

Running Header: EXPLORING THE HEALTH EDUCATIONAL EXPERIENCES OF
PREGNANT YOUTH

**Maternity and Meaning-Making: A Qualitative Study Exploring the Health Educational
Experiences of Pregnant and Parenting Youth**

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Abstract

Regardless of maternal age, the transition to motherhood is acknowledged as one of the most challenging in the life cycle. This transition poses even greater challenges for young mothers that are experiencing housing instability. Grounded in the words and stories of women, the aim of this study was to elicit, explore, and interpret the experiences of a group of pregnant and parenting youth living in a residential maternity shelter and accessing community-based services. More concretely, this study explored how a group of pregnant and parenting young women came to construct their health related knowledge and views, and how these perceptions fit with their expectations and experiences. Guided by a constructivist lens and informed by a multiple instrumental case study approach, this study addressed two overarching research questions: 1) how do pregnant and parenting youth come to understand maternal health? and 2) how do the meanings they construct relate to their lived experiences and contexts?

A combination of convenience and snowball sampling strategies were used to recruit 11 women, aged 17-20 and living in a temporary maternity shelter in Eastern Ontario, to participate in a series of in depth interviews. From these interviews, four central themes were recognized: 1) the influence of the living environment on learning and health, 2) the perinatal period as a time of reflection and re-envisioning, 3) pregnancy as a catalyst for change, and 4) learning resources and resourcefulness. This qualitative case study revealed that learning and meaning-making in the perinatal period are complex, contextually situated, and fundamentally influenced by environment, experience, culture, and activity.

Pregnancy influenced how participants felt about themselves, their bodies, their relationships, and the choices they were presented with. The young pregnant women in this study used varied resources to shape and inform their health-related knowledge and views. While young pregnant women may be subject to similar influences and expectations in pregnancy as the

general pregnant population, their health educational experiences differed due to a combination of their learning needs and preferences, the intensity and frequency of stigmatization they faced, the multifaceted transitions they were negotiating, as well as their relative lack of resources. Thus, the findings of this study illustrate the importance of understanding the experiences of young pregnant women in order to support their health and educational experiences.

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Chapter One – Introduction

This chapter begins with a definition of key terms, followed by a description of the research problem and the relevance of this research study. Next, the contexts of the study are explored and the positioning of the researcher is discussed, as the positioning of the research also adds contextual understanding to the study. Finally, this chapter concludes by outlining the organization of the ensuing five chapters.

Description of Problem

Pregnancy rates among Canadian youth have declined over the last decade, with significant variation noted across provinces and territories. Trends indicate that the combined birth and abortion rates for youth in Canada dropped from 44.0 per 1,000 women aged 15-19 in 1990 to 28.2 per 1,000 women aged 15-19 in 2010, a decline of 37.2% (McKay, 2012). However, during the period 2006 to 2010, the national teen pregnancy rate increased by 1.1% and in four provinces (New Brunswick, Newfoundland, Nova Scotia, Manitoba) the rate increased by 15.1% or more (McKay, 2012). In Ontario, the pregnancy rate for women aged 15-19 is 25.7 per 1,000 women aged 15-19 (Ministry of Health and Long-term Care, 2009). The decline in Canadian adolescent pregnancy rates likely reflects the number of public health initiatives aimed at prevention, and the availability of emergency contraceptive measures. That said, those that do experience pregnancy in adolescence are disproportionately more likely to have come from socioeconomically disadvantaged backgrounds (Bissell, 2000; Haveman, Wolfe, & Wilson, 1997; Rabeeah, et al., 2017), and to have reported experiencing of child abuse, maltreatment or neglect (Garwood, Gerassi, Jonson-Reid, Plax, & Drake, 2015). Challenges often faced by young pregnant women include lower social support (Hanna, 2001; Statistics Canada, 2008), poverty (National Council of Welfare as cited in Best Start Resource Centre, 2003), violence (Covington, Justason, & Wright, 2001), lower educational attainment and poor academic achievement

(Fessler, 2003), stigmatization (Berman, Silver, & Wilson, 2007; Ekstrand, Larsson, Von Essen, & Tyden, 2005; Hanna, 2001), and precarious housing (Fowler, Toro, & Miles, 2009). Further, homelessness and housing instability preceding or occurring in pregnancy compounds vulnerability; women and their children are at greater risk for negative outcomes when pregnancy occurs at a time when they are less prepared economically, physically, and emotionally to provide care for an infant (Thompson, Bender, Lewis, & Watkins, 2007). Given the unique circumstances faced by pregnant and parenting youth (PPY), their perinatal health and educational experiences and needs may differ from those of the general pregnant population.

Regardless of maternal age, the transition to parenthood is acknowledged as one of the most challenging in the developmental life cycle (Delmore-Ko, Pancer, Hunsberger, & Pratt, 2000; Nystrom & Ohrling, 2004). This poses even greater challenges for adolescents as they undergo the abrupt transition from being mothered to mothering. Once pregnant and parenting, youth must simultaneously develop as adolescents, manage maternal-child health and educational needs, and negotiate parental roles. Some research suggests that adolescent development may conflict with early motherhood (Daley, Sadler, & Reynolds, 2013; Flanagan, McGrath, Meyer, & Garcia, 1995; Sadler and Cowlin, 2003). For instance, parenting adolescents take on the role of being mothers rather than focusing on other adolescent developmental tasks such as independence and individuation. Further, motherhood is a full-time role that tends to minimize peer socialization, and may render some youth dependent on others for income support and child care (Sadler & Cowlin, 2003).

Some pregnant youth delay accessing prenatal services, comprising prenatal health care and education, which increases their risk of developing health complications during pregnancy (Hueston, Geesey, & Diaz, 2008; Sarri & Phillips, 2004). Adapting to pregnancy moves beyond the biological and is influenced by a process of meaning-making and identity renegotiation that is

informed by values, beliefs, and past life experiences (Anderson, Elfert, & Lai, 1989; Cashdollar, 2017; Prinds, Hvidt, Mogensen, & Buus, 2014). As such, the exploration of personal experiences, understandings, and meanings become important in research and practice. That said, the literature is replete with research that focuses narrowly on the biomedical risks and social outcomes of young motherhood rather than the exploration of understandings and meanings, coping and adaptation, or learning experiences.

Education may be of particular importance during the transition to parenthood, as supportive conditions that influence how PPY make informed health decisions, access services, and come to understand their experiences are paramount. Thus, exploring the experiences of a group of PPY regarding their access to services, engagement in prenatal health and education, and construction of health-related knowledge and views will address an important gap in the literature. The findings from this study will offer insight into ways of actively engaging PPY to help them build links between prenatal health education and their day-to-day lives.

Definition of Terms

Definitions of some of the key terms used in this study will be presented in this section: youth, health education, meaning-making, homelessness, perinatal period, prenatal health education, prenatal care, prenatal services, determinants of health, and social determinants of health. Some of these terms will be revisited and expanded on in the literature review.

Youth: There are a variety of definitions of the term youth available in the literature, which poses a challenge when different age criteria are used. The variance in definitions may reflect the notion that life stages can be conceptualized as biological, psychological or by social standards at select ages, such as the legal and policy norms defined in a context. For the purpose of this study, United Nations' universal definition will be used, which defines youth as

individuals aged 15 to 24 years (United Nations Educational, Scientific and Cultural Organization, 2017).

Health education: Health education encompasses a combination of formal and informal learning experiences intended to help individuals and communities improve their health by increasing their knowledge or influencing their attitudes (World Health Organization [WHO], 2014). Health education is an active process that is concerned with the communication of information, as well as with fostering the motivation, skills and confidence necessary to take action to make informed decisions (Nutbeam, 1998).

Meaning-making. Meaning-making is the process of understandings individuals form to make sense of and interpret experiences, events, objects, relationships, and contexts in light of their previous experiences and knowledge (Zittoun & Brinkmass, 2012). It has been defined as the “mental representation of possible relationships among things, events, and relationships. Thus, meaning connects things” (Baumeister, 1991, p. 15; Park, 2010). Other definitions of meaning-making focus more on issues of self-understanding, acknowledging that meaning-making involves the processes with which: “individuals seek to make meaning of their lives, both how they understand themselves as unique individuals and as social beings who are multiply defined by life stage, gender, ethnicity, class, and culture” (Singer, 2004, p. 438). Meaning-making becoming particularly important at times when individuals confront stressful life experiences, and recent research has focused on the restoration of meaning in the context of highly stressful situation (Park, 2010).

Perinatal period. The perinatal period commences at 22 completed weeks (154 days) of gestation and ends approximately one month after birth (WHO, 2014).

Prenatal services. Comprise both the prenatal education and prenatal health care that aim to help women prepare for pregnancy and childbirth.

Prenatal health education. Most narrowly, prenatal health education is viewed as a formal educational activity that consists of a series of classes, either online or in person, provided for groups of pregnant women and their partners or support people (Nichols & Zwelling, 1997; Palermo, 2000). A more holistic conceptualization of prenatal education encompasses all formal or informal interventions and interactions that prepare women for pregnancy, birth, and motherhood (Loos & Morton, 1996). Sources of prenatal education could include, for example, established prenatal classes, informal discussions, instructions and information from health care providers, advice or support from social networks, media messaging, role modeling by peers and family members, and self-directed learning activities.

Prenatal care. The regular health care recommended for women during pregnancy (Grady & Bloom, 2004). Prenatal care is a type of preventative care that is offered throughout the course of pregnancy, and allows health professionals to monitor for potential health problems (Fiscella, 1995).

Determinants of Health: Determinants of health are the “range of behavioural, biological, socio-economic and environmental factors that influence the health status of individuals or populations” (WHO, 1998, p.6). Health Canada defines the determinants of health more broadly as the factors interacting to influence health (Health Canada, 2013). The Public Health Agency of Canada (2011) notes that the 12 key determinants health are: income and social status, social support networks, education and literacy, employment and working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender, and culture.

Social determinants of health. The social determinants influence the health of individuals and populations. They comprise the circumstances, contexts and conditions that people are born into, live in, work in, and age in. These influences are shaped by the distribution

of resources, funds, and power at global, national and local levels, and the social determinants of health are primarily responsible for health inequities observed within and between countries (WHO, 2018). There are a variety of models of the social determinants of health, including one developed in Toronto that has provided insight into the health of Canadians (Raphael, 2009). The 14 social determinants of health included in the Canadian model are: Aboriginal status, disability, early life, education, employment and working conditions, food insecurity, health services, gender, housing, income and income distribution, race, social exclusions, social safety net, and unemployment and job security (Mikkonen & Raphael, 2010; Raphael, 2009). According to Mikkonen & Raphael (2010), these social determinants have a strong influence on the health of Canadians, and “their effects are actually much stronger than the ones associated with behaviours such as diet, physical activity, and even tobacco and excessive alcohol use” (p. 9).

Homelessness. Homelessness is conceptualized in a number of ways. Most directly, homelessness is defined by the Canadian Homelessness Research Network (CHRN) as the “situation of an individual or family without stable, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it” (CHRN, 2012, p. 1). Many definitions of homelessness differentiate between various housing circumstances. For instance, a definition proposed by the United Nations distinguishes between what they term as absolute homelessness and relative homelessness. Absolute homelessness describes the circumstances of individuals without physical shelter, and relative homelessness describes the circumstances of those with physical shelter but lacking in the standards of basic health and safety (Huang, 2001). The CHRN proposes a more detailed typology of housing circumstances that ranges from unsheltered (including those living on the streets), emergency sheltered (including those staying temporarily in emergency shelters), provisionally accommodated (including those in transitional housing arrangements such as couch-surfing or institutional contexts without permanent housing

arrangements), and at risk of homelessness (including those not currently experiencing homelessness but experiencing precarious financial or housing situations).

Youth homelessness. Youth homelessness has been conceptualized as individuals below age 25 that are “living in extreme poverty, and whose lives are characterized by the inadequacy of housing, income, health care supports and importantly, social supports that we typically deem necessary for the successful transition from childhood to adulthood” (Gaetz S, 2009, p.13; Kulik, Gaetz, Crowe, Ford-Jone, 2011). For the purpose of this study, I will use this broad and holistic definition of homelessness; however, I will highlight cases of absolute homelessness by referring to these youth as street-involved.

Context of the Study

To understand the experience of PPY, it is important to consider the broader context of pregnancy in young women. This background section will describe: 1) the context of prenatal health care during pregnancy, 2) the context of prenatal education, and 3) the context of risk and outcomes associated with young motherhood.

Context of prenatal health care. In North America the context of prenatal health care is situated largely within a biomedical model of health (Downe, 2008; Parry, 2008). The model rose to prominence in western countries during the 18th and 19th centuries, and since this time there has been a trend towards the medicalization and prescription of issues pertaining to sexuality and fertility (Cherrington & Breheny, 2005; Lawlor & Shaw, 2002). Medicalization is defined as a “process by which non-medical problems become defined and treated as medical problems, usually in terms of illnesses or disorders” (Conrad, 2000, p. 324). While pregnancy is not a state of illness, it is treated conceptually as a medical condition by the health care system (Litt, 2000), and medicalization exerts a powerful influence on both social norms and women's perceptions of

pregnancy and childbirth (Neiterman, 2013). For example, in North America there is a continued institutional expectation that women access prenatal care and give birth in hospitals.

Select options are available to women in terms of health care providers during pregnancy, ranging obstetricians, family doctors, Registered Midwives, and Nurse Practitioners, though availability and access vary widely. Midwives are integrated into the health care system and some provinces include midwifery care as part of publicly funded health care. In Ontario, the regulatory body for midwives determines the eligibility criteria for a home birth, as well as the conditions that necessitate the consultation with, or transfer of care to, a physician (Hutton, Reitsma, & Kaufman, 2009). In Canada, there has been a steady increase of babies born under the care of midwives, and the involvement of general practitioners or family physicians in the provision of prenatal care and delivery of babies has decreased (ICES, 2006). That said, provincial-level data supports that obstetricians remain the most accessed care providers during deliveries; 84.7% of births in Ontario in 2011 and 2012 were attended by obstetricians, followed by family doctors (8.6%), and midwives (5.2%) (BORN, 2012).

Prenatal health care for expectant women with no identifiable risks involves a recommended prenatal visit every four weeks until 30 weeks of gestation, every two weeks from 32 to 36 weeks of gestation, and weekly from 37 weeks of gestation until birth (Society of Obstetricians and Gynaecologists of Canada, 2014). Additional prenatal care is recommended for women that are underweight or overweight, carrying more than one baby, suspected of abuse or with the potential for abuse, managing depression or other mental health concerns, and using alcohol, cigarettes, drugs, or other substances (Trotman, Chhatre, Darolia, Tefera, Damle, & Gomez, 2015). Enhanced prenatal care is also advised for women with a history of preterm labour or previous pregnancy concerns, diabetes, high blood pressure, a family history of genetic

conditions, and previous uterine surgery such as a caesarean section (BCPHP, 2010). In isolation, pregnancy in youth is not an indication for additional prenatal care.

The Better Outcomes Registry Network (BORN), Ontario's pregnancy, birth and childhood registry and network, is a Prescribed Registry under Ontario's Personal Health Information Protection Act (PHIPA, 2004). According to BORN data (2011-2012), 86% of women that delivered babies in Ontario hospitals attended a prenatal visit with a health care professional in their first trimester (BORN, 2015). On average, pregnant women in Ontario attended seven to eleven prenatal appointments throughout their pregnancy (Guttman, Schultz, & Jaakkimainen, 2006). Prenatal care received by PPY was explored in a retrospective cohort study of 3,886,364 nulliparous pregnant youth, with a live singleton birth during 1995 and 2000 in the United States (Chen, Wen, Fleming, Demissie, Rhoads, & Walker, 2007). In this study, prenatal care was categorized as adequate, intermediate or inadequate according to the criteria of the Modified Kessner Index, and data revealed that prenatal care was largely categorized as adequate (62.12%) as compared to Intermediate (29.31%) or inadequate (8.57%) in PPY aged 10 to 19 years old. This suggests that while most youth do access prenatal care during their first or second trimesters of pregnancy, there may be a more vulnerable group that delays access. Factors associated with youth initiating and completing care include increased age at time of pregnancy, longer intervals between pregnancies, presence of partner and social support, and participation in a specialized adolescent pregnancy program (Cox et al., 2008).

Context of prenatal education. A variety of prenatal education programs are available in Ontario (Godin et al., 2014), including programs offered by public health units, hospitals, community health centres, non-profit organizations, and private businesses. There is a degree of variability in terms of cost, as some programs are free to access, while others involve a registration fee (Tough, Siever, & Johnston, 2007). Access and availability to programs also vary,

with expectant parents in larger cities having greater choice of programs. Participating in prenatal education is strongly recommended but entirely optional. Prenatal education is designed to provide women with the knowledge and skills with the aim of improving pregnancy and birth outcomes. Programs are offered both in-person and online, and delivered in a multitude of formats: traditional prenatal education classes (designed and advertised for the general public), group prenatal education courses offered through health care provider practices, registered and non-registered groups (such as drop-in groups at a Parent Resource Centre, youth programs, the Canada Prenatal Nutrition Program), one-on-one prenatal education through population-wide programs (for example, Healthy Babies Healthy Children), general universal prenatal information provided by a health care provider (but not individual medical information or care), brochures, handouts and resources, and online courses, apps, websites.

Many benefits have been associated with prenatal education including: improved maternal mental health (National Institute for Health and Care Excellence, 2015), increased mental preparation for childbirth among pregnant women (Koehn, 2008), decreased use of epidural anesthesia during childbirth (Ferguson, Davis & Brown, 2013), an increased likelihood of arriving at the hospital in active labour (Ferguson, Davis and Brown, 2013), higher rates of breastfeeding initiation and continuation (Schrader-McMillan, Barlow & Redshaw, 2009), and greater satisfaction with the couple and parent-infant relationships after birth (National Institute for Health and Care Excellence, 2015). While the benefits of prenatal education are well documented, there are a number of known barriers to accessing traditional prenatal education including: a lack of time (Tighe, 2010), a lack of transportation (Fabian, 2008; Tighe, 2010), distance from where the class is being offered (Fabian, 2008; Simpson, Newman & Chirino, 2010), the cost of prenatal education (Simpson, Newman & Chirino, 2010), a lack of space in the classes (Nova Scotia Health Promotion and Protection, 2008), transitioning to a new country

during pregnancy (Boerleider et al., 2013), and language barriers (Boerleider et al., 2013). These logistic barriers may be even greater for pregnant youth who are experiencing housing instability.

Participation in prenatal education classes is low for pregnant women in Ontario. It is estimated that approximately 1 in 4 women (23.5%) delivering babies in Ontario hospitals participated in prenatal education classes during their pregnancy (BORN, 2017). According to the BORN Information System's educational data for 2015-2016, trends were observed in relation to individual and neighbourhood demographics such as parity, maternal age, socioeconomic status, language, place of birth, and ethnicity. In terms of parity, the majority of participants in prenatal education in Ontario were first-time mothers (42.9%), followed by women with one previous birth (10.2%) and 2 previous births (7.4%). Trends were also noted regarding socioeconomic status; when data were analyzed across the province of Ontario, higher rates of participation were observed among women living in neighbourhoods with the highest income quartile (28.6%), neighbourhoods with the highest educational level quartile (30.0%); neighbourhoods with the lowest quartile for unemployment (24.3%); neighbourhoods with the lowest proportion of visible minorities (21.9%), and neighbourhoods with the lowest concentration of immigrants (22.2%). This local data aligns with the greater body of literature that supports that select groups of women are less likely to access prenatal education, including single mothers (Fabian, 2008), visible minorities (Lu et al., 2003), mothers without a high school diploma (Lu et al., 2003), mothers who have lower incomes (Fabian, 2008; Lu et al., 2003), and those who are unemployed (Fabian, 2008).

While there is clear support for the benefits of prenatal education, the ideal format and delivery method remain unclear. The literature confirms that there are a number of effective approaches to prenatal education, including: traditional group prenatal education – group classes offered on a regular basis (Maimburg, Væth, Durr, Hvidman & Olsen, 2010; Nova Scotia Health

Promotion & Protection, 2008), psychology-based prenatal education – prenatal education that focuses on the psychological aspects of childbirth (Brown, Feindberg & Kan, 2012; Feinberg & Kan, 2008; Larra, Navarro & Navarrete, 2010), drop-in prenatal education (Rosen, Krueger, Carney & Graham, 2008), online prenatal education (Pate, 2009; Salonen et al., 2011), one-on-one prenatal coaching (Milgrom, Schembri, Ericksen, Ross & Gemmill, 2011; Sercekus & Mete, 2010), group prenatal care – medical care and childbirth education offered simultaneously in a group setting (Ickovics et al., 2007; Ruiz-Mirazo, Lopez-Yarto & McDonald, 2012), and combined group and individual prenatal education – classes that are delivered through a mixture of both individual and group prenatal sessions (Doherty, Erickson & LaRossa, 2006; Hesselink, Van Poppel, Van Eijsden, Twisk & Van der Wal, 2012). These findings suggest that preferences in terms of format are highly individual.

Context of risk and outcomes associated with young motherhood. Contemporary research supports that maternal age alone is not solely responsible for pregnancy outcomes; however, there are an abundance of studies observing adverse consequences occurring among pregnant youth and their children that cannot be ignored (Gregson, 2009; SmithBattle, 2007). It is, nevertheless, difficult to discern whether the factors predisposing youth to pregnancy (e.g. poverty, school dropout) would produce similar long-term outcomes in the absence of childbearing. For example, while pregnancy does interrupt an adolescent's education, a history of poor academic performance usually exists prior to conception (Klein, 2005), rendering it difficult to predict which factors exerted greater influence on educational attainment. That said, some research designs have employed longitudinal designs that feature peers who miscarry or non-pregnant siblings as comparison groups for PPY (Geronimus & Korenman, 1993; Hotz, Mullin, & Sanders, 1997). After controlling for differences, these designs allow for a closer approximation of the effect of the pregnancy and birth. In fact, analysis of the miscarriage cohort

data challenges some of the traditionally held beliefs about the beneficial effects of delaying childbearing until later in life (Hotz, et al., 1997). The findings support that, even in the absence of early childbearing, social determinants of health are the strongest predictors of long-term outcomes.

There is a body of literature to support the notion that youth with intended and unintended pregnancies face increased risk for a number of health complications in pregnancy, particularly in the absence of early and regular prenatal care. Pregnant youth below age 17 have a higher incidence of health complications than their adult counterparts, with greatest risks observed among the youngest women (Chen et al., 2007; Forrest, 1993; Satin, Leveno, Sherman, Reedy, Lowe, McIntire, 1994). The incidence of low birth weight (<2500 grams) is more than double for infants born to youth, and the neonatal death rate (within 28 days of birth) is almost 3 times higher (Davidson & Felice, 1992; Gilbert, Jandial, Field, Bigelow, & Danielson, 2004). Later in life, these children have been found to lag in standards of early childhood development, have academic difficulties, and experience behavioural disorders, substance abuse, and depression (Furstenberg, Brooks-Gunn, & Morgan, 1987; Jaffee, Caspi, Moffitt, Belsky, & Silva, 2001; Nord, Moore, Morrison, Brown, & Myers, 1992).

There is a range of psychosocial implications that accompany young motherhood. Pregnancy and parenting often impact the time available to socialize, graduate from high school, and develop healthy interpersonal relationships (Hotz, McElroy, & Sanders, 1997). PPY are more likely to encounter negative social pressure and experience social isolation from their friends (Birkeland, Thompson, Ohares, 2005), as well as alienation from their families (Grady & Bloom, 2004). Following pregnancy, parenting youth are less likely than their childless peers to pursue higher education or marry (Hoffman, 2006), and are more likely to experience intimate partner violence (Newman & Campbell, 2011). They are also at increased risk of struggling with low

self-esteem, experiencing mental illness, depression, and substance abuse (Barnet, Rapp, DeVoe, & Mullins, 2010; Flaherty & Sadler, 2011; Stiles, 2010).

Positioning of the Researcher

As the observer and interviewer for this study, I was the key instrument in data collection and analysis (Bogdan & Biklen, 1992). I too gave meaning to the data through my own unique lens and brought personal values and biases to the research process. Thus, I have contemplated my positioning throughout the research process, from conceptualization through analysis and interpretation. I am not a mother nor have I experienced pregnancy. That said, I have been witness to numerous births and have experiences as a woman, daughter, sister, aunt, and friend. I acknowledge my position as one of privilege. I am a married, English-speaking, Canadian-born, Caucasian woman with a strong support network and advanced level education. While I have not faced many of the social barriers described by the women in this study, I have had my own journey with mental health and wellness. As a woman with a diagnosed and treated mental illness, I can appreciate the stigma and barriers that remain regarding mental health. Living with mental illness is part of my story but it does not define me. It has, in fact, made me more aware of the labels and stereotypes assigned to some groups and question some of my own biases. Given my personal experiences and professional background in nursing, I approach disclosures of mental health challenges in a non-judgemental manner and with great sensitivity and care.

I view adolescence as a time of growth and resilience, building towards independence. Not unlike some of the participants in this study, I was born to chaotic family circumstances and moved out on my own at age 17. This has influenced my view of family and I have adopted an expanded view that isn't bound by biology but rather defined by relationships. I was a highly resourceful youth, working three part-time jobs to support myself through a nursing program at

Cégep. I don't believe that age is incommensurate with goal achievement. It is also important to note upfront that I do not view young pregnancy and parenthood as innately problematic or deviant, nor do I believe that adolescents are less worthy of experiencing motherhood. In fact, I have an appreciation for how resourceful youth can be when adequately supported, which is likely why I am drawn to working with these young women.

I carry an interest in exploring the narratives of oft marginalized groups and commonly find myself seeking counter-narratives to widely accepted social ideologies. My 18-year career in nursing exposed me to different contexts, health care environments, and clinical specialties like pediatric Emergency Medicine and pediatric surgery, and urban community health work in homeless outreach and the needle exchange program. Working in a community environment with street-involved individuals allowed me to develop a deeper understanding and appreciation for harm reduction. This work also added a human facet to issues of addiction, poverty, and mental health. In these environments, I worked with real people with real stories, not just statistics on a page or admission diagnoses in an Emergency Department.

As a child of the MTV generation of reality programming, I have been exposed to numerous social representations of PPY. I've come to see these social representations as largely damaging, as they tend to reinforce select stereotypes of young parenthood. I have also been witness to judgemental comments and actions towards young parents on public transit, in public spaces, and even in health care environments. In fact, across all clinical and community settings I have worked in, I have overheard or witnessed commentary by the health care team regarding young parents or their childcare practices. I find homogenous generalizations of young parenthood problematic as I believe that PPY are distinct and unique. My clinical experience also revealed that these parents often had different questions, concerns, and educational needs than their older or non-parenting counterparts.

My views have also been shaped by other community-based research I have collaborated on. I have been a co-investigator on two studies that explored different facets of adolescent pregnancy. The first examined the perceptions of PPY regarding the portrayal of youth pregnancy in reality television programs, such as *16 and Pregnant* and *Teen Mom* (Harrison, Clarkin, Worth, Norris & Rohde, 2016). From this data set, we published a second paper based on incidental findings that emerged regarding reported health care interactions between PPY and their providers (Harrison, Clarkin, Rohde, Worth & Fleming, 2016). Stories and insights shared by the youth themselves aligned with my experiences as a care provider. The second study explored body image issues and disordered eating behaviours in a community sample of PPY. This study highlighted the interrelated nature of mood, eating behaviours, and body image in pregnancy and the post-partum period. It also made me more aware of the strong influence of environment and peer relationships in shaping self-concept.

Having worked with adolescents for most of my professional career, I was very comfortable interacting and communicating with the young women in this study. I understood the importance of establishing rapport and maintaining a non-judgemental attitude. That said, during my interactions with PPY, I was struck by how forthcoming they were. Sometimes their stories or the delivery of their stories were a little destabilizing for me because they reflected issues of abuse, violence, and trauma. I took measures to avoid vicarious trauma, as possible. During the data collection and analysis phases, I engaged regularly with my therapist in order to develop and strengthen coping strategies so that I could process some of the traumatic experiences shared by my participants. I also used reflective journaling to help me make sense of these stories, remain aware of my assumptions and preconceptions, note my reactions to interview content, and consider how I might be constructing and imposing meaning on the research process.

Many of the young mothers that I've worked with, whether in my capacity as a nurse, researcher or graduate student, have yearned for avenues to advocate for themselves and their children. I approached this study with an eagerness to elicit these narratives and insights, feeling honoured to have the opportunity to work with these young women.

Relevance of Study

Grounded in the words and stories of youth, this study will be the first to explore how a group of PPY, living in a residential maternity shelter and accessing community-based services, engage in prenatal education and construct their health-related knowledge and views. This study will elicit the perceptions of PPY in order to describe the contextual factors that influence their decisions, their learning, and their lives. Through an exploration of the perspectives, experiences and preferences of youth, efforts can be made to provide support to these women when and how they need it most.

Organization of Thesis

This thesis is organized into six chapters. In this chapter, I have offered a description of key terms, introduced the problem, and provided background information about the context of adolescent pregnancy in Canada. The remaining chapters are organized as follows: Chapter two provides a review of the literature as well as a description of Bronfenbrenner's Bioecological System's Theory. Chapter three discusses the research design, methodology, and procedures used for data collection and analysis. Chapter four presents the results of the within-case analysis, presented as participant demographic data and narrative descriptions. Chapter five follows with the results of cross-case analysis, presented thematically. In chapter six, findings are discussed with contributions to theory and recommendations for practice and research highlighted.

Chapter Two - Literature Review

The purpose of this chapter is to describe, synthesize, and evaluate literature relevant to this study. Thus, I review two bodies of literature with specific purposes. First, I review literature on adolescent sexuality and pregnancy, exploring sexual health education and outcomes. Second, I examine the literature related to health and educational services in the perinatal period, comprising prenatal health care and prenatal education, to identify unique educational considerations for the adolescent population. Finally, I describe the conceptual framework used to guide this study.

Adolescent Sexuality and Pregnancy

Adolescent sexual health. In discussions of adolescent sexual health, it is important, first, to recognize that adolescence is a period of rapid physical growth and psychosocial development. This transition between childhood and adulthood is characterized as a time of great emotional, physical, social, and hormonal change (Blakemore & Choudhury, 2006; Buck & Ryan-Wenger, 2003). The period is often sub-divided chronologically into early (ages 10-13), middle (ages 14-16), and late (ages 17-20) adolescence (Dixon & Stein, 2000). Sex can be an integral part of adolescence, and a time when youth begin to explore sexual agency and experimentation (Arbeit, 2014; Michels et al., 2005; Dixon & Stein, 2000). In fact, the majority of Canadians become sexually active during adolescence, with over 70% of youth engaging in sexual intercourse before age 20 (Maticka-Tyndale, Barrett, & McKay, 2001). The Canadian Association for Adolescent Health conducted online interview with 1,171 youth between the ages of 14 and 17 to examine their current sexual health knowledge and educational needs (Frappier, Kaufman, Baltzer, Elliott, Lame, Pinzon, & McDuff, 2008). This study found that by age 15, 27% of respondents were sexually active with an average of 2.5 lifetime partners. Adolescent sexual behaviour is also

known to correlate with socioeconomic status, cultural norms, and community contexts (Kraft, Kulkarni, Hsia, Jamieson, & Woner, 2012). For example, adolescents living in communities characterized by poverty, residential instability, and social disorganization are more likely to have early initiation of sex, less likely to use contraception at first sexual encounter, and more likely to give birth as youth (Steinburg & Sheffield Morris, 2001). Given that youth are engaging in sexual activity, access to sexual education that acknowledges social environment and supports the development of healthy sexual experiences is of critical importance to the promotion of health.

Sexual health is a social construct that is described in a variety of ways in the literature, and there is no international consensus on the definition of sexual health. The Canadian Guidelines for Sexual Health Education note that the “values and norms about sexuality and health come from a variety of sources including social and religious viewpoints, science, medicine and individual experience” (Public Health Agency of Canada [PHAC], 2008, p. 5). At a national level, trends in youth pregnancy, sexually transmitted infections (STIs), age of first intercourse, and condom use are often proxy measures used to assess the sexual health of youth (Ivankovich, Fenton, & Douglas, 2013). These outcome-driven appraisals, however, present a very limited conceptualization of youth sexual health and offer limited insight into young people’s sexual decision-making, factors that influence sexual choices and behaviours, or how they navigate and make meaning of their sexual experiences. As such, social contexts and factors that influence decision-making regarding sexual activities are often overlooked in formal sex education programs (Michels et al., 2005).

The development of healthy sexual relationships is considered a milestone of adolescence (Brunk et al., 2008). Adolescent sexual experiences are complex and involve a number of motivational factors, including sexual identity, orientation, opportunity, relationship

characteristics, and desire (Giordano, Longmore, & Manning, 2001; Manning, Longmore & Giordano, 2005). Motivation for adolescent sexual engagement may also reflect the belief that goals in areas such as intimacy and social status can be achieved through sex (Ott, Millstein, 2006). While most research focuses on whether or not adolescents are sexually active, a smaller body of research explores the relationship contexts of sexual engagement, including adolescents' involvement in non-romantic sexual activity or sexual experience occurring outside of dating relationships. It is estimated that 25% of youth initiate sex with someone they are not dating (Manning, Longmore, & Giordano, 2000), and that non-romantic adolescent sexual activity may present greater risk for unplanned pregnancy and exposure to sexually transmitted infection (Ford, Sohn, & Lepkowski, 2001; Manning, Longmore, & Giordano, 2005).

Adolescent sexual health education. Sexual health education is defined as the “process of equipping individuals, couples, families and communities with the information, motivation and behavioural skills needed to enhance sexual health and avoid negative sexual health outcomes” (PHAC, 2008, p. 5). There is currently no gold standard approach to sexual health education; however, outcome data highlights the value of developing more holistic approaches to sex education that take into account adolescents' own sexual experiences (Abel & Fitzgerald, 2006; Cameron-Lewis & Allen, 2013; Lindgren et al., 2009). While youth are commonly included in peer sexual health education, youth voice remains largely absent from much of the planning, program design, and implementation of sexual health education initiatives (Cameron-Lewis & Allen, 2013).

In Canada, public health initiatives targeting enhanced sexual health have employed a range of strategies (e.g., abstinence promotion, contraception awareness, condom distribution) with varying degrees of success. Sexual health education is included in school-based curriculum and school-linked programs because it is understood that “sexuality is a fundamental aspect of

being human, and as such, needs to be addressed as part of the educational experiences of children and youth” (Meaney et al., 2009, p. 107). The aim of formal school-based sexual health education is such that “students who have completed their secondary school education are expected to have sufficient sexual health education to actively pursue healthy sexual relationships.” (Meaney, et al., 2009, p. 108). However, this aim is not always achieved, especially for those who do not complete high school. Moreover, access to formal sex education appears to vary by social strata, with disadvantaged youth being the least likely to benefit from school-based sexual health education programs (Kohler, Manhart, & Lafferty, 2008).

In Ontario, school-based sexual health education falls within the Health and Physical Education (HPE) curriculum (Ontario Ministry of Education, 2015a; Ontario Ministry of Education, 2015b). Teachers therefore play a key role in helping young people understand the complexities and diversity of sex and modern sexuality, develop sexual agency, and acquire the tools necessary to recognize and engage in healthy sexual relationships. The revised curriculum, introduced in 2015, proved contentious for some (Bialystok & Wright, 2017), as it was regarded as incompatible with a number of faith-based groups’ understandings and traditions (Gee, 2015; Sagan, 2015). This curriculum sparked protest and exposed tensions with progressive notions of gender and sexuality (Bailey, 2017). Prior to the curriculum update in 2015, school-based sexual health education in Ontario had not been amended since 1998 (Ontario Ministry of Education, 2015a; Ontario Ministry of Education, 2015b). The updated curriculum addressed sexting, sexual orientation, pleasure, and consent (Do, 2015; Ontario Ministry of Education, 2015a; Ontario Ministry of Education, 2015b; Ross, 2015). In the broader Canadian context, the province of Ontario was the first province to include definitive discussions of consent in the curriculum (Smusiak, 2015).

Learning about sexual health is not limited to the classroom. Internet and mobile technologies are largely integrated into the lives of youth, and it is unsurprising that information and resources about sex are accessed this way. Technology has also influenced the evolution of sexual attitudes and beliefs (Kippax et al., 2005); and it is important to examine how these messages influence learning (Abel and Fitzgerald, 2006). Messages about adolescent sexuality are replete in the media and pop culture, stemming from television programs, movies, newspapers, magazines, popular music, and social media (Sprecher, Harris, & Meyers, 2008). Engaging in various forms of social media has shown to benefit adolescents by enhancing communication and a sense of social connectedness, and enriching technical skills (Ito, Horst, Bittanti, Stephenson, Lange, et al., 2009; Levine, 2011).

