006) United Kingdom	Systematic review. Review of the nature of support for breastfeeding adolescent mothers.	Systematic review using a priori search strategy.	N/A. n=7	Five types of supports identified: emotional, esteem, instrumental, informational and network.	Limited number of studies reviewed.
Nelson, A (2009) United States	To investigate the attitudes, beliefs and concerns of pregnant and postpartum adolescents regarding breastfeeding. Naturalistic/ Constructivist Study.	Focus groups (X2).	Young parents outreach center. Pregnant (n=8) and postpartum (n=8) adolescents <19years of age (n=16).	Key beliefs that breastfeeding best for baby, often in passive voice, to breastfeed is the mothers' choice-ok to sacrifice for baby. Belief that breastfeeding is "difficult".	Strengths: Clear methods section, triangulation done, clear definitions of key concepts, clear link to clinical practice. Limitations: limited sample (African- American/Hispanic sample), limited transferability of findings, did not explore cultural implications of findings.
Wambach,K., and Cohen, S. (2009) United States	To examine the breastfeeding experiences of urban adolescent mothers. Emergent Descriptive Study.	Focus groups (X3) and semi- structured interviews (X17).	Home visits. Breastfeeding (or breastfed within six months) mothers ages 13-18 years (n=23).	Most mothers choosing to breastfeed for health of infant, and bonding. Barriers were pain, return to school, lack of confidence and embarrassment breastfeeding in	Strengths: Clear concepts, saturation achieved. Emergent design. Limitations: Homogeneous sample, low focus group attendance.

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Wambach,K., and Cohen, S. (2009) United States	To examine the breastfeeding experiences of urban adolescent mothers. Emergent Descriptive Study.	Focus groups (X3) and semi- structured interviews (X17).	Home visits. Breastfeeding (or breastfed within six months) mothers ages 13-18 years (n=23).	Majority of mothers choose to breastfeed for health of infant, closeness and bonding. Major barriers were pain, return to school, lack of confidence and embarrassment breastfeeding in public.	Strengths: Clear concepts, saturation achieved. Emergent design. Limitations: Homogeneous sample, low focus group attendance.
Dykes, F., Moran, V., Burt, S. And Edwards, J. (2003) United Kingdom	To explore and support the needs of breastfeeding adolescent mothers. Exploratory multi-method study.	Focus groups, vignettes, and semi-structured interviews.	Interviews via telephone, setting unknown for focus groups. Adolescent mothers who were or had breastfed between ages of 13-19 years. Focus groups (n=7), interviews (n=13).	Five themes: feeling watched/ judged, lacking confidence, tiredness, discomfort, and sharing accountability.	Strengths: Strong link to clinical practice, focus groups and interviews for richness of data. Limitations: convenience sample, small number of participants in focus groups, no triangulation.
Spear, H. (2006) United States	To examine the breastfeeding experiences and related behaviours of	Telephone survey.	Non-profit hospital birthing unit. Postpartum mothers between 13-19 years of	22% of sample breastfed to 6 months, education limited, desire	Strengths: Clear research aim, objectives and concepts. Limitations: Not