A survey of Americans aged 8-18 revealed that over a third had used online searches for information on topics they deemed difficult to talk about, including sex and drugs (Kaiser Family Foundation, 2010; Levine, 2011). More recently, Selkie, Benson, & Moreno (2011) conducted a qualitative study with 29 youth to explore the role of technology, texting, and social networking sites in sexual education. While the sample size of this study was small, focus group discussions revealed that participants wanted immediate answers to their sexual health questions and relied on Internet search engines to find answers to their questions quickly. Participants cited the availability of information at all hours, ability to provide education in interactive formats unlike textbooks, and confidential nature of searches as benefits of technology-based resources. Suzuki and Calzo (2004) conducted an examination of peer advice provided through digital youth bulletin boards about health and sexuality. They reviewed 273 posted questions posted, with topics ranging from general sexual health (41.8%) including questions about ejaculation, penis size and shape, menstruation, and vaginal infections; pregnancy and birth control (22.9%); sexual techniques (11.8%); and interpersonal issues (9.4%).

Informal sexual health education also arises from other commonly cited sources, including family members and peer group (Christopher, 2001). In fact, the peer group is the most frequently cited source of informal sexual education (Sprecher et al., 2008). Given the strength of peer influence, sexual health education programs that use peer education and engage youth in the design, development, and delivery of programs for their peers are gaining acceptance (Dunn, Ross, Caines, & Howorth, 1998; Elliott & Lambourn, 1999; Haberland & Rogow, 2015). It is suggested that peer leaders are more effective at changing attitudes and norms about sexual health than education provided in adult-led initiatives (Mellanby, Newcombe, Rees, & Tripp, 2001). One such Canadian program, Youth Educating About Health (YEAH), employed a youth empowerment framework and engaged youth in the design and delivery of sexual health education and resources. This program was targeted at post-pubescent youth and their significant adult, such as parents and teachers (Hampton, Jeffery, Fahlman, & Goertzen, 2005). After the first year of operation, a process program evaluation of YEAH was published; the evaluation concluded that community-based programs offered more autonomy than school-based programs (Hampton, Jeffery, Fahlman, & Goertzen, 2005).

Other interpersonal sources of sexual health education include members of the adolescent's family or social network, including older siblings, extended family, and unrelated adults (George et al., 2013). There is also a strong relationship between family intactness and sex education in the home (Cox et al., 2008). This means that youth who have dropped out of school or have limited parental contact may face inadequate access to broad based sexual health education through these traditional routes. As such, the Society of Obstetricians and Gynecologists of Canada has recommended that sexual health education be supplied by a variety of sources, including schools, parents, the community, and health care providers (McCall &

Mckay, 2004). That being said, educational interventions are unlikely to be fully effective unless they realistically address the socioeconomic inequities that these youth may face (Bissell, 2000).

Pregnant and parenting youth. When exploring issues pertaining to PPY, it is important to note that I do not suggest that pregnancy itself is a state of illness or that early pregnancy is unequivocally a problematic situation. That being said, I think it is important to explore the social determinants of health and socioeconomic inequities that may predispose some youth to pregnancy.

On a global scale, an estimated 16 million women aged between 15 and 19 give birth every year, comprising 11% of all births worldwide, with 95% of these births occurring in developing countries (WHO, 2009). The live birth rates among Canadian youth have declined steadily, likely reflecting the availability of abortions and accessibility of emergency contraceptives. That said, not all youth pregnancies are accidental or unplanned. In fact, a study conducted in the United States revealed that 18% of pregnancies and 44% of live births to women aged 15-19 were intended (Guttmacher Institute, 2010). While it is clear that the majority of youth pregnancies are unintended, the reality of intended pregnancies and births cannot be ignored. Moreover, for some youth that have faced economic and educational obstacles, a baby can represent success and hope for the future (Young et al., 2004); others may seek parenthood as a means to solidify relationships, provide love and care for another, assert independence, or escape a chaotic home environment (Cox et al., 2008).

While a percentage of youth pregnancies are planned, the majority remain unintended and there are several key characteristics that place young women at increased risk of becoming pregnant during adolescence. Growing up in poverty is arguably one of the most critical determinants of adult life experience, including age at first pregnancy. Pregnancy is disproportionately more common among adolescents from socioeconomically disadvantaged

backgrounds, and pregnancy in adolescence further compounds many of these challenges (Bissell, 2000; Garwood, Gerassi, Jonson-Reid, Plax & Drake, 2015; Haveman, Wolfe, & Wilson, 1997). In fact, as annual family income increases, the proportion of adolescent mothers declines (Franklin, Corcoran, & Ayers-Lopez, 1997; Smith, Strohschein, & Crosnoe, 2018). For example, daughters of manual workers are almost ten times more likely to become pregnant during adolescence than those whose parents have professional qualifications (Lane, 2008). Longitudinal cohort studies support the presence of intergenerational transmissions of parenting norms, and children of PPY are more likely to become parents as youth themselves (Nord, Moore, Morrison, Brown, & Myers, 1992; Stiles, 2010). Other factors correlated with pregnancy in youth include poor academic achievement, a lack of family and community support, chaotic family circumstances, family structures featuring single parents, school dropout, a history of substance use, and being a non-immigrant (Franklin, et al., 1997; Garwood, Gerassi, Jonson-Reid, Plax & Drake, 2015; Gortzak-Uzan, Hallak, Press, Katz, & Shoham-Vardi, 2001; Rosembaum & Kandel, 1990; Singh, Darroch, & Frost, 2001).

Another notable group of adolescents at high risk for early pregnancy are homeless youth and those experiencing housing instability. Youth comprise roughly 20% of the homeless population (Gaetz, Donaldson, Richter & Gulliver, 2013), are the fastest growing age group on the streets (Ringwalt, et al., 1998), and as many as 20% of homeless young women become pregnant (Thompson, Bender, Lewis & Watkins, 2007). It is estimated that 150,000 street-involved youth are living in Canada (Baker, Kerr, Nguyen, Wood, & DeBeck, 2015; Public Health Agency of Canada, 2006). However, rates of youth homelessness in Canada are difficult to measure; most youth who are chronically homeless will move between different housing situations over the course of a year (Gaetz, 2009), rendering snapshot survey measures problematic. Equally, estimations based on shelter use alone fail to capture the number of street-

involved youth that opt out of shelter living or youth that are temporarily and precariously housed in conditions such as couch-surfing (Canada Mortgage and Housing Corporation, 2001). In Toronto, for example, approximately 75% of homeless youth do not use shelters (Community Social Planning Council of Toronto, 1998).

Many adolescent mothers experience housing instability long before their pregnancies. In fact, many have lived through cycles of homelessness, the foster care system, or arrangements within their extended families for periods of time (Levin & Helfrich, 2004; Omolade, 1997; Saewyc, 2003). Among homeless adolescent mothers, the most commonly cited reasons for being homeless include escaping abuse (Omolade, 1997); being evicted because of pregnancy (Johnson, 1999, Omolade, 1997); and leaving home because of feeling unloved or conflict with family members (Begun, 2015; Leppard, 1991; Levins, 1995; Saewyc, 2003).

Women that become pregnant during adolescence are also more likely to experience repeat adolescent pregnancies. In fact, 25% of adolescent mothers become pregnant again within 2 years of delivery (Schelar & Manlove, 2007). Socio-demographic factors associated with a repeat adolescent pregnancy include a poor relationship with the father of the baby within the first three months of delivery, not using long term contraceptive within three months of delivery, being three or more years younger than the father of the first baby, experiencing intimate partner violence within three months of delivery, not being in school three months after delivery, and having many friends who are also adolescent parents (Raneri & Wiemann, 2007). Further, repeat pregnancies are not all unplanned; a Canadian retrospective study revealed a subsequent pregnancy was an intended outcome for one third of adolescent mothers (Kives & Jamieson, 2001). The idealization of pregnancy may influence subsequent intended pregnancies; a prospective cohort study of adolescents in a multidisciplinary care setting revealed that over 50%

of adolescents described pregnancy as the “single most exciting and positive event” they experienced (Quinlivan, 2004; Fleming, O’Driscoll, Becker, Spitzer, Allen, Millar, et al., 2015).

Prenatal Services

Prenatal services, comprising both prenatal education and prenatal health care occurring during the perinatal period, may be a point of intervention to support maternal transitions, health, and wellbeing. For PPY, delayed access to the recommended prenatal services remains a major barrier to maternal health (Sarri & Phillips, 2004). Not surprisingly, youth and adult mothers differ in their access to and utilization of prenatal services, as well as their educational needs (Debiec, Paul, Mitchell, & Hitti, 2010). In this section, I discuss prenatal health care, prenatal education, and special considerations for adolescent prenatal education.

Prenatal health care. Prenatal care refers to the regular medical and nursing care recommended for women during pregnancy (Grady & Bloom, 2004). It is a type of preventative health care that is offered throughout the course of pregnancy, and allows health professionals to monitor for potential gestational problems (Daley, Sadler, & Reynolds, 2013; Fiscella, 1995). The general approach to prenatal care is to assess, treat, teach, and provide support for healthy lifestyle choices that will benefit both mother and child (Leslie, 2006). Pregnant youth typically access prenatal care through hospital-based clinics or school-linked youth clinics (Debiec, Paul, Mitchell, & Hitti, 2010; Smith & Gingiss, 1996). Adolescents often require more intense prenatal assessment and counseling in the areas of nutrition, substance use, and intimate partner violence (Cartoof, Klerman, & Zazueta, 1991; Daley, Sadler, & Reynolds, 2013). Tailored sexual health counselling is also particularly important during pregnancy due to lower than average rates of condom use (Koniak-Griffin & Turner-Pluta, 2001), increased risk of acquiring one or more STIs, and high incidence of repeat pregnancies (Raneri, & Wiemann, 2007; Stapleton, 2010).

Prenatal care remains a major predictive factor for positive birth outcomes (Debiec, Paul, Mitchell, & Hitti, 2010; Fiscella, 1995). Engaging youth in the early initiation of prenatal services is of critical importance; women without prenatal care are at increased risk of low birth weight and have a 7-fold higher risk of preterm birth, with risk decreasing linearly as prenatal care increases (Brubaker, 2007; Debeic, 2010). American statistics from 2011 report late or no prenatal care in 22% of births to women under age 15, and 10% of births to youth aged 15 to 19 (Centers for Disease Control and Prevention, 2011). Barrier to accessing care, particularly among younger women, include the denial of the pregnancy or an attempt to conceal the condition (Cox et al, 2008). Adolescents are less likely to seek or continue care if they are dissatisfied with prenatal services for reasons such as long waiting times and inconvenient clinic hours, lack of child care or transportation, and insensitive staff (Cartoof, Klerman, & Zazueta, 1991; Daley, Sadler, & Reynolds, 2013).

Prenatal education. There is a clear relationship between maternal-child health outcomes and prenatal education, with documented benefits extending into the post-partum period. Engagement in education is associated with perinatal well-being, which is defined as “the cognitive and/or affective self-evaluation of the individual’s life specific to the period before and/or after childbirth, which encompasses a multitude of elements such as: physical, psychological, social, spiritual, economic and ecological” (Allan, Carrick-Sen, & Martin, 2013, p. 390). Prenatal education is defined and enacted in a number of different ways. Most narrowly, it is viewed as a formal educational activity that consists of a series of classes, either online or in person, provided for individuals or groups of pregnant women, and their partners or support people (Nichols & Zwelling, 1997; Palermo, 2000). The attendance and retention of youth in generic prenatal classes is significantly lower, which could reflect the fact that prenatal programs are primarily designed to meet the needs of adult mothers (Philliber & Brindis, 1996). In fact,

research on access and utilization of formal prenatal classes in North America indicates that they are characteristically attended by white, married, upper-middle class parents who are expecting their first child (Keeton, Perry-Jenkins, & Sayer, 2008; Perry, 1992).

Since pregnant youth are not a cohort that typically attends formal prenatal classes, a more inclusive view of prenatal education will be adopted in this study, encompassing all formal or informal interventions and interactions that prepare youth for pregnancy, birth, and motherhood (Loos & Morton, 1996), including established prenatal classes, informal discussions, instructions and information from health care providers, advice or support from social networks, media messaging, role modeling from peers and family members, and self-directed learning activities. For the purpose of this study, this definition of prenatal education will be used; it will be understood as encompassing both formal and informal learning, as well as the broader social and cultural contexts in which learning occurs.

Special considerations for adolescent prenatal education. For many youth, both formal health care interactions and the appraisal of health information are largely absent from their experiences before becoming pregnant (Brubaker, 2007). Within health care, fear of judgment and stigmatization acts as a barrier to information seeking and can result in unmet information needs related to concrete aspects of pregnancy and infant care, such as where to obtain feeding supplies (Robb, McNery, & Hollins Martin, 2013). The fear or expectation of stigmatization and self-stigmatization acts to hinder young mothers from obtaining or making use of information and support (Robb et al., 2013). As such, inquiry to develop youth-informed of prenatal interventions and supports is vital.

Studies have been conducted to examine the health information needs of pregnant youth; however, the strength of findings stemming from quantitative designs using survey items generated by health care providers remains in question. Further, research has started to challenge

the efficacy of prenatal education programs designed by health professionals based on their perceptions of the needs of PPY (Svensson, Barclay, & Crooke, 2007). For example, an older study by Levenson, Smith and Morrow (1986) revealed significant differences between pregnant adolescents' and health care providers' beliefs about the type of educational content most important to the learner. In this study, 146 pregnant adolescents and 46 physicians completed self-administered questionnaires about prenatal and infant care to provide insight into the informational needs of youth. The results indicated that the physician group did not accurately estimate the importance youth would attribute to 23 of the 24 survey items ($p < 0.001$), and they anticipated that youth would attach significantly less importance to items than they actually did. For instance, psychosocial concerns, which physicians anticipated would be considered most important, were often minimized by youth while they placed greater importance on knowing about prenatal and parenting behaviours. The difference in youth and provider perspectives on health informational needs and interests emphasizes the danger of 'teacher-driven' agendas for the dissemination of information during the perinatal period.

Typically, the goals of comprehensive prenatal education extend beyond the delivery of information, and encompass strategies to enhance coping, foster support systems, and integrate advocacy (Lothian, 1993). These goals align well with health empowerment perspectives, as they emphasize one's ability to participate knowingly in health and health care decisions (Shearer, 2004). It has been suggested that the ultimate goal, and perhaps the most critical dimension of prenatal education, is the promotion of informed decision making (Lothian, 1993). Recognizing the goal of empowerment in the conceptualization of adolescent prenatal education has important implications for the scope, communication, and delivery of health education. Prenatal educational programs informed by a health empowerment approach should aim to move beyond the simple transmission of health information to actively engage and empower learners, and help them to

build links between health knowledge and their day-to-day lives. Further, they should ensure that the content of health communications not only focus on personal health, but also on the social determinants of health.

Conceptual Framework

Understanding health behaviour, including health education, is multifaceted and complex. As noted in the literature review, the topic adolescent pregnancy spans multiple factors, rooted in all aspects of the adolescent experience, including educational policies, socioeconomic environment, family characteristics, and individual understandings (He & Blum, 2013). As such, in the field of adolescent sexual behavior, researchers are making the call to implement ecological models to study the multi-level influences on health behavior (Salazar et al., 2010). The World Health Organization and the Healthy People initiative also encourage an ecological lens, as it can offer a deeper understand of the meaning of health, and help conceptualize dynamic relationships between individual factors and environments (Golden & Earp, 2012; US Department of Health and Human Services Office of Disease Prevention and Health Promotion, 2015). An ecological model, the bioecological systems theory, forms the overarching conceptual frameworks for my research. A brief review of the theoretical foundations and key concepts will be presented, as well as how the theory will be applied to this study.

Bioecological Systems Theory

Bioecological systems theory is an ecological model that emphasizes the environmental and policy contexts of behaviour, which incorporates social and psychological influences. Formerly known as ecological systems theory (Bronfenbrenner, 1979), the bioecological systems theory stresses person-context interrelatedness, as well as the interconnectedness of human behaviour and the social environment (Tudge, Gray & Hogan, 1997). According to this view, in

order to understand human development, one must first consider the entire ecological system in which growth occurs (Bronfenbrenner, 1994). The ecological environment consists of multiple layers that directly and indirectly affect people throughout their lifetimes (Moen, Elder, & Lüscher, 1995). In other words, people experience events or happenings within specific contexts, and as such, personal experiences cannot be separated from the settings they occur in; individuals both shape and are shaped by social context (Bronfenbrenner, 2005; Swick & Williams, 2006). In terms of this study, this implies that a woman's understandings of prenatal education and the overall childbearing experience are embedded within the greater cultural and social systems that impact on the society at large and on women in particular. For the purpose of this study, I focus on what is described as Bronfenbrenner's 'mature' work: the Process-Person-Context-Time (PPCT) model (Tudge, Mokrova, Hatfield, & Karnik, 2009; Bronfenbrenner, 2005). In this section, I describe the components of this model.

Process. The concept of process addresses the complex interaction between the individual and the environment. Bronfenbrenner and Morris (1998) state "human development takes place through processes of progressively more complex reciprocal interaction between an active, evolving biopsychological human organism and the persons, objects, and symbols in its immediate external environment" (p. 996). More specifically, proximal processes are activities and interactions in the immediate environment that individuals engage in routinely, over prolonged periods of time. As such, biological predispositions can either be amplified or reduced by the moderating effect of the contextual environment (Riggins-Caspers, Cadoret, Knutson, & Langbehn, 2003).

Person. The person refers to the individual and his/her characteristics. This not only encompasses individual biology, genetics and demographics, but also differences in cognition, attitudes, beliefs, and expectations (Adamson, O'Brien, & Pasley, 2007).

Context. Bronfenbrenner's ecological theory places human development within a series of interconnected systems. These systems are presented visually as nested, concentric circles. Figure 1 presents a diagram of Bronfenbrenner's Ecological Framework for Human Development that has been adapted to feature influences that may be particularly applicable to the perinatal period.

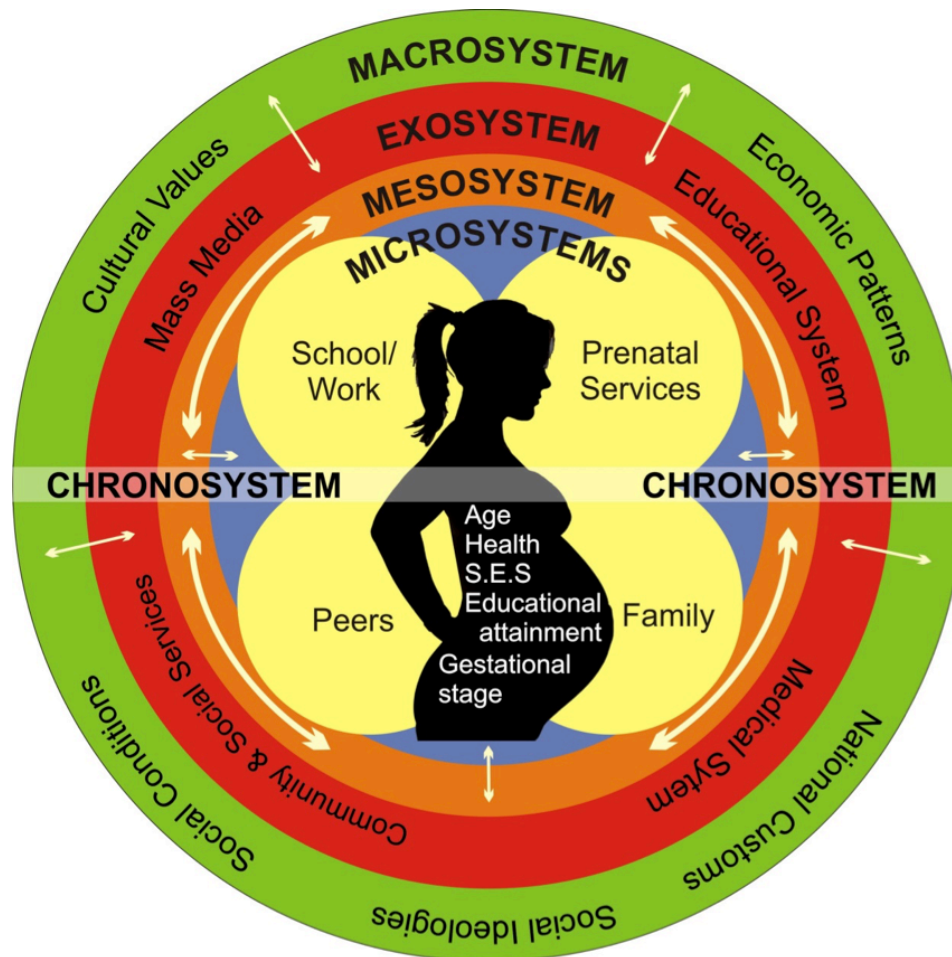


Figure 1. Diagram of Bronfenbrenner's Bioecological Systems Theory

The different systems in this model range from those that a human interacts with directly (microsystem), to broad and overarching principles that direct society (macrosystem).

Bronfenbrenner (1977) explains the microsystem as the relationship between an individual and

the individual's environment in an immediate setting such as a school or home. This system has the most direct and immediate effect on the individual, and the focus at this level is on the activities individuals engage in within a particular setting (Berk, 2006; Bronfenbrenner, 1979). The mesosystem is a system of two or more microsystems in which the individual actively participates. In other words, the mesosystem is the relationship between different settings in an individual's life. For example, mesosystems of a pregnant youth may include direct relations between environmental systems that include the family, school, peers, and a community outreach program.

The exosystem is the third layer of the model and consists of the social systems beyond the immediate environment that shape and are shaped by the individual (Adamson, O'Brien, & Pasley, 2007; Bronfenbrenner, 2005). Bronfenbrenner describes this system as an extension of the mesosystem which comprises "other specific social structures, both formal and informal, that do not themselves contain the developing person but impinge upon or encompass the immediate settings in which that person is found, and thereby influence, delimit, or even determine what goes on there" (1977, p. 515). For example, the exosystem contains entities such as mass media, social services, medical systems, and neighbours.

The fourth layer is the model is the macrosystem, which comprises cultural beliefs and customs, societal values, political occurrences, social ideologies, and laws (Bronfenbrenner, 1979, 2005; Sigelman & Rider, 2003; Swick & Williams, 2006). As Bronfenbrenner (1994) explains, "the macrosystem may be thought of as a societal blueprint for a particular culture or subculture" (p. 1646). Although this system is the most distant source of influence on an individual, the other three systems are embedded within this outer most layer. In fact, interactions between the other systems are defined by and define this outer layer (Bronfenbrenner, 1994). The macrosystem level contains broad patterns of what a particular society or culture values, such as

parenting, health or education. The macrosystem level includes social ideologies, and the greater cultural and social systems that impact on society at large and on women in particular.

Time. Gestation and becoming a mother are great periods of transition. In addition to the basic passage of time over which development occurs, in this model time refers to individuals' chronological age, the historical period within which they reside, as well as the developmental stage of the family (Adamson, O'Brien, & Pasley, 2007). Transitions in time can include internal and external changes in the environment, such changes in family structure, different place of residence, or change in socioeconomic status (Berk, 2006). Additionally, the widespread availability of the internet via computers and mobile devices, and access to health information and online social networks creates an interesting landscape for the study of the contemporary prenatal educational experiences of youth.

Application to research. Bioecological systems theory has been used to guide research exploring and addressing numerous facets of child and adolescent health. For instance, it has been used to frame research studies that address child health disparities (Reifsnider, Gallagher, & Forgione, 2005), as well as studies that examine adolescent sexual health behaviours (L'Engle, Brown, & Kenneavey, 2006). In terms of adolescent pregnancy, Logsdon and Grennaro (2005) used the bioecological model to guide their inquiry into the complex environmental processes that influence the delivery of social support. This study employed the bioecological model to structure the review of the literature at three levels: the macrosystem (described as influences that are outside of the individual's control such as parental variables and neighbourhood variables), the mesosystem (described as the setting in which the adolescent commonly interacts, including mother, partner, family, peers, school, and work), and the microsystem (described as the stable characteristics of the adolescent including personality traits, self-esteem and optimism, communication skills, age, and health status). The framework allowed the authors to

conceptualize numerous factors impacting whether pregnant adolescents' desires for social support were met. While this study outlined variables thought to impact the level of social support required and desired by adolescents, it failed to step beyond description to highlight key variables or tailored recommendations for practice. This paper did, however, demonstrate that the bioecological model could be applied to help conceptualize factors that influence pregnant adolescents. Logsdon subsequently published a study exploring the relationship between the context of social support and symptoms of postpartum depression in adolescents, which also used the bioecological framework (Logsdon, Hertweck, Ziegler & Pinto-Foltz, 2008). In this study, validated self-report instruments were used to assess select social support related variables at three contextual levels: macrosystem (exposure to community violence), mesosystem (social support, social network), and microsystem (perceived stress, mastery, and self-esteem). The ecological lens allowed for the identification of significant predictors of adolescent postpartum outcomes, and suggested areas for interventions that might have otherwise been overlooked.

While the bioecological model is well suited for the study of adolescent lives and experiences, it has not yet been used to explore how pregnant youth come to understand or make meaning of maternal health experiences. In terms of this study, the bioecological model will be used to inform lines of inquiry and analysis. It will also help me to consider the multiple dimensions within each woman's life as I listen to and contemplate the meanings of her stories and experiences.

Chapter Three - Methodology

This chapter outlines the research design, as well as the methods and procedures used in this study. In this section, I provide detailed information about: 1) the philosophical approach for the study, 2) the recruitment and sampling methods, 3) ethical considerations, 4) the data collection method of semi-structured interviews, 5) the data management and analysis methods, and lastly 6) a discussion of trustworthiness.

Research Design

The purpose of this case study is to explore a group of young women's health and educational experiences during the perinatal period. As such, a multiple instrumental case study was conducted (Stake, 1995). Case study research is commonly used to understand complex social happenings within real life contexts (Yin, 2003). A multiple instrumental case study design entails the choice of multifaceted, bounded cases based on the phenomenon under investigation (Stake, 2005). In this study, each participant acted as an individual case. Individual cases are presented as narrative descriptions for each participant and cross-case analysis is presented thematically. The individual cases themselves were explored with a primary focus on insights that contributed to an understanding of the perinatal experiences of a group of PPY living in a temporary, community-based maternity residence.

Case study research was a well-suited design to explore this topic as it allowed for the examination and preservation of the most meaningful characteristics of real life events (Merriam, 1988), while exploring both the uniqueness and commonality of cases (Stake, 1995). Each individual's story contributed understanding of their experiences and contexts, and together the collective presented a collage of young pregnancy and parenthood with the potential that

“understanding them will lead to better understanding, perhaps better theorizing, about a still larger collection of cases” (Stake, 1995, p. 237).

Philosophical Approach

A constructivist paradigm provided the epistemological foundation for this study. This study was designed with the consideration of the following constructivist principles: individual knowing is a complex, recursive, continuous process of subjective construal through which the individual attempts to maintain fitness and coherence with the experiential world (Proulx, 2006). According to Piaget (1970), knowledge is not a passive copy of reality or an objective match with an external world, but rather takes the form of schema constructed through experience that enable us to interact more or less effectively with reality. In this constructivist view, learning is a non-linear process that is described as a “complex event through which one’s past experience, current activity, and imagined future are stitched together into, hopefully, an interpretation that is adequate for the moment” (Davis & Sumara, 2007, p. 130).

In terms of social constructivism, individual knowing is viewed as being rooted in, unfolding from, and shaped by the collective knowledge and larger social practices one participates in (Davis & Sumara, 2007). As such, social constructions do not simply facilitate or influence learning, but shape and define it in fundamental ways (Proulx, 2006). Thus, learning cannot be dissociated from the contexts and collective social processes in which it arises. In fact, Vygotsky (1978) stated that “every function in the child’s cultural development appears twice: first, on the social level, and later, on the individual level; first, between people (interpsychological) and then inside the child (intrapsychological). This applies equally to voluntary attention, to logical memory, and to the formation of concepts.” (p. 57). That is, individuals internally reconstruct social norms and practices, which in turn become a framework

for most human thinking. As such, I explored how PPY came to construct their maternal health-related knowledge and views, and how these perceptions fit with their expectations and experiences. Moreover, I considered how these youth may or may not have internalize social norms such as those enacted by popular media, education, family, friends, social media, and street culture.

Research Purpose

While research has established the risks and consequences of adolescent pregnancy, and the dangers of delayed access to prenatal services, there remains a gap in the literature in terms of qualitative studies that explore formal and informal maternal education within the context of youth pregnancy. Qualitative studies could contribute to the discovery of in depth meanings, understandings, and features of this complex phenomenon, rather than focusing exclusively on quantitative outcomes and correlates. As a response to this issue, the current research sought to elicit, explore, and interpret the experiences of a group of PPY living in a residential maternity shelter. More concretely, this multiple instrumental case study (Stake, 2005), explored how pregnant and parenting youth came to construct their health-related knowledge and views, and how these perceptions fit with their expectations and experiences.

Research Questions

While the challenges of becoming a mother in adolescence are numerous and well documented, little is published about their understandings of maternal health or their perinatal educational experiences. Moreover, little is known about how perceptions of health impact and are impacted by a woman's childbearing experience. In this qualitative study, I explore the following research questions:

- 1) How do pregnant and parenting youth come to understand maternal health?

2) How do the meanings they construct relate to their lived experiences and contexts?

These interrelated questions have equal weight and are being studied together. Education will be approached in a broad and holistic manner, that is, as encompassing both formal and informal learning, as well as the broader social and cultural contexts in which learning occurs.

Setting and Population

This study was conducted at a youth maternity home associated with and located down the street from multidisciplinary outreach centre for young parents. For the remainder of the thesis, the maternity home will be referred to as the residence, and the multidisciplinary outreach centre will be referred to as the outreach centre. The outreach centre is a non-profit social service agency designed to provide multidisciplinary, collaborative services and programming for PPY. Services include a youth obstetrical clinic, pre-and-postnatal medical care, parenting courses, a satellite high school classroom, childcare, support groups, and counseling. Prior to study commencement I met with the director of the residence for her approval. The director was supportive of the study but suggested that I actively recruit participants from the residence rather than the outreach centre due to the number of concurrent studies being conducted at the centre. Once we agreed on timelines and terms, I presented the proposed study to the residential staff and public health nurses at a staff meeting. They offered insightful feedback and suggestions about recruitment.

The residence was founded in 1933 by Les Soeurs de la Providence, and has offered support and shelter to pregnant and parenting young women since its inception (St Mary's Home, 2017). It is the only youth maternity home of this type in Eastern Ontario, and is licensed by the Child and Family Services Act of Ontario to house a total 15 youth and 5 newborn infants at a time (St Mary's Home, 2017). There is often a waiting list for living space at the residence, and

requests are triaged based on urgency with those prioritization given to those fleeing unsafe conditions. Young women seeking shelter and care at the residence characteristically have a history that includes addictions, homelessness, family dysfunction, mental health issues, and street involvement (Nolte & Allan, 2006). These youth have traditionally avoided accessing social and health services, and tend to have very little prenatal care (Nolte & Allan, 2006).

Participant Selection and Recruitment

A combination of convenience and snowball sampling strategies were used to recruit PPY living at the residence. Two participants were identified and introduced to the study by snowballing, a method of expanding the sample by asking one participant to recommend others for interviewing (Miller & Crabtree, 1992). In order to recruit participants, I visited the residence on a weekly-basis to establish a regular presence, speak with the women, and discuss the study. I ate at the youth tables rather than with the staff in lunchroom and made a point of introducing myself to the residents. I carried information letters with me in case a resident wanted to learn more about the study (Appendix A), and put up posters advertising the study (Appendix B) at local organizations that service PPY: the residence, outreach centre, and a school program for pregnant and parenting youth. One participant contacted me from a study poster that she saw posted at the school program, while the other participants were recruited or referred from the residence. During recruitment, I recognized that recruiting only women living at the residence narrowed the scope of this study significantly and targeted a specific demographic of PPY. That said, the intent of this study was never to generalize the findings to all PPY but rather to provide rich description and offer insight into the experiences of an underrepresented group.

A list of inclusion criteria was developed to ensure that participants represented the population of interest (Polit & Beck, 2012). To be eligible for inclusion in the study, young

women had to meet the following criteria at the time of enrollment: 1) females aged 13-20 years at the time of pregnancy; 2) Pregnant or parenting in their first 6 months post-partum; 3) accessing community services; 4) available to participate in two interview sessions and willing share their experiences; and 5) able to communicate in English. Having more than one child was not an exclusion criterion for the study and the aim was to recruit a mix of first time and multiparous mothers. The target sample size was approximately eight to ten PPY. This sample size was consistent with the case studies literature, as it is noted that many multiple case studies contain between four and 15 cases (Stake, 2006).

Regular presence at the residence was the most efficient means of recruiting participants. My first visit to the residence was over lunch hour because most of the residents assembled at mealtimes. Walking into the dining area with my cafeteria tray the first day was intimidating and I had the distinct impression that no one wanted me, the outsider, to join their table. I was acutely aware of my status as guest in their home. I realized, in this moment, how important fostering trusting relationships would be to recruitment. I received a sympathetic smile from a young woman at a table in the back of the room, and I ate lunch with her and her friends. We chatted pleasantly and she was the first person to join the study. Recruitment became easier over time; I became more relaxed and residents seemed to become curious about me when they realized that I was a recurring presence. Word of mouth among residents was also very helpful with participant buy in. Recruitment continued until data saturation was achieved; that is, when no new themes emerged from the data (Bowen, 2008). Data saturation was assessed throughout recruitment, data collection, and analysis, which were conducted concurrently and in iterative cycles (Bowen, 2008; Varpio, Ajjawi, Monrouxe, O'Brien, & Rees, 2017). While the stories I heard were unique and nuanced, recruitment stopped when I reached redundancy in terms of my guiding research questions, overall study focus, and recurrent themes.

Once someone demonstrated interest in the study, I explained what participation involved and provided an informed consent form (Appendix C). During the consent process, I emphasized that participants did not have to complete the interviews or answer any questions that made them feel uncomfortable, and that their involvement in the study would have no impact on the services they received from the residence. These points were revisited at the start of each interview as well. Once informed, written consent was obtained, participants selected a study pseudonym. At this stage, a contact information form (Appendix D) was completed and the first interview was scheduled. A reminder text message including the interview details was sent to participants for confirmation 24-hours prior to the scheduled interview session. One participant did not have a cell phone so a reminder message was left on her weekly calendar at the residence. At the start of each interview, participants received an honorarium to thank them for their time in the form of a \$20 gift card to a grocery chain.

Ethical Considerations

Ethical approval for the study was obtained from the University of Ottawa Research Ethics Board (see Appendix E). The director of residence and outreach centre requested a copy of the study proposal, consent forms, and ethics approval from the University of Ottawa, but no additional ethics reviews were required. Recruitment at the residence began shortly after ethical approval was received. While I could not guarantee that the other young women living at the residence would not know who was participating in the study, efforts were taken to be as discreet as possible about study participation. For instance, I exercised discretion when visiting the residence, speaking with the young women, eliciting informed consent, and scheduling interview times. When interviews were booked, the staff at the residence would find the participants and remind them that their appointment had arrived in the visitation room rather than indicating that

the researcher from the study was there to see them. Staff members at the residence were accustomed to approaching their clients when visitors arrived, and this added an additional layer of privacy regarding the study. Moreover, I spent time at the residence during the recruitment period, outside of my scheduled interviews, in order to become a familiar presence there. As such, the women living at the residence were less acutely aware when I was there to conduct an interview rather than just being there to spend time at the residence. Interviews were always conducted in private rooms with the door closed.

There were no direct risks to young women participating in this study, except for potential discomfort in answering questions. Aside from the possibility of feeling some personal vulnerability associated with the information participants chose to share during the interviews, it was not anticipated that the interview sessions would cause the any emotional harm. Prior to each interview, participants were reminded that their participation was voluntary, they did not have to answer any questions they were uncomfortable with, and that they could end the interview at any time without any penalty. All participants were given the name of a certified counsellor from the outreach centre to contact should they wish to speak about their feelings following the interview sessions. To my knowledge, none of the participants contacted the counsellor for added support.

Data Collection and Procedures

I used a combination of six data collection sources in this qualitative case study: 1) interviews, 2) demographic questionnaires; 3) field notes; 4) key document and source review; 5) researcher reflexive journal; and 6) an optional personal reflection activity. Each method is described below.

Interview. I interviewed each participant twice using a semi-structured approach to guide the sessions. In this flexible interviewing format, the participant was regarded as the experiential

expert on the subject (Smith & Osborn, 2003). An interview guide (see Appendix F) was developed although the direction of the interview was strongly influenced by the participant and emergent discussion. Topics explored in the interviews included, for example, the exploration of the participants' daily lives and contexts (i.e., person, process, context, time), reactions to and perceptions of pregnancy and prenatal health education, and discussions of health experiences.

The interview guide and process was piloted with a young pregnant woman before broad enrollment occurred. The pilot interview was used to identify ambiguities and difficult questions; estimate the time required to complete the interview; refine, revise and discard unnecessary questions or jargon; and assess whether the questions yielded a sufficient range of responses (Peat, Mellis, Williams, & Xuan, 2002). This participant was asked for feedback regarding the interview questions and process, and two questions were revised following the pilot. As extensive revision was not recommended, a second pilot interview with another participant was not conducted. At the end of the second interview, all participants were asked to comment on their experience participating in the study. Participants were asked for suggestions regarding ways to improve the study or make it more meaningful for subsequent participants, and whether any important questions were left unasked. Feedback and recommendations were incorporated throughout.

Interview sessions were scheduled and conducted two to five weeks apart. Table 1 presents the timing of interviews by study participant.

Table 1

Interview Schedule for Participants

Participant	Interview One	Interview Two
Kat Minou	October 9 th	November 6 th
Lady Godiva	October 9 th	November 6 th
Oh Henry!	October 16 th	October 30 th
Lila	October 16 th	November 25 th
Fettuccini Princess	October 30 th	November 18 th
Camille	November 11 th	November 25 th
No Name	November 11 th	November 27 th
Mich Mich	November 3 rd	November 18 th
Carlie	November 18 th	December 4 th
Princess Akita	November 20 th	December 8 th
Mason	December 4 th	January 12 th

The first interview was designed to focus on life histories and experiences; the second interview focused more on meaning-making and was designed recursively to elaborate on emerging themes and responses from the first interview. This method of interviewing was appropriate for research involving youth because it enhanced rapport and trust over time, and provided the opportunity to revisit and clarify discussions from previous interviews. I noticed a difference between interview one and interview two in terms of how relaxed participants were. We could jump into the questions with greater ease in interview two and there seemed to be less hesitation on both parts. Having reviewed my notes and recordings between interviews, and in some cases having had time to transcribe the first interview before the second was conducted, allowed me to identify areas where I neglected to ask important follow up questions or did not get enough detail to inform a fulsome understanding.

A notable example of the benefit of the two-interview approach occurred early on in my interviewing when a participant started to describe a past history of family abuse. As a novice interviewer, I did not know how much to probe or to ask, and the details included in this disclosure were somewhat jarring for me. I felt uncomfortable in the moment but maintained a

relaxed manner and expression. I listened actively as my participant shared their experiences, but I needed time to process this disclosure before deciding whether more information was necessary or which follow-up questions to ask. The time between the two interviews allowed me space for critical reflection, something that proved to be of great importance in this study. The second interview provided an opportunity to revisit topics or clarify my interpretation of what was previously discussed. All interviews were conducted in person and all participants completed both interview sessions. Interviews were audio recorded and transcribed verbatim for analysis. I conducted the verbatim transcription. Several participants remained in the room to chat with me once their interview concluded and the recording stopped. In these cases, I asked whether I could continue to take notes and all participants agreed.

Demographic questionnaire. Participants completed a paper-based demographic questionnaire at the beginning of the first interview session (Appendix G). The questionnaire collected background information about the participant's pregnancy status, number of children, educational attainment, media use, and housing stability over time. Demographic questionnaires were completed using the participant's study pseudonym and did not collect directly identifying information.

Field notes. Field notes were collected for two purposes: 1) I collected field notes while observing interactions at the residence to gain an understanding of the context, dynamics, and atmosphere of the environment; and 2) I maintained descriptive field notes as the interviews progressed in order to describe the setting, record initial thoughts including things that went well or did not go well, and note participant manners and moods. Notes collected during the interview sessions were used to document pertinent non-verbal behaviours or reactions that could not be captured in the audio recordings. I also made detailed reflective notes after listening to the

recordings and reading the transcripts to document initial impressions and potential follow-up questions.

Key documents and sources. I reviewed select key documents from the research site, including the mission statement, program guides, news stories, and website to gain a greater contextual understanding of the residence and its history. Additionally, I asked participants to describe the sources of health information or educational resources they accessed while pregnant, including reference materials, media sources, chat groups and websites. I reviewed any publicly available sources they identified in detail, including television programs and social media sites (e.g., Facebook groups, Twitter feeds) to gain greater insight into the sources participants identified as contributing to their health education during the perinatal period. While formal document analysis was not conducted, these key documents and sources were reviewed for context and background, and to gain a general sense of their content and style. The review of these documents provided a foundation that enriched interview discussions because I had some awareness of the resources they described.

Researcher journal. Maintaining a researcher reflexive journal strengthened my role as researcher, and facilitated critical reflection (Guba & Lincoln, 2005; Janesick, 1999). I completed a reflective entry prior to study start, and continued to complete journal entries immediately following each interview to describe my experience and document my feelings about both the process and data being collected (Hatch, 2002). These entries helped me remain aware of my preconceptions and assumptions, document my insights, and clarify my personal feelings. I wrote entries almost every time I was at the residence or engaged with the data, and this was more journaling than I've ever done before. In some instances, journal entries were lengthy and detailed, in others they were merely a few words scrawled in my notebook with exclamation

points or question marks. Regardless, these regular journal entries allowed for a tracing of my thinking as the study progressed. As such, they served as a supplementary data set. These reflective moments also allowed me some distance from the interview subjects and stories I was being told because my journaling was done through the lens of the researcher. I read relevant journal entries before conducting the follow-up interviews to review information that could enhance the interview quality. I also completed journal entries during preliminary analysis to note recurrent themes, which helped inform the sense of data redundancy.

Participant's personal reflection activity. Following the first interview, study participants were invited to take part in a personal reflection activity. The personal reflection activity was intended to be a discussion point during the second interview. Participants were guided by the following broad and open-ended question: 'If you were going to send a message to your baby about your pregnancy experiences, what would you say?' In terms of format, this personal reflection could be shared verbally during the second interview or could take the form of artifacts, images or texts that they brought with them. These could include, for example, letters, notes, lyrics, poetry, drawings, videos, or photographs. This activity was included because the research site offered numerous programs and activities that promoted the arts, and the reflection activity was an opportunity for creative expression. No participants opted to create a personal reflection piece and many noted that they were too fatigued by pregnancy or parenthood to feel creative. Rather, we discussed the personal reflection during the second interview. This question was often the first shift of the women talking about their baby to talking to their baby, which fostered interesting dialogue.

Data Management and Analysis Methods

Preliminary analysis started soon as the interviews were conducted and transcribed. Between interview one and two, I familiarized myself with the interview data by reading it a minimum of four times with different purposes: 1) to gain an overall sense of the data and record initial impressions through field notes and journaling; 2) to transcribe the audio recording verbatim; 3) to verify the completeness of the transcript; and 4) to review the transcript data before the second interview was conducted. I conducted all transcription myself, which gave extra opportunities to hear my participants' voices and words. At times, the additional listening, writing, and reading of my participants' words was useful to highlight areas that I should follow-up on or subtle moments of hesitation in speech.

Data analysis involved a process of returning to the raw data numerous times, and systematically organizing and arranging the interview transcripts, field notes, key documents, and reflexive journal entries. As per the recommendations of Merriam (1998), analysis involved the iterative 'back-and-forthing' between data and concepts, as well as descriptions and interpretations. As I collected data, my goal was to identify patterns and themes. Throughout data analysis and interpretation, I remained open to contrary or alternative explanations for my findings. More specifically, data analysis began with within-case analysis, and the detailed description of each case and context. The process described by Bogdan and Biklen (1992) guided preliminary data analysis for each case: iterative cycles of reading and rereading the data; developing codes; adding, modifying, refining, and discussing codes; sorting the information found into categories; and finally, analyzing the categories for patterns and themes. During within-case analysis, I examined and described each case within its context to explore themes and relationships that confirmed and conflicted with the evidence on adolescent prenatal education

(Miles and Huberman, 1994). Each individual case (PPY) is presented in the form of a narrative description (Creswell, 1998), structured around the most prominent categories that emerged from the data and informed by the interconnected systems described in Bronfenbrenner's bioecological systems theory. The goal of the within-case analysis was to describe, systematically and in narrative form, the experiences of the women interviewed.

Interpretive cross-cases analysis followed. In this process, themes and patterns were compared across cases for similarities and differences. Stake (1995) suggests four forms of data analysis to guide cross-case analysis: direct interpretation or drawing meaning from a single instance (Creswell, 1998); categorical aggregation; the establishment of patterns and correspondence; and the development of naturalistic generalizations or "generalizations that people can learn from the case either for themselves or for applying it to a population of cases" (Creswell, 1998, p. 154). Findings that arose from cross-case analyses are presented thematically.

Initial cycles of data analysis were conducted on paper, with notes in the margins of transcripts and emerging themes recorded on index cards. Index cards were used for their ease at organizing and reorganizing themes and categories as data collection and analysis progressed. There were often colourful index cards posted to the wall in my office with words or ideas written on them, and I spent long hours viewing, considering, and contemplating the best fit for the data. Once I started to recognize patterns and findings seemed to stabilize, these index cards were organized into a preliminary coding scheme. This scheme became a data dictionary featuring a summary description of each code. At this point, analysis shifted to using the computerized qualitative research analysis software NVivo10 (QSR International). Transcripts were imported into the software, my data dictionary became parent and child coding nodes, and I used my margin notes to help highlight passages of quotes that could be organized more clearly

into their corresponding codes. This software facilitated data management, and quotes could be re-ordered and re-organized with ease. NVivo also facilitated the maintenance of analytic memos as my coding structure developed, with some codes collapsing and others expanding. As time and analysis progressed, the structure and content of codes continued to evolve, and the software permitted data retrieval and organization, as well as word searching and data querying. When I started to write my within and cross-case analyses, representative quotes were efficiently accessed using the software. Demographic questionnaire data were entered into IBM SPSS version 21 and analyzed using descriptive statistics.

Trustworthiness

Demonstrating the trustworthiness and rigour of the research process informs the quality of discoveries and research findings. During data collection, reduction, and analysis, I used the criteria proposed by Lincoln and Guba (1985) – credibility, dependability, confirmability, and transferability – to form the framework for demonstrating the rigour of my research. Credibility refers to the value and believability of the findings (Lincoln & Guba, 1985). This was enhanced through peer debriefing, a process in which I discussed all analytic and methodological decisions with a colleague of equal status who was experienced in qualitative methods and had worked with adolescent populations. The peer debriefer did not have access to any identifying information or audio recordings, but at times we did review de-identified passages of transcripts together. They did not keep research materials (e.g., transcripts, data) in their possession and signed a confidentiality agreement prior to being reviewing any study materials (see Appendix H). I also made additional efforts to demonstrate credibility through member-checking. I invited participants that had shared their email addresses and agreed to follow-up contact to read a summary of the key preliminary findings, reported as themes. The list of themes was sent to 6

participants to verify whether the analysis resonated with them. Participants were invited to submit feedback to me by phone or by email, though none was obtained. At the completion of the study, I also presented the study findings back to staff from the residence and outreach centre during one of their meetings. Several staff members had suggestions about potential implications from my study and next steps for research.

Confirmability refers to the neutrality and accuracy of the data (Tobin & Begley, 2004), and was enhanced through the maintenance of a detailed audit trail and through reflexivity. A systematic log of notes and electronic memos outlining decisions made to provide a rationale for my methodological and interpretative choices comprised my audit trail. I also kept a reflective diary throughout all phases of the study to provide insight for decision making, as well as to highlight my values, instincts, and any personal challenges experienced during the research process. Dependability refers to the stability of data (Graneheim & Lundman, 2004), which was enhanced through auditing. In addition to maintaining an audit trail, I completed duplicate coding of three interview transcripts in NVivo to examine code-recode consistency. The coding scheme displayed a good level of agreement, and thus did not require further review with the assistance of the peer debriefer. Transferability refers to whether or not particular findings can be transferred to another similar context or situation while still preserving the meanings and inferences from the completed study (Leininger, 1994). While I recognize that the group of participants in this study represent a very specific population of PPY, this criterion was enhanced through thick description and the detailed field notes that I collected throughout the study. My field notes and records included accounts of the context, participant characteristics, and the research methods.

Chapter Four: Results: Within - Case Analysis

This chapter explores the results from within-case analysis. The aim of the within-case analysis is to describe, in narrative form, the experiences of the women interviewed in this study at they relate to maternal health and their views. Within-case analysis begins with an outline of demographic information, followed by a detailed narrative description of each participant. Participants selected their own pseudonyms and these will be used throughout. The narrative descriptions are presented in the order that participants were enrolled in the study, and feature verbatim quotes whenever possible to honour the words and voices of participants. Each narrative is structured according to key features that emerged during the interviews, as are organized to highlight as some of the proximal processes or close relationships in the women's lives. The results from cross-cases analysis, presented thematically, follow in Chapter Five.

Demographic Information

Demographic data was collected during the first interview. Table 2 presents select demographic data for study participants, in the order of study recruitment. A total of 11 young women aged 17-20 years and living at the residence participated in the study. Three participants were born outside of Canada. Five participants were pregnant and six were parenting. Four participants were dating, two were engaged, and five were single parents without any involvement of the baby's father.

Table 2

Demographic Data of Participants

Pseudonyms	Age (years)	Pregnancy (months)	# of Children	Age of infants (Months)	Age of other children (Months)	Relationship Status	School Completion
Kat Minou	20	6	-	-	-	Single	Y1-University
Lady Godiva	20	-	1	1	-	Engaged	12
Oh Henry!	18	-	1	1	-	Single	12
Lila	20	-	1	6	-	Single	11
Fettuccini Princess	20	6	-	-	-	Dating	12
Camille	20	-	1	2	-	Dating	11
No Name	18	-	1	3	-	Dating	11
Mich Mich	20	5	2	-	12, 24	Engaged	11
Carlie	17	6.5	-	-	-	Dating	10
Princess Akita	17	5.75	-	-	-	Single	11
Mason	18	-	2	3	24	Single	9
Mean	18.91	5.85	1.29	2.67	20	-	11.18

Kat Minou

Kat was the first young woman enrolled in the study and was very eager to participate. Her demeanour was friendly and relaxed, and she shared her experiences candidly. She held eye contact and smiled often, however when the discussion turned to what she described as the “hard times” she tended to avert her gaze to her hands or the floor. Her interview sessions were conducted in the private visitation room at the residence. Both times we met she sat cross-legged in the leather club chair, and frequently rubbed her pregnant belly. During her second interview, Kat proudly lifted up her shirt to show how much her belly had grown in the month since we last spoke. I learned, at the completion of the study, that Kat delivered a healthy, full-term, baby boy in January.

Becoming pregnant. This was Kat’s first pregnancy and she described it as both unplanned and unexpected. She became pregnant with someone that she had known only briefly: “I had a boyfriend and we were together; we were madly in love with each other for like five

years. [Then we] broke up and I [got] pregnant with someone else's kid." The pregnancy was confirmed at four and a half weeks gestation but Kat had a sense she was pregnant much sooner. Kat didn't have the funds to purchase a home pregnancy kit so, following a missed period and some early symptoms, she went to a walk-in clinic alone for a pregnancy test. This decision was made "on a whim" one morning on her way to school. She chose a walk-in clinic rather than her family doctor's office due to the location, convenience, and an enhanced sense of confidentiality.

She was overwhelmed with emotions when the pregnancy test revealed a positive result: "I started bawling my eyes out." The physician arranged a follow-up ultrasound and briefly reviewed pregnancy outcome options with her. Her initial thoughts wavered between adoption and motherhood. Immediately following the doctor's visit she called the father of the child to inform him of the pregnancy.

Beliefs about pregnancy. In terms of decision-making, Kat sought signs and believed in "letting the universe decide." She remarked: "I don't want to change much. Like if it's gonna happen, it's gonna happen, and it's gonna happen for a reason." She believed that the pregnancy happened for a reason, and her decision to carry it to term was influenced by her personal beliefs about abortion:

Whenever women do, do it I'm not like "oh you baby killer" I'm not like that at all. I'm like: that was your decision. I, myself, didn't choose that...I'm more of a person that would kind of go down the adoption route if I really felt that I wasn't capable but I know that I am mentally and physically. Obviously, I'm ready.

Before becoming pregnant, she empathized with young mothers: "I kind of, I felt sorry for them. I always felt really bad." She never thought that young motherhood was a reflection of negative life circumstances or choices: "Doesn't matter how *ghetto* you are, you know? People think that people get pregnant because they're like sluts and whores and stupid and not done high

school and all stuff. But I did university, I did college, I graduated high school, and I'm still here."

Relationships. *Family.* During the two interview sessions, Kat frequently compared and contrasted her experiences with her those of her mother. Her mother was "very young" when she had her first child and raised their family alone: "she was a single mom as I'm gonna be — I'll be a single mom too — and she knows how hard it is... and she was just upset because she didn't want me to go through what she went through." Her younger brother and sister are still living with her mother in a one-bedroom basement apartment. She felt that her family lacked closeness and remarked that their communication was somewhat poor: "we didn't talk that much as a family." Kat did not discuss her father.

Father of the baby. Kat and the father of the baby "tried to make it work" initially but found the relationship quite challenging. He moved in with her for a few weeks and attended two prenatal ultrasound appointments before their relationship ended. Kat described this time as a period of conflict and stress: "we didn't know each very well; we didn't know each other at all really." She is no longer in contact with the baby's father.

Peers. Kat always had a somewhat small group of friends. Her school peers became a very important part of her life while she moved to a new city to attend university and was living in residence. That said, she hadn't socialized with them since leaving school. Upon return to her hometown, she reconnected with her peer group from high school, work colleagues, and a select few friends from her college.

Work. Kat worked part-time in a retail store that sells a range of natural, handmade bath and body products. She reflected on her work enthusiastically: "I love my job, I love my coworkers, it's an amazing job." She worked three shifts per week throughout her pregnancy,

eager to eventually attain fulltime employment. That said, as her pregnancy progressed, she started to notice the strain on her back and joints from prolonged standing.

The Residence. Housing and finances became some of the biggest concerns for Kat once pregnant. She questioned her capacity to provide for herself and a child. Soon after she learned she was pregnant, she moved in with family friends but the relationship became strained because “[they] thought I wasn’t doing enough ‘cause I was depressed. I just didn’t want to do anything so living there was not helpful either.” Concerned for her wellbeing, the family friends staged an intervention that resulted in Kat feeling “ganged up on.” She realized that this living situation was not a viable option long-term.

Kat had never heard of the residence before becoming pregnant. Once she and her family came to the decision that there was no room for her and an infant in the small apartment they shared, her mother searched for alternatives and community supports. Her mother came across the website for the outreach centre and Kat called to inquire about their programs. She visited the residence the following day and moved in one-week later. At the time of the first interview, Kat had been living at the residence for three weeks. Her first few weeks living there were a steep learning curve because she had to adjust to the schedules, routines, and rules of the residence.

Sources of Social Support during the Pregnancy. Many of Kat’s relationships changed once she became pregnant. She waited until her second trimester of pregnancy to tell her friends and family about it; first Kat told her close friends, then her siblings, and finally her mother. Her sister expressed concern about the pregnancy initially but has since become a source of support. She commented:

They were really mean at first, my sister was really mean just because the dad is not ideal and he’s not- we’re not going to be together. I mean we knew that from the start when this happened...so she was kind of pissed off about that and she said ‘this baby’s gonna be a

crack baby' and just like hating my baby because of him, right? And then she came around as well, of course, and she's more excited than anybody.

Kat was most anxious about telling her mother: "The initial conversation that I had with her went better than I thought. And like I was expecting her to just *bawl* right away but she didn't; she actually like talked to me and was kinda like shocked." Her pregnancy helped unite her extended family, and during the second trimester of pregnancy, her grandparents, aunts, and uncles became added sources of emotional and instrumental support: "They're really supportive- except for my one uncle who's being a dick- but the rest of them, you know, they're dropping off baby clothes that they find online for free, they're collecting stuff for me and it's amazing." She has formed friendships with the other young women living at the residence: "I would say yeah, I have a few friends but the ones that are here are probably my most important ones. And I've only known them for a few weeks."

Health and educational experiences. *School.* Kat was the only study participant to attend post-secondary education. University afforded Kat opportunities for learning and personal growth, and she spoke about her experiences with enthusiasm: "I loved it! [...] I learned so much, made great friends, learned a lot about myself, learned a lot about lots of things." By the end of her second semester, she realized that she had inadequate funds to continue with the program. At this point she withdrew from school to work full-time and minimize her debt load before returning to her studies. In January 2014, she enrolled full-time in a two-year law clerk diploma program at a local college because she "loved school [and] did not want to be out of school." She completed one semester of the program before learning of her pregnancy. The accompanying stresses and symptoms of pregnancy resulted in several failed or incomplete courses. Kat intended to return to college when her child is a year old to complete the law clerk program.

Health and previous health experiences. Before becoming pregnant, Kat would schedule physical exams with her family doctor every few years. She described her overall health as very good, despite a history of anemia that required daily medication and monthly injections.

Participating in prenatal education. Kat has learned about her body, pregnancy, motherhood, infant care, and labour and delivery from a number of sources including her friends at the residence, the public health nurse, her doctor, instructors at the outreach centre, staff at the residence, and family members. She has also engaged in formal prenatal educational classes offered at the outreach centre: “I’m in a Transitions to Parenting class, so that’s learning about when the baby gets here, more focusing on that when he’s actually here. And then Pregnancy Circle is all about the pregnancy and what to expect and labour and delivery.” Kat appreciated that men and women aged 17-22 attended these courses.

Navigating prenatal health. Kat was being assessed by a physician at the outreach centre every two weeks and had monthly appointments with her family doctor. She completed all recommended prenatal care and testing: “I have like a bunch of tests that I go to, I have an echocardiology test appointment for myself, I have the glucose test eventually, I need shots cause I’m a negative blood type, I need my B12 shots.” Focusing on her health became a priority while pregnant: “I want to be able to get myself full and healthy.” Kat admitted to being “very, very bad” at remembering her vitamins but noted: “my baby is 100% healthy so I’m happy about that. I’m not too worried about my vitamins. Doctors are but I’m not.”

Time. The first trimester. Kat reflected on the first trimester of pregnancy as: “The worst three months of my entire life.” She preoccupied with concerns about disclosing her pregnancy status, and experienced intense episodes of depression and anxiety. She felt very alone:

I had to go through a really shitty relationship with the father. I had to go through failing classes um... yeah it was really tough.... In those three months too I didn’t tell anybody.

My mom didn't know I was pregnant; nobody knew I was pregnant. So that as well, I had to go through all this without telling anybody.

She also experience a number physical symptoms at this time including nausea, vomiting, fatigue, abdominal cramping, and cravings from having quit smoking "cold turkey."

The second trimester. During the second trimester of pregnancy, she started to feel better and was prescribed Diclectin to manage her morning sickness. For Kat, the second trimester was a period of self-discovery: "[I'm] learning about how I'm gonna be able to take care of it.

Learning about my body right now... and how to take care of myself. Um...learning a lot about who's really there for me in the long run." She completed a birthing plan in anticipation of the delivery. Her mother and sister will be present for the birth of her child, as her birthing partners.

Lady Godiva

Lady Godiva's (LG) love of chocolate inspired her name choice. She had a flair for fashion and proudly showed me photos of herself, dressed in a canary coloured blazer at her recent Canadian citizenship ceremony. Her daughter was one month old at the time of the first interview and she was, by far, the most reluctant participant to speak while being audio recorded. Our first interview session featured a number of long pauses and short responses. I was surprised that, once the last question was read and the recorder was turned off, she remained in the room for an additional 40 minutes. During the post-interview period, she became more relaxed, laughed and shared anecdotes, and showed me numerous baby and pregnancy pictures on her phone.

While reflecting on our first interview together and recording my researcher journal entry I realized that, in addition to the recorder, taking notes and reading from an interview guide were barriers to communicating with LG. I tailored my approach accordingly and the second

interview featured a much more relaxed atmosphere, enhanced eye contact and non-verbal cues, and flowing dialogue. The interviews were conducted in the private visitation room at the residence.

Becoming pregnant. LG was born in Jamaica and she was in Jamaica visiting her family and fiancé when she found out she was pregnant. Following some menstrual irregularities, she went to a doctor to be examined and tested for sexually transmitted diseases, which all came back negative. After a missed period, she went to the pharmacy with her fiancé to buy a pregnancy test. The results of the first test were inconclusive so her fiancé returned to the pharmacy to purchase a different brand of test the following day. LG was in disbelief when the indicator showed a positive result, so she sought independent confirmation: “I’m like oh my god, so we went to the pharmacy just to confirm if I’m was actually- well we asked the pharmacy and she’s like ‘yeah she’s definitely pregnant.’” At this point, LG was 4 weeks pregnant. During the same trip, she learned that her 18-year-old cousin was also pregnant.

Beliefs about pregnancy. LG had strong Christian spiritual beliefs. While in Jamaica, before confirming her own pregnancy, she provided counsel and support to her newly pregnant cousin:

She’s a Christian and she’s baptised and I’m like: don’t listen to what people say. I know you’re young but abortion is bad and you know that, you read the bible, that’s not an option and adoption is not an option either so you’re going to keep the baby...

These same beliefs helped LG come to terms with her own pregnancy. Young pregnancies are more common in Jamaica, and LG felt greater stigma and judgment regarding young parenthood in North America

Relationships. Family. LG immigrated to Canada a week shy of her 13th birthday. She was reluctant to speak about her parents but commented: “I lived with my mom then I came here

and lived with my dad. We didn't really get along so that's why I was always moving around, living with people." She lived with her father at the time of her pregnancy but that relationship was already tense: "I was having issues with my dad and he told me to get out." Her parents and fiancé have not yet met the baby.

Adjusting to the Canadian context was a little challenging for LG at first. While she experienced strain due to geographic separation from her extended family and later from her fiancé, she listed the advantages her daughter would have in Canada:

It's better economy-wise and I want her to go to school here because if you go to school here you can work anywhere in the world you want so that's why it's I stayed here instead of going back home and I haven't lived there in a long time so it's different for me. I'm so used to working here and environment here.

LG described pregnancy and parenting as rewarding experiences but felt that her life would be enriched by the presence of family: "It's good to be a mom, it's great. She smiles at me makes me happy. Just wish I had my family support so I just can't wait to go back home..." Her family in Jamaica experienced a recent "baby boom" with four new babies, including hers.

Fiancé. LG's fiancé lived in Jamaica and had not yet met his daughter. He had two children from previous relationships, a 9-year old daughter and a 4-year-old son.

Peers. As a teenager, LG met another Jamaican-born girl in Canada and they became best friends: "'cause her dad and my dad, they're friends, when we were kids, kind of like growing up always Thanksgiving or birthday and stuff. So that's how we kind met each other and then we kind of click." This friend remains close and became the godmother to LG's daughter. She also developed a close friendship with one of the women living at the residence and planned to maintain this relationship once they received housing offers.

The Residence. LG moved into the residence at 20 weeks gestation: "I've been here since May, so it will be 8 months for me and it's been a really, really, really long 8 months." Living at the residence was a challenge for LG, and she described this time as "The longest months of my life." She came to live at the residence because she had nowhere to go when her father kicked her out, so she contacted her cousin in Jamaica for advice. Her cousin performed an Internet search to find community resources: "She's like: 'Oh I'm sure there's places' and she was Googling and she found it and she told me to call and that's how I kind of found out about it." She visited the residence in February but they were full and she was put on a waiting list. She couch surfed for three months until a bed became available at the residence. Couch surfing is a form of provisional accommodation that involves frequent moves from one temporary living arrangement to another, without a secure 'place to be'. It refers specifically to people who live "temporarily with others but without guarantee of continued residency or immediate prospects for accessing permanent housing" (Gaetz, Barr, Friesen, Harris, Hill, Kovacs-Burns, et al., 2012). Couch surfing describes people who are staying with relatives, friends, neighbours, or strangers because they have no other option.

Sources of Social Support during Pregnancy. LG established a few close friendships that formed her primary support in Canada: "Pretty much all my support is back home. I'm pretty much on my own with her cause the dad doesn't live in the country either." LG also listed her public health nurse and Birth Companion (BC) as sources of emotional, tangible, and informational support while pregnant. Her BC was a 23-year-old with a 15-month-old baby. She explained the role of the BC:

[She] is someone that helps you through your labour, massages you before, tell you before they do anything, if you want them to video or take pictures she's there just to comfort

you before your labour like when you're in like active labour you want to go in like a bath she's there to help you go through it to tell you how to breathe and everything.

She and her BC remain in close contact: "Yeah, she still comes around, she helps, she brings stuff for her and she brought a carrier for me to use for a little bit and then I have to give it back."

Health and educational experiences. *School.* LG completed high school and intends to become a nurse. She decided to take a year off to be home with her daughter before applying for school.

Experience with childcare. Growing up, LG was very involved with the childcare of family members. She learned about parenting by observing her family and assisting with their care:

My family is really good and always made me stay and take care of kids. Like growing up, I was always cooking, cleaning, and taking care of my cousins. So parenting is not that bad for me as it is for the other girls, because I was used to doing all that stuff and I was always responsible. So it's not a hard thing.

Health and previous health experiences. Before becoming pregnant, LG accessed health services when she was sick or had a concern. She had a family doctor but did not schedule routine annual physicals. She described her overall health as good, aside from being asthmatic and requiring inhalers.

Participating in prenatal education. LG has completed a number of prenatal educational programs offered at the outreach centre, including Baby and Me and Making the Connection. When learning about topics such as labour and delivery, she preferred watching videos instead of engaging in discussion with other mothers at the centre because their experiences scared her. She found the structure and format of some of the classes somewhat uncomfortable: "It's really

awkward (laughs) cause like you have to sit in front of other people and sing to your baby and play with your baby...”

LG considers herself a "visual person and hands-on-hands" person. When learning a new skill, she prefers to watch first and then be coached through it: "You have to be there, showing me step-by-step." The public health nurse used this method when teaching her about baby baths, and LG felt that this approach helped her build confidence: "Because they're so small and tender. I didn't want to bath her when she first came out. Now it's nothing now--I'm so used to it."

Navigating prenatal health care. When LG returned from Jamaica, she contacted her family doctor right away for an assessment and was referred to a physician that delivers babies. She had appointments with the new doctor every two weeks during the first 36 weeks of gestation, then weekly. She became very comfortable with this physician and they developed a good rapport. In fact, the physician shared her personal cell phone number with LG and she could send her a text message if she had a question or needed to reschedule an appointment. During the pregnancy, LG became more aware of her nutrition and food choices, which she would like to keep up long term. In the first month post-partum she received weekly visits from the public health nurse and now sees her every two weeks.

Time. Pregnancy, labour, and delivery. LG felt very well throughout her pregnancy and, unlike many of her peers, never had issues with nausea, vomiting or weight gain. Her contractions began a few days before the delivery of her baby. She presented to hospital when her contractions were 2-4 minutes apart but was sent back to the residence because she wasn't progressing. She contacted her doctor for advice at 2 a.m., when the pain and intensity of the contractions became unbearable. Her doctor advocated for her admission to hospital for pain management and monitoring: "I'm like 'I can't do this' and she's like 'go back, I'll call your hospital, I'll talk to them.' I go back still having contractions every 2-4 minutes, I was 2 cm

dilated and then they just admit me.” Once admitted, she received an epidural which helped relieve her pain. A few hours later, LG was rushed to an emergency C-section due to a sudden deceleration in her baby’s heart rate. She felt inadequately prepared for this: “I knew they were gonna cut you open that’s the only part. Yeah, that’s all I knew. I didn’t see anything, they just put something right in front of you.” She found the experience overwhelming and reflects:

I didn’t expect to have a C-section cause I was there waiting to push eventually. But then all of a sudden they’re like “oh we have to do a C-section” and was rushing me to a different room and it was like 10-15 people, so much people, yeah. So I was kind of scared and started crying cause I’m like what did I get myself into? I wasn’t prepared for a C-section.

The BC became invaluable during the delivery process and was able to accompany LG into the Operating Room. After the delivery, she acted as a conduit between the Special Care Nursery and recovery suite: “As soon as she was born they took her away and I asked and she’s like 4 hours she was gone.” The BC brought her frequent updates and information: “She took pictures, video of her, carry it back and show it to me and stuff ‘cause I didn’t get to hold her or anything when she was born so it was good.”

Post-partum period and parenthood. LG described her overall experience in hospital as good, although she recounted a negative encounter regarding breastfeeding teaching with a nurse. She questioned whether her breastfeeding outcomes would have differed had she been assigned a different nurse or received more comprehensive explanations and coaching about breastfeeding technique:

They were good other than one ‘cause like I was trying to breastfeed and like she’s pushing her head on my boobs like she’s a newborn they can’t, take gentle with her and like she was screaming and crying. I’m like: ‘I don’t want to breastfeed her anymore

‘cause she’s getting really upset, just kind of stop and give her a few minutes’. She’s like: ‘well babies, that’s what they do they cry’ and I’m like: ‘I don’t want my baby to crying for ten minutes because I’m trying to force her to onto my boob and I don’t want her to be upset when she goes to the boob’ and then she doesn’t understand and I’m like: ‘you know what? Just give me your formula’ and then I gave her formula and that was a help.

Despite numerous attempts at establishing a latch and breastfeeding following the introduction of formula, “[Her daughter] didn’t want boob anymore so then I just had to keep on giving her formula.” She described her time as a new parent as good but overwhelming: “I have to do everything for her myself, I don’t get no help.”

Oh Henry!

Oh Henry! (OH) selected this pseudonym because she craved Oh Henry chocolate bars throughout her pregnancy; she insisted on the exclamation point to express enthusiasm. She had a one-month-old daughter and, of all participants, she appeared to have the least support outside of the residence. She was the only participant without a cell phone or email address. She spoke openly and candidly about her life experiences. She arrived to our second interview upset, wanting to discuss issues she was having with the baby’s father rather than respond to my questions. Despite attempts to redirect the interview, this dominated most of our discussion. Her interviews were conducted in the private visitation room at the residence.

Becoming pregnant. OH was critically ill and nearing the end of her second trimester when she discovered that she was pregnant. Follow a three-day period of back pain, high fever, and malaise, she was admitted to the hospital with a severe kidney infection. This was the first time she had ever visited a hospital and she was alone. Her condition soon worsened, requiring blood transfusions and measures to stabilize her electrolytes and vital signs. The hospital staff

contacted her father: "Some people say they didn't think I would make it and some people saying they were calling some priest to pray for me." After extensive testing and treatment, the pregnancy was an incidental finding, confirmed by ultrasound. She recalled how she was informed of the pregnancy: "First of all, when I found out I was pregnant I could not talk because they put a tube inside me, I have like a tube and they say I was kind of not wake-up for like a while and I was like passed out for a while." OH's initial reaction to the pregnancy was complete shock. Abortion was no longer an option because the pregnancy was discovered at an advanced stage. She mentioned several times that, at this point, she thought her life was over.

Beliefs about pregnancy. Before becoming pregnant, young parenthood was not something that OH thought about. She had many career aspirations and life goals: "I'm not thinking like I wanna become a mother, I was thinking I wanted to become a back-up dancer. No, I wanna go like to be like an actress since I love drama. No I wanna be a gym coach." She experienced intense decisional conflict about the best course of action for herself and her baby:

Well, since I became pregnant I was mostly like my life was over and I'm not going to be able to do everything that I wanted to do because I am going to be really busy. At first I was going to give her to adoption and then I was like...well the first time I had problem with my dad he was like, what if you have problem having other kids. So I think about it and I decide I'm going to try to be a good mom and if I'm not going to be able to take care of her then later on I give her for adoption. But now I see I'm being pretty good with her. So yeah, that was a tough change and so I mostly focus on her and I barely have time for me.