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	adolescent mothers after hospital discharge. Cross-sectional descriptive study.		age breastfeeding at hospital discharge (n=53).	for increased support, primary reasons for weaning included pain, return to school and challenges related to pumping.	specified how often or at what point postpartum the surveys were done, self selection of participants, majority older adolescent and high school graduates, potential self report and social desirability bias.
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Author (year) & Country	Study Design/ Objective	Methods	Setting/ Sample	Intervention Duration/Frequency	Findings	Notes on Quality
Dennis, C., Heaman, M., Mossman, M. (2011) Canada	Methodological study: Assess reliability and validity of BSES-SF antenatally in adolescent population	Orally administered questionnaires X3 @ antenatal visit (BSES-SF and Breastfeeding Attitudes, and demographic data).	Convenience sample 15-19 year olds- >34 weeks gestation (n=100). Two prenatal clinics in tertiary care hospitals in Manitoba.	Interventions X3: Prenatal (visit), 1 wk postpartum (telephone), and 4 weeks postpartum (telephone).	Antenatal BSES_SF score significantly predicted breastfeeding initiation. Antenatal and postpartum scores significantly predicted duration and exclusivity at 4 weeks postpartum	Strengths: use of validated tools (X2), use of adult control group, well defined variables. Limitations: convenience sample, homogenous sample, only included adolescent mothers who presented at the prenatal clinic.
Mossman, M., Dennis, C., Heaman, M., and Morris, M. (2008) Canada	Prospective correlational study: To examine the influence of adolescent mothers	Orally administered questionnaires X3 (BAQ, BSES-SF and demographic data).	Convenience sample 15-19 year olds- >34 weeks gestation (n=103). Prenatal	Intervention X2: Prenatal and 4 weeks postpartum (Telephone.)	Significant positive correlation between prenatal scores breastfeeding initiation and	Strengths: use of validated tools, large heterogeneous sample (good transferability of findings).

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	breastfeeding confidence and attitudes on breastfeeding initiation and duration up to 28 days postpartum		clinics in tertiary care hospitals in Manitoba		duration rates.	Limitations: Only followed to 4 weeks postpartum, convenience sample of teen motivated to use clinic, correlational study therefore weak ability to infer relationships
Karp, S., and Lutenbacher, M. (2010) United States	Descriptive cross sectional study: to explore associations of maternal psychosocial factors with beliefs and practices related to infant feeds of young (15-22 years) first time mothers.	Interviews including orally administered questionnaires X5 (CES-D, RS-E, duke-UNC Functional Social Support Questionnaire, Nevenson and Schiafino Social Support Measure and a nine item Infant Feeding questionnaire).	Mothers (15-22 years old) of 6-12 month old infants (n=67) recruited from a pediatric and a WIC clinic. Private space in clinics before or after well baby or WIC appointments	1X	Significant correlations found between symptoms of maternal depression and impaired infant feeding styles.	Strengths: validated scales used (X4), very clear definitions of variables. Limitations: convenience sample, predominance of subjects over 18 years of age.
Alexander, A.,	Prospective cross-sectional	Orally administered	Convenience sample of	1X	Support of the father of the	Strengths: Use of control group,

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O'Riordan, M., and Furman, L. (2010) United States	survey: to compare the rate of intent to breastfeed and differences between self assessed knowledge related to breastfeeding between pregnant low income inner city teens and non teens.	Questionnaire	pregnant teens <19 years (n=46) and non teens >20 years (N=130) recruited from metropolitan hospital outpatient clinic. Administered in exam room at prenatal appointment.		baby, primiparity, good self assessed knowledge about breastfeeding's benefits all positively correlated with intention to breastfeed.	consistency due to single researcher administering all questionnaires, wide age range of sample. Limitations: Potential social desirability bias, mean age of youth sample 22 years of age-limited transferability of findings.
Tucker, C., Wilson, E., and Samandari, G. (2011), United States	Mixed Methods- Descriptive analysis and qualitative analysis to investigate breastfeeding practices, barriers and facilitators among young adolescent mothers.	Data collected from six years of North Carolina Pregnancy Risk Assessment Monitoring Systems (PRAMS) and semi-structured interviews	Mothers 13-17 years of age. Quantitative (n=393). Qualitative (n=22). Interviews conducted at home visits.	N/A	52% initiated breastfeeding, half stopped by 1 month. Common barriers included school, pain and decreased milk supply. 88% of Hispanic mothers breastfed at hospital	Strengths: Looked at cultural differences, heterogeneous sample, mixed methods design Limitations: Saturation of qualitative data not noted, convenience sample-qualitative, missed