Relationships. Family. OH did not want to discuss her childhood or life in Haiti. When asked about her early life, she commented that it was "kind of like an upside-down life," then indicated that she'd like to change the subject. Without a fixed neighbourhood or a steady home

from age 5 onwards, she described this longstanding history of housing instability as “moving around a lot.” When she was quite young her mother passed away and she has no memories of her. Her older brother was killed the year before she left Haiti. She immigrated to Canada at age 12, as a means of establishing a sense of permanence:

So I wasn't stable because I was always moving. When I came here in Canada it was kind of the same thing because I didn't really live with my dad. I was living in his friend's house and then went to his other friend's house and living, and then to another friend's house.

OH entered the shelter system at age 16, following several years of couch surfing and short stays with friends of her father. She recounted how frightening her first stay in a shelter was because she felt surrounded by abused or addicted women. She slowly became comfortable with shelter life and developed a few friendships.

Father of the Baby. OH did not know the baby's father well. She informed him of the pregnancy as soon as she was stable enough to communicate. He was absent throughout the pregnancy and had not met his daughter at the time of the first interview. In fact, he changed his phone number once notified about the pregnancy, rendering communication nearly impossible. When the baby was born, she mailed him a letter and called his aunt to notify them of the birth. The morning of the second interview, the baby's father and his aunt had come to the residence to meet the baby. This was a strange experience for OH; he held his daughter for approximately 3 minutes, without interacting with her or speaking, then asked to leave. She recounted:

Yeah, he did have experience, he have a son, yeah. But the thing is, I don't know, this one he was not expect to have her. It was kind of like a surprise for him so it was something he was not willing for, ready for. It just happened, so it's kind of like overwhelming for him. It's like, this is why he came this morning. I saw him with the baby I was gonna like

try to see ...what he's feeling, what he's thinking, and I tried to see some reaction from him but no reaction, nothing. He was just blank. It was like he was kinda in this space for some reason; he was just like a wall or something.

She was unsure of the best course of action moving forward, and hoped that, with time, the baby's father would want to engage in her care. If not, she was prepared to parent alone.

Peers. OH preferred to communicate in person or by telephone rather than in writing or through social media, opting not to have an email address or Facebook account. She found this isolating at times. For instance, she felt very lonely while hospitalized because her shelter and social worker could not disclose her location or circumstance to her classmates, even though they were looking for her. Since relocating to the residence, she formed a close friendship with another young parent: "I learn with her and now we go to our program together: Baby and Me. We're pretty close and we meet here and our babies are like 2 days apart."

The Residence. OH compared and contrasted the residence with her other shelter experiences. Her previous shelter had a more transient client base and a curfew but few other rules: "At the other shelter you barely see the people in the house. Sometimes someone will go away for weeks and come back, sometimes the house is empty and you can watch TV and use computer." She was transferred to the residence at 34 weeks gestation. OH had a very hard time adjusting to the rules and the number of women she shared space with.

During the post-partum period, OH became quite ill with a repeat kidney infection. OH was not able to articulate the cause of her repeat kidney infection and appeared to have a very surface level of understanding about the treatment of her kidney issues. The staff at the residence notified the CAS after witnessing her weakened state and questioning her capacity to parent while sick. Following a brief investigation, the CAS placed her newborn in temporary foster care. She felt hurt and betrayed, largely because "No one talked to me about it." Following the

temporary apprehension she harboured a deep sense of mistrust for the staff at the residence: "I'm not feeling like safe pretty much while I'm here and telling my emotions or anything like that."

She was determined to conceal any future illness from the staff at the residence for fear of losing her daughter:

So if it's something I will keep everything for myself since now I don't trust any staff and I don't need any help from them right now. I just want to do everything on my own and then like get out of here as soon as possible. So yeah, if I'm sick or anything, I would probably try to like do something on my own like ask for one of my close friends to say I have this problem and I need some help and ask if I can find another way to get some help.

Sources of social support during pregnancy. When she became ill, the hospital social worker contacted OH's father and he came for a visit. Once he learned of her pregnancy, he ceased all contact with her. She found this particularly difficult: "He's the only one I have that's family here--my other family members are in Haiti and other countries." Since then, she has started to build a new support system: "He was the only support I have and he's not around now so I'm mostly on my own. And now there are other people around me that are giving me support and other stuff." She had a BC that she remained in contact with: "We're still very close." She noted: "I was her first, first client. It's pretty cool." Her social worker and CAS worker developed a care plan to ensure continued, long-term community support. She found this care plan helpful in identifying additional services and sources for donations at local centres. She will continue taking programs at the outreach centre once she moves out of the residence, including a program to enhance mother-child attachment.

The Children's Aid Society. OH's daughter was placed in foster care for 10 days while she recovered. The process to regain custody of her daughter was not straightforward. She had to

attend supervised visits with her baby, followed by a 24 hour trial of custody during which time her care was observed by staff at the residence. Following the trial period she regained the fulltime custody of her daughter, however her case will remain open with the CAS for a minimum of 6 months. This experience made her acutely aware that, without family support or the involvement of the baby's biological father, her daughter would be placed in care if anything was to happen to her. This motivated her to contact the child's father again, noting: "I don't want her to go to some foster home with some complete stranger. I want her to go with someone I know and not some random people."

Health and educational experiences. *School.* OH's senior year of high school was packed with extra-curricular activities: "I was a very, very, very busy person and I mostly contributed to finish my high school and then like, sometimes like a lot of projects I wanted to do." She was determined to obtain her diploma and achieve the grades necessary for college admission. She missed three weeks of school when hospitalized but was adamant about returning to her studies. In fact, she advocated for an early discharge from hospital: "I wasn't supposed to go do school but I was supposed to stay in the hospital for more weeks and then I leave the hospital and go to the shelter and say that I have to do my courses." She completed her diploma requirements and wrote her exams while receiving intravenous infusions. She acknowledged that this likely jeopardized her health: "I finish and after that feel even more sick but I have to keep going and stuff." After completing her courses, she was determined to attend prom and graduation, wanting the "full high school experience." She contacted her social worker to request funds for a prom dress, and beamed with pride as she recounted: "Then I go shopping for my prom dress, get appointment for my makeup, hair and everything, and then I go to my prom. Then I go to get my diploma and everything like that." No one knew she was pregnant at prom

because she didn't start to show until 36 weeks gestation. She was admitted to a nursing program at a local college but had to put her studies on hold due to her daughter's birth.

Health and past health experiences. Health care engagement was largely absent from OH's experiences prior to the kidney infection and pregnancy: "I never, ever, ever go to a hospital before because I was a very healthy person." She had never had any type of health examination, preventative care, or treatment from a physician, dentist or optometrist: "this was the first, first, first time I ever see a doctor." Since engaging in programs at the outreach centre, she has received dental and eye exams. She was pleased to learn that she didn't have any cavities: "I was a really healthy person and eat healthy stuff."

Engaging in prenatal education. Talking about pregnancy did not come easily for OH. When she moved into the residence, she decided not to take any formal educational prenatal classes offered at the outreach centre. She recalled: "I don't like group stuff and especially with strangers and I was not ready to talk pregnancy. I was still shocked and overwhelming so I decided to just stay and be home." She opted instead to read the book *What to Expect When You're Expecting*, and another one about labour. She questioned her readiness for this information, as she found it more frightening than helpful: "I've been reading something about the labour or... or after the labour how you're gonna be and I was kinda like okay this is creepy I don't want to see myself like that! No! Uh huh." Following the birth of her daughter, she started to attend the *Baby and Me* and *Transitions to Parenting* programs at the outreach centre.

Navigating prenatal health services. Once her pregnancy was discovered, OH started to see an obstetrician every two weeks. Once the baby was born, she received visits from the public health nurse every two weeks. During the pregnancy, she was not comfortable asking her obstetrician questions: "No, I never ask questions." She found the appointments awkward and did

not want to listen to the fetal heart rate. While pregnant, she took iron supplement and prenatal vitamins.

Time. *Pregnancy, labour and delivery.* OH's pregnancy passed quickly and smoothly, likely because it was discovered at 25 weeks gestation: "I was not feeling pregnant. I didn't have a chance to feel the pregnancy from the beginning and at 41 weeks, I feel like I was just starting and I was just getting there. It was nothing for me." The staff and other mothers at the centre became concerned because as her pregnancy progressed, she had not made any purchases or started to prepare for the arrival of her baby. One day, however, she felt ready to prepare: "It just happened, it was really weird. When I was close to thirty-eight weeks pregnant and this is when I was started to plan everything." She felt that, up until that point, she was still processing the whole experience:

One day I just wake up and after I clean my room and then I go to downstairs, filled a basket with supplies and I go take money...and I go to Shoppers buy some baby stuff, buy everything, and I ask for a list and I buy everything they ask me to. And after that I get in my room and I get her crib ready, everything ready and then every staff was pretty shocked about it.

OH went into spontaneous labour two days before her scheduled induction date. When the contractions started, she contacted her BC and went into the hospital. On arrival, she was 4 cm dilated. She received an epidural at 6 cm of dilation, and remained both composed throughout: "Some moms were screaming but I was focussed and followed all the instructions." Her healthy daughter was born at 41 weeks gestation, weighing 7.5 lbs. She was surprised by the size of her daughter because her weight had remained unchanged throughout the pregnancy and her baby bump was very small.

Parenthood. The post-partum period was somewhat overwhelming for OH: “So you mostly focus on the baby... you totally forget about yourself sometimes.” Early on, she had some difficulty learning her daughter’s cues and needs:

At first it was hard and I didn't know what was going on. I was kind of like lost but now I feel more comfortable and I like know what she needs and know when the baby cries – since the baby can't talk. But I get used to it now and I know when she's crying, why she's crying now.

Breastfeeding was a challenge at first but ongoing support from the public health nurse helped her continue. She was quite proud that, at one-month of age, her daughter weighed 10lbs, 14oz.

Lila

Lila was the only participant to contact me based on my research poster. She saw a poster at a school program for pregnant and parenting youth, where she was enrolled fulltime and completing two high school credits. Lila was parenting a health 6-month-old son, and was very motivated to share her story in order to help other young women. She was very energetic and loved to laugh, even when discussing some of the struggles she experienced. She had a strong presence, powerful voice and a sure tone. She was late to both interviews, arriving directly from school with her son in a car seat and numerous bags. She completed her interviews in the visitation room at residence.

Becoming Pregnant. Lila described her pregnancy as “kind of accidentally on purpose.” Though she and her partner decided to stop using birth control, they were not explicitly trying to become pregnant: “I wouldn't say that I was trying to have a kid, in my head, but it just happened and I guess I wanted it to happen. It's like subconsciously something ticked and I was like: let's do this.” A seven month period of unprotected sex preceded the pregnancy: “We stopped using

protection and we knew what the outcome would be and I actually went to the clinic to take tests about 5 times a month." The pregnancy was confirmed by a pregnancy test taken at school. She was unsure whether the test was displaying a positive result because it was so faint, so she brought the test to her guidance counsellor for independent confirmation. Lila reaction was calm concern: "I just was like okay, okay, this has happened." She shared the news with her boyfriend who requested a repeat pregnancy test. Two days later, a second pregnancy test revealed a positive reading.

Beliefs about pregnancy. Motherhood was a lifelong goal for Lila; she elected to complete her high school parenting class twice. She was very comfortable openly discussing sexuality and became a resource for her classmates: "Everyone came to me to ask me about pregnancy, even people I didn't know." She bought pregnancy tests for her peers if they were too shy to buy them. Lila had a previous, unplanned pregnancy at age 17, which was aborted. She thought of this often, "I kind of also mentally promised myself that if I was ever to get pregnant again I'd keep it."

Relationships. Family. Lila grew up in a small town in Western-Quebec with a close-knit community where "Everybody knows everybody." She lived at home with her parents until she turned 16, when she moved out to live with friends, often transiently couch surfing. When she told her parents about the pregnancy, they seemed supportive, though her father insisted that her two options were to carry the baby to term then give it up for adoption or to marry her boyfriend right away. She moved back home with her family but found it difficult due to her mother's mental health issues: "She was just really a downer and just kept taking things out on me." Following the delivery of her son, Lila decided not to return home to live with her parents. In the post-partum period, her mother was "kicked out twice" from the hospital ward due to fighting.

Since then, Lila hasn't had much contact with her parents but they are slowly working to rebuild their relationship.

The father of the baby. Two days after they learned of the pregnancy, their relationship ended. Lila described this time:

Emotionally I was really under a lot of stress because I didn't know what to do because he left and before that I said honestly if I was to get pregnant, I think you'd leave--and he left. I think he was just shocked or under shock or something because he was like a good guy and would go to church every Sunday and he flipped and started doing drugs and started seeing this other girl and started going all off rails.

He disclosed the pregnancy to his parents approximately one-month later, without Lila present: "They freaked out and told him that it's not an ideal situation." Lila has dated other people since the birth of her son but felt that it never worked out because she was still hoping to rekindle the relationship with the baby's father: "We've been through hell and back so why stop now." At the time of the first interview, they had started to see each other again, though she was keeping this information from her CAS worker due to the volatile nature of their relationship in the past. She commented: "We fought a lot, we really did but we're just trying to make things work and we're so set on trying to be a family still." He planned to participate in programs at the centre but had not yet, and had shared custody of his son.

Peers. Lila felt that her "family isn't really there" and that her friends "aren't really that important." While pregnant, she posted pictures and status updates frequently via social media. Throughout the pregnancy, she maintained a close friendship with her best friend from childhood who was also parenting a young child. She developed some close relationships with her classmates at school, and believed that friendships among the network of young mother would last.

Church. Lila was a member of the Mormon Church, and her Bishop was influential in her decision-making. The Mormon Church frowned on pregnancy outside of marriage: "It's kind of like a big deal to be pregnant at a young age or before marriage even. We're Mormon, right? So it's very strict and all that." Her Bishop counselled her about the options the church would support: "They said, you know 'cause they're strict, you know: adoption or get married." The church provided resources and support to Lila throughout the pregnancy.

The Residence. Lila was aware of the residence and had spent an afternoon at the centre offering makeovers as part of an aesthetics course she once took. Following the birth of her son, when returning to live with her parents was no longer a viable option, she moved in with her son's fathers' family. His family had suggested that she transition to the residence directly from the hospital but she was uncomfortable with the idea of living with strangers. She lived with them until she felt that the living situation was no longer healthy.

She arrived at the residence at 2 a.m., with her 3-month old son: "Everything happened so quickly, I just felt like I was on a carousel that was going so fast that I couldn't stop or even see anything." She had a very difficult time adapting to life at the residence, feeling lost and alone: "The first 2 weeks were the hardest, I didn't eat, I didn't sleep and it was a big adjustment for the baby too. We were both miserable." Lila slowly adapted to life at the residence and engaged more in the services and programs offered at the outreach centre. She made an effort to get to know the other women: "I feel like the only way to get by is if you get along with everybody, even if you really don't like them. You find something good about everybody."

Sources of social support during pregnancy. Lila struggled throughout her pregnancy and described some very dark times and suicidal thoughts: "It was really tough, it was really hard. I just honestly had a few times when I wanted to end it all. It was tough...it really was hard...it was just so hard." She lost many friends and thought she has disappointed her family and church.

She limited social interactions and refused to use the city bus while pregnant, which limited her mobility. Lila had trouble making up her mind throughout her pregnancy and continued to struggle with the prospect of adoption: “all the way up until the baby being six months, it's still not made up.” She accepted a housing offer with a moving date of January. She spoke excitedly about her apartment’s gym and pool, and how this would be her first time living alone:

I know it comes with a big responsibility also but I'm just so happy to have a home for my baby and I, finally. Since I was in the hospital I've had no home--I lived with his father for a bit but it's not like it's my home.

The Children’s Aid Society. Unlike her peers, Lila spoke positively of the CAS, noting that they’ve provided additional support for her. For example, her CAS worker helped her secure housing and wrote letters of support on her behalf.

Health and educational experiences. *School.* Lila struggled before switching to an alternative school where she attended class on a full-time basis throughout her pregnancy. It offered aesthetician courses that she enjoyed. Attending class while 9-months pregnant proved difficult at times: “Everything was painful and I was huge but I still went to school, I went to school up until the day I gave birth.” After the birth of her son, she enrolled full-time in the school program for pregnant and parenting youth to complete her remaining high school requirements: “Juggling everything has been difficult and trying to get school done is tough, I have 2 credits left, which is like a semester.” Being a full-time student and new mother was simultaneously challenging and rewarding: “I’m always on the go, I never stop and it's so tiring. It can be stressful but it's also—you feel really good about it because you're finishing.” Lila believed that her return to studies was only possible due to the resources in place: “School offers daycare and they're very attentive to the children. They really get to know the babies and you can pick up any phone in the school and call down to check in.” She valued being able to visit her son

during her day and breastfeed at school. One challenge of attending classes was the distance of the school from the residence, requiring two city busses to get there. She also found the class scheduling challenging: "I wish there were more hours in the school day. We go from 10-2:30 but you get a lot of breaks, lunch, fitness; there are not a lot of academic hours in a day." She planned to follow her career aspirations of becoming an aesthetician in time: "Everything is postponed now, everything you need to do is to accommodate your child."

Experiences with childcare. Lila worked part-time as a nanny for two young children up until her fifth month of pregnancy. At that point she no longer had the energy to work and attend classes. While she had some preparation in terms of courses and being a nanny, she noted that her expectations of infant care were not entirely realistic:

I knew it would be hard but I didn't know it would be that hard. They said you wouldn't sleep but I didn't know that you really wouldn't, 100% not sleep for a while. No, I was miserable for a while and I was like okay, I'm going to die.

Health and past health experiences. Before becoming pregnant, Lila had very little engagement with health care. She had annual dentist appointments but did not have a family physician. She had never undergone a full physical exam or Pap test, and accessed walk in clinics if she needed treatment. Seeking medical care was regarded as a "last resort" due to time constraints. She relied on home remedies stemming from traditional cultural practices: "Lemon water, tea, bundle up, sweat it out and take a shower. I'm Spanish, you got a headache, you slice some potatoes and put them on your face." In the post-partum period she started seeing a doctor at the outreach centre on a regular basis and had an IUD inserted for birth control.

Participating in prenatal education. Throughout the pregnancy, Lila found a sense of comfort in knowing what was happening to her body and her baby. She made an effort to learn everything she could: "I just read as much as I could and made friends with people who had

babies so that I could learn how to take care of babies.” She was engrossed in YouTube videos about everything from the effects of the external world on the developing fetus, to the changes to expect each trimester, to the labour and delivery process. She preferred way to learn from videos and even watched videos of animals giving birth. During our interview she enthusiastically described what this process involved for elephants.

Lila attended 3 formal educational programs at the outreach centre, including Transitions to Parenthood and Baby Basics. Her most trusted source of information was the public health nurse that she saw at the residence. Her other preferred sources of information were search engines like Google, mothers at the residence, staff at the residence, and daycare staff. She typically cross-referenced sources until satisfied that the information was accurate.

Navigating prenatal health care. Lila engaged in prenatal health services as soon as her pregnancy was confirmed. She had a “horrible” rapport with her Obstetrician and recalled feeling very rushed during their sessions: “She was very quick and out the door. You waited in the waiting room for an hour and then had 5 minutes to see her.” She never felt comfortable asking her questions: “Every question I had was just out of my head the minute I would see her because she would talk so fast.” She brought lists of questions with her to appointments, but would forget to address them before her provider had left the room. In order to seek answers to her questions, she would call TeleHealth or wait to ask the public health nurse.

Time. Pregnancy, labour, and delivery. Lila described her pregnancy as normal but uncomfortable. She felt “completely lazy” while pregnant, noting that things like showering and putting on socks were difficult due to her big belly. That said, the most challenging aspects were emotional rather than physical. She made a number of health-related decisions while pregnant, including improved nutritional choices and attempts to take prenatal vitamins, though these

would often make her vomit. Lila went into spontaneous pre-term labour, which she believes was the result of her stress levels and her body being “at capacity.”

Lila had a somewhat traumatic labour and delivery experience. She spontaneously haemorrhaged at 34-weeks gestation, resulting in a call to 9-1-1, trip to the hospital by ambulance, and an emergency Caesarean section (C-section). She felt disappointed about having a C-section because her birth plan and preparation was geared towards a vaginal delivery: "It really sucks, I wanted to go through the whole labour process and the miracle of life." Her time at the hospital was a frenzied whirl; she was brought to the operative suite with very little explanation or discussion when her baby's heart rate decelerated. Initially alone at the hospital, she felt scared and confused. It was reassuring when the baby's father, his parents, and her father arrived to the hospital.

Weighing 4 pounds and 12 ounces at birth, her son was brought directly to the Neonatal Intensive Care Unit (NICU): “I was injected with so many drugs that I don't even have these memories, I didn't get to hold him.” Post-operatively, she required 2 blood transfusions and was quite unwell. Her recovery was painful and she was admitted to the hospital for a week, during which time her parents informed her that she could no longer live with them: “[They] told me they didn't want me and the baby back.”

Parenthood. Lila's pre-term baby was seriously ill at birth. This was a surprise because all of the prenatal tests were uneventful. He was admitted to the NICU for one month, during which time he required respiratory support, treatment for jaundice, and dialysis for insufficient kidney function. Lila was at the hospital with him every day and got to hold him for the first time when he was 5 days old. He was initially allowed out of the incubator for 20 minutes and she recalled his many lines, machines, and monitor. She spent her days at his crib side, from 7 a.m. medical rounds until midnight each day: "It was routine, like I worked there or something." The

health care team were incredibly supportive and she became very comfortable during her month parenting in the NICU. She joked: "I was even friends with the janitor at that point."

Her son was discharged from hospital at 39-weeks corrected gestational age, or 5 weeks of life, weighing 5 pounds and 3 ounces. He thrived once discharged and she proudly shared pictures of his progress with me. Experiencing an extended NICU stay with a critically ill newborn provided her the reassurance that she would be able to handle any subsequent illnesses her child may develop: "He's been sick and that was my biggest fear and it was okay." Her confidence as a parent grew daily.

Fettuccine Princess.

Fettuccine Princess (FP) told stories punctuated by animated hand gestures. Her speech was slow and deliberate; she had been speaking English regularly for the past year and made a point of apologizing for her French accent. Our first interview was conducted in the visitation room at the residence and the second interview was conducted in the education room. At 24 weeks gestation, she described herself as feeling "really pregnant" because of her weight gain, fatigue, and the baby's movements. By the second trimester, she had adapted to the notion of carrying a child: "I'm getting used to the fact that I'm pregnant and I'm getting used to live with someone else in my body!"

Becoming Pregnant. FP became pregnant following the inconsistent use of birth control. She understood the risks of unprotected sex: "I knew that I was getting pregnant because I was talking to my boyfriend: 'Don't do that, I will get pregnant' and he would say: 'No you won't.'" She suspected the pregnancy early on because this was her second pregnancy. Following a few weeks of increased fatigue and morning sickness, she decided to buy a home pregnancy test: "I knew that I was pregnant but I was keeping telling myself that I'm not pregnant, it will pass, it's

just nothing but at one point it just was there, I just decided to buy a pregnancy test.” She was devastated by the positive result: “I just see that my whole world just (makes noise) crash before me, I cried and nearly passed out.” She was at 10 weeks pregnant at that point and the father of the baby reacted to the news with anger: “His reaction was not that good for me [...] we were fighting, yelling, all the stuff.” After some independent reflection, she drew on her beliefs to come to a decision about the pregnancy:

At the beginning my sister said that I should abort or I should put the baby in adoption. I said none of them. I just cannot think about it like that. I’m gonna give my baby away? What if my parents give me away? What if my parents aborted me and I wouldn’t be here? So, I should not do that and I just keep the baby.

Culture. Having immigrated to Canada from the Democratic Republic of Congo, FP felt very connected with the Congolese-Canadian community. She commented on how this community was very close knit and explained that young pregnancy and parenthood occurred frequently in the Congo. That said, young parenthood was only considered socially acceptable when accompanied by marriage:

It’s normal if I’m married, it’s not normal if I’m not married. In my culture, I have to be married before I have children. But it was just a mistake so I have no choice if, if some stuff happen in life like you didn’t prevent them. They just happen and ...you just have to accept the consequences of your behaviour and then try to live with it; learn from your mistakes.

She also commented on the patriarchal nature of her cultural group, with either the eldest living male in her family or her boyfriend assuming responsibility for her. Even in times of conflict, there was an expectation that she would follow the wishes of the eldest familial male, in this case her uncle. She found this cultural expectation very difficult:

Yeah 'cause in my culture we have to get along with each other because even though he's wrong I have to get like... to apologize to him to, to humiliate myself to him, so then he can forgive me. I do that a lot of times, several times, and I'm just tired. I don't know what to do anymore.

Beliefs about pregnancy. FP developed views on young parenthood before her pregnancy because a number of her peers had children: "Actually, last year, all of, most of the big part of my friends were pregnant." She discussed Christianity at length, and how her faith helped her make sense of the pregnancy:

I'm confident because I know with God everything is possible and also I'm a child of God and God never give up on me because I've passed through a lot of difficulties in my life. So this is just one of His steps; I will pass through that.

Though this pregnancy was unanticipated and she acknowledged that the circumstances were not ideal, she chose to view it as a blessing: "When two people they get together and then they create something and inside the womb it's creating something, like someone in God, with God putting his grace inside and just growing and taking some genes from each parent; it's just a miracle." Her faith and spirituality were a source of strength and comfort: "I had bad, bad really bad times and God just never gave me up and I hang on that words that say that God is my Shepherd and he will never let me go so... I keep on that."

Relationships. Family. When discussing her life in Africa, she became quiet and pensive: "I survived and it made me stronger today." She had a difficult time describing her neighbourhood, but recalled a childhood surrounded by family. She reflected on her early childhood as joyful and fun, however following the murder of her parents, she and her sister were moved between the homes of extended family members: "I'm an orphan so before my parents

died I was the happiest girl and then after that... it was like the saddest part of my life.” She learned to cope with the loss of her parents by focusing on her Christian beliefs.

In 2008, her paternal uncle sponsored her immigration to Canada; the following year her sister joined her. She discussed her arrival to Canada at length and how she learned to adapt to winter weather and use of synthetic fabrics in clothing. She took pride in her ability to adjust to new environments and circumstances: “I have no choice when I was moving but after my parents’ death I was moving a lot so I have no choice to get used to everywhere I go. (...) Yeah I’m a mover.” The relationship with her uncle was tumultuous from the start and while she did not wish to share details about it, she stated: “We don’t really get along with each other.” The year immediately following immigration was her most challenging:

I was fourteen and he didn’t treat me very well like I deserved, like a children came here in a new country. He didn’t treat me that way, so I decided to learn by myself and to let life teach me how to live here. And if I turn badly it’s not my fault, it’s the way he treated me at the beginning. Not my fault because I was really like fourteen and I didn’t know anything about this country and I have to learn from my friends, I have no choice.

FP had an aunt and a cousin living in a city nearby. The announcement of her pregnancy negatively impacted this relationship and left FP feeling betrayed: “She was important to me, really important...her and her daughter. But when I told her that I was pregnant she just stopped talking to me and then she told me to not go to her house again.”

The father of the child. FP’s boyfriend was in school fulltime during the week and worked on Saturdays. They typically shared time together once a week, on Sundays. Her boyfriend only attended one prenatal class with her because he found it “annoying.” FP was one of the few women to attend the prenatal classes alone: “Most of the girls came with their partners and the group we were like just two of us, like me and one girl who had (trails off) who had

nobody there, no partner. The rest had their partners with them.” She and her boyfriend lived together before she became pregnant, and she made casual mention of verbal and physical abuse a number of times during our discussion. She also noted how, over time, these types of behaviour became a normal part of their relationship: “So if for example, you (hesitates) hit me or something like that I’m getting used to the fact that you hit me and I forgive you and just forget about it.” I asked her whether she had counselling and support for these issues, and she assured me that she was attending counselling.

Work. FP was employed as a food service attendant at a home for the elderly. She had been working there since graduating from high school and enjoyed her position. She was looking forward to maternity leave: “I’m waiting for all my maternity leave to come this month, this month is my last month of work so I will be waiting for how much I’m going to receive for the maternity leave so then I can plan my stuff, all the stuff, and to save for the house.”

Church. Religion was highly influential in her youth. She was an active member of her church community and choir up until her pregnancy. Though she experienced companionship from the other members of her congregation, she decided not to return to church while pregnant to minimize the gossip. She planned to return to her church community following the birth of her son.

The Residence. FP learned about the residence from her sister-in-law and her social worker. She contacted the residence to explain her needs and they recognized that the relationship with her boyfriend was unhealthy: “They asked me if I could come right away because my situation really was really bad with my boyfriend (laugh awkwardly), believe me”. FP waited several days to tell her boyfriend that she was moving out: “I was waiting for a time where we’re not in fight and we not very good so, I was waiting for the right time to ask him.” She moved in to the residence several days later, with the assistance of her sister.

Sources of social support during pregnancy. FP felt rejected and betrayed by a number of her close friends and family members when she became pregnant: “like the only person that I can count on 100% is my sister, that’s it.” In order to cope with these changes, she became increasingly independent:

I just put everything in my head because the beginning wasn’t easy and I had problems with my boyfriend so I figured at that time I would be kind of alone. I can count only myself at 100% so I, I just decided like at the beginning of the pregnancy everyone that I was saying like I’m pregnant was betraying me or leaving me alone so I was like okay, I think I’m just alone in this pregnancy.

She also spoke of her best friend, who she considered like a sister. She planned to have her sister, best friend and boyfriend present for the delivery.

Health and educational experiences. School. FP enjoyed learning and being in school. She found the French Catholic high school system here quite different from the system she was accustomed to in Africa. FP planned to return to college to study business or finance.

Experiences with childcare. FP became pregnant at age 16 but the pregnancy ended in a spontaneous miscarriage in the first trimester. Her boyfriend had shared custody of a 22-month-old daughter from a previous relationship, so she had some experience with toddlers. She also babysat her cousins before immigrating to Canada.

Health and previous health experiences. FP described her general health as very good. She did not have a family physician or regular medical care before becoming pregnant but did attend annual dental appointments. She was assigned a primary health care physician at 14 weeks gestation.

Participating in prenatal education. The majority of FP’s prenatal learning was self-directed. She sought educational resources early on in her pregnancy as a way of mitigating

tension and uncertainty. She was initially concerned that her emotional state would impact her child:

The beginning of the pregnancy was really stress for me so I tried to find different stuff for me to do to get my stress low, because of the baby because I realize that there is someone depending on me. So I have to do everything to calm myself because if I don't he's going to feel that and I don't want my baby to feel depressed because of me and the other stuff. So I made all these researches that's why I'm becoming addicted to those websites of moms, babies stuff.

She also had concerns whether her physical health would influence the growth and development of her baby: "I was just worrying if it's dangerous for the baby if I have too many headaches if I don't sleep a lot, if I don't drink too much water." She continued to seek educational resources and books about pregnancy, finding comfort in learning. The pregnancy turned her into an avid reader and she made frequent trip to the library for books: "Now I'm a reader; I'm a reader because of the baby." She also completed the series of prenatal programs offered at the outreach centre, including self-defence, which she started the week of our first interview. At first, language was a bit of a barrier to participation in the programs:

English is not my first language, so there's some words that I'm not sure to say in English, but in French I know them. It's just in English I'm not sure. So, at the beginning I wasn't asking questions because I was waiting for someone to ask the question.

Her comfort level increased as the classes progressed and, by the end of the programs, language was no longer a barrier to participating: "During the end I was getting used to it. I was asking any questions, stupid questions." She also attended 'Ca Mijote', the only program French-language program offered at the outreach centre. In terms of parenthood, was waiting until her baby was born to learn more about infant care: "Now I'm just waiting for the baby to come to learn new

things about the baby; I know already stuff about the baby but I want to make sure that I know them so I'm waiting for the baby."

Navigating prenatal health. Before being assigned a primary care physician at 14 weeks gestation, FP attended walk-in clinics to manage her health needs. FP described her health during pregnancy as good, though she experienced frequent episodes of heavy vaginal bleeding in her first trimester. She felt that these were related to her stress level:

I wanted to see a doctor but at the beginning with the fact that I was really stressed make me bleeding so I was really worried. Ever since I stopped stressing, ever since I came here, I did stop bleeding. So before that I was bleeding a lot, a lot, a lot, a lot and I was going always to a walk in clinic. But at the beginning of the pregnancy I didn't have like a family doctor to take care of me so I started to apply for it and then it took me awhile to get my own doctor so, now I'm good.

She made a number of health changes once pregnant, including increasing her fluid intake, taking regular vitamins and folic acid, and starting a daily prenatal yoga morning routine. She felt comforted by having a family physician of her own now: "My own doctor and everything is in place and we're doing stuff, like, step-by-step."

Time. FP discovered her pregnancy towards the end of the first trimester, at 10 weeks gestation. The 4 weeks following the discovery of her pregnancy were challenging both on a personal level and in terms of her relationship with her boyfriend. She moved into the residence early in her second trimester and started to engage in health and community-based educational programs at the outreach centre. She had less overall stress and reduced health concerns in the second trimester of pregnancy, and she credited many of these changes to living at the residence. During the third trimester of pregnancy, FP felt heavy, sore, and fatigued: "it's getting worse and worse. I'm getting more tired and it's getting harder to work." She looked forward to giving

birth: “I just feel like I’m ready for a baby right now (laughs) ‘cause I just want the baby out right now.” She wasn’t nervous about the delivery and had a rough birthing plan in mind. She was focused on preparing for the arrival of the baby, and having everything organized at least one month before her due date.

Camille

Camille was an expressive and animated 20-year-old with a 2-month-old daughter. She filled the room with exuberant energy. During both interview sessions, she scrolled through dozens of photos and videos of her pregnancy and her daughter. She also offered to show me the unedited video of her delivery, though I declined. Each interview session with Camille exceeded 60 minutes in length. Her first interview was conducted at in a private office at the outreach centre and her second interview was conducted in the visitation room at the residence. Camille’s daughter was present for both of the interviews, sleeping through most of the first interview and breastfeeding during the second half of the second interview.

Becoming Pregnant. Being Camille’s first pregnancy, she had no idea that the symptoms she experienced in January 2014 were pregnancy-related. She took a pregnancy test after a month of abdominal cramping, breast tenderness, fatigue, nausea, and a missed period. She was out of town and visiting with her ex-boyfriend when she learned she was pregnant. She experienced shock and disbelief at the initial positive result: “I peed on the stick, waited and was sitting there and the next thing I know it said ‘positive’, and I was crying and he came to me and started hugging me. I was crying for a good 20 minutes.” She repeated the pregnancy test the next morning and visited a walk-in clinic for confirmation. She cried at the clinic when a positive result was returned once more. She was referred for blood work and an ultrasound, which established that she was in her 8th week of pregnancy. The ultrasound appointment was the first

time the pregnancy felt real: “This little thing was inside of me and I fuckin’ started crying so hard because I was smoking and I felt so bad, and I was like ‘oh my God, this is so crazy, this is why I was getting so sick and didn’t even know.’” Seeing the image of the fetus changed Camille’s whole perspective and for the first time, she felt a pang of excitement: “I’m like ‘I have a little baby in me!’”

Beliefs about pregnancy. Camille always wanted to be a mother: “When I was like 16 and stuff I had baby names, I always wanted to have a baby.” She believed that, irrespective of age, if you have sex and become pregnant then you must take responsibility for your actions. She held lifelong beliefs about abortion: “I don’t believe in abortion, I just don’t. I feel like it’s just evil or it’s just really wrong.” Her family physician never discussed abortion with her as an option but did mention the possibility of adoption. Camille felt that adoption was a viable and respectable option for those that cannot provide for their child.

Relationships. Family. Camille came from a large family with 1 sibling and 5 half-siblings. Her siblings share the same father but have 4 different biological mothers, and range in age from 2-years-old to 24-years-old. She was the second born, with two younger brothers and three younger sisters. She grew up in a 2-bedroom apartment with her mother and brother, and described both the apartment complex and the neighbourhood as “ghetto.” She felt unsafe because: “The people and it was a bad neighbourhood...it was bad. Like my building—I swear that there was like a drug person right beside me.” She did not feel safe being alone, playing outdoors or spending time in the neighbourhood: “It was so freaky, I hated being in the house by myself.”

Camille’s mother got pregnant with her older brother at age 17. Her father left their family before her first birthday. Camille disclosed the pregnancy to her mother as soon as it was confirmed at the clinic. Her mother was initially shocked but accompanied her to the first

ultrasound appointment. Camille felt that her mother views were influenced by her own experiences as a PPY: “She judges me a lot and criticizes my parenting.” She also believed that her mother was dubious of her boyfriend’s continued involvement because of her experience raising two children as a single parent.