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					discharge.	marginalized teens.
Brown, A., Raynor, P., and Lee, M. (2009), United Kingdom	Retrospective questionnaire to investigate the factors associated with breastfeeding duration in younger mothers	Retrospective self report questionnaire	Mothers 17-24 years of age (=138) with infants between the ages of 6-24 months. No information on setting.	1X interview	Attending a breastfeeding support group, believing breastfeeding was easy, being encouraged by others in being in an environment where breastfeeding was normative were all positively correlated with breastfeeding 6 months and beyond	Strengths: Control group, good link to clinical practice, strong discussion section. Limitations: No notes on research setting. Mean age 22 years, retrospective design, possible social desirability bias.
Wambach, K., Aaronson, L., Breedlove, G., Domain, E., Rojjanasrirat, W., and Yeh, H. (2011) United States	Randomized control trial to determine if education and counselling by lactation consultants and peer counsellors increase breastfeeding	Prospective non blinded three group RCT.	Prenatal ages 15-18 years in second trimester (n=309), postpartum (n=201). Prenatal clinics (7), public and private	Interventions X11. Prenatal classes (X2), one-one support (X4), telephone call (X5)	Interventions positively influenced (p<.001) breastfeeding duration but not initiation or exclusivity.	Strengths: Well designed study, multiple interventions, 2 control groups (including 1 attention control group), peer/professional interventions. Limitations:

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	initiation and duration rates in adolescent mothers.		teaching hospitals (3), high schools (4) in metropolitan area			Predominately African-American, self reports/potential social desirability bias.
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BREASTFEEDING PRACTICES OF YOUNG MOTHERS

Appendix C: Ethics Approval

File Number: H06-13-13

Date (mm/dd/yyyy): 07/10/2013



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
Rosann	Edwards	Health Sciences / Nursing	Student Researcher

File Number: H06-13-13

Type of Project: Master's Thesis

Title: What Factors Influence the Breastfeeding Practices of Young Mothers Who Live or Have Lived in a Maternity Shelter?

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
07/10/2013	07/09/2014	Ia

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

Special Conditions / Comments:
N/A

BREASTFEEDING PRACTICES OF YOUNG MOTHERS

File Number: H06-13-13

Date (mm/dd/yyyy): 07/10/2013



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.research.uottawa.ca/ethics/forms.html>.

Please submit an annual status report to the Protocol Officer four 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.research.uottawa.ca/ethics/forms.html>.

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5387 or by e-mail at: ethics@uOttawa.ca.

Signature:

Kim Thompson

Protocol Officer for Ethics in Research
For Daniel Lagarec, Chair of the Health Sciences and Sciences REB

BREASTFEEDING PRACTICES OF YOUNG MOTHERS

St Mary's Home Letter of Support

**ST. MARY'S HOME • MAISON SAINTE-MARIE**

780 ,rue de L'Église Street • Ottawa, Ontario K1K 3K7

Tel: (613) 749-2491 Fax: (613) 569-6582

www.stmaryshome.com

May 9, 2013

Office of Research Ethics and Integrity
 Tabaret Hall
 550 Cumberland St., Room 159
 Ottawa ON K1N 6N5

Dear Members of the Research Ethics Committee,

The purpose of this letter is to indicate our strong support of the proposed study set forth by Master's of Science in Nursing student Rosann Edwards. We have met with Rosann to discuss the proposed study *"What Factors Influence the Breastfeeding Practices of Young Mothers Who Live or Have Lived in a Maternity Shelter?"* This proposed study fits well with the mandate of St. Mary's Home to provide a specialized shelter setting for this at-risk population of young mothers and their infants while providing a supportive environment in which young mothers may make informed decisions regarding feeding their infants.

St. Mary's Home / Maison Sainte-Marie is committed to providing comprehensive services, programs and advocacy for pregnant and parenting youth and their children. Serving Ottawa since 1933, St. Mary's is the only Residential program in Eastern Ontario for at-risk pregnant and parenting young women (age 12 to 24) and their newborn infants. Thanks to development of a dynamic, youth friendly Young Parent Outreach Centre, St. Mary's Home / Maison Sainte-Marie offers 'one-stop' services and programs especially designed to mitigate the risk factors historically associated with teen pregnancy. These are offered in collaboration with many service partners.

St. Mary's Home is very interested in using the study results to guide the design and implementation of breastfeeding promotion and supports for the mothers at the Home and is supportive of recruitment for the study from among the clients of St Mary's Home. Please feel free to contact me (see below) should you have any questions.

Sincerely yours,

[Redacted Signature]
 Nancy B. MacNider
 Executive Director

Phone: [Redacted]

Email: [Redacted]

"Building on the Strengths of Pregnant and Parenting Youth and their Children"

Appendix D: Recruitment Poster



How Can Nurses Help Breastfeeding Moms?

Are you a mom 24 years old or younger?

Do you have a baby who is 5 months old or younger?

Are you living at or have you ever lived at [REDACTED]?

Did you ever breastfeed your baby?



What has it been like to feed your baby?

My name is Rosann and I am a graduate nursing student at the University of Ottawa. I would like to interview moms about their experiences with feeding their babies.

This research study will be in English only

For more information or to join the study, please contact:

Rosann Edwards at [REDACTED] (call or text) or email



BREASTFEEDING PRACTICES OF YOUNG MOTHERS

Appendix E: Verbal Recruitment Script

Hello my name is Rosann and I am a Master's of Science in Nursing student at the University of Ottawa. I'm here today to invite you to participate in a research project I am completing for my program. I'm conducting a study looking at the breastfeeding practices of moms who live at or have lived at St. Mary's Home.

I'm looking for moms who would like to talk to me about what helped them breastfeed their babies and what made it difficult or why they stopped.

I'm hoping to use your experiences to help create better nursing programs and supports for future moms at St. Mary's to help them reach their breastfeeding goals.

If you have a baby five months of age or under, and have breastfed even one time, I would love to talk to you about what made it easier and what made it harder. This project is independent from St Mary's Home and whether or not you decide to participate will not have any impact on the services you receive here at St Mary's or your relationship to St. Mary's in any way. I'll give everyone who is interested a handout with information on the study and my contact information. If you would like to participate, I will be interviewing participants on a first come, first served basis.

Does anyone have any questions?

[Time for question and answer]

I will be here for about half an hour, please feel free to talk to me if you would like more information or would like to participate in the study.

Thank you for your time.

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Appendix F: Consent Form



uOttawa

Université d'Ottawa
 Faculté des sciences de la santé
 École des sciences infirmières
 University of Ottawa
 Faculty of Health Sciences
 School of Nursing

Consent Form

**Barriers and Facilitators Influencing Breastfeeding
 Practices of Young Mothers Who Live or Have Lived in a
 Maternity Shelter.**

Researchers: Rosann Edwards, RN, BScN,
 Masters 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 invited to participate in the above mentioned research study conducted by Rosann Edwards, supervised by Wendy Peterson because I am a mother 24 years old or under, I have an infant five months of age or under, breastfeed my infant at least one time, and I live at or have lived at St. Mary's Home with my infant.

Eligibility:

To take part in this study I must be:

- 1) 24 years of age or under; AND
- 2) Living at or have lived at St. Mary's Home with my infant; AND
- 3) Have an infant who is 5 months of age or under; AND
- 4) Have breastfeed at least one time

Purpose of the Study:

To learn about the factors influencing breastfeeding practices of mothers who live or have lived in a maternity shelter.

Participation:

My participation will consist of one or two in-person interviews (about four weeks apart) with Rosann Edwards.
 Each interview will last about one hour.

☎ 613-562-5473
 📠 613-562-5443

451 Smyth Road (3051)
 Ottawa ON K1H 8M5 Canada
www.uOttawa.ca

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During the interview I will be asked questions about how I choose to feed my baby, and my experiences with support, or influences (positive and negative), around my experience with breastfeeding while living at St. Mary's Home. The interviews will be recorded and transcribed by Rosann Edwards.

The pre-interview has been scheduled for _____ (*place, date and time*).