Father of the baby. Camille has been in a relationship with the father of the baby for roughly one year and had plans to move in with him. She wanted to move in with him as soon as she discovered the pregnancy, but he wasn’t ready for this step. He was employed fulltime and lived approximately 4 hours away. At 30 years old, this was his first child. When Camille informed him of their pregnancy, he was initially shocked: “I remember when I told my boyfriend he was like: “are you serious? Are you lying?” Despite the distance, Camille made effort throughout the pregnancy to maintain communication and a sense of closeness with him: “I sent pictures of my belly and stuff, I’d send him every ultrasound picture—I went down there 3 times when I was pregnant, I gave him one of my ultrasound pictures and he has it in his mirror.” His absence was quite challenging at times: “He wasn’t really there, which made me sad, but he still knew what was going on.” Midway through the pregnancy, Camille’s boyfriend confronted her with suspicions about the paternity of the child. She described this period of time as very difficult and hurtful. She and her boyfriend worked through these issues and she assured him that he was the father of the child. The reality of parenthood struck her boyfriend once the baby was born and he saw his daughter for the first time: “It took him until she was born for him to realize that he was a father. I was like: ‘you’re becoming a father! Hello—does this compute?’ When she was born he was like: ‘OMG, I’m a father right now.’”

Peers. Prior to becoming pregnant, Camille enjoyed going out on weekends and spending time with her friends: “I always had free time to do whatever, you know? On the weekends I went clubbing or just sleeping at my friend’s house and having girl time. And all that’s changed

now but it's fine." Starting at age 16, Camille's social life involved the habitual use of marijuana: "Smoking weed, hanging out—that was an every day thing." Her priorities shifted with her pregnancy, and Camille spent time taking naps, visiting with her sister-in-law and other family members, hanging out with other moms from the centre, and "Just chilling and playing with our babies and stuff." Since becoming a mother, her focus has become her daughter: "Now I do nothing for myself—like look at my hair! What the hell?" She found the transition to parenting challenging, as there was little room for spontaneity or time for self-care activities:

It's hard though because you want to have you time and there's no free time, you know?

You just want to have a time for yourself—like maybe not for the whole day but for a couple of hours at least, you know like pamper yourself, do this, do that, shop for yourself. Like everything is for your child. It's all you're thinking about.

Camille developed a number of close friendships from the outreach centre day programs that she attended regularly since the ninth week of pregnancy. She had one very close friend living at the residence, with an infant of a similar age.

Work. Camille worked as a housekeeper during the first trimester of her pregnancy, for a company managed by her aunt. She had to stop working in her second trimester due to the physicality of the job: "My back was killing me because you always have to bend down."

The Residence. Camille's sister-in-law connected her with the outreach centre and she started attending programs there. She moved into the residence at approximately 5 months of pregnancy after having a disagreement with her mother: "My mom kicked me out of the house when I was pregnant. We've been having problems since I was 15 or so." Camille called the residence to explain her living situation, toured the facilities, and moved in the following week. Camille hated living at the residence, and voiced dislike for many the other young women living there and most of the staff. She had activity restrictions imposed following the birth of her

daughter and could not leave the residence: “I was trapped in the house for like a week or two. I was so bored and I was so annoyed, all I could do was just sleep.” Following these restrictions, Camille became very focused on moving out: “I hated being in the house like for days. So then I was freakin’ bored in the house, man. I want to get the fuck out of here.” She also felt that many of the staff at the residence were judgemental of her parenting practices. She resented having her approach to parenting scrutinized: “I don’t like that shit—don’t,” and was greatly looking forward to moving out.

Sources of social support during the pregnancy. Once pregnant, Camille experienced a shift in social support: “They all changed, they were all shocked.” Camille felt that the pregnancy strained her relationship with her mother: “She feels that I’m unfit to be a parent.” Camille’s aunt had the most negative reaction to the news of her pregnancy. She described feeling betrayed by her aunt and ceased contact with her. Her sister-in-law became her primary sources of support during the pregnancy; she attended most of the ultrasound appointments and was present for the delivery. Despite acknowledging the support she received from her family and new friends at the outreach centre, she felt isolated and abandoned while living at the residence: “You don’t understand, I’m alone in this, I’m here by myself.” Her biggest stressor while pregnant was not feeling supported by her boyfriend, largely due to him living in another city: “This is not what I wanted, I wanted a family—when I get pregnant it’s me and you together and it’s not just me by myself.”

Health and educational experiences. School. Camille was one credit short of completing high school; an English credit. She intended to complete her remaining credit at some point. At age 18, Camille began working part-time, overnight shifts cleaning a stadium and this was a major contributor to not finishing high school. She worked from 6 p.m. until 6 a.m. while attending grade 11 and 12 high school classes during the daytime. Camille found this routine

exhausting: “There were times I would be sleeping in class because I was just so tired.” She eventually dropped out: “I missed so much school because I was just so exhausted.”

Experiences with childcare. Camille had some exposure to babysitting her younger siblings and cousins, but no experience with newborns.

Health and previous health experiences. Prior to becoming pregnant, Camille would rely primarily on walk-in clinics for her health care needs and the sexual health clinic for annual PAP tests. She described her health as generally good and noted that she did contract one sexually transmitted disease at age 18, but that it was diagnosed and treated quickly.

Participating in prenatal education. Camille completed a number of formal prenatal programs offered at the outreach centre, including Buns in the Oven, Baby and Me, Food on the Cheap, and Transitions to Parenting, though she must repeat this program because she missed the final two classes. Camille describes herself as being: “Really involved with the programs.” She “wanted to know everything” about her pregnancy and the health of her baby, and was very comfortable asking questions. At times, being too focused on norms and milestones caused Camille anxiety. For instance, during the third trimester of pregnancy, Camille’s physician informed her that she should be feeling the baby move approximately six or seven times every two hours. This information, in particular, caused Camille a great deal of stress because she couldn’t routinely sense this amount of movement. She began monitoring and timing every kick and roll she felt.

Camille voiced infant-related questions about jaundice, cradle cap, baby acne, breastfeeding techniques, infant weight gain, and constipation. She cautiously observed and monitored the health of her baby, especially at night: “Checking the lips, checking the breathing, watching the chest to make sure it’s moving.” Her most recent concern, that she plans to discuss with the public health nurse during their next visit, is “flat head syndrome”. This became a concern when she overheard other mothers at the outreach centre discussing it and she wanted to

ensure that her child did not develop the condition: “I’m freaked out, I don’t want her to have flat head because that’s serious.” Since learning of this, she started repositioning her child frequently and monitoring her fontanelles.

Navigating prenatal health care. Camille made a number of health and lifestyle changes while pregnant that she maintained into the post-partum period. These changes included smoking cessation, leaving the ‘clubbing’ lifestyle, discontinuing daily marijuana use, developing an increased awareness of nutrition, and reduced caffeine intake. Camille had a loosely formed birth plan in mind regarding the delivery of her daughter: she wanted to attempt a natural birth but wasn’t opposed to an Epidural if the pain became unbearable, and she definitely wanted to breastfeed. She was encouraged by the staff at the residence to seek a BC, but she declined this service. The health professional she confided in most was the public health nurse that visits the residence: “I ask her and tell her everything.” The public health nurse helped prepare her for labour and delivery, coached her about parenting, and taught her about breastfeeding and newborn care. She described the nurse as her “most trusted source of information.”

In terms of health follow-ups, she had appointments with the public health nurse every two weeks and her contact information in case a question or situation arose between visits. Camille’s daughter had a community pediatrician and she had a family physician. Otherwise she planned to continue the “constant monitoring” of her baby’s development and health status: “I’m so on top of it.”

Time. Pregnancy, labour, and delivery. Camille’s pregnancy progressed without complications: “It was crazy seeing my stomach stretch and in the beginning I couldn’t keep any food down and I was like throwing up everything constantly.” The nausea and vomiting persisted into the second trimester of pregnancy before slowly dissipating. She carried her baby until 40 weeks gestation and underwent two membrane sweeps before going into labour. Her contractions

started at midnight and her baby was delivered at 11:07 a.m. Her experience at the hospital was a positive one: “They were all so nice, they were all women doctors but that pain was like: holy shit! That was pain, man.” She had a natural birth, assisted only by inhaled nitrous oxide and oxygen: “Took the gas—that shit didn’t do nothing, that shit didn’t work. I was inhaling the gas like it was water and it didn’t do nothing for me.” She requested a mirror to observe the delivery but soon asked that it be removed: “I was like eww, look at my vagina, like eww my butthole is stretching...OMG, it was so nasty.” Lacerations occurred during the delivery of the placenta, which resulted in internal and external stitching. Her only disappointment with the labour and delivery was that she couldn’t reach her boyfriend by phone and he wasn’t present for the birth of their baby. He arrived at the hospital the following day.

Post-Partum Period. The early post-partum period was largely uncomfortable for Camille. She experienced intense discomfort from her vaginal stitches and described her baby’s latch as extremely painful: “My nipples were red, cracked and bleeding.” She received education at the hospital about breastfeeding but the pain persisted. Once home, the public health nurse corrected her breastfeeding technique and it was the first time that she fed her baby without discomfort: “I swear I would have stopped breastfeeding because of the pain with the latch.” The first week breastfeeding was the most challenging and this had a major impact on her mood and confidence as a new mother.

Camille proudly shared her baby’s weight: “Now she’s like 9 pounds and it makes me so happy and excited, like 6 pounds 11 ounces, to 6 pounds 2 ounces, to 9 pounds, you know?” During the first month post-partum, she followed a strict plan of breastfeeding followed by formula supplementation to increase her baby’s intake and weight. This feeding plan was devised by the public health nurse and worked well.

Parenthood. Camille spoke at length about the baby's daily routine and care: "Either they want to play or they want to burp or they want you to cuddle them—there's so many different things." It took a while for her to learn to read her baby's cues and decode her signals. She took great pride in each new skill her daughter learned: "Now she's holding things, she eats with her hands, she rolled over, making sounds. She is doing signs of teething already!" It took about a month for the daily reality of parenting to set in: "Reality just kind of hit me in the face, like I'm a mom—I'm a mother. I always wanted to be a mom but now it's happening, like this is real—this is reality." Parenting was a lot harder than she initially anticipated:

I think everyone's different. I'm not saying that I know everything. I'm still learning and I'm going to learn every day. But I feel like I'm going really good at learning about babies and stuff like that, learning about what they need and things, and how to take care of them ... there's a lot, it's hard to explain in words, but there's a lot. It's not just about feed and breastfeed and change their butts and dress them up. There's so much stuff and it took me a while for parenting to hit me so hard.

No Name

No name was an 18-year-old woman with slow and deliberate speech, giving me the sense that she chose her words carefully. As a First Nations youth, she grew up on and off the reserve. We conducted our two interviews in the resource and visitation rooms at residence. Her baby was present for both sessions; the first time he bottle-fed, the second time he mostly slept and was very congested from having contracted a respiratory virus. She asked me to hold her baby on both occasions and I gladly complied. Her son was a big boy with chubby thighs and a full head of hair.

Becoming Pregnant. NN went to the Emergency Department (ED) following a one-month history of severe abdominal cramping, nausea and vomiting, and a missed period. The pain became so intense that she could not walk or stand upright. She became concerned that she might have appendicitis: “Your appendix is usually between your belly button and your hip bone and that’s what- where it was hurting and so I went to the hospital they checked my appendix to see if it was inflamed.” Following some examinations, additional tests were conducted to rule out pregnancy: “They even checked my uterus and they said: ‘you’re not pregnant’ and I was one month pregnant at the time. One month pregnant when they checked my uterus.” On discharge from the ED, she felt reassured that it was neither appendicitis nor pregnancy, noting: “I put that out of my mind completely.” Over the next two months, NN noticed continued weight gain, intermittent nausea, and the absence of menses. She completed 3 additional pregnancy tests at the clinic which all showed negative results. At 12 weeks gestation, still feeling unwell, NN completed bloodwork that confirmed the pregnancy: “I’m one of those people that the pregnancy tests don’t work with me.” At 13 weeks gestation she had her first ultrasound.

NN’s initial reaction was disbelief: “When I first found out I was pregnant I couldn’t believe that I was pregnant like I was shocked like the doctor was asking me if I was okay...cause I had this blank stare on my face.” The father of the child, NN’s boyfriend, initially suggested that they have an abortion. By 15 weeks gestation, NN and her boyfriend made the decision to keep the baby and they told both of their immediate families.

Beliefs about pregnancy. NN never thought she would become a mother; it was not something she envisioned for herself and she didn’t have strong preconceptions about pregnancy or parenting. She shared several spiritual beliefs that influenced her decisions though she could not recall whether they stemmed from her aboriginal culture. In fact, since moving off the reserve, she felt a little disconnected from her culture: “I didn’t really know about my culture... I

mean I know some parts of it.” One conviction that influenced her decision-making was the belief that her fetus had passed a development stage that produces soul formation and therefore had rights:

Cause I was told that when they’re 7 weeks they get like their soul and stuff like that ...

So like I was over 7 weeks and I was 12 weeks and almost 13 weeks actually when I got the ultrasound and it was just like scary... it’s a human being living in me and they don’t even have the choices to make themselves. So I’m gonna let him be born and make his own decisions and stuff like that ‘cause it’s my choice: either I get abortion or not and it’s not his choice ...

Relationships. Family. NN didn’t have a “proper childhood”. She mentioned this a number of times during both interviews when she discussing life on and off the reserve. She noted: “I had had a rough kind of childhood I guess and it wasn’t really a childhood that you could say but...so I kind of had to grow up quicker than others.” Her childhood environment was “not safe at all” and different from that of her peers: “I wasn’t type of, the kind of average children I guess ‘cause I didn’t really grow up with a childhood.” She experienced verbal and physical abuse at home: “My mom was... kind of violent and she neglected me a little bit, well not a little bit but most of the time...” By age 8, NN assumed the role of caretaker for both herself and her twin siblings. Growing up without a strong parental presence shaped her views of motherhood: “Cause my mom wasn’t really much of a mother to me and so I want every way to make (my son) feel like that he has a mother and show that he can like trust me.” She was no longer in close contact with her family but she had met some of her boyfriend’s family and felt that they would offer significant support. This was a welcomed change because she noted: “I can’t really rely on my family to help and stuff so.”

Father of the child. NN's boyfriend was the father of her son. He was 26 years old and lived in a neighbouring province. They lived together for four months during the pregnancy, prior to her boyfriend's relocation for work. She described this as a very tumultuous time in their relationship. Ultimately, they decided to live apart in order to work on themselves and reflect on their relationship. While she acknowledged some progress in their relationship while living separately, she admitted there was still a lot of work to be done: "We used to have an argument like every week when he was here and so after that like we made it a month when he was gone and so at the end I said maybe we can make it longer next time." Some of the ongoing relationship challenges stem from her boyfriend's failure to understand her mental health issues:

I know I have issues I mean but I'm trying to fix them. I can't just fix them with the snap of a finger. So like... he thinks that mental health is not real and so I mean like what if I had cancer? Are you gonna say that's not real, it's all in your head?"

At times, she questioned the long-term viability of the relationship:

I don't know if I can follow through with him and he always says 'oh think positive, think positively' but then he points out every negative thing about me or every negative thing and stuff like that. So how am I supposed to think positively when you're pointing out everything- and manipulate me all the time, and I got sick and tired of it ...

NN's boyfriend returned for a week immediately following the birth of their son. She will be relocating to live with him at the end of the month so that he can be a regular presence in their son's life: "I'm still planning on going... 'cause I'm trying to be the mature one so I can bring his son, so he can be able to see his son." She felt that his regular and continued presence was important: "If I stay here he'll only be able to see his son maybe once or twice a year. But then if I go there he'll see his son pretty much all the time."

Peers. NN only spent time with peers at the residence: “I just sit around and talk to people. I socialize with people here.” Several of her peers had children too: “Quite a bit of my friends got pregnant... but then like one of my friends gave her baby up for adoption cause she was so young when she gave birth. Like she was very young.” She continued on to describe how this friend became pregnant at age 12 and delivered soon after her 13th birthday. In fact, one of her friends had lived in the residence and another attended programs at the outreach centre.

The Residence. NN was aware of the residence before becoming pregnant. Once the decision was made to continue the pregnancy, NN applied for programs and services at the outreach centre. Soon thereafter, she came to the realization that her living conditions were not conducive to a healthy and restful pregnancy. After moving out from the apartment she shared with her boyfriend, she moved in temporarily with her mother:

I was living at my mom’s cause my mom told me she would help be through the pregnancy... but I was sharing a bed with two people, like a single mattress with two people. [I]- wasn’t eating properly, I ate one meal a day.

When she discussed her living situation with staff member at the outreach centre, they encouraged her to contact the residence immediately: “I told them like I have nowhere to go, I mean, I didn’t have a proper bed to sleep in and stuff like that and so I came here emergency.” She was able to adapt to life at the residence because she’s used to a variety of structured living environments such as group homes, sponsor homes and addiction rehabilitation programs. NN described the rules at the residence and how living at the centre impacted her ability to socialize with her outside peers. For example, she commented on how personal outings, other than visitation with family or trips to the store for necessary supplies, were discouraged:

If we need to pick stuff up at the store like, say like formula or diapers, then they’ll let us. Or we need to pick some stuff like for the baby... [I]f it’s for us, we can’t leave. But

let's say if we want to go to the mall or just hang around and go do things with friends they won't let us do that."

Sources of social support during pregnancy. NN distanced herself from some of her peers once pregnant because she no longer wanted to engage in the drug scene. She found support from other young women at the residence during her 10-month stay. She felt that living at the residence and being supported by PPY eased her transition to parenting. She commented that she'd "probably be more terrified" if she was living in an environment without peer support.

Health and educational experiences. School. NN struggled in school and has not completed her high school requirements: "I wasn't so great in- because I'm a hands-on person and I'm the type of person that can't sit in a desk for 8 hours!" It wasn't until she transferred to a technical high school that she started enjoying her classes: "...Except for like English and Math- cause you sit in a desk for that. But all the other classes you are doing stuff physically and stuff like that. Cosmetology, I loved cosmetology 'cause we would actually have a little mannequin head."

Past Experiences with Childcare. NN provided care for her twin siblings, a boy and a girl, which largely informed her views: "I pretty much raised them growing up and I would always take care of them and stuff, so I thought I would be able to take care of a baby but there's a lot more than that." This experience provided her with a basic understanding of childcare but she quickly recognized that parenting involved so much more.

Health and previous health experiences. Before becoming pregnant, NN would visit walk-in clinics when she was unwell or if she was "trying to figure out what was wrong..." She did not have a primary physician and managed her own health needs. That said, she has anemia and some mental health needs that required follow-up: "I have a whole bunch of mental illnesses, like I have maybe three or four mental disorders and so like I'm not your average person I guess."

She elaborated on these issues: “I have issues with anxiety and depression as well and also like borderline and then... bipolar and sort of all these mental health issues.” Managing her mental health needs was challenging in the absence of a primary care team.

Addictions. Drug and alcohol abuse were featured in NN’s childhood because they were a part of daily life on the reserve. Drug use, she noted, was extremely common on the reserve, even among children: “Yeah it’s cause it’s pretty much like handed to you on the reserve.” She started using alcohol and drugs at an early age:

I got involved with drugs and like alcohol since I was 8 years old ‘cause I came... we went to visit my reserve and then came back ... it started all on my reserve and then I came back to Ottawa again and then- like I met people that were doing drugs as well and so did I, and we were drinking all the time and smoking cigarettes and so...

Drug and alcohol addictions were common in her family; her cousins, mother and many other relatives struggled with additions. She posited that this was due to role modeling and the availability of alcohol and drugs in the home:

‘Cause like every...all the parents are like drinking in front of their children. They leave empty cans everywhere and they forget about like cans that they haven’t even opened and stuff like that ‘cause they were too drunk or they were smoking weed and stuff like that and they- they leave roaches around...

When she left the reserve, she developed a peer group that was also in the ‘drug and drinking scene’: “Oh I did have friends ... and then they started smoking as well and stuff like that and like we all- and I met people that were already smoking and stuff so I kinda got into that scene very young.” NN used marijuana, NDMA, cocaine and alcohol regularly throughout adolescence, and attended a drug treatment program once. She used drugs, “mostly weed, drinking and Mollie” during the first trimester of her pregnancy because she was unaware that

she was pregnant: “I did a little bit of MDMA here and there. I did MDMA 3 times in my pregnancy and I didn’t know that I was pregnant though.” She reduced her use when she learned she was pregnant: “I did drink more than 5 times and then I smoked weed, not... cause after I had my seizure I didn’t smoke weed as much but before that I used to smoke weed regularly.” As her pregnancy progressed she stopped using drugs and alcohol entirely.

Participating in prenatal education. NN completed many of the formal educational programs offered at the outreach centre that focused on prenatal health, prenatal education, parenting and child care, healthy eating, and personal finances and budgeting. To date, she completed: Transition to Parenting, Prenatal, Buns in the Oven, Baby and Me, Housing Smarts and Beat the Budget. She started questioning her childcare beliefs as she attended classes and realized that she needed to both learn and unlearn. In the absence of the courses and programs, she would have likely replicated the practices she learned from her family:

Well growing up I used to help my mom raise my little brother and sister and like take care of them and everything so that kind of gave me an idea of how to take care of a baby. But then I thought I knew everything about taking care of a baby. But then I started to take prenatal classes and I went to programs at the centre and it showed me a lot more... because things change over the years and I didn’t know that and so I thought at least you could still microwave a bottle or you can do certain things because that’s what my mom used to do. She used to microwave a bottle and she used to use carnation milk instead or formula, and so that’s what my little brother and sister used all day it’s just carnation milk.

She found the courses focused on childcare and parenting most useful: “I mean I learned a lot of things too so I thought I knew everything about being a parent but no I learned a lot about being a parent.” She found the courses engaging because they used varied teaching approaches including

games and demonstrations on both dolls and newborn infants. She also found the educators knowledgeable and approachable: “I mean ‘cause it’s two people that were doing the program. They are very fun and like very easy to talk to and stuff like that. And like, we were joking around and stuff at the end.”

NN preferred discussing questions rather than turning to books or the Internet for answers: “I’d ask other girls here at the residence. And then some of the staff and then I’d go to the Centre and I’d go ask people there, I’d go ask my prenatal teacher.” She was sceptical of information online, feeling that it was romanticized or the “Hollywood version of the truth.” She commented: “I mean cause like when people will say ‘oh you’re glowing’ and ‘pregnancy glow’, I don’t really find that true. Cause I dunno...no one ever told me that I was glowing.” She had also become a resource for other women at the centre and was happy to share her experiences and knowledge with them: “A lot of the girls here do ask me questions and stuff like that cause they’re wondering like why- if the baby’s moving, if it’s okay for the baby not to move at certain times of the day...”

Navigating prenatal health. Early into her pregnancy, NN had a negative health care encounter that greatly influenced her decisions:

When I went to the ultrasound clinic they did an ultrasound and the doctor just started playing the heartbeat right away. They didn’t even ask me to play it and stuff like that and... I didn’t want to hear the heartbeat. And then she just automatically started playing it and then I just started crying and... like I started crying until I couldn’t see.

Without prior explanation or eliciting her preferences, the ultrasound technician played the heartbeat aloud and NN felt helpless to ask them to stop: “I just kept crying ‘cause I didn’t know what to say anymore. So then I was watching the baby move — him move inside me — and I was just scared and the heart... like there’s an actual human being in there.” Hearing the

heartbeat made the pregnancy feel real and she questioned her predisposition towards termination: “After I heard the heartbeat I was like I can’t...he has his own choices now he’s a living person.”

Following this incident, NN attended one appointment at an abortion clinic because: “His dad didn’t really want him.” Following a review of her medical history, the clinic informed her that they would not be able to perform the procedure on site because of her past seizure episode. Learning that she was not eligible to have the procedure conducted in the community clinic made her reconsider her options. She was aware that abortions were typically only performed up to 18 weeks gestation. Once she and her boyfriend made the decision to continue the pregnancy, she began care with an Obstetrician at the outreach centre every two weeks. In the post-partum period she was followed by the public health nurse every two weeks and relied on walk-in clinics if she felt unwell.

NN describes her pregnancy as generally healthy. She made a number of lifestyle changes including the cessation of marijuana and alcohol consumption. Having been a cigarette smoker for 10 years, she decided to continue smoking throughout her pregnancy because she felt that she’d become very sick if she tried to quit smoking. She took the recommended prenatal vitamins and made health-conscious decisions regarding nutrition. She hoped to keep up these lifestyle changes while parenting.

Time. Pregnancy, labour, and delivery. NN described pregnancy as “a lot of hard work.” It was a major adjustment to transition from feeling strong and healthy all the time to feeling uncomfortable and unwell: “It was really hard I mean ‘cause like it was my first pregnancy and like it was so hard ... everyone thinks it’s easy being pregnant but it’s really not.” She vividly described what it felt like when the baby kicked her colon or pushed against her spine. She

commented: “I carried wide and like round as well. Just so big.” She joked: “They say ‘oh pregnancy’s beautiful’...not!”

NN went into labour a month prematurely but her boyfriend was able to arrive in time for the delivery of their son. Their baby experienced a number of complications at birth and required treatment in the Special Care Nursery for a week: “He was not breathing when he came out. And so he also had the umbilical cord wrapped around his neck.” Due to this, she did not get to hold her son right away:

I watched them whisk him away into the other room and stuff like that and he was in an incubator for a week. It was really hard I didn’t get to hold him ‘til the next morning at like 7 or 8 in the morning and I gave birth at 4.

Despite being born prematurely, he weighed 6lbs 6oz at birth and recovered quickly.

Parenthood. NN felt that parenting was difficult to adequately prepare for in advance: “I mean you’re preparing yourself your whole entire pregnancy but then you don’t think it’s actually challenging.” This sense of preparation changed once her baby was home: “You think you’re going to be good at it and then you’re terrified ‘cause you’re taking care of this little person which you have to hold 24/7 for the rest of your life...” Her son’s prematurity compounded her fears and she felt overwhelmed with her new role: “It’s scary I mean you have this tiny little baby that’s a premature in your arms all the time and doing everything...” His condition at birth exacerbated her worries: “I was afraid when I brought him home ‘cause he had jaundice, his breathing was bad and stuff like that but now his breathing is perfectly fine.”

NN beamed when she discussed her son’s progress in his first 3-months of life, pointing out the rolls and dimples on his body. She proudly announced his weight: “16 pounds”, that he was wearing clothing for 6-12 month olds, and that he was generally quite healthy. She breastfed for the first month before starting to introduce formula because her milk supply couldn’t keep up

with the demand: “He just wanted to eat more and eat more and like I wasn’t producing enough milk and so then like I started feeding my breast first and give him a bottle and that worked fine.” She reflected on her experiences as a parent, noting her gradual increase in confidence as a mother: “I’m only 18 having a child and so a lot of people didn’t think I’d be very good at it but then people noticed that I’ve actually been doing a pretty good job, like I’m a very good new mom.”

Mich Mich

Mich Mich (MM) was an energetic 20 year old woman that described herself as an “open book.” She was upbeat throughout the interviews and spoke with a slight lisp. As an experienced and proud mother, she was very eager to share her experiences and perspectives on young parenthood. She was 5-months pregnant while co-parenting her two other children: a 12-month-old and a 24-month-old. Of all the interview participants, she was the most confident in her knowledge of pregnancy and was able to discuss issues such as placental placement in utero. During our first interview, she shared a recent ultrasound image and, with a beaming smile, announced that her son had reached a length of 11.8 centimeters. Throughout the interviews she demonstrated advanced knowledge of the local health care system, discussing which ultrasound centres produced the best quality images. Despite her experience as a mother, she described this pregnancy as her hardest yet. She also assisted me with snowball sampling and introduced the study to two of her peers living at the residence; they later both became participants. Our interview sessions were conducted in the visitation room at the residence.

Becoming pregnant. MM’s pregnancy was unplanned and was an incidental discovery during a visit with her family doctor: “I go to the doctors and I’m like I think I’m constipated and I was just about to get my birth control shot, the Depo, and they’re like we have to do a

pregnancy test and it comes out positive.” She was quite shocked to discover that she was pregnant: “I was bawling and like crying, crying and so they sent me for an ultrasound I was only 3 days pregnant.” MM told her fiancé, the father of the baby, about the positive urine result but he was sceptical of the pregnancy: “He didn’t believe me and so I had to do all these tests for him and then he still didn’t believe me and I got an ultrasound and there was a baby there...so he finally believed me.” Until the pregnancy was confirmed by ultrasound, MM was also in disbelief: “I was like: okay it’s all in my head.” She had not been using any method of birth control reliably up to this point but was planning on using injectable birth control: “I’m telling you no birth control works for me.”

Beliefs about pregnancy. MM voiced strong opinions about reproduction, responsibility, and parenthood. Abortion was never an option she considered: “Yeah, I’m totally against abortions and all that so I’m like: I can do it!” MM started to want children after spending time with her nieces, cousins, and the children of her friends:

When I was young and before I became a mom I was like: ‘oh heck no, I’m not having kids!’ That means I gotta change stinky bums, deal with puking, and next thing you know my sister had a baby and I was like oh I’m ready for it and I was like I want a baby! Then I was watching my cousins, and I was helping my friends raise their kids, and I was like: ‘yeah, okay!’ So a year later I got pregnant.

She also strongly believed that young parenthood was nothing to be ashamed of: “I love being a mom, I love how it takes up all my time. I don’t really even miss my freedom, I really don’t. It’s hard work because you get tired so fast and everything but I love every minute with my kids.” She felt that parents should take responsibility for their actions once they’ve conceived a child: “When you have your own you’re just like wow! I popped that out of my vagina; I made that and it’s beautiful!” She commented on how some of her peers reacted to their pregnancies:

“[They are] more like drama queens and they’re like: ‘Oh my God my life is gonna end, I won’t be able to have parties and go out...’ It’s like no, you opened your legs, you made this baby, take responsibility.”

Relationships. Family. MM was the youngest of four children and her parents separated early in her life. She described the neighbourhood she grew up in as largely unsafe: “People smashing stuff, breaking stuff, breaking into your house, and so my parents got fed up and went separate ways.” For the most part, she was raised by her father: “My dad always favouritized because I have two sisters and a brother and I was the less favourite one.” She felt that her position as least favoured child related to her learning disability. She commented on their relationship: “Growing up with my dad was rough.” Some of the dynamics established in childhood transitioned into adulthood as her father continued raises his voice, put her down, and call her names on occasion.

MM has a distant relationship with her family: “I hardly see my family but I know they’re there and they’ll help me out but I hardly talk to them.” Her father was the first family member she disclosed her pregnancy to. She called him while he was at work delivering pizzas and asked that he pull over the car. Calling him at work was a strategic decision to mitigate a negative response, as she had experienced when she disclosed her two previous pregnancies: “He would’ve put me down, called me names...” She was pleasantly surprised by his reaction: “He was a lot more calm with this pregnancy than my other two ‘cause he knows I love kids, but he was calm.” She told her mother about the pregnancy a few days later.

Father of the child. MM was engaged to the father of her current pregnancy. He also fathered her second child. She described him as supportive and attributed his initial sceptical reaction to a previous relationship in which his partner faked a pregnancy in order to “trap him.” MM and her fiancé lived together for approximately a year before she moved into the residence

and she planned to return to live with him once their son is born. Her fiancé is currently providing fulltime care for their 12-month-old son. Childcare for MM's eldest child was being providing fulltime by that baby's father, though she visited both of her sons each day. She found strength in her immediate family: "I believe that if we stick together we're a lot more stronger".

Peers. MM's peer group was primarily composed of young mothers; all of her close friends already had children. Many of her friends became pregnant before she did and she helped them with childcare. She was also the unofficial birth companion for three of her friends. MM announced her pregnancy broadly via social media, at approximately 20 weeks gestation. Up to this point only her immediate family and friends at the outreach centre were aware.

School and work. MM was not working outside the home or attending school. She had no plans to return to school or work because she wanted to focus on raising her family.

The Residence. This was MM's second time living at the residence; she also lived there while pregnant with her second child. During that residential stay, she moved in at six months gestation and moved out when the baby was three weeks old: "Well with my second son I was pregnant and I had a social worker and she told me about [the residence] and she was talking about all these different shelters that help moms." She made the decision to move out early because she didn't enjoy the residential environment in the post-partum period: "I left 'cause I had enough with the stress and now I'm back!" This time she planned to continue living at the residence during her pregnancy and move back with her fiancé once the baby was born. She described the residence as "Safe and secure and respectful." While the environment was highly structured, she felt that the staff were more lenient with her:

Oh, there's a lot of rules but I don't pay attention to them cause I'm not like the other clients here, I'm a different type of client because I have two children that's outside like

in the community with their dads so I don't have to follow all the rules that they have here [...] and because I am high-risk and I'm always with doctors I get more leeway.

Sources of social support during pregnancy. This pregnancy did not impact MM's close personal relationships negatively. In fact, she felt that this pregnancy improved her family relations: "They are a lot closer to me because I have kids and like yes, we still get into arguments but it's normal and I don't find it changed much." MM felt adequately supported by friends, family, and health care professionals: "I know I have a lot of support and a lot of people are there for me, even here, my doctors, a lot of peoples is there for me." MM also felt very well supported by her assigned Birth Companion (BC). This was not her first experience with a BC; she used one for her second pregnancy though she never felt entirely comfortable with her. MM reported a much better rapport with her current BC and kept contact with her by text messages or daily phone calls. She was confident in her BC's expertise regarding childbirth and childrearing, and they attended her most recent ultrasound appointment together.

Health and educational experiences. School. MM discussed being diagnosed with a learning disability and how it impacted her educational experiences. She noted: "You can tell me something and teach me, and teach me, and teach me, and I'll still look at you and be like: huh?" Despite her struggle at school, she completed grade 11. She feared that her children would have learning disabilities too: "I think my kids have a learning disability like me and we don't like, they don't know, and like I can't blame them..."

Experiences with childcare. Prior to having children, MM gained childcare experience by helping raise her cousins. She was involved with their care from the time they were newborns because their parents returned to work. This boosted her comfort level with young infants. She also learned from each of her previous pregnancies, building on to her pre-existing knowledge a little more each time. Her first pregnancy was not classified as high risk and asked a lot of

questions during this time. She experienced many worries related to the health, growth, and development of her first baby:

I didn't know but like is he growing good, does he have asthma like I do, does he have Down's Syndrome? I don't care if my kids have Down's syndrome I'm still gonna them equally and I'm like does he have brain concern or anything? Is his head too small? Does he have all his little toenails and toes and fingernails and fingers? Oh my gosh I was like asking everything I even asked them to do a 3D ultrasound so I can make sure everything was all right.

Though she had fewer questions during this pregnancy, there were still several topics she wanted to learn more about before the arrival of her third son, including breastfeeding, because she did not exclusively breastfeed her other two children.

Health and previous health experiences. MM described herself as a healthy asthmatic. Prior to her first pregnancy, she had a family doctor but did not see them regularly. She shared: "I hate doctors but I hate them less now." She was also followed by psychiatry for the treatment and management of anxiety and depression. She was monitored for post-partum depression in the past and took an oral antidepressant medication during this pregnancy.

Participating in prenatal education. MM completed a number of programs offered at the outreach centre: "I've taken Building Blocks, Transition to Parenting. I'm taking Buns in the Oven and TLC, it's a toddler playgroup, and TLC plus, another toddler play group but you learn preschool stuff. Basically that's it. And doctors, doctors, doctors!" She also sought advice and information from peers and family members with children. She considered experienced parents as sources of expert opinion and tended to confirm information from a variety of sources before applying it:

There's like- everybody has different opinions and different parenting skills but I know it's good because I go to the people that have a lot of kids that know more and that are well-trained and that are like helping out with kids and everything. If you're young and you just have a kid and you give me advice, I'm like: okay I'll try it but then I go take that advice and I talk to a person that's more trained.

She also sought advice and information from a variety of health care professionals, describing herself as a "health detective." She was particularly cautious regarding medication interactions during pregnancy:

I continue asking until I get the answer and if that person cannot answer I go to the next person. I'm very like precautious like especially when the doctor gives me medication I like, I triple search it to see if it's safe, I talk to pharmacists, I talk to doctors, I talk to my psychiatrist, I talk to everybody that's medical wise and knows this stuff I talk to them before I take it.

Navigating prenatal health care. This pregnancy was designated medically high risk: "knowing that I'm a high-risk client it's more worrisome..." MM had medical appointments weekly or twice each week, and was quite accustomed to being "poked and prodded." This pregnancy was high risk because it was a tubal pregnancy and because of her medication: "I'm on medication for my mood swings and it's called Zoloft and it causes the baby to have an irregular heartbeat." She was concerned for her health and the health of her baby:

This pregnancy, it's been spiking my asthma 'cause I have bad asthma, and it's been antagonizing it, and because I'm on a new medication, and being a high risk always seeing doctors it's stressful because you're worried because you're like: what's going on with the baby? You're like what's the heartbeat, what's the placenta doing, what's it's

joints and bones doing, how's the head developing, and the spinal fluid, and appendix, and liver, and kidneys? Sorry I know all this stuff.

She made a number of health and lifestyle changes during the pregnancy, most notably reducing the number of cigarettes she smoked daily and increasing her dietary intake of fruits and vegetables. She smoked roughly five or six cigarettes per day and continued to wean that number down with a goal of smoking cessation.

Time. *The first and second trimesters.* MM struggled with sustained nausea and vomiting throughout the first two trimesters of pregnancy: "I've been tired and I've been sick a lot, like morning sickness, but I think- it's not just in the morning, it's all day!" This was a new experience for her: "It's kind of different because with my other two I wasn't getting sick as much. With this one I've been puking since I got pregnant. My other two I was puking for a week, two weeks max." Despite this, she was quite content with her 15-pound weight gain.

MM planned for her labour and delivery. She intended to have her BC present for the delivery, and if childcare could be arranged, her fiancé would also be present. She did not develop a written birthing plan but hoped for a natural birth, like she had with her other two deliveries: "I'm just gonna let it go as it goes cause I dilate pretty fast and if it happens, it happens. As long as the baby comes out healthy and I'm at a hospital when I have the baby, I'm fine." Her birthing preferences were based on what worked well for her in the past and she discussed these with her BC: "I told her I don't want any bouncing ball, I want the bath tub, I want to be able to walk around, I don't want no epidural, and I wanna be like able to have like freedom."

Carlie

Carlie was an upbeat and energetic 17-year-old woman. At 6.5 months pregnant, she had a small but visible belly. Carlie appeared very relaxed during our sessions; she recounted stories with enthusiasm and joked around. She remained cheerful even while discussing sensitive topics such as mental health struggles and self-harming behaviours. Our interviews were conducted at the residence and both of our sessions ran overtime, reaching 85 and 90 minutes respectively. We stopped to make sandwiches and shared a meal while finishing the second interview.

Becoming pregnant. Carlie's pregnancy was unplanned but not entirely surprising due to her inconsistent use of birth control: "We weren't particularly careful and we- you know. It's just I had so many pregnancy scares I was like: 'I'm scared like, you know?' It always was stuck in my head." At the suggestion of her physician and due to her history numerous pregnancy scares, she was scheduled to have an intrauterine device (IUD) inserted. She became pregnant before this happened: "I'm not sure how close it was but I knew within the next week. I don't know I just felt these cramps- these really bad back cramps but then my period never came." Carlie took a home pregnancy test that yielded inconclusive results, so she and her boyfriend scheduled a visit with her family doctor. The doctor confirmed Carlie's suspicions: "I kinda was like I knew but I was all calm I'm like: 'yeah, I'm pregnant, whatever' but when the doctor actually told me and she's like 'you're in fact positive for being pregnant' and my heart kind of dropped."

Her family physician encouraged them to consider their options, highlighting termination: "She was- she was calm but she was very on the side of abortion." Carlie's mind was flooded with questions and disbelief as her doctor explained and reviewed the options: "I donno I was kind of like: are you serious? Am I dreaming? Am I just hearing this? Like I wasn't sure...like am I just pretending? Are we just pretending?" She also considered her readiness to have a baby: "I was 16 so of course I was like: everyone's gonna judge me ... Oh my God, what am I gonna

do? I'm in foster care; I'm in foster homes. How am I gonna raise a baby?" Many of Carlie's earliest concerns related to a fear of judgement:

If people find out you had an abortion you're gonna be judged for having abortion. If people found out you're keeping you baby and you're about to have a baby you're going to be judged regardless. Either way. It's young moms or you aborted a baby um so I was just very scared I didn't know what to do. My life was revolved around what other people thought of me so it was very like I didn't know what to do. So it was funny that my doctor, my personal doctor, my family doctor, was more on the side like "Oh yeah you won't be pregnant for long we'll get you in to have an abortion and then we'll get you on the IUD" she has like this plan for me and I'm just sitting there nodding thinking sure, sure but of course I'm- I was like I'm not ready to make that decision yet.

After considering her options, Carlie told her doctor that she might not want an abortion: "I sat there and I listened to what she had to say but I'm like I'm not sure if I will be able to get an abortion or even if I want to." Carlie's doctor referred her to a crisis worker for further information and support. The crisis worker spoke with her and her boyfriend at length, and elicited their preferences. The crisis worker took a strikingly different approach during their interaction and, for the first time, Carlie received positive reactions about her pregnancy: "I was like: 'oh yeah well I just found out I'm pregnant' and everyone's like: 'congratulations!' so I got a lot of congratulations and it kind of made me think this could be a good thing!"

Beliefs about pregnancy. Carlie envisioned herself as a mother but not this early in life. Her boyfriend wanted to start a family: "[He] didn't want an abortion, he wanted the baby, he was so into having a baby, wanted it so bad. He wanted it even before I became pregnant."

Carlie was not the first woman in her family to become pregnant in their youth; her mother and her grandmother both had adolescent pregnancies. When making a decision about

pregnancy outcomes, Carlie drew on the experiences of family members to help inform her decision. At 18 years of age, her grandmother gave her baby up for adoption. She shared stories about this with Carlie in greater detail once she too became pregnant. She noted: “I knew that I wanted to have my child. I don't really believe in—I'm pro-choice but I just couldn't have an abortion, I just couldn't set my mind on it.” Carlie’s sister underwent an abortion as a teenager and experienced deep emotional conflict: “...she was crying because she had just gotten an abortion and she's like she regrets it to this day, even though it might of been the best decision for her, it's still so emotional.” Following open discussion and reflection on the experiences of the other women in her family, Carlie made her decision: “I knew either way, either it's going to be really tough on me or I'm going to break down crying for the next couple of years. So I just chose, you know, it might be really tough but the satisfaction of doing it would be amazing.”

Relationships. *Family.* Carlie had a long history of housing instability and had been “in the system” for most of her life. She didn’t speak at length about her biological family, though over the past year she had started to have visitations with her mother, sister, and older brother. She had no contact with her father or his side of the family. She also had a younger sister that was adopted into another family. At five years of age, Carlie was apprehended by the Children’s Aid Society and placed in foster care. She spent the next 12 years living in a variety of foster homes and structured living environments: “Actually I’m still technically in it. I’m still considered a ward.” Carlie lived in a parent-model home for 3 months before coming to the residence. She described life in the parent-model home: “It’s better than group homes to be honest but the only problem is that group home kids were put into parent-model homes so it became hectic. The last one I was in, it just wasn’t a place for someone pregnant.” Parent-model homes differ from traditional group homes in terms of supervision; they have a combination of staff and foster parents that provider supervision and care: “It’s like different rules like the foster

parent go away for the weekend or go away for respite and they don't need to bring you with them to their vacations..." When asked if she felt safe in that environment, she relied: "No. I didn't feel safe... basically I'm not afraid of anything but just safe as in if I stayed in foster care, the foster homes, there's less a chance of me keeping my child, so I didn't feel safe to stay there."

Father of the baby. Carlie was in a committed relationship with the father of the baby. He was 21 years old and they shared a similar upbringing in that "He grew up in the system, foster care and stuff." She elaborated on his family situation: "[His mother] gave him up to the hospital when he was a baby and never named him. She was a crack head and drank throughout her whole pregnancy and then she was found dead when he was 3 years old." She commented: "I'm almost 9-months with my boyfriend who is also the father of my baby and I'm still with him and never cheated on him once. We're working together so wonderful." She felt that the pregnancy had a positive influence on both of their lives: "We used to--when we first met we were drinking, hanging out at [downtown area] and being like children. The amount we have grown up--not just me but him too--is so impressive." Carlie's boyfriend had strong opinions about the pregnancy. He was very aware of her health while pregnant because he was born with Fetal Alcohol Spectrum Disorder. As such, her boyfriend was firmly against consuming alcohol while pregnant and stopped drinking to show solidarity with Carlie.

Peers. Carlie's schedule at the centre, including classes and curfews, rendered it more difficult to socialize with her peer group: "Sometimes I feel lonely because I realize I try and make plans with friends and I'm like I'm only free one day." She did not announce her pregnancy broadly to friends or post about it on social media: "I haven't declared my pregnancy on Facebook so it's really weird for people when like I run into them." She also asked that her boyfriend not share their news over social media: "He did once but I don't think a lot of people saw it. Cause he didn't like- it wasn't like it didn't have me tagged in it or anything it was

actually in the comments he mentioned something about me being pregnant and I was like: oh dude don't do that!" Carlie's approach to social media changed once pregnant and she became more concerned about her privacy: "My Facebook has changed like I don't post anything and I used to always post like selfies or like just funny quotes but I don't- nothing goes on my Facebook." Carlie felt very comfortable discussing her pregnancy with the other women at the centre because of their shared experiences: "I'm so comfortable telling people at [the residence] just 'cause they're all pregnant but know someone who's pregnant or here, same thing."

The Residence. Carlie hadn't heard of the residence before she became pregnant. The crisis worker she saw provided information about community supports for young mothers, including a pamphlet for the outreach centre. She started to attend programs at the outreach centre and while there, Carlie voiced concerns about having her baby apprehended by the CAS if she continued to live at the parent-model home: "I was honest with them and I was like: I'm afraid my child is gonna get taken away." The other young women at the outreach centre told her about the residence and advised her that living there would increase her odds of maintaining the custody of her baby. Shortly thereafter, she moved into the residence to be surrounded by pregnant and parenting women, and to improve her chances of keeping of her child.

Sources of social support during pregnancy. Many of Carlie's close personal relationships changed once she was pregnant because she was "not the same person she used to be." In addition to her boyfriend, Carlie felt tremendously supported by the other women at the centre and the residence.

The Children's Aid Society. The CAS were always an active presence in Carlie's life. She spoke of them as almost another entity involved with her pregnancy and made efforts to gain favourable perception in the eyes of her CAS worker: "It's so much work--just putting on a smile because I'm still in care, I'm only 17 so I'm still in care myself. They watch me a lot more than

they watch other moms and it gives me more motivation too." She remained cautious when interacting with her worker: "I choose my words very carefully when I'm around them." The CAS worker also interviewed the father of the baby and Carlie had to remind him of the power the CAS holds over their future:

At the end of the day, it's not my choice to decide if I co-parent with you but it's also CAS that makes that choice. If they don't trust the father with the child, they'll say: you can't co-parent together if you want custody of the child.

Health and educational experiences. *School.* Carlie dropped out of high school before completing grade 11. She attributed this largely to her level of maturity and social circle at the time. Since becoming pregnant, she returned to school part-time to complete credits towards a high school diploma. She developed a new perspective towards school and was very committed to obtaining her diploma: "I'm at school every day, never miss a day. Even if I feel sick, I've walked to school and puked and still continued."

Health and previous health experiences. Carlie had a history of disordered eating, anemia, scoliosis, and Developmental Coordination Disorder. Before becoming pregnant, she had regular interactions with her family physician and physiotherapist: "I always had something different wrong with me. I was like- I was that person." Carlie also described longstanding mental health issues, including anxiety and depression. Before becoming pregnant, Carlie engaged in behaviours that she now viewed as reckless, including regular drinking, recreational drugs use, and casual sexual encounters: "I started doing really stupid things—I had this thing where I never would date, I would only mess around and be with one guy one day and another guy the next day." Carlie believed that this pregnancy offered her time to reflect on her previous patterns and make deliberate decisions towards change.

Participating in prenatal education. Carlie completed a number of formal prenatal educational programs offered at the outreach centre. This was her preferred way to learn: “Attending groups or programs with other people! Laughing, joking around, and learning.” She completed Pregnancy Circle, Transitions to Parenting, Reaching In/Reaching out, Housing Smart’, Food on the Cheap, Buns in the Oven, and self-defence. The majority of her questions about pregnancy were answered in the programs: “I asked a lot of weird questions in Pregnancy Circle, we all did.” Carlie felt that the group discussion format and casual environment were conducive for asking questions she would normally find awkward. In addition to attending programs, Carlie observed and studied the other women at the residence. Living with pregnant and parenting women created an ideal learning environment:

I learned how to hold a baby and they're not judgemental because all these moms learned it not so long ago too so like a lot of moms are helping the ones who are pregnant with how to hold a baby and push a stroller, and give you a lot of opportunity to help out with their baby. It's amazing how they like they trust you.

She trusted the information her more experienced peers shared with her; the other mothers were a wealth of expert tips and realistic responses. Her peers differ as a source of information, often offering perspectives that diverge from what is provided in the programs or online: “[It is] awesome for me to hear, like, the truth.”

Navigating prenatal health. When asked what being healthy during pregnancy meant, Carlie described a set of actions and behaviours:

To be able to get out and do all the things you're supposed to do without always feeling sick or being tired and all the effects that come with pregnancy--and eating healthy would be beneficial to your health and you just feel better, drinking a lot of water, and exercise but not to a point that you're exhausting yourself but walking around is nice.

Carlie initiated prenatal care with the Obstetrician at the centre at eight weeks gestation, and attended follow-up visits every two weeks. She was also received care from a psychiatrist on a weekly basis and the public health nurse visited her at the residence every three weeks. She reported having good relationships with her health care providers and felt supported by her team:

I feel healthy and I'm negative for all the tests they do like glucose and STIs, so I'm healthy in that degree but they were really concerned that I'm not gaining weight so I'm actually going to an ultrasound, another one, because they want to make sure that my baby's growing. But I feel healthy as a horse, they're just telling me that it's a concern that I'm not gaining weight.

Having lost 10 pounds during the second trimester of pregnancy, Carlie struggled to gain and maintain her weight. She admitted to feeling overwhelmed at mealtimes: "You have to eat every two hours and it doesn't matter what you eat at times, as long as you're getting calories to the baby." She made a number of other lifestyle changes, including sleeping more, taking prenatal vitamins routinely, avoiding alcohol and drugs, and limiting her daily caffeine intake.

Carlie experienced a major depressive episode during her pregnancy that lasted roughly three weeks. She was quickly referred to psychiatry for evaluation, treatment and a monitoring plan:

It's way harder to handle depression and anxiety while being pregnant, while having a baby so they put you on the minimal dose what will effect your baby and measure it to make sure the baby's not getting effected, and then they can give more.

Carlie noted a marked improvement in her mood once on the new medications. This experience helped reassure her that she would be able to cope with post-partum depression, should she develop it: "I'm hoping that my mood stays because now I'm so motivated, like everything's being thrown my way but I'm like: meh, I'm good."

Time. *First, second, and third trimesters.* Carlie described her first and second trimesters as a “rollercoaster” of excitement and fear: “It was really hard on me I just- I wanted to break down. But I guess that I couldn’t I had to stay strong.” She experienced a lot of judgement at the parent-model home: “Every wrong thing that I did, if I broke down in tears people would just look at me and judge me and call me emotional and then I’ll be like: well you try having a baby this early! It’s difficult.” Carlie felt her physical and emotional health improve significantly once she moved into the residence.

Carlie was in her third trimester of pregnancy at the time of our second interview. During the session, she lifted her shirt to show how her baby bump had grown since the last time we spoke. She was eager to meet her daughter and proclaimed happily: “You can actually tell I’m pregnant now!” Aside from some recent difficulty sleeping, she felt very well: “This is the first week of the 3rd trimester and I was running for the bus the other day and I’m surprised I can do so much. I’m doing all these things and I’m so surprised at myself.”

Princess Akita

Princess Akita (PA) chose her pseudonym because of her love of Japanese Anime and the character Akita Neru. She seemed slightly nervous and hesitant at the start of the first interview but became quite animated when discussing school and pregnancy. She felt strongly that she was carrying a boy though that had not yet been confirmed by ultrasound. Our interview sessions were conducted in the resource room and in a private visitation room at the residence. During the second interview, we stopped briefly mid-way through to eat lasagne, and completed the interview while sharing the meal. During the first interview, she commented that she “just looked fat” but by the time of the second interview, she proudly outlined the curve of her belly, noting that she was finally unmistakably pregnancy.

Becoming pregnant. PA discovered her pregnancy at 5 weeks gestation: “I missed my period and had discharge. And then I went with my boyfriend to the ‘sex health clinic’ downtown.” She was initially upset about becoming pregnant “They told me I was pregnant and then I did cry.” However, she never considered termination or adoption as pregnancy outcomes. The physician at the health clinic provided information about her options and follow up instructions: “She referred me for classes and gave me a bunch of pamphlets and said to call my family doctor and so on.”

Beliefs about pregnancy. PA didn’t have strong opinions about motherhood before becoming pregnant. She had a friend in summer camp that got pregnant at age 15 but otherwise had no pregnant or parenting peers in social circle. She drew on the past experiences of her family members that experienced young motherhood to inform her choices: “I guess now we have something in common (laughs), you know what I mean?” She described her relationship with her aunt:

My aunt had her son at 16 so she actually cried when my mom told her that. She cried when she learned that I was pregnant. I don’t know if it was a happy cry, I don’t actually think it was (laughs) but yeah for her it was really hard ‘cause I guess at that time they didn’t get that help so she brings me a lot of stuff...

Relationships. Family. PA had a “close family” that included her mother and her boyfriend. She made efforts to see her mother and boyfriend every day or two. She considered her father and half sister as more distant family members. Her parents separated when she was an early adolescent. She and her half-sister did not grow up in the same home and have different fathers.

PA disclosed her pregnancy status to her family, first to her half-sister and then to her mother. She was not the first woman in her family to experience young motherhood: her mother

had her first child at age 22, her sister became pregnant at age 20, and her aunt had a child at age 16. Her sister was supportive and discussed options with her: “She hugged me and she’s like if you want to keep it I’ll come with you and if you don’t want to keep it then I’ll come with you, you know? And then she’s like: ‘it’s okay, I had four abortions.’” PA was very worried about how her mother would react to the news: “At first she seemed disappointed and then after she was more...excited. Like ‘aww, you know, I’m gonna be a grandma again’, because my sister has two kids.” Her mom encouraged her to tell the rest of her family about it. Her boyfriend disclosed the pregnancy to his family though he is not close with them.

Father of the baby. PA and the baby’s father were dating and maintained a close relationship; they saw each other as much as possible. Her boyfriend attended a prenatal program at the outreach centre with her, called Pregnancy Circle. She felt that his presence in prenatal programs was important so that they could have a similar knowledge base: “We sit in chairs in a circle and then we discuss topics. Uh, stretch marks, contractions, labour—stuff like that. My boyfriend went to every class with me. We don’t miss one. It’s pretty much like before prenatal information.” The prenatal class was moderated by a nurse and included a balance of pre-planned topics as well as informal discussions. At the time, she felt embarrassed by the questions her boyfriend would pose: “Like I’ll be honest, my boyfriend did ask: ‘you know, like is the vagina going to be that loose?’”

Peers. PA’s peer group didn’t change much once she was pregnant. She had not announced the pregnancy broadly via social media or posted photos to reveal her pregnancy status, but planned to post a photo with her boyfriend when she “gets much bigger.”

Work. In addition to full-time studies, PA was working part-time at a Lebanese restaurant. She made the decision to leave her job because due to fatigue. Before quitting, she was working

three shifts per week, each shift lasting four hours and requiring her to standing for the duration of her shift.

The Residence. PA's doctor referred her to the outreach centre for prenatal classes and support. During this time, her mother experienced some financial difficulties and could not provide for her daughter and upcoming baby: "I got here because my mom's supportive you know emotional but then financially she...two-three years ago, went bankrupt." PA explained further: "She obviously can't support me and a baby and then, you know, I needed to make my own stuff pretty much and support myself." She applied for housing at the residence and moved in within a week of her intake interview. She had been living at the residence for approximately three months at the time of the first interview. The move to the residence drastically lengthened her commute to school; she spent approximately three hours per day traveling to and from school by bus.

Adapting to life at the residence was a little challenging because of the rules and routines: "I mean I get it's a shelter but then the rules sometimes are a bit strict like you can't go out on the week." PA posited that the transition was more difficult for her because she had never lived in a structured living environment before and the rules at the residence were less flexible than the rules she had at home.

Sources of social support during the pregnancy. PA felt fortunate that her family and friends continued to support her throughout the pregnancy: "No one neglected me or pushed me away." Having other family members who experienced young pregnancy and parenthood wasn't always necessarily of benefit because they were inclined to make sense of her situation through their own experiences. For example, her aunt voiced concerns about the long-term viability of her relationship with her boyfriend because: "As her baby daddy left she thinks that mine will—like,

you know what I mean?” When her aunt became a teenage mother, there were far fewer supports available to young parents. Her aunt tended to assume that she would have similar life outcomes:

I mean at that time she didn't get all of the support that we do now...so for her she had to stop school and she could not read or write so then she had to go back for ABCs or something like that—I don't know what it's called. She got married but then he left and stuff. For her, you know, she knows it's hard so she wants to help.

Health and educational experiences. *School.* PA grew up in a rural setting and loved being surrounded by nature. She attended a small school; her French Catholic high school eventually closed due to low registration: “I think like we were sixty and then it went to like thirty so people were like: okay, we're going to close this.” In grade seven, her school closed and she was transferred to a much larger school with approximately 700 students. She was in her final year of high school and attending class on a full-time basis when she became pregnant. She decided to finish off her school year rather than transferring to a school specialized for PPY. She was the only pregnant student at her school and was on schedule to graduate on time: “I think the fact that I'm finishing school still, right now I'm just like I have a month left and I really just want to sleep (laughs). You know like you're almost done so you're like kinda slacking.” Her classmates were curious yet supportive: “They're actually pretty nice, well in front of me at least. And then my friends, well you know, people are gonna stick up for me if they do talk. But yeah...I didn't get that sort of bashing; I guess I got lucky.” She had a clear vision regarding her post-secondary education; she submitted applications for five different programs and planned to start college in the fall. She has been researching options for bursaries and daycare programs.

Health and previous health experiences. PA described positive health encounters throughout her youth. She completed annual physical exams with her family doctor, underwent a back surgery, and had anemia that required monitoring.

Participating in prenatal education. Before becoming pregnant, PA was aware of the basics of pregnancy. She also received ample unsolicited advice from family and friends once pregnant. For instance, she was warned not to run or lift heavy things and to avoid eating at McDonalds too much. Peers advised her to abstain from sex, though she was aware that this was inaccurate advice. She valued learning from women that experienced labour first hand in order to augment the factual information available in books. She planned to complete more prenatal classes once school finished, including Transitions to Parenting. She was looking forward to the programs because she found the combination of group discussions, written materials, and interactive lectures engaging.

Navigating prenatal health. PA had monthly prenatal assessments with her family physician, and these appointments will become more frequent in her final trimester. The public health nurse will also start to visit her at school or at the residence every two weeks. She described her first and second trimesters of pregnancy as generally healthy: “I didn’t get morning sickness as much as I think—I maybe threw up three times but I had a lot of acid in the morning. And then my pelvic bone is starting to hurt; feels like someone is sitting on me and I can’t breathe.” She didn’t have to make many health changes once pregnant, other than ensuring that she ate regularly and healthfully, and took her prenatal vitamins: “I was never a smoker, drinker, coffee drinker, drug user so there was less to give up.” When describing what it meant to be healthy in pregnancy, she listed a number of health behaviours: “Eating right, so not skipping a meal or missing my vitamins. Um...that my baby has, you know, all his arms (laughs). Mostly just like general health. Relaxing too.” She compared her health with some of her peers at the residence: “I can’t say I was unhealthy before. I mean some people come here and they have drug problems which makes it unhealthy but then in the end it’s like... you have to be healthy so in the end they change!”

Time. *The first and second Trimesters.* PA really started to feel her baby's movements during the second trimester of pregnancy: "It's not annoying...like some people don't like it after all. I like...sometimes I want it out (laughs), I mean like it's getting heavy." She planned to have her mother, sister, and the father of the baby with her during labour and delivery. She remained somewhat apprehensive about the delivery process: "I'm probably gonna freak out and be there like how's it gonna come out? And I'm just gonna like get an anxiety attack or something like that so (laughs)..." She considered her preferences in terms of medications and would like to have a natural birth. She also started considering what childcare would involve: "I feel like I'm just gonna go home and be like what am I supposed to do now you know what I mean?" She was eager to learn more about the hands-on aspects of infant care: "It's like what's the- how many times am I supposed to bathe him and how do I know if his diaper's full like I haven't done that..." She felt that her determination and persistence would help her overcome any challenges she encountered: "Just because there's a wall I won't just stop there, you know what I mean?"

Mason

Mason was, without a doubt, the participant that experienced the most life changes between our two interview sessions. By 18 years of age, Mason had lived through homelessness, abuse, addiction to crack, rehabilitation, numerous miscarriages, and the births of two children. Her children were 24 months old and 3 months old. Her eldest child was apprehended by the Children's Aid Society at birth and was in kinship custody with her mother. She had visitation rights with her eldest child and was very focused on maintaining the custody of her 3 month old. She would like to regain the full custody of her eldest child at some point but realized that this was a long-term goal. She jokingly referred to her life as "a disaster" and reflected, at length,

about street culture and the ways in which homelessness influenced her current life. Mason was very energetic and spoke enthusiastically.

Mason learned about the study from Mich Mich and agreed to meet me to hear more about it. We conducted the first interview in the visitation room at the centre, while she bottle-fed and rocked her baby. Following our first interview, I became disconnected with Mason because she changed her phone number and moved out of the residence. On a cold afternoon 5 weeks after our initial interview, I received a text message from an unknown number stating: “Are we going to do this second interview or what? This is my new phone number :)”. A few days later I met with Mason at the school program for pregnant and parenting youth and completed her second interview during a break between classes. She arrived to the interview wearing a neon pink, one-piece flannel pyjama with Batman logos and a zipper up the front.

Becoming pregnant. Mason started having sex at age 14 and experienced 13 pregnancies since then. These pregnancies resulted in 11 miscarriages and two live births. She discovered her last pregnancy incidentally, after shoplifting a pregnancy test from a pharmacy for a close friend and demonstrating how to use it correctly. She was shocked when a plus sign appeared, indicating a positive result. It was later confirmed that she was three months pregnant. Following the birth of her first child, she had a spontaneous miscarriage at 5 months gestation, which Mason described as a traumatic experience. She was, therefore, sceptical about her latest pregnancy and believed that conceiving the month following a late-term miscarriage was “too soon.” She noted: “I literally stopped like, stopped, finally stopped like bleeding from my miscarriage in December and didn’t even have a period and got pregnant again.” Mason confirmed her pregnancy status at a clinic, while also being diagnosed with a bladder infection and urinary tract infection. She announced the pregnancy broadly and on social media soon after it was confirmed.

Beliefs about pregnancy. Mason's views and perspectives changed dramatically once she became a mother. Her relationship with her mother also changed following the birth of her first child: "Well I knew that as soon as I became a mother that like, as soon as I gave birth to my first, I told my mom like I have so much respect for her, I understand her point of view completely." Mason spoke at length about how the delivery of her first child was a major transformative event in her life, despite the child being apprehended immediately:

Well I was using- as I told you I was using a lot of drugs and I was slowly weaning off of them so my main priority was making sure the baby was healthy, making sure everything came first and then my drug addiction like came last so by the end of the night it all came down to that, I was so clouded by the drugs that my mind wasn't really focused. I was like I got this, I'm gonna be a great mom, until like um like a month in when I was not like barely smoking the crack anymore and so like my mind was less clouded and it was like oh my God I'm having a baby what's going on! And then the labour, and... it changed my life. I know it sounds bad but like I was an addict so I guess it's normal for my mind to think this way like I was happy, I was happy doing my drugs, living my life, no responsibilities, living on the streets, no rent to pay nothing to pay, no taxes no nothing just living life free of cares and I was happy that way and then as soon as I gave birth it was like I don't want to live this life anymore like... it just changed my whole life perspective like this is not a good place to be, I need to get back on my feet.

Mason described her street peers as "crackheads" and recounted how street life was incompatible with motherhood:

There's some mothers that are on the streets, having drugs, got pregnant because they were on the streets being stupid with drugs, no protection, and then they go through having nothing to something. And they just get their kid taken, and they don't care. Like I

met someone who has seven kids, lost them all to CAS because of crack and they looked at me cause I was seven months pregnant and said ‘don’t worry if you lose your kid I’ve lost seven it gets easier.

Relationships. *Family.* Mason kept contact with her mother but no longer communicated with the other members of her family or her two younger brothers. Mason’s parents separated when she was a young child and drug addiction was something she was exposed to at a very early age. She noted: “My mom was such a great mom and she’s been there. Like my real father abandoned us for crack when I was two years old and he stopped visiting at 5 years old because of the crack.” Growing up with a parent with addictions had a profound impact on Mason and shaped her views on parenting. These early memories fuelled her desire to become sober and change her life:

I do not want to be like my dad and lose my kids, have no contact with my kids like my dad, cause I know how much that screwed me up as kid so I wanted to be like my mom, support my kids, be there no matter what and not let an addiction like come in between me and my kids.

Mason described her “street family” as a second family when she became homeless at 15. Her memories of life on the streets were, initially, very happy ones. She termed her first few months of homelessness as a “honeymoon phase” because it was the summer and she was drunk or high most of the time: “Like life is great, on top of the world, no responsibilities.” Her boyfriend at the time was also homeless but soon turned to theft and drug dealing to fund his growing habits. The honeymoon phase was fleeting: “the hardest part hadn’t come yet.” Within a year, Mason was single, addicted to drugs, and alone on the streets for weeks at a time. She engaged in a number of highly verbally, physically, and sexually abusive relationships during this period, including the relationship with the father of her first child.

Father of the baby. Mason was not in contact with either of the fathers of her children. Her daughter was conceived with the father of a friend that was renting her a room. The relationship featured significant abuse: “There was a lot of verbal abuse ... and he was like ‘Oh I’m gonna beat you...I’ll just come over and beat you right now like he did’ and that was the last straw for me.” Mason moved into the residence shortly thereafter and the relationship ended two weeks before her daughter was born: “I had finally had enough of his yelling and controlling and accusing me of cheating all the time so I left him.”

Peers. Mason had one very close friend at the residence that was pregnant and parenting two children. She no longer maintained relationships with her peers from the streets. At the time of the second interview, she was no longer in contact with the other women she had met while living at the residence.

The Residence. Mason was aware of the residence and was preparing to move in just prior to her miscarriage at 5 months gestation: “I did my intake and then I...and then I miscarried so I couldn’t move in.” She moved in shortly after confirming the current pregnancy and described her time at the residence as “a bitch”. She commented: “You get treated like you are back in school—not even high school—school.” Having lived in structured living environments before, including a family shelter, she observed many differences in the level of autonomy residents were provided: “Yeah, people telling you when you can and can’t eat, times to go bed, times to wake up, times for this, times for that.” If she could change one thing about the residence, it would be the rules and how they were enforced. She did, however, note that moving into the residence had a direct impact on her health and wellbeing. She felt that her mental health and nutrition had improved dramatically while at the residence. Mason received a housing offer and moved into her first apartment just before Christmas. At the time of the second interview, she

had been living on her own for almost a month. While she left home at age 15, she had never lived alone for an extended period of time:

I went from living with parents, to living on the streets where you hang with friends so you're not really alone like once in awhile you're alone but there's the city and everything, and then I went from there to constantly having my boyfriend around.

She described a newfound sense of peacefulness and freedom: "Not having someone hovering leaning down my back telling me what I should and shouldn't be doing, I like now it's based on my own judgement." The most challenging part of this transition for Mason was the quiet: "I went from constant noise to like dead silence, like I don't even have TV right now so I like pace my floors." Mason's primary sources of social support were her mother and her best friend.

The Children's Aid Society. Mason felt the strong presence of the Children's Aid Society in her life. She felt that the CAS were forthcoming about their expectations; her CAS worker was clear about the actions she must take in order to retain the full custody of her daughter: "She had told me I needed to do these classes but she didn't say how many, I want to see you at the drug counsellor and I want to see you in a stable home for three months." She reported having a positive relationship with her CAS worker, however there were many expectations for a new mother to meet: "Yeah, and then I correct it and then they come out with another thing, then I correct that and they come out with another thing."

Health and educational experiences. *School.* Mason completed grade 9 but dropped out in grade 10. She had learning disabilities and struggled during high school. She had just returned to fulltime classes at the school program for pregnant and parenting youth, and believed that her experiences as a student would be different this time. Located in the downtown core, the school was a non-profit, registered charity that served adolescent mothers and their children. It offered an accredited secondary school education, free daycare, drug counselling and mental health

programs on-site, and was considered a care and treatment centre. Mason missed a number of classes in her first week of school:

I haven't been here for the full week yet like I started last Monday but I was still sick so I didn't go, then Tuesday I went, then Wednesday it was the frostbite weather so I didn't go out at all and then, Thursday I went, and then Friday I dropped the baby off and then had to go do my other things that I needed to do and then coming here again.

Experiences with childcare. Mason didn't have much experience with children prior to having one. She had terrible morning sickness throughout her first pregnancy: "Cause like it was just slowing my day down and I was a drug addict, right? So was my boyfriend at the time he wanted to go, go, go, go, go so I just went (makes vomiting noise) walking down the street (laughs) playing with nothin'." Mason described her labour and delivery experience with her first child, noting that she was at an "asshole hospital" and received a lot of stares from staff and other patients. Mason was in labour for 2.5 weeks, though the actual delivery itself consisted of three minutes of pushing.

Health and previous health experiences. Mason did not engage with health services on a regular basis prior to her first full-term pregnancy. She didn't attend annual physicals or dental appointments. Mason didn't use contraception routinely during sexual encounters which, on reflection, she regretted: "Well for my first child, like when I had to give my first child up because of the drug use and everything I looked at myself and said I definitely like should've taken time to find out information on contraception." She credited the gap in her sexual education to leaving home and school at age 15:

I had left home before my mom ever really had that talk with me, and I just never really had that talk and then I never really paid any attention in Sex Ed, I had no interest for it, so I was already having sex I was like I don't care I already know things.

Once pregnant with her first term pregnancy, Mason engaged with health care on a weekly basis and developed a close relationship with her public health nurse: “Had seen the doctor and told I was pregnant and so right away I called public health and got a public health nurse and she educated me, got me on prenatal vitamins, got me a dietician, everything.”

Addictions. Mason struggled with addictions since early adolescence. Her addictions progressed rapidly from the use of speed and ecstasy to crack cocaine:

We were used to doing 40 pills a day, each, like 20 pills of E and 20 pills of Speed, so he told me Crack was just like a stimulant like Speed like make me rushy and stuff so I tried it and automatic addiction.

At the time she learned that she was three months pregnant with her first child, she was consuming large quantities of drugs on a daily basis: “They said that the withdrawals with the amount that I was doing would probably kill the baby cause the baby was now addicted I was smoking seven hundred dollars a day worth of crack.” She started drug counselling at the outreach centre to reduce her daily intake of crack cocaine: “By the last three months I was smoking \$60 every three days. From \$700 every day to \$60 every three days was amazing. The doctor couldn’t even believe I did that much.” Mason continued drug counselling and meetings regularly following the birth of her first child, and was proud of her sobriety: “I’m sober like I haven’t relapsed at all, don’t feel like I’m gonna relapse I’ve had temptations and they don’t bother me.” She recalled the exact date her drug sobriety began.

Participating in prenatal education. While Mason initially started attending prenatal programs as a requirement of living at the residence and an expectation from CAS, she soon realized that she enjoyed them: “I was already doing programs for prenatal but I liked it, and I liked learning more about how to care of my baby and stuff so I kept doing, like I’ve done almost

every single program there is.” While living at the residence she completed Pregnancy Circle, Transitions to Parenting, Buns in the Oven, Baby and Me, and Making the Connections.

Mason felt confident in her knowledge of pregnancy and delivery because she experienced these before. She felt less confident about infant care and parenting. She found some of the information in the formal prenatal programs too prescriptive and felt that the teaching was most beneficial for novice mothers. Her preferred ways to learn were to ask questions, consult others, and observe everything.

Navigating prenatal health. Mason described her health care experiences as largely positive. She believed that this was due to seeking prenatal care from the residence and the outreach centre versus organizations that don’t typically service young mothers. Mason initiated prenatal care when she learned of the pregnancy: “I was like: I’m having another baby I have to make sure that I at least get to keep this one.”