The interview has been scheduled for _____ (*place, date and time*).

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 uncomfortable or bring up sensitive topics. If I require further support, I may contact my case worker at St. Mary's Home. 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 be used to help nurses create better supports for young mothers and their babies, and provide future young mothers and their babies with better programs and nursing care.

Confidentiality and anonymity:

I have received assurance from Rosann Edwards that the information I share will remain strictly confidential. I understand that my confidentiality will be protected by the removal of all identifiers including my name and my baby's name. All transcripts will be assigned a random code. The researchers will not use any identifiers in reports, publications, presentations, or in discussion of the findings with St. Mary's Home. It is possible that staff at St. Mary's Home will know that I am participating in this study. However, my decision to participate or not in this study will not affect my access to services at St. Mary's Home.

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.

Conservation of data:

The data collected via digital recording be kept in a secure manner by downloading to a secure, password protected laptop that is transported in a locked bag. All recording will be assigned a random identifying code and all identifying information will be removed. The digital recorders' memory will be erased following the downloading of the data. The original materials will be kept for a period of five years, locked securely in the office of the Wendy Peterson at the University of Ottawa (RGN 1118F).

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Compensation:

At the beginning of the interview, I will receive a \$20 gift card to Loblaws/Great Canadian Superstore in appreciation for my participation in this study. I will receive the gift card for overall participation (regardless of if I participate in one or two interviews). I will receive the gift card even if I chose to withdraw from the study, at any point, for any reason.

Voluntary Participation:

I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, I may request that all data gathered until the time of withdrawal will be destroyed. I understand that this project is independent from St Mary's Home and whether or not I choose to participate will not have any impact on the services I receive at or from St Mary's Home now or in the future.

Acceptance: I, _____ (*Name of participant*), agree to participate in the above research study conducted by Rosann Edwards, of the School of Nursing, in the Faculty of Health Sciences at the University of Ottawa, under the supervision of Dr. Wendy Peterson.

I agree to be audio recorded during the interview:

- ☐ Yes
- ☐ No

If I have any questions about the study, I may contact Rosann Edwards [REDACTED] or Wendy Peterson [REDACTED].

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5
Tel.: (613) 562-5387
Email: ethics@uottawa.ca

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

Participant's signature:

Date:

Researcher's signature:

Date:

BREASTFEEDING PRACTICES OF YOUNG MOTHERS

Appendix G: Initial Interview Guide-Used for First Four Interviews

Topic	Interview Question	Prompt
General Information	How are you feeding your baby?	-Tell me more about why you have decided to feed your baby this way..... -When...
Health beliefs related to infant feeding	Do you think it makes a difference how you feed your baby?	-Do you think breastfeeding or bottle feeding is better and why....
Facilitators to breastfeeding	What makes it easier for you to continue breastfeeding your baby?	-Is there anyone who helps you, encourages you... -How do you feel when you feed your baby...
Facilitators: Support Network	Who do/did you go to for information and support with feeding your baby? Should the supports offered to young mothers be different from those offered to older mothers?	-Who do you trust to give you help when it comes to feeding your baby and why... -Whose opinion do you trust and why... -Is there anyone's help or advice you don't want and why...
Barriers to breastfeeding	What makes it hard for you to continue breastfeeding your baby? Or What made you stop breastfeeding your baby?	-Who doesn't help- but you wish would.... -What makes you feel like quitting... -What do you not like when you breastfeed your baby

BREASTFEEDING PRACTICES OF YOUNG MOTHERS

Feelings of being judged by adults and healthcare professionals as an adolescent mother	How do/did you feel when others see/saw you feeding your baby?	-Where do you think people judge young mothers... -Who do you feel criticized by, why do you think they do that... -By friends, staff, professionals, others...
Peer group, partner and maternal grandmother as influences to infant feeding decision making	Is there anyone whose opinion on how you feed your baby really matters to you?	-Who would you like to approve of you as a mother... -Tell me more about why this person's opinion of what you do is important to you...
Peer influence, teen culture	When you see a young mom breastfeeding what do you think of her? When you see a young mom bottle feeding what do you think of her?	Why do you think you feel that way... Does seeing other young moms feeding their babies make you think about the kind of mom you want to be...