Time. Mason described this pregnancy as a healthy one. She was a “go-getter” throughout, linking her need to stay active with her time on the streets:

With my first pregnancy I was in the streets so I had no place to relax, I had to keep moving constantly, my boyfriend at the time the father was a full-blown addict, he could not control his addiction, so when I’d be wanting to stop and take a break somewhere and eat he’d be like no, no, no, we gotta go the dealer’s waiting and he’d be like make me go, go, go, go he’d get the drugs and be like ‘kay we gotta go, go, go, go we gotta go make this place to shower or go go go go here so I constantly had to like speed walk trying to keep up with him so when this pregnancy hit I was like speed walking cause that’s what I used to. It felt unnatural for me to just take the easy.

Her experience with labour and delivery was also positive and she remained in the hospital for 2 nights post-partum.

Parenthood. Mason was very energetic during the first few weeks of the postpartum period: “I found like the first month all baby wants to do is sleep, wakes up a little for his or her bottle and has to get a diaper change and goes back to bed, and that’s basically its daily routine.” Infant care became more complex in the second month postpartum and she became more fatigued: “I guess it’s called a honeymoon stage, same as a relationship, like everything seems amazing until later on when reality hits, everything hits, you’ve been with the child for a little while it gets hard.” She elaborated on the challenges of childcare:

I am exhausted, baby’s constantly crying, baby wants this, baby doesn’t want that all of a sudden, I’m almost ready to go out walking out the door and baby poops, and I gotta restart everything all again and it’s very time consuming everything so it’s like you pass that honeymoon stage and reality finally hits you that you are a full-time mother.

Parenting was not “a walk in the park” and required constant learning and re-learning as the baby grew and changed. Mason offered advice to other expecting mothers: “So I’d tell, right now, I’d tell people that after birth and before like the pregnancy is hard but it’s nothing compared to what’s coming like a month after your birth.” In December, Mason’s daughter became ill with bronchiolitis and required two trips to the Emergency Department at a pediatric hospital. This was her first experience with a sick child and she found it quite harrowing. That said, she learned a lot from the experience and gained confidence in managing the care of her child the next time she is unwell.

Summary of within-case analysis

This chapter began with a summary of participant demographic information followed by detailed narrative descriptions for each participant. The demographic information and narratives of the 11 study participants reflected certain commonalities including interruptions in and returns to schooling, chaotic family circumstances, experiences of trauma, desire to learn and provide

safety for their infants, and despite some of the challenges they've faced, a sense of optimism about the future. When individually examined, each narrative revealed a unique story. In other words, these collected stories demonstrated the complex and heterogeneous nature of the PPY in this research study.

Chapter Five: Cross-Case Analysis

Interpretive cross-case analysis involved the comparison of themes and patterns, across participants, for similarities and differences. Cross-case analysis was conducted following within-case analysis. This chapter presents the findings from cross-case analysis, highlighting the prominent themes and sub-themes that were recognized in the data. The four overarching themes are as follows: 1) the influence of the living environment on learning and health; 2) the perinatal period as a time of reflection and re-envisioning; 3) pregnancy as a catalyst for change; and 4) learning resources and resourcefulness. These themes provide insight into the women's understandings of maternal health, as well as the experiences and contexts that have shaped their views. Each of themes and sub-themes will be discussed in detail and this chapter concludes with a summary of the cumulative research findings.

Theme 1: The Influence of the Living Environment on Learning and Health

At the time of the first interview, all study participants were living at the residence on a fulltime basis. The two-storey building was structured with sleeping rooms upstairs and the communal living areas downstairs. The communal areas included: a play room with floor mats and toys for infants and toddlers; a lounge area with two computers, craft supplies, and board games; a large and mostly open concept kitchen; an interview or treatment room for visits with CAS workers and other service provides; a television lounge with couches and comfortable chairs; a private staff area that I never entered; locked offices; an education room with pamphlets, books, and resources about pregnancy and parenting; and a cafeteria-style dining room with several long tables. Video cameras adorned most of the communal rooms and hallways, and to enter the residence through the front door you had to be buzzed in.

Each bedroom was private and came with a crib to accommodate newborns. The shared washrooms and shower rooms, largely reminiscent of college dormitories or military barracks, were located upstairs. Residents also had access to laundry facilities in the basement. The private interview or treatment room featured a leather futon that could fold down to create a bed and transform into a recovery room for mothers recovering from Caesarean Sections, as climbing up and down the stairs could be challenging in the immediate post-partum. I conducted most of my interviews in this private room, several in the education room, one in the director's office, and one off-site. The participants offered their thoughts on living in this residential environment.

The residential program as a micro-community. During discussions of life at the residence, it became clear that many participants conceptualized it in terms of a micro-community, though they did not outright articulate it as such. The women described a sense of group membership, which was welcomed as most had experienced recent disruptions in their social circles. Participants commented on shared mealtimes and rituals of the residence, sharing their perceptions of both the formal and informal codes of conduct. In terms of rituals, my interviews spanned two festive times at the residence, Halloween and Christmas. During each holiday, staff organized activities for the mothers and their babies. I personally witnessed pumpkin carving activities and winter-themed photoshoot setups. An example of self-organized, informal rules related to the program scheduling for the single, communal television. With television viewing only permitted at select hours of the day and up to 15 pregnant or parenting youth living together at a time, the women crafted a schedule based on consensus in order to mitigate conflict. While nothing ever appeared in writing or had to be posted, they formed an understanding, and each could tell you what would be playing at any given time during the assigned television period. Television schedules were a serious thing at the residence.

Common experiences. The residential environment promoted the development of a sense of collective identity and social integration, and a key component to group belonging was the presence of common experiences. While participants' life experiences leading up to living at the residence varied greatly, there were some notable common features across narratives, and above all, recent losses or volatility in terms of family connections, home, or peer group was a main point of intersection. For instance, in the 12 months preceding their most recent pregnancy, ten participants demonstrated housing instability with a mean number of six housing moves (range 1-21 housing moves). This was also true in the five years preceding their most recent pregnancy, with a mean of 28 moves (range 3-150 housing moves). While only one participant had been street-involved, others had precarious housing situations including shelter, couch surfing or other short terms living arrangements Table 3 presents data regarding housing stability by participant over time. Though the context of instability and degree of precarious housing were mixed, the notion of living in a state of transience was common to 10 of the 11 participants.

Table 3

Housing stability over time

Pseudonyms	Years in Canada/Age	Moves, past year	Moves, past 5 years
Kat Minou	20/20	3	5
Lady Godiva	8/20	4	10
Oh Henry!	6/18	21	40
Lila	20/20	4	5
Fettuccini Princess	6/20	4	4
Camille	20/20	4	4
No Name	18/18	11	75
Mich Mich	20/20	3	7
Carlie	17/17	5	7
Princess Akita	17/17	1	3
Mason	18/17	6	150
Mean	15.45	6.00	28.18

A history of family disruptions also featured prominently in all participant narratives. That said, as described in the within-case narratives, the context of disruption varied vastly,

including parental deaths; parental mental health or substance abuse issues; arguments, conflicts and violence; and separations, divorces, and single parenting. While circumstances surrounding tumultuous dynamics were diverse, a lack of harmonious family relations was common to all. In fact, during the first set of interviews, which aimed to get an understanding of context and history, I asked participants to describe their childhood neighbourhoods. I was surprised by how many struggled with this concept. This was one of the areas where I reflected and acknowledged my own biases. The notion of belonging to a family, let alone a neighbourhood, was foreign to a number of women. For instance, Carlie spoke at length about growing up in “the system” from age 5, and how incongruent this was with developing a sense of attachment to any one place: “Well, I grew up in foster care so I moved around a lot. I didn’t just have one neighbourhood.” Further, living at the residence was perceived as a temporary measure for all as residents could not stay beyond their eighth month post-partum. Many women were motivated to move out before this deadline.

The women were also navigating pregnancy and parenting at the same time, with nine women expecting or experiencing the first pregnancy they intended to carry to term. They shared the experience of young motherhood and the residence provided reprieve from the stigma and judgement they perceived in other environments. Lila commented: “We were with a whole group of people but people who were supportive and not judging. So that’s always great.” Kat Minou described the ease of befriending peers that shared the experience of motherhood: “I got really close with people here. We built some good friendships and it is way easier for me to build friendships with women who already have children or are expecting.” Living with other PPY has a normalizing and validating effect at times: “Living here helped me though, I’ll admit that, ‘cause I was so overwhelmed and everything like that” (No Name). Other cohabitants enjoyed reaching gestational milestones together because they could compare and contrast their

experiences and understandings. For instance, Fettuccini Princess and Kat Minou shared the same due date, and Fettuccini Princess commented:

We're due the same day, the same hospital; we are waiting for our boys. It's funny and like for example we are experiencing the same thing. Our bellies are not growing the same way because mine is bigger... It's funny because our babies are growing together and the same experiences.

Safety and being part of a group: All participants believed that moving into the residence was of vital importance, whether due to a lack of safe and secure alternate living conditions, the need to flee tumultuous relationships, inadequate income options and access to resources or food, or as a means to improve their chances of retaining the custody of their infants. In other words, they were there because they had to be. Carlie transitioned from the parent-model home to the residence in order to seek safety and supportive peers:

This is actually way better for me having people that I can relate to and it's actually better that a lot of them are older than me cause I lived with a whole bunch of fourteen and fifteen year olds who were getting into trouble, stealing money from the actual house, starting drama, like it was just... insane. That's actually why I was like I have to leave. Not because of the setting, or the parents, or the staff; it was because of the girls. I was like: I can't be around this.

Living at the residence also afforded opportunities for enhanced social and emotional support, when needed. There was also an element of informal role-modeling occurring at the residence, as well as a counter narrative that young moms can be good moms. Cohabiting with other PPY proved to be inspirational for Carlie and informed her decision-making:

When I came [to the residence] mostly--I think that was my big...like it all dawned on me that I can do this because before I didn't have like all these young moms around me and

seeing them, and I was battling the option of abortion or adoption and I just didn't think I could do it, I just didn't think I could keep my baby. So after I was like: "you know what? I can do it, it's what I want" and "so many young moms are succeeding and I can too."

Lila, who was reaching the end of her eighth month post-partum at the time of the second interview, commented on the bonds of friendship she formed at the residence:

You develop friendships here that carry on outside. We all have different outlooks on life and different problems but we just help each other. You know, one's going through one problem: Oh good, I already went through that so let me be of assistance or help you or support you. One girl came home the other day crying and we just group hugged her; we're there for each other.

Kat Minou echoed this sentiment. She reported having "tough times", including a difficult breakup while living at the residence and felt very supported by her cohabitants: "Right away when they see something wrong or they see you're upset or somebody else sees that you're upset everybody kind of becomes concerned and it's really awesome. I mean it, it helps." For others, living at the residence offered a safe space for disclosing and discussing matters related to their pregnancies. A number of participants chose not to disclose their pregnancies to friends or family, and as such, felt quite isolated before arriving at the residence. For instance, Fettuccini Princess felt silenced by her desire for privacy, and only discussed the pregnancy with her baby's father. This proved to be less support than she required:

At the beginning of the pregnancy I had nobody to talk to because if I talk to somebody, someone will tell on us. And then my boyfriend and I, when we were talking at the beginning we were always finishing by yelling at each other and fighting and so. (...) I didn't want that. So it was just for myself and then I discovered here and I decided to come here.

Improved mood and wellbeing. Once settled in at the residence, most participants shared a sense of improved health. The most common areas where improvements were reported were dietary habits, physical health, mood, and psychosocial wellbeing. For instance, No Name felt that living at the residence had a rapid and positive impact on her health:

I was more energized once I got here. Within like 3 days I felt better, I felt more energized. I can do more things rather than live with my mom. I was eating a meal a day having snacks throughout the day.

In addition to providing safety, comfort, company, and nutritious meals, she felt that the program-rich environment was an asset: “I didn’t really do much [before coming to the residence], all I did was sit around but here you do things, you go to programs, you do appointments, you get a hold of the public health nurse and stuff like that.” She also felt that the atmosphere was conducive to learning: “I was scared, a little [about motherhood]. And then after a while and some time here I figured that this is actually a pretty good place to be and to learn new things.”

Programs offered at the residence or centre also linked a number of participants to health services. Mason, for example, accessed treatment and medication management through health care providers at the centre: “Living here has helped me like get on meds, get diagnosis, I didn’t even know I had some of the stuff I have.” Carlie accessed mental health services to manage worsening symptoms of her mood disorders, and valued the close monitoring that was available to her:

It's funny how I'm more on them [medications for anxiety and depression] now than when I wasn't pregnant but they're like: you kind of need to get that treated if you're about to have a baby, especially because like you get really bad hormones and you after post-partum, that's something to worry about.

She also received dental care through the visiting dentist at the centre, something that she had not done in years: “I just got 13 cavities filled and I had to have 4 sessions.”

Tensions. There were also a number of tensions related to life at the residence and adapting to the new setting wasn't always easy. Some posited that adjusting to the residential environment was easier for those accustomed to shelters or “already in the system.” For example, Princess Akita was new to residential living and commented: “I'm kind of new at this so it's kind of confusing. I mean, some people that come from shelters—like they've lived in shelters their whole life—and so it's pretty normal for them but I'm not like that.” Several participants struggled in their early days at the residence. Lady Godiva, also new to this type of environment, remarked: “I used to cry all the time. I've never been to a shelter before living here so I didn't know what I was getting myself into until come to live her and they were telling me all the rules.” The speed at which a woman adapted to the environment was very context-specific and related to the structures she was accustomed to in the past.

Rules, roles and responsibilities. The residence functioned in accordance with set schedules and rules, and this posed a major challenge for some. Lady Godiva found the structure smothering: “they tell you when to eat, go to bed, and when someone else does something we all feel it.” At times, she compared the residential rules to those at a prison, and was eagerly awaiting a housing offer and the return to normal life: “I feel like it's a jail and I served my time for this lovely girl here.”

Previous experience in structured living environments or shelters allowed some participants to compare and contrast their environments. Carlie, for example, had been living at the residence for approximately one month at the time of our first interview. Her previous environment was more regulated than the residence and she felt that the regulations were in place to protect the women and their children: “you need to be strict when you're taking care of like—

there's babies here so there's a lot of rules." She acknowledged that the transition for someone new to structured living could be quite shocking:

I came from like a lot, a lot of rules like so for me it feels like a break but I guess coming from no rules it feels like wow honestly it's awful. Like I guess that it's easy for me cause I'm in school like for one thing you have to up by 8:30 and out of your room by 9:00 and that's a rule that a lot of people struggle with.

No Name's also felt that her experiences "in the system" helped her adapt:

I'm used to structured living. I've lived in group homes, sponsor homes, I went to treatment, I was almost adopted... and so... I'm just kind of used to it I kind of adapted quickly but then I'm just tired of living in structured homes 'cause I've been living in it for so long so I just can't wait to live in my own place and have like my rules, my place, (laughs) my way.

For No Name, the perceived benefits of being surrounded by other PPY outweighed the inconvenience of the rules: "I [had] a lot of people here that were pregnant as well so it helped me with my pregnancy.... if I was having a hard time I'd be able to talk to other people here so I found that good I mean but the rules are kinda, I think, a bit ridiculous."

While Oh Henry was not new to the shelter system, adjusting to life at the residence was a challenge because her previous shelter environment, which housed women of all ages, was "more like a hotel." Adhering to the enforced timetables while managing the care of her infant was difficult:

I'm not used to being with like the whole entire people--like 15 girls, c'mon. So I'm not used to live with so much people, I'm used to live on my own and sometime it can be like stressing with everything that's going and especially with the time of the morning.

She continued on to explain that morning routines applied to all residents, regardless of how well the moms or babies had slept. Between her infant's feeding and sleeping schedule, and the timetable at the residence, Oh Henry felt sleep deprived: "At 8:30 I have to be down and I have some programs that start at 9 in the morning and sometimes I don't have time to even eat." She did not feel that the requirement to strictly adhere to the residential schedule was reasonable in the post-partum period. Many others felt that the rules were stricter than they need to be: "I mean, to be honest, I had more fun time in treatment than here" (No Name). Like No Name and Oh Henry, Mason's previous shelter experiences were far more relaxed: "I know an organized shelter can run better than this one." She also felt that staff actively discouraged input or feedback from the residents about their environment: "you actually speak up and you get kicked out." This issue was not voiced by the other participants.

Turn over and "drama". The number of women living together could be challenging at times, depending on the mix of ages, personalities, and past experiences. In addition to the volume of PPY, the continual flux in and out became tiring for some participants over time. Fettuccini Princess believed that it took a lot of patience to live at the residence:

Every time there's a new person and you try to understand all the behaviours and try to live with that. And even though the person like will... just stay a week or two or a month that's it and you have to deal with it and try to be nice always so... So I'm used to it. To safeguard her energy, Fettuccini Princess learned to engage minimally with the new arrivals, opting to be friendly rather than investing in lasting friendships: "it takes energy each time if you wanna get to know them... I don't really like go into it because I have to focus on my pregnancy so if the new people, new person comes in I'm just like okay." Lila commented on occasional "drama" at the residence due to the mix of people living there at times and divergence over issues like cleanliness standards. Mason noted that you can cohabitate without having to befriend

everyone: “There’s some girls yes, some girls no. Like you’re gonna run into some girls that you’re not too fond of here. It happens.”

Fear of losing their children and apprehension over constant surveillance. Some women moved into the residence to demonstrate stability and increase the odds of maintaining the custody of their children. Carlie, for instance, was attending programing at the outreach centre and, after speaking with other PPY, came to the realization that child apprehension could be a reality: “I was like I’m afraid my child is gonna get taken away and then everyone was like the reason I kept my child was because I went to [the residence] and they’re like you go to [the residence] and you follow the rules you’re most likely gonna keep your child. So I was like that sounds like a good deal.” That said, living with the fear of losing one’s child, coupled with the requirement for observation and reporting by staff, was challenging for some.

Once at the residence, Carlie learned to adapt to life under what she described as “constant surveillance” and “frequent casual visits.” She noted: “They're not watching me every day but they're watching my steps: 'oh, why didn't you attend this day? Oh, you didn't attend this program?', So I have to do what I'm told and also like [the residence]—I love all the staff here but because I'm young they have to tell CAS. Anything and everything goes to them.” Mason, who had her first daughter removed from her custody at birth, was also very aware of the system of surveillance and reporting around her. She engaged with health care and classes to demonstrate her ability to provide a responsible and safe home for her child. Her prenatal education involved building on her previous experiences:

I started seeing my drug councillor even though I felt that I didn’t need it and I still don’t feel like I need it to this day but I’m still going to it, just to prove to CAS that I am serious about this so like I just took what I knew from my first pregnancy and then I went to parenting courses to find out about the after care.

The requirement for monitoring and surveillance, including enforced visiting hours open to those living outside the residence, posed challenges for mothers that wanted to parent with the father of the child. Princess Akita worried the restrictions at the residence will act as a barrier to co-parenting, and negatively impact the attachment and bond between father and child: "...not just for me but I mean it's not just my child." Given the opportunity, she would prefer to spend her post-partum recovery in another environment: "after giving birth obviously I'd rather be at my boyfriend's or mom's than stay here." Due to this requirement for monitoring, Camille felt that sometimes the residential staff overstepped their roles and became judgemental of parenting practices. For example, when she did not pick up her baby as soon as it cried, a staff member commented: "oh, you don't attend to her needs." Camille vehemently disagreed with this comment: "I was like 'what the fuck are you talking about? I attend to her needs all the time.'" She resented having her approach to parenting monitored and has become very sensitive to comments made by staff: "now that I have her I'm so defensive of people judging my parenting."

Theme 2: The Perinatal Period as a Time of Reflection and Re-Envisioning

Temporality featured heavily in every interview. The perinatal period was a time when life phases were considered, evidenced by moments of reflection, introspection, and prospective futures. Participants also reflected on their current situations and how they felt they were regarded; many expressed a sense of being in the 'in-between' while straddling sociocultural identities. This section focuses on issues of time and identity, as discussed by the women in the study.

Contemplating life. Participants were forthcoming with stories and sentiments that intricately intertwined past experiences, current circumstances, and future aspirations. We discussed places, peers and plans. Many described their life histories as journeys building up to

the point of parenthood, as though all the smaller components of their lives led them here. Pregnancy and parenthood prompted considerable reflections on their experiences, origins, and values. Participants most commonly framed their views of parenthood in terms of their own early lives; most were adamant to parent differently to avoid repeating the same early traumas and struggles within their family units. During our discussions, I noted verbal and non-verbal indicators that these early familial experiences remained quite raw for some as speech patterns, tone, and tempo would change for a moment when discussing the past. It wasn't uncommon for participants to trail off for a moment or to sigh deeply mid-sentence, as if recalling past events with intensity. Others voiced a sense of achievement for having overcome challenging circumstances: "It wasn't a (falters)- it wasn't an easy childhood but it was okay. I survived. It made me stronger today" (Fettuccini Princess).

Past Experiences. Life stories featuring past traumas including familial or partner abuse, addiction, and neglect were commonplace. Participants openly discussed some of the sequelae they felt were related to these early traumatic exposures. For instance, Carlie believed that her mental health issues and anxiety stemmed from negative family experiences prior to entering the foster system. She was adamant not to repeat this cycle: "I will never neglect my children like my parents did to me so I'm very like, you know. I want to make a proper life for her and me."

Having experienced the dissolution of family through divorce, separation, death or immigration also made participants want a different family composition for their children. For instance, informed by her single-parent upbringing and absent father, Kat Minou was resolute to raise her son in a shared household with both biological parents present. This desire influenced her decision to live with the baby's father once pregnancy was confirmed, despite their negative dynamic. However, during the pregnancy her views shifted and she realized that her main priorities were to safeguard the wellbeing of the child and provide a stable, loving home:

It was always a tough thing to think about but now that I understand, like I truly understand the best interest of the child now. Because I know that having grown up with parents that would fight all the time, I don't want my kid to grow up in that. So I'd rather have him grow up having to go from mommy to daddy's house rather than seeing us fight together, hearing the arguments and stuff.

Oh Henry reflected on her origins and losing her sense of family. On several occasions, she mentioned feeling like her childhood and youth were stolen from her after immigrating to Canada at age 12 because she was no longer connected to a larger family unit. She began couch surfing at age 14 and by 16 years of age she found herself living in a youth shelter, and having to learn to navigate a very real, adult world. She did not want her daughter to have a similar fate:

I never have like my dad, like my family, I never have that someone who showed me like good care, good formula, everything like that. But me I wanted to see like she have a good life cause like I don't even have stuff, I don't, and I want her to be able to have them. Everything I don't have in my life I want her to be able to have them and childhood not like growing up so fast like just like me, become an adult when she's already a kid, when she's still a kid.

Current Circumstances. Pregnancy also prompted a significant amount of appraisal about more recent life events and the meaning of motherhood. Some participants felt like mothers as soon as they discovered their pregnancy or at the first ultrasound appointment when they saw or heard the fetus. Others developed a feeling of motherhood, described as a sense of bonding, as the pregnancy progressed or even at the time of birth. For Lady Godiva, fetal visualization made the pregnancy real to her: "you go to the actual ultrasound appointments and you see her and you're like: there's something growing inside me!"

Conversely, Kat Minou experienced significant depression when she found out she was pregnant, initially believing that her life was over. She did not feel an initial bond to the fetus and had a very difficult time coming to terms with the pregnancy. She contemplated adoption and abortion, and described the first trimester as a struggle: “It was so stressful! I don’t know how I got through it all. I don’t know how this baby got through it all. So that’s when I realized that this baby’s a fighter.” Over time she started to feel movement in her growing abdomen, which prompted her to seek housing, health care, and educational resources. At this point she noted that a sense of motherhood emerged: “I’m ready for this baby, this baby will be coming and this baby is still here so it must be meant to be.”

Mason discussed the tumultuous relationship she had with her parents, which resulted in street involvement and homelessness by age 15. She rebelled and resisted household rules put in place by her mother, opting instead for the freedoms afforded by life on the street. Her father was largely absent during her childhood and was addicted to crack cocaine. She found herself addicted to drugs at the time of her pregnancies and these were defining moments for her. It wasn’t until the birth of her first child that she experienced a sharp shift in perceptions: “the reality, like when I gave birth, the reality hit.” At this point in time, she gained a new understanding of her mother’s viewpoint:

When I gave birth to my first I did not understand my mom at all and why she was always giving me these rules and telling not to do this and drugs and alcohol and then I gave birth to (baby #1 and baby #2) like both of them I was just like: oh my God! Like my whole perspective went into my mom’s perspective.

Optimism and aspirations. A sense of hope about the possibilities in the future was interspersed throughout interviews. Participants that shared their tales of pre-pregnancy struggle were, perhaps, the most hopeful in their outlooks as parents. Mason reflected on her past

struggles with addictions and untreated mental health issues, while simultaneously reporting a sense of optimism about her current circumstances: “I’m back in school, I have my daughter, I get to see my other daughter, I’m a year and 6 months without no slip-ups. I’ve gone from absolutely having nothing to like having everything.”

No Name discussed how the unplanned pregnancy meant a change in her imagined future, notably that she did not complete high school and will not be starting college with her peers. There was a hint of regret in her tone when she discussed the ways in which she deviated from her planned life. That said, her goals realigned and now relate to parenting and the wellbeing of her son; she felt that he was motivating her to make positive choices. She was resolute to help her son achieve his dreams and to support him:

I kinda wish I had waited but I mean he was so unexpected ‘cause I wasn’t in a place to be prepared I mean I haven’t even finished high school yet and so I’m, I’m 18. And shit, I was supposed to graduate last year and I was supposed to be starting college this year. But it didn’t I mean- so I wasn’t really in a position before because I mean I used to be in drugs and alcohol all the time and so... but then I guess everything kind of- I mean I guess everything kind of I mean I donno... I guess there’s a good thing to have had a child early on ‘cause like they push you to go to school I mean ‘cause like me I want his dreams to come true now, whatever it is.

Fettuccini Princess experienced the death of her parents, followed by a period of turmoil and the eventual immigration to Canada to stay with her uncle. She starkly contrasted the happy memories she associated with life in the Congo with her parents, with her oft abusive and uncertain life in Canada with her uncle. The way she spoke about the time periods seemed distinct and incongruous. She felt strong bonds with her son throughout the pregnancy and, drawing on her own life experiences, spoke of their imagined future together:

I love my baby even though he's not here, I love him already. And I'm sure that I will never, ever, ever, ever leave him alone. And I will raise him the way my parents raised me, not the way my uncle treated me. The way my parents have raised me and with God's grace on him I hope so too. I will do better, I will be a good mom. And he's gonna be my baby even though he will be turn like thirty years old later, I don't care, I will call him my baby anyways.

Negotiating new identities. Beyond the biological, pregnancy was a confounding experience for some participants in terms of embracing new identities, including that of mother. Becoming mothers, something typically celebrated in North American culture, arose in an atmosphere of intense judgement perceived from both their social circles and from complete strangers. The following section explores how participants negotiated their new, and sometimes conflicting, identities.

Peer group and socialization. Since becoming pregnant, all participants experienced major shifts in their peer groups. Many felt that their pregnancies left them changed, and feeling "older" than their non-parenting peers. Some felt isolated due to lost or strained friendships: "I like spending time with friends but I can't do the things with friends I did back then like I do now, and I don't have that much friends now as I did back then" (Carlie). For a number of reasons, participants felt that their pregnancies set them apart from their non-pregnant peers: "I mean I go to a public school where I'm the only pregnant girl" (Princess Akita). Some participants observed a shift in common interests with their former peer group: "I noticed that I lost a lot of friends 'cause I mean I was in kind of with the drug scene and like the drinking scene" (No Name). Lila become more active on social media during pregnancy because she felt disconnected from her peers: "I was so bored because no one wanted to hang out or anything.

Everyone was out drinking and partying and I can't do that; if I dance and try to, you know, drop it like it's hot, I need help getting back up.”

Princess Fettuccini self-identified as a Christian and spoke frequently about the importance of her faith. The other members of her congregation largely formed her social circle, particularly when she fled her uncle's home and relied on couch surfing and other precarious forms of housing:

Since I'm 16 I'm like independent on my own so since then God never gave me up. Like I had bad, bad really bad times and God just never gave me up and I, I, I hang on that words that say that God is my Shepherd and he will never let me go.

While she identified her faith and religious beliefs as a major source of strength, she found herself intentionally distancing from church services and socials. She eventually stopped attending church because she feared judgement and wanted to keep her pregnancy private:

I don't go to church where my sister goes now because at that church I have like the many people who were there who loves and who I was friends with them and but, I (falters) but I didn't tell them with my own mouth that I was pregnant. I think they all knows because my community they, they all talk so when someone knows something everybody will know something. So, sometimes they say “Hello how are you? It's been a long time” and I just say: “I know I'm just too busy I cannot come to church. I work a lot at, all the time” I just give reasons. Yeah, I just don't want to deal with it right now.

It was common for participants to seek likeminded new friends and sometimes other PPY reached out to them: “[a friend] just found out she was pregnant and she came to me cause she knew I was pregnant so we've been bonding more and my other friend has a three month old so we take the baby to the mall and, you know, talk about pregnancy” (Carlie). It also prompted some to seek out new activities and interests: “now that I don't have my best friend anymore now

it's kind of like I have to find other thing to entertain myself" (Kat Minou). Some women felt that the pregnancy helped them identify and strengthen select friendships or familial bonds. Camille felt that her true friendships were revealed when she needed support:

Since I'm pregnant I've found out that it's in the really bad times that you know who is your best friends and who your real, real friends are. Like since I'm pregnant I'm finding out who can be there for me if I'm down [...] Those who cannot be with me, like help me, during my pregnancy, I just keep them away because they are not here for me and don't support me. I'm just putting things in order to get my baby ready and to do everything better for me and my baby

Societal judgements. Participants were acutely aware of the stigma of young motherhood. They believed that pregnancies among older moms were celebrated and valued socially whereas younger mothers received far greater scrutiny and judgement: "No one throws us baby showers but we're the ones that need it" (Camille). Lila felt that the stigma was widespread: "They automatically look at me and go: oh, she doesn't have her life together, she's probably doing this, she probably smokes, maybe she does crack, they back into my stroller, nobody holds the door." Mason commented on the importance of understanding context and personal narrative before making assumptions:

There's just so many different way of being pregnant and so many people have gone through different things and everyone has their own story. But I find teen moms get the most bailed on them and bad credit and everything when everyone could have the same situation or different stories.

Once pregnant, all participants believed they received more attention in public spaces than they used to. Being approached by strangers, and frequently receiving negative comments, was common to all but one participant. The one participant that had not received negative comments

from strangers did, however, notice that people were watching her: “I didn’t get any rude comments or anything. Sometimes I do get stares, I can’t say like rude sort of stares but you know just stares” (Princess Akita). It was widely believed that young motherhood was accompanied by a set of generally accepted assumptions. Princess Akita voiced what she believed were the common stereotypes of young motherhood: “they’re single teen moms that wear slutty clothes and don’t go to school. Maybe drugs, partying too.” Mason felt that stereotypes emboldened people to approach her and offer critique of her behaviour. For example, during her first pregnancy she smoked cigarettes as a harm reduction measure to decrease the amount of illicit drugs she was consuming each day. She would routinely get approached about smoking and felt that older pregnant women wouldn’t receive such direct commentary by strangers:

Young mom’s there’s a lot of stereotypical stuff for one like you get like, you’re sitting on a bus or having a cigarette on the street or something and older people or people around your age will walk up to you and be like: ‘what are you doing? You’re too young to have a kid, you’re not gonna be able to take care of a kid, look at you smoke’, and like for the smoking piece people don’t realize that like even like people in their thirties will be on the street and they’ll be smoking too if they were smokers! Some moms quit, some mom’s don’t.

Some participants felt that strangers speculated about their life decisions leading up their pregnancies. For example, Lady Godiva felt that travelling with other young pregnant women people led strangers to believe that she was in some sort of intentional pregnancy pact:

They always staring at us cause we were both pregnant they think- probably think that we did it on purpose or just at the same time or something cause our bellies were like the

same size cause we were like a week difference so we always get looks and people stops and staring at us.

Of all public spaces, public transit was cited as the environment in which they receive the most negative attention. No Names noted: “a lot of people are very arrogant and very rude on the bus.” Commentary on city buses was so commonplace that it was addressed in prenatal classes: “we were just talking about that in class today how the young moms are, especially the ones that look young, get lectured a lot on the bus” (Camille). Some felt that discussing this issue could help prepare others for the inevitability of unwanted attention.

The optics of young motherhood. There was agreement that certain assumptions about early motherhood were pervasive, namely that the pregnancy was unintended and preceded by questionable decision-making, that young fathers weren't engaged in parenting, that partying and drug use was commonplace, and that young parents were uninformed about parenting or prone to neglect. Participants felt that the comments they received were curtailed by cues that challenged these stereotypes. For instance, Kat Minou felt that public perception became more favourable when she was in the presence of a male:

I was walking with my boyfriend of the time, three days ago (chuckles), then I found myself walking a little bit more proudly when with him. He's not the baby's dad at all, like there's no chance, but it made me feel more comfortable if he would hold my hand and walk through public because that way people look at us in a positive light as like: oh the dad's in the picture you know they're in love... you know things like that.

In order to navigate public spheres and avoid judgement, many women learned to conceal their pregnancies, alter their physical appearance, or change their behaviour when in public. Lila commented: “Everyone bashes teen mothers all the time. That's why I wear my old ring or I wear

heels or something, I don't know if you dress up or something then automatically they give you a little more respect." Kat Minou echoed this sentiment:

When they see a young girl they think- and she's big and she's pregnant and, you know, I'm by myself because I am on the bus by myself a lot but it depends, to be honest, it depends on what I'm wearing that day because if I'm dressed in my sophisticated look going to work or whatever then I look older and they think: oh she's gonna be a great mom, she's gonna have a beautiful baby, she knows what she's doing, she's off somewhere important, she looks important... and then if I'm wearing sweatpants and things like that and a t-shirt and my hair is up and I don't have any makeup on it's like: eugh, where's her baby daddy?

Carlie chose to conceal her pregnancy, when possible, in public:

If I'm wearing something tight they notice me more and I feel like I'm being watched more and I feel like I need to be aware of how I'm sitting and how I'm acting. Whereas um if I'm hiding it and stuff I have nothing to be worried like if I'm wearing a big bulky sweater....

Given the choice, she would rather conceal her pregnancy than be offered priority seating on public transit "When I have a coat on you cannot see my belly. And so no one sees my belly and so no one offers me a seat, which is frustrating, but it's ok so I usually stand on the bus." On the other hand, every time I visited Carlie at the residence she was wearing clothing that displayed her growing belly. When I asked about her pregnancy, she did not hesitate to lift her sweater to show me how she had grown or to trace the outline of her abdomen with her hand. The worry she conveyed about public spaces clearly did not translate to the residence; there was no need to hide in this environment.

Lady Godiva felt a shift in public perceptions once the baby was born: “It’s funny how people are, they will see me with the baby and they’re all smiles now “oh she’s so cute” but when you’re pregnant they just give you looks.” Even then, she still felt that her knowledge of infant care was questioned when stranger would ask whether her baby had a hat to wear outside or socks: “I know I’m young but I’m not stupid. It’s like they think you have no knowledge because you’re young.” Mason believed is possible to develop a certain level of immunity to the public commentary over time. She reflected on how stares and comments were less impactful during her second pregnancy.

I was sixteen when I got pregnant, gave birth at seventeen, I was living on the streets, I was doing drugs, I had dirty looks left right and center every single time I lit up a cigarette, dirty looks left right and center like I had been there, done that. Now here I am eighteen years old I’m getting stared at I’m like: I don’t care! If you would’ve been in downtown seeing me like a couple years ago, I was nowhere near as well cared for myself as I am now. So like, the looks didn’t mean nothing.

Mich Mich, who was pregnant with her third child at the time of our interview, had also become resistant to public commentary. She felt that efforts to conceal the pregnancy in public do nothing to combat the stereotypes: “I just don’t like the fact that they hide it! Like it’s something beautiful that’s growing inside of you that you and that partner made. You shouldn’t be ashamed or anything from hiding it. That’s what pisses me off.”

The advantages of young parenthood. Participants strongly believed that all mothers benefit from encouragement and support, and there was agreement that being older didn’t necessarily make you a more competent parent. Participants raised several strengths of young parenthood that they felt were largely lost in the negative messaging about young mothers. Princess Akita felt that an advantage to parenting at a younger age was the capacity to be more

involved in the daily life of the child: “A lot of people say like when you’re younger it’s, that’s it, not to have your child now but I mean cause you have more energy, so it means like maybe more hands on as a part of you know having, usually a nanny or a sitter.” Several participants also discussed the biological advantages of early pregnancy:

You know people tell me ‘well think about it when your kid’s 20 you’re only gonna be 40 and look at all the things you get to do together and you’re gonna have all this energy’ and then you hear things like ‘it’s better to have your kids younger because the chances of Downs Syndrome are lower, healthier births, healthier babies’ and there are positives to having- the younger you are- it just sucks that things aren’t ideal when teens become pregnant. You know they don’t have careers, they don’t have husbands, they don’t have houses... (Kat Minou)

Oh Henry believed that readiness was more important than age, but noted that unexpected pregnancies are more difficult when you have less resources and life experience:

Well, if I see someone that’s older that have more like, some of them have more experience and some of them is more like ready for it and then for someone who is just like more younger having it is like you don’t have any experience and then it’s kind of like a little bit lost, everything like that so especially when you’re not ready for it and it’s just happens it’s kind of like more harder on you.

That said, participants had different views of what it meant to be ready or prepared to parent. The material, financial, social and educational aspects were discussed. Mich Mich felt strongly that young moms accessing services, resources and programming were perhaps better prepared to enter into parenthood than someone older with less prenatal education and support:

I find that people that are older, no offence to older people, (laughter), it takes them a lot more time to parent because they have to like look back into like the past and everything

and then look into the future of what's allowed, what's not allowed anymore. And us young moms are like okay and we have all these parenting classes, all these places that help....”

Theme 3: Pregnancy as a Catalyst for Change

Study participants talked at length about the transformations they experienced. For some, the sense of transformation occurred at the time of the birth of their child: “I’m sure no mother can describe the way they feel as soon as they push that baby out. It is indescribable, unbelievable, everything. Like your whole life changes and it’s not all about you anymore, it’s all about that child” (Lila). During the interviews, many participants used the term to “step up” when discussing parenting, meaning to assume responsibilities which they had not previously had. Camille noted that while relatively little time had passed between the confirmation of conception and arrival of her child, she felt profoundly changed: “Like everything changed, you’re not the same person anymore.” This section focuses on issues of deliberate change and the emergence of a new sense of responsibilities.

Deliberate life changes and harm reduction measures. Pregnancy and parenting triggered some degree of harm reduction measures or deliberate lifestyle changes for all of the women in the study. Most commonly, changes involved healthier food choices, avoiding alcohol and drugs, reducing caffeine intake, distancing themselves from peers that they perceived as negative or unhealthy, and accessing regular medical care and prenatal assessments. All participants received prenatal care and visits from a Public Health Nurse while living at the residence. Carlie discussed the transformative effects of pregnancy at length:

Like I said the ones who have had babies or are pregnant have stepped up and I’m more friends with then than I am with people who are going nowhere in life. It’s true once you-

well it's true for me it'd not true for everyone- once I found out I was pregnant I changed my whole life around! I just was dedicated for school, I was dedicated to do right, you know and I stayed away from people who did drugs, drinking, just going nowhere in life and I'm making my own way.

Some life changes were more difficult than others. Issues pertaining to self-harm, substance abuse, and smoking cessation emerged as challenges that required ongoing support. Two respondents disclosed self-harming behaviours and how difficult it was to learn new coping mechanisms: "Not abusing my body basically or substance abuse... It's hard 'cause I can be really hard on myself and I needed to not be that for my baby.... that was probably the hardest thing. And coffee, of course" (Carlie). Smoking cessation also proved very difficult for some; four participants were regular smokers at the time they discovered their pregnancies. Kat Minou quit smoking "cold turkey" in the first trimester of pregnancy, and three other participants smoked less than before. Participants that continued to smoke cigarettes while pregnant acknowledged the health impact to their fetus, and took measures to reduce the number of cigarettes smoked per day.

In light of her history of addictions, Mason had very passionate views about harm reduction and discussed these at length. The desire to regain the custody of her first child and retain the custody of her second child was a major motivation for sobriety. She was unable to overcome drug addiction during her first pregnancy, but was able stop using following her second stay in drug rehabilitation treatment:

So I didn't have anyone like: "oh you have to quit, you have to quit, you have to quit", like 'cause barely anyone knew except my doctor and my public health nurse that I was a crack addict and they, they didn't help me out at all. They'd ask how my use was and I'd tell them and they'd say that was amazing. And like when I had my baby, I went to a day

treatment for three months and then came out and my ex got me re-addicted cause I didn't have my daughter at the time. So he got me re-addicted. He had drugs waiting for me at home to say congratulations so I re-went into it and a month after that I'm like: "fuck this like my kid's in Ottawa right now I need to get back to Ottawa and I need to try getting my kid back"...And I'm a year and 6 months sober, today.

Mason discussed the deliberate lifestyle changes she made during her most recent pregnancy: "I found out in the first month this time and I reduced my cigarettes, I started a lot more, I started eating a lot healthier, I did all my prenatal follow-ups, prenatal vitamins everything right away as soon as I found out." Her first child was apprehended at birth and Mason was adamant not to repeat that cycle.

Fettuccini Princess discussed the measures she took to diminish pessimistic influences in her life. Prior to moving into the residence, she was living with her boyfriend and felt surrounded by negativity. She took active measures to be surrounded by other young pregnant and parenting women, and to seek guidance peers and educators at the prenatal classes:

The friends that are not going to help you during the pregnancy just to put them away for a moment because the pregnancy is your whole thing and it's really stressful if you're not- if you have only negative people around you and you're not strong like for example me, my boyfriend is a negative person I'm like a positive person so it's like kind (falters)- the different thing but I deal with it and I don't have a problem with it because he's not mean every time but if you have a lot of friends and 50% of them are negative, you have to deal with the 50% of it like, it's a lot.

Placing fetal wellbeing first. Three participants disclosed having experienced deep depression while pregnant which resulted in thoughts of suicide. When their moods were at their lowest points, the fetus inside of them acted as a protective factor that dissuaded that from

following through with their suicidal ideations.

I used to have like a lot of disorders like I have anxiety disorders and I was going through a depression episode, of course a lot of pregnant do this, but you can't come to terms with suicide because you know- like suicide for example once you think about suicide you're not just killing yourself you're killing the baby inside of you so you start thinking.

In all cases, the fact that they were pregnant prompted them to seek mental health care. Similarly, Carlie started to feel as though many of her decisions were being filtered through the lens of her unborn child, recognizing that she was now responsible for another life. Prioritizing the care of another was new to her:

And you start "if I can take this coffee it's not just giving me a hype it's going to affect my baby. If I do this drug, it's going to affect my baby" so there's all this stuff you're not just thinking about the effect it has on you because before of course you a teenager you don't care you would drink until your organs give up, you know? But after you think "Oh, I'm caring for someone else" a baby is so small. I didn't really care about school like now they're all like "I can just live on minimum wage" but then I was like: oh, I need to support a baby. And you do this for the baby so she can have a good life. It just changes your whole perspective.

Mich Mich also commented on how her children were a source of strength for her and how she found meaning in parenting: "my kids helped me with so much like they make me happy and they're my reason to wake up and smile every day." Oh Henry developed a deeper understanding of herself as her confidence as a parent grew:

Well I know myself pretty much. But I'm starting to know myself even better and I'm starting to surprise myself with stuff I've been doing like I never thought I would like for example I never thought I would like care like about like a baby like so much. I love kids

but I didn't know whether the love of kid as much as I think I would love her. And I never thought I would be like step up one day to see like: you have a baby now you have to try to like figure out things for your baby and I never think about like those kind of stuff. So it's like by having a baby I see myself more stronger pretty much.

Determination to provide a good home. The women in this study were determined to provide what they viewed as a healthy and safe home for their children. The impetus to create a stable home often fueled other life choices, including the desire for financial and housing stability, as well as the decision to return to school or to complete educational credits. Carlie noted:

I'm doing my life like I'm in school like I dropped out of school for a bit I was just being stupid and I wasn't like following the rules and I was like just being a teenager but now it's- I have responsibilities and I follow them....The most important thing is my baby of course and uh, creating a future and being- trying to get stable for when my child actually comes so I'm in school trying to graduate high school, get all my credits and hopefully go to university and just planning my life. That's the one thing I worry about, I- I'm focusing on.

Similarly, when asked about her priorities, Princess Akita stated: "Baby, housing, college." At the time of our second interview, she had just submitted her college applications. Lady Godiva echoed these goals: "Take care of her and trying to like get housing and like figure out my future plans to go back to college and stuff that's pretty much like the main stuff."

Mich Mich was focused on raising her children and making sure that her dependents were "well taken care of." She commented: "What's important to me right now is my two children, making sure this pregnancy is healthy, school, and making sure my children and everything is clothed, bathed, dressed, fed." Lady Godiva was also focused on creating the best life for her

daughter. She made a deliberate life choice to raise her in Canada because she felt that it would provide a better quality of life: “I wanted her to be a Canadian.... She’s born here she’s automatically a like a Canadian. She was even a Canadian before I was!” This decision wasn’t easy because the baby’s father and primary support system are in Jamaica, and she felt the toll of not having her support system in place here. Lady Godiva was uncomfortable leaving her infant in the care of non-family members, which impacted her availability to work or study:

I’m not gonna leave her with just a stranger to be taking care of and she’s way too young I want her to be able to like say: mommy this is what happened or something so that leave her with like somebody that I don’t know. So that’s why I’m taking like a year off to be with her. I don’t want to send to her to like a daycare.

The financial realities of young parenthood. All participants discussed the financial challenge of parenting on a limited budget. This was a common concern across all participants. Kat Minou discussed the financial burden, reality of government subsidies, and challenge of obtaining fulltime employment:

I was basically at a point where I needed to find somewhere to go. Where am I going to raise this baby? That was my biggest fear: where the hell am I gonna go? Subsidized housing was a 10 year waiting list, OW was only giving me 260 bucks a month... and so I was trying to find full-time jobs and all I could get was part-time so I’m still working at my part-time job.

That said, when considering the possibilities and outcomes, Kat Minou came to the realization that, no matter what, she could provide care and affection to her child: “this baby’s not gonna have all the money in the world but he’ll definitely have all the love cause I figured that was a little bit more important.”

No Name also discussed life on Ontario Works (OW) government subsidies: “I mean well

I'm on OW and I don't really find they give you much." When asked whether it would be enough to live off of, she noted: "like barely, I mean if you go to like two food banks a month." She was skeptical whether government funds would be adequate to support the care of herself and her son: "just to provide everything for yourself and your baby it's pretty tight." The financial challenges of single parenting and a desire to have her son's father engaged in his care culminated in No Name's decision to move to the prairies: "If I stay here he'll only be able to see his son maybe once or twice a year. But then if I go there he'll see his son pretty much all the time." She discussed how moving out of province was "kind of a big deal" for her but that she felt it best for her son.

The uncertainty of housing. Establishing safe and stable housing was a major concern for all, and being "on the list" for housing remained an unknown in their minds. Carlie discussed the uncertainty of obtaining a housing offer: "for me it could take less than a year for sure and it's already been a couple of months. The average person it takes three to five years." Princess Akita discussed the process of receiving housing: "Sometimes it's long and sometimes it's short... sometimes it does depend if you're picky." She continued on to explain that you can refuse up to three housing offers: "after the third time they just take you out, like you're not serious, you don't really need a place if you're that picky..." The lag time between applying for public housing and receiving an offer influenced her approach to applying: "maybe I shouldn't have done that but I checked everywhere on the paper and I wasn't picky. I was like: 'I need a place.' But then there are some bad neighbourhoods and some apartments are way nicer." When asked to explain what she meant by bad neighbourhoods, she described areas she wouldn't feel safe in or locations with a lot of drug trafficking. In order to secure a housing offer, she felt that she had to be prepared to live somewhere she perceived as potentially unsafe.

Theme 4: Learning Resources and Resourcefulness

This section focuses on issues directly related to both formal and informal prenatal education, highlighting conditions that enhance learning. Accessible education emerged as a key component of learning, with accessibility denoting both convenience of service acquisition and methods that are tailored to learner characteristics.

Clustered, convenient, and coordinated services. The logistics of seeking resources and attending programs were a constant consideration. While “hustling to get things done” (Mason) was expected for those that had experienced homelessness or precarious housing, caring for themselves and a growing fetus or infant often presented unique challenges. As such, participants greatly valued the clustering of services, with programs and treatments available to them on the same street and within walking distance of the residence. For some, it was a deciding factor for living at the residence while pregnant: “I picked this one because it was closer to me, it was a lot more secure, and it’s down the street from my school and my Centre where I do programs and so I picked this place and I loved it” (Mich Mich).

Several stated that they would not have sought out all of the services and treatments they engaged in if they had to source them individually. The clustering of services reduced logistic barriers related to time or travel. Enhanced access and proximity to multidisciplinary services was perceived as a benefit that improved compliance, attendance, health promotion measures, and engagement in prenatal education. Carlie described the benefits of having access to care that was youth-friendly and specialized:

I can do my schooling, this is where I live, up the street I can go to the doctor’s, the dentist, programs, so like every stop is legit just on this street. It’s pretty amazing and they’re all like supportive cause they work with pregnant ladies so they know what they’re going through.

When asked whether she would have engaged in those same services had she continued to live at the parent-model home rather than the residence, she enthusiastically replied: “no”.

Education that acknowledges and builds on past experiences. While discussing learning, it became evident that participant’s educational needs evolved as their confidence as mothers progressed. Prior to becoming pregnant, many participants had developed some baseline childcare skills that they felt were transferable, commonly from being tasked with the care of siblings or extended family members. For instance, Lady Godiva was very involved in the care of her siblings and cousins in Jamaica, thus entered into parenthood with a level of comfort regarding the care of her daughter: “well ‘cause I have so much cousins, I’m always babysitting, and my dad has 2 kids so the mom is around taking care of them too. So having her is not really like a challenge really...it’s not that hard for me.” Several women gained comfort and childcare skills through babysitting and role-playing caregiving scenarios: “I was always taking care of the younger ones so I was just always really good with babies ... I was always with my doll, I carried the baby doll everywhere, changed its diaper” (Kat Minou). She continued on to contrast her comfort level with a peer that had less prior exposure to infants: “I was raised really well when it came to babies and stuff ... I see some girls, one in particular, who’s like: how do I hold this baby? I need to support its head, right? I’m just like: oh my goodness.”

In addition to building transferable skills over time, participants experiencing repeat pregnancies reflected on how their learning preferences had changed. For example, during Mich Mich’s first pregnancy she relied on YouTube videos to familiarize herself with natural labour and other pregnancy tips. On her third pregnancy, she felt adequately informed about the basics and preferred to pose questions directly to other parents and her health care team: “it’s my third child and I pretty much know the stuff already.” She changed information seeking approaches because she felt that most prenatal websites and books presented generic information geared

towards first-time mothers. Mason, with 14 previous pregnancies and one previous birth, also felt as though some educational resources were a better fit for first-time mothers: “I know some moms like they don’t have the confidence or for whatever reason they take prenatal classes and they’re like okay this is exactly how I have to be a parent.” During her first pregnancy, she relied heavily on members of her health care team for information and guidance, and attended prenatal classes:

With my first kid like I was in with Public Health for the whole way and I had a dietician so I knew everything about how to be healthy and stuff and started going into prenatal courses ‘cause I knew that would help me get my kid and show that I was well educated.

Timing, relevance, and readiness to learn. Timing and a sense of readiness to learning emerged throughout a number of the narratives. Many first time moms were terrified about labour and delivery, which impacted their sense of readiness to learn about it; some felt that learning too much, too soon could trigger unnecessary worry. The pacing of learning was most prevalent in the women with unexpected pregnancies because they often required time to come to terms with gestation. For instance, Kat Minou expressed apprehension about labour and delivery, which in turn made her reluctant to watch the videos her public health nurse provided during her first trimester of pregnancy. As her pregnancy progressed, she made the decision to view the videos so that she could make informed decisions. She commented:

I was one of those people that was totally against watching those videos ‘cause I did not want to psych myself out and then I watched it and I’m like it’s not as bad as I thought! So it kinda worked backwards in that sense whereas I thought like I was gonna see all this blood and all this stuff and I’m like I don’t wanna know what’s happening down there but seeing it was like: oh well that’s not so bad.

Oh Henry also chose to defer learning until she had time to process the pregnancy. She did not attend any prenatal classes before the birth of her baby and was the only participant that declined program participation while pregnant. She shared her sense of disengagement throughout much of the pregnancy: “I was just like not even care. I was just like okay I’m pregnant; okay have a baby, okay, whatever.” It took time to reconcile the reality of the impending birth and she felt didn’t feel ready to learn about it. In fact, she delayed learning about childbirth as long as she could: “I started to prepare when I was like pretty close to forty weeks.”

Similarly, in terms of timing and readiness, participants voiced enhanced engagement in learning when the content was perceived as directly applicable and well aligned with their gestational stage or present circumstance. For instance, Carlie’s favourite class was Pregnancy Circle because: “it’s actually about relevant timing, meaning pregnant. It talks more about what to expect.” Other programs were not as directly applicable in the moment: “Food on the Cheap was about budgeting and buying food and then I’m like: sure this is a good tool for me to have but I live in [the residence] right now where I don’t have to worry about that.” Carlie felt less engaged in ‘Food on the Cheap’ because what she was learning could not be applied right away.

Participants also discussed relevance as a means of filtering advice, information, and instructions they were given. Several participants commented on the differences between what was taught in classes and what worked best in real life. Many felt that learning about theory and childcare skills was helpful but that much of what they really needed was to try out different techniques with their own babies. Mason felt that prenatal education offered a good overview but recognized that there were no “one-size fits all” methods for child care: “people can know about babies, but every single baby is different and has their own personality, own attitude, own way of doing things.” Many moms first considered how relevant the information was to them or their

child before deciding whether to apply, adapt or ignore it: “I know her better than they know her so if I know she won’t like it, I won’t do it” (Lady Godiva).

The presence of trusting and safe relationships. The importance of trust emerged repeatedly. Trust and safety were a prerequisite for information seeking and advice, as the young women viewed themselves as the safety guardians of their growing fetuses and infants. The women often had a sort of implicit hierarchy of trusted sources of information, built over time. This hierarchy varied depending on what type of information they were seeking. For example, No Name explained that her typical information seeking process involved consulting different sources depending on the question: “I’d ask other girls here at the residence, and then some of the staff, and then I’d go to the Centre and I’d go ask people there, I’d go ask my prenatal teacher.” It wasn’t uncommon for the mothers to triangulate sources of information in order to determine the best course of action or response.

While there was some divergence in terms of what participants considered ‘good information’ or trustworthy sources, they all took measures to seek the most reliable information available to them. For example, Lila developed a therapeutic relationship with the visiting public health nurse, and this became her most trusted source of information: “We have a public health nurse that tells us a bunch of things and I know that she's telling me something right.” For Mich Mich, her birth companion became a dependable source of information, and she would text questions on a daily basis: “I have a good connection with [her], I didn’t even meet her the first day and I was talking about how my nipples hurt, anal sex, everything.” Lady Godiva developed a close relationship with her doctor, noting: “I can text my doctor. She’s actually cool.”

Equally, the loss of trust carried significant implication for learning and information seeking. Oh Henry, for example, had a baseline mistrust of health professionals at the onset of her pregnancy which resulted in her feeling uncomfortable asking her Obstetrician questions:

"no, I never ask questions, I just shut my mouth." This was further compounded by feelings of betrayal when the CAS temporarily apprehended her infant: "I'm not feeling like safe pretty much while I'm here and telling my emotions or anything like that." As a result, she was determined not to ask question of the staff for fear of losing her daughter: "after what happened, if I have anything or any sickness I'm not going to say anything. I will shut my mouth because I don't want people to come out and say: okay, I take your baby away again."

While living at the residence and attending programs at the outreach centre, Mason felt monitored by the staff and educators: "everything I do right they write in the books." The constant sense of surveillance impacted her living and learning, and she was concerned about making mistakes: "everything I do wrong they call CAS." As a result, she developed strategies for seeking information that relied largely on questioning peers or using the Internet: "people, Google, everyone; sometimes only one person sometimes a bunch; sometimes Google and a bunch of people because you can't believe everything you hear on the Internet." She established the credibility of information by cross-referencing it between individuals and website sources. Oh Henry also felt more comfortable with the anonymity inherent to Internet searches and started to rely on Google searches for information more than any other resource: "I just go to the computer and I use Google or Wikipedia--but sometimes Wikipedia doesn't give good answers." While the Internet and Google searches were consistently mentioned by all participants as convenient methods of accessing information and often an initial step in inquiry, there remained a significant amount of scepticism about the accuracy of some online content. For instance, Lady Godiva refrained from seeking information pertaining to childcare online due to questions of credibility: "I don't want to go on the Internet when it's about my baby cause some stuff you don't want to go with 'cause it's probably not true....So I rather ask like, a good source."

Education that fosters a sense of involvement. Feeling involved in the educational process was key to learning. There was consensus that a sense of engagement enhanced learning and recall. While there were some similarities in learning preference, there were also marked differences in self-identified learning preferences. Staff at the residence and the centre acknowledged the high prevalence of learning disabilities in their client base. Attendance at the outreach centre programs was a mandated rule for the women living at the residence, and participants described the prenatal programs offered at the outreach centre as employing a number of engaging teaching approaches. Learning was facilitated by the accessibility of educational resources and approaches, and described in terms of the availability of varied educational materials such as reading and visual materials; hands-on learning opportunities; rich description, discussions, and storytelling; and coaching and role-modeling.

Reading and visual materials. When touring the residence for the first time, I was struck by the number of posters on the walls in the main corridor and amount of information hanging on bulletin boards. Posters advertised programs and support services, provided reminders of residential rules, and shared health tips and information. My colourful study enrollment advertisements were added to the mix on an already busy bulletin board. Additionally, there were books and binders full of articles curated on a variety of pregnancy and wellbeing-related topics, and I often spotted copies of “What to expect when you’re expecting” in the lounge. Pamphlets and handouts featured a mixture of text and images, which appealed to some of the young women: “I want to see it to be sure about it. Especially when I’m learning. I love when I’m learning and I have the image” (Oh Henry). Women at the residence were living surrounded in text and pregnancy became a period of enhanced reading for some. Fettuccini Princess commented:

I'm reading- before, before pregnancy I hate reading. Give me a book of 100 pages it's going to take me a month to finish it. But now I start a book, pregnancy book, I finish them in 2 days. I go back to the library to take one more (laughs) and I read. So now I'm a reader; I'm a reader because of the baby.

Princess Akita was self-proclaimed life-long reader but found her tastes in reading material shifting from 'zines to pregnancy-related books: "I've been reading. I've read like three books. Like one on prenatal, one's on prenatal too, a small book that's from my public nurse, and then I have The First Year." She valued the medical information shared in educational texts, she yearned for personalized stories and anecdotes: "I mean a book they more state facts and so on which sometimes could be better, I mean everyone's pregnancy kind of is different so I mean I can't just listen and believe someone else's' opinion."

Hands-On learning opportunities. Learning "through using your hands" (Fettuccini Princess) and a preference for tactile learning methods emerged repeatedly during discussions of ideal learning scenarios. Many participants reported learning best while doing, not just by reading, seeing, or hearing information or instructions. In my group of participants, Mich Mich, No Name, Mason and Carlie each disclosed having a diagnosed learning disability that impacted their capacity to concentrate and recall information. Mason discussed how this, as well as the responsibilities that accompany parenting, impacted her return to school: "I haven't been, done it in a while and I have ADD and ADHD. So... It's like, I dropped out half grade ten so I was in school and it was like forever. Now I got like two kids and I want to go back to school so, it's definitely gonna be different."

The four participants with learning disabilities were in agreement that they did not respond well to education provided via didactic methods. They preferred to be actively involved in the instruction rather than following along, watching, or reading. Mich Mich described: "I'm a

hands-on type of person. You gotta show me hands-on or I'm just gonna stare at you and be like: what? I have to do it with them... 'cause I won't remember what they did." The optimal place for her to learn was in individual or small group sessions where external distractions were minimized: "I'm the type of person you do one-on-one 'cause I'm not a big gang of people type class type person and I'm a hands-on person, I have to have hands-on and if I don't then I get extremely frustrated." Similarly, when learning a new skill, No Name preferred to be shown and then to have a return demonstration: "I'm more of a hands-on person so I need someone to show me first and then I can follow through with it." This was the most effective first step in learning for her.

Rich description, discussions, and storytelling. Participants often contrasted the "facts" with the "real story", creating a distinction between what can be taught in an educational setting and what can be learned firsthand or from another person. In addition to seeking information deemed accurate, many were interested in what they regarded as the authentic side of things: "moms are more detailed, they're more like can tell you the feelings, the reality of it." Carlie felt that the prenatal programs and health care interactions focused primarily on the theory of pregnancy, childbirth, and parenthood rather than the reality of parenting:

The nurses and the programs just like tell you the basics of it. The programs are more like a test, like 'what's the name for this? This is called blah-blah-blah', but the moms tell you more about what's important, you know when you see this, this is what you do.

It was common for the women to speak distinctly of what they read, what they were taught, and the real story: "I'd like to hear the stories, for sure. Hear the real stories" (Kat Minou).

Information couched within personal narratives was often described as impactful and memorable: "If you tell me facts versus if you tell me a story I'll remember that story but I may not remember the facts so I learn well through stories, something interesting" (Carlie). Kat Minou described a

blend of fact and story seeking: “Yeah, I like to do both. I like to do the facts first I think and then go see what the other moms are saying.” Similarly, Princess Akita commented on how she can learn procedural information in text but can only get a sense of the essence of an experience through discussion:

I mean if you’re talking about childbirth the book will be more precise about what’s happening but not the pain, how it feels, sort of it’s different views I guess like. They’ll explain what happens to you placenta and so on but if you go and ask someone who’s been through it, it’s more like their labour so. I like a blend of both.

Conversation and discussion emerged as powerful teaching tools. Participants were also very keen to point out the differences between a lecture and a taking part in a conversation or discussion. Carlie:

If you actually involve me in the conversation I’m way more likely to pick it up like if I’m talking about it and I can have my say and somebody else has their say instead of just like lecture, like someone else giving a lecture, cause that will bore me and I will fall asleep. But if you have a conversation about it I like that.

Programs offered at the outreach centre often used an approach to education that emphasized a combination of group discussion and teaching while encouraging independent learning:

I think that’s why the programs help because they do both. I mean you have papers and you read books but someone’s still explaining it or talking about it, which is more entertaining because like I have a book upstairs like... It’s like why breastfeed, why not and then it’s like more time, less time and then I’m like: what? (Princess Akita).

Other women commented on how the characteristics of the instructor or storyteller are key to the quality of education. No Name mentioned the need for rich description: “I mean when people describe it very well. When it’s descriptive and like I know it is and they do step-by-step of how

it's gonna happen or how it is and stuff like that." Fettuccini Princess highlighted the importance of putting information in context and using plain language:

You talk to me- you give me a paper to do this, this, this I prefer you talk to me and tell me to explain me like with your own words what it means because I'm a gestural person.

Coaching and role-modeling. All participants learned through daily interactions and experiences, as well as the resources in their environment. Learning through informal interactions at the residence, outreach centre, and with peers and family members was cited as a preferred way to learn for some. These learning experiences often involved elements of coaching, role modeling, and observation. Learning through observation and coaching allowed for the introduction of multiple ways of doing, which was greatly valued. Participants wanted to remain open to multiple methods of child care and adapt their techniques to the circumstances and preferences of their infants: "people can show you different- seven different ways of bathing a baby but only you...feel comfortable with one" (Mich Mich). Family and friends were also acknowledged as parenting role models. Mason identified mothering exemplars in her life to model her parenting style after. To learn about parenting, she observed her mother: "I watch how my daughter's being raised, watch how she's raising my brothers, taking into consideration how she raised us and the lessons she taught me."

Many participants enjoyed coaching and demonstrations before attempting new skills for the first time. For instance, when Camille was learning about newborn baths she completed a number of practice sessions on a plastic baby doll, watched a video, received demonstrations by a staff member, and received 1-on-1 coaching from the public health nurse during the first bath she performed on her daughter. She appreciated the availability of a variety of coaching opportunities because she felt somewhat overwhelmed at first:

I'm not saying that I know everything, I'm still learning and I'm going to learn every day but I feel like I'm going really good at learning about babies and stuff like that, learning about what they need and things, and how to take care of them and how to....like there's a lot, it's hard to explain in words but there's a lot.

Close coaching allowed Camille to build a sense of confidence in the care she was providing her daughter. Over time, a number of participants described an increase in confidence and comfort, finding themselves in coaching and role modeling roles for newer moms at the residence.

On-the-spot teaching. Some participants remarked that despite the amount of prenatal preparation, encompassing programs, observation, and independent learning, there were numerous intangible aspects of parenthood. Underlying mood disorders, such as depression or anxiety, exacerbated a sense of worry during the initial few weeks of new motherhood. No Name described how attendance at prenatal programs enhanced her sense of preparedness: "I felt confident when I was going through all these programs, and figuring out all these things but then like when it actually happened, reality hit." Regardless of feeling prepared, she vividly recounted her harrowing first overnight at the residence with her son after he was discharged from the Neonatal Intensive Care Unit (NICU). She found herself fixated on the fear that he would suddenly stop breathing in his sleep. The information, recommendations, and teaching from the nurses and health professionals in the NICU provided little reassurance in the moment. She noted:

When I first brought him home I was okay but then going to bed was hard for me like I was scared. I woke up the next morning cause I was afraid he was gonna stop breathing like literally anything like that. And so, like I was checking him like every night. I would check him maybe 5 times during the night I'd wake up and see. Like I'd sleep for maybe

20 minutes, wake up, check again maybe then next time sleep for maybe forty minutes or thirty minutes or so.

On-the-spot teaching was most useful for these unexpected situations. Peers at the residence provided social and emotional support during difficult transitions. No Name valued being taken out for a smoke break by one of moms women at the residence while another watched her son because this gave her a moment to talk through her worries. Staff offered her close guidance and reassurance. That said, No Name still woke up multiple times overnight gripped with the fear of finding her infant in distress.

Technology for independent learning. The two computers at the residence were in high demand and all but one study participant had smartphones they used for Internet browsing. Internet-based searches, social media, videos, and mobile apps were regarded as quick and simple. Limited only by their data plans and the absence of free WiFi at the residence, the young women relied on digital media and mobile technologies for entertainment, to stay connected, and to learn. Nevertheless, since their most recent pregnancy, 10 participants (91%) reported changes in their use of digital media. Table 4 presents reported changes to pregnancy or health related television programs and Internet site.

Table 4

Television viewing and Internet browsing habit changes since the most recent pregnancy

Change since pregnancy	n(%)
I am watching more TV shows with PPY (e.g. Teen Mom, 16 and Pregnant)	3 (27.3%)
I am watching less TV shows with PPY (e.g. Teen Mom, 16 and Pregnant)	4 (36.4%)
I am watching more TV shows that provide health information (e.g. Dr. Oz, The Doctors)	3 (27.3%)
I am browsing more internet sites that provide information about general health issues and pregnancy (e.g. topics related to nutrition, illnesses, prevention)	9 (81.8%)
I am browsing more internet sites that provide information about newborns or baby care	6 (54.5%)
I am browsing more discussion forums or chat groups for PPY	2 (18.2%)

Internet Searches and Google. All participants used the Internet to seek information and access resources while pregnant. Two participants learned about the residence through an Internet search of local resources for young mothers. Internet searches, namely Google, played a large role in the early education of many participants. Participants were comfortable and familiar with this method of information seeking prior to their pregnancies. One highly valued feature of Internet searching was the perception of anonymity and confidentiality. Camille, for example, used the Internet to gain information about topics she perceived as more sensitive or for questions she felt less comfortable posing in person: “vaginal discharge, how the baby grows, breasts—looked up everything.”

For Fettuccini Princess, Internet searching provided a foundational base of knowledge earlier in her pregnancy: “I don’t really go to Google too much right now, I ask questions more to like my doctors and... I ask more questions than Google. I was going to Google more at the

beginning of the pregnancy because I didn't know anything." For many, Google searches became a quick and accessible sounding board for comparing their symptoms to others and determining whether their experiences were "normal" and expected. Participants did not use these searches to self-diagnose or as a replacement for medical care, but rather as a first step in determining whether medical treatment was warranted. For instance, Kat Minou remarked:

I find myself turning to the Internet a lot, like when it comes to myself. And if I'm feeling something like for instance like cramping or watery discharge and then stuff like that then I turn to Google and I Google it to see if it's worth calling the doctor and making an appointment and then if it is then I call the doctor and then I just ask them questions and they do stuff and figure it all out.

Videos and digital storytelling. Many participants cited online videos, interviews, and vlogs as important sources of information. Prior to becoming pregnant, few participants self-identified as avid readers but all noted their use of video for learning. Videos can deliver a lot of information quickly, in a format that is easy to understand: "If I don't want to spend two hours, four hours searching, so you want everything to go really quick so you just check out a video" (Oh Henry). The ease of sharing online content was also a noted advantage and social media was recognized as a major dissemination method for youth, almost to the point of eclipsing traditional print materials. Fettuccini Princess described her experiences with information sharing via Facebook:

Young people don't read books anymore. They're just stuck on Facebook. What I see now is like people sharing video on Facebook and that video is watched by many people and it's 'like, like, like, like, like'. That's how it works now.... there's no more books. No, people don't know what to read anymore.

Videos were often regarded as a rich form of storytelling. Videos also helped many participants set their expectations and understand some of the social norms of medical encounters. Fettuccini Princess viewed many labour, delivery and birth videos that helped her understand some of the dynamics of these experiences and inform her choices. In terms of formulating a birth plan, videos helped her understand the process and allowed her to conceptualize her needs for support: “You see what is real and really how the mom is feeling and emotion like how she’s acting and how the people around her, the support people, are acting and then you can use some of what they’re doing.” Princess Akita found encouragement in the form of videos and vlogs created by other young mothers: “I go on YouTube and then people have their blogs or say their opinion on it ‘I was a teen mom and I turned out fine’ and stuff like that. You can see the positive if you actually try and don’t give up.”

Mobile applications (apps). Similar to online content, mobile applications provided users a sense of anonymity in their information seeking. The ten participants that had smartphones regarded pregnancy apps as easy to use and convenient. They discussed their preferred apps, noting that apps used plain language to share updates, information, and tips: “I had an app and it would tell you how big the baby is by fruit-wise or vegetable-wise and like how much the baby weighs and everything and it doesn’t use really big words” (Mich Mich). Updates at regular intervals sent information and reminders about the growth of their fetus: “just to see how that baby looks because every month, for example every month I want to know how the baby look like on the internet or on my applications here they explain me what baby’s doing every week, all the stuff” (Fettuccini Princess).

Summary of Chapter Five

This chapter presented four themes and numerous sub-themes that were recognized inductively through cross-case analysis in order to examine how PPY come to understand maternal health, and how the meanings they construct relate to their lived experiences and contexts. As described in Chapter Two, prenatal education is defined in a broad and holistic manner to encompass both formal and informal learning, as well as the broader social and cultural contexts in which learning occurs. Themes explored the influence of the living environment on learning and health; the perinatal period as a time of reflection and re-envisioning, pregnancy as a catalyst for change; and learning resources and resourcefulness. In this chapter, verbatim quotes were used whenever possible to honour the voices of the participants.

Living in a residential environment fostered a sense of group membership through the sharing of common experiences and rituals. With a focus on health, education and support, many participants experienced enhanced mood and general wellbeing while living at the residence. That said, there were notable tensions inherent to this environment, including the rules and regulations in place, flux of residents, and requirement for surveillance and oversight. The residential environment offered structure and the women didn't have to focus on costs or living, food purchasing or meal preparation while living at the residence, which allowed them some extra time to attend programs and do independent activities. Transformative effects seemed to accompany pregnancy, including a greater desire to learn. A new sense of responsibility surfaced, complemented by the desire to protect their fetus or newborn, which included being able to make informed decisions. This internal sense of accountability also dictated deliberate changes. These changes and efforts were not explicitly taught, but stemmed organically from protective instincts and were supported by programs and services at the residence and outreach centre. Participants

were very driven to create safe, healthy, stable homes for their children. Participants were quite resourceful in their approaches to learning about health, pregnancy, and parenting. While specific learning preferences varied by participant, they all yearned to feel involved and engaged in education and in prenatal programs. Technology was a tool they used extensively for independent learning. Chapter Six follows with a discussion of these findings and implications for practice.

Chapter Six: Discussion and Conclusion

The aim of this study was to elicit, explore, and interpret the experiences of a group of pregnant and parenting youth living in a residential maternity shelter