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Appendix H: Follow-up Interview Guide

Topic	Interview Question	Prompts
General Information	How are you feeding your baby now? Have you changed how you've been feeding your baby at all?	-Tell me more about why you have chosen to feed your baby this way..... -Tell more about why you stopped breastfeeding/started breastfeeding /started pumping/introduced formula....
Health beliefs related to infant feeding	Do you think it makes a difference how you feed your baby? Do you feel you are doing what is best for you and your baby?	Do you think breastfeeding or bottle feeding is better and why... Is one healthier than the other... Who do you trust for advice on which is better/healthier...
Facilitators to breastfeeding	What makes it easier for you when you feed your baby?	-Is there anyone who helps you, encourages you... -How do you feel when you feed your baby...

BREASTFEEDING PRACTICES OF YOUNG MOTHERS

Facilitators: Support Network	Who do you go to for information and support with feeding your baby?	-Who do you trust to give you help when it comes to feeding your baby and why... -Whose opinion do you trust and why... -Is there anyone's help or advice you don't want and why...
Barriers to breastfeeding	What makes it hard for you to breastfeed your baby? Or What made you stop breastfeeding your baby?	-Who doesn't help-but you wish would.... -What makes you feel like quitting... -What do you not like when you breastfeed your baby
Feelings of being judged by adults and healthcare professionals as an adolescent mother	Do you ever feel that people are judging you when feed your baby?	-Where do you feel people judge you... -Who do you feel criticized by, why do you think they do that... -Do you feel people respect your decision to feed your baby the way you've chosen to...

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Peer group, partner and maternal grandmother as influences to infant feeding decision making	Do you feel you had a choice on how you are feeding your baby?	-Was it your decision or did you feel pressure from others and who... -Do you feel supported by the important people in your life with how you feed your baby...
Peer influence, teen culture	When you see a young mom breastfeeding what do you think of her? When you see a young mom bottle feeding what do you think of her?	Why do you think you feel that way... Does seeing other young moms feeding their babies make you think about the kind of mom you are...

BREASTFEEDING PRACTICES OF YOUNG MOTHERS

Appendix I: Revised Interview Guide**Prenatal**

1. Tell me about your pregnancy- what was it like?

-How far along were you when you found out you were pregnant?

-Did you see someone for prenatal care?

-Probes: Family doctor, midwife, obstetrician, nurse, nurse practitioner, PHN...

-Did you take any prenatal classes/groups?

-Probes: Buns in the oven, pregnancy circles, baby basics; did you sign up for any baby clubs?

2. During your pregnancy, did you get any information on how to feed your baby?

-Who gave you advice about how to feed your baby?

Probes: Health care providers, which ones, friends, family...

-Who gave you ideas about where to find information?

-Where did you get information?

Probes: Internet, websites, social media, pamphlets...

-Which information was most helpful and why?

-Which information was least helpful and why?

3. During your pregnancy did you ever get any free stuff for feeding your baby?

-Probes: Free formula samples, baby shower gifts (bottles, breastfeeding pillow, pump...) and from whom?

4. When did you start thinking about how you were going to feed your baby? What were you thinking at the time?

5. When did you make a decision about how you were going to feed your baby? What were you thinking at the time?

6. Did you talk to anyone about feeding your baby before he/she was born, who was helpful, what was helpful?

-Did any of your friends or family talk to you, give you advice on feeding your baby?

-Did you know anyone who breastfed their babies or was breastfeeding?

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Hospital (day 1-3)

1. Tell me about your labour?

-Probes: Length of time, support person, natural/induction/ SVD, C/S, pain medication...

2. Tell me about what happened right after your baby was born?

Probes: Skin to skin, breastfeeding, SCN...

3. What was your experience in the hospital like?

4. How did your baby do in the hospital, how did the feeds go?

5. Was your baby given any supplements in the hospital?

-If yes, who first brought it up, who made that decision, were you comfortable with this, how old was your baby at the time?

-Did you use anything to help you feed your baby (pump, nipple shields, etc.), and who suggested these and helped you?

6. Did you have a favorite nurse or nurses, what did she do that made her your favorite?

-What was the best way anyone helped you with feeding your baby in the hospital?

7. Who was your least favorite nurse; tell me about her, what happened?

Hospital Discharge to Six Weeks

1. Tell me about feeding your baby when you got home?

-What was it like feeding your baby before your six week checkup?

-Who helped out when you got home?

2. Who helped the most with feeding your baby, what did they do that really helped you?

-Did you talk to the staff, a nurse, your doctor, friends about feeding your baby?

-If yes, who and what was the most and least useful?

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3. Was your baby given any supplements and who suggested you supplement?

- If yes, tell me about it....
- Did you pump, if so, who helped you, who provided the pump, were you comfortable with it?
- Did you give formula, if so, who suggested it, provided it, how did it go?
- Did you use anything to help you feed your baby (pump, nipple shields, etc.), and who suggested these and helped you?

4. Where did you usually feed your baby, tell me about that...

- Would you feed your baby with other people around, in public?

5. What advice would you give to other moms for feeding their babies in the first six weeks?

Six Weeks to Six Months

1. Tell me about feeding your baby after your six week checkup?

- What was it like, did anything change?

2. Who helped out when your baby was older?

- Who helped the most with feeding your baby at this time, what did they do that really helped you?

3. Was your baby given any supplements?

- If yes, tell me about it....
- Did you pump, if so, who helped you, who provided the pump, were you comfortable with it?
- Did you give formula, if so, who suggested it, provided it, how did it go?

4. Did where you would feed your baby change, tell me about that...

5. What has been the best thing about feeding your baby since he/she was six weeks old?

- What has helped the most?

6. Tell me about the hardest part about feeding your baby?

BREASTFEEDING PRACTICES OF YOUNG MOTHERS

Ending

1. If breastfeeding,

-How long would you like to continue breastfeeding?

- What is important about continuing?

2. What advice would you give to other to help with feeding their babies, what was the most helpful thing for you

3. Is there anything we've missed that you would like to add?

4. Do you have any questions for me?

BREASTFEEDING PRACTICES OF YOUNG MOTHERS

Appendix J: Demographic Data Questionnaire

Study ID:

Question	Answer
Age	
Relationship Status	☐ Single ☐ Dating ☐ Living Together ☐ Other (describe):
Education Completed	☐ Grade 8 (or less) ☐ Some High School ☐ High School ☐ Some College ☐ College Diploma ☐ Some University ☐ University Degree
Are you currently a student?	☐ Yes ☐ No If Yes, what level and part or full time?
How long have you/did you live at St. Mary's Home and in what year?	
Age of baby at time of interview	
Age of baby when living at St Mary's Home	
Are you exclusively breastfeeding, formula feeding or mixed feeding your baby?	☐ Breastfeed ☐ Formula feed ☐ Both (mixed feed)
If breastfeeding, how long do you plan to breastfeed you baby?	

Contact information for second interview:

BREASTFEEDING PRACTICES OF YOUNG MOTHERS

Appendix K: Feasibility and Timeline

The study was conducted following the timeline below. This timeline was developed in keeping with feasibility for a eighteen month research design of the a masters' level study with a two hundred dollar budget.

Timeline

	Jan– May 2013	Jun- Aug 2013	Sept-Oct 2013	Nov-Dec 2013	Jan-Feb 2014	Mar- Apr 2014
Proposal development and review						
Research Ethics Board review						
Recruitment of participants						
Data collection						
Data analysis						
Writing of thesis report						
Submission of thesis						

*The proposed timeline was in keeping with the time restraints of a one and a half year period to complete a Master's level research project and thesis as a part time graduate student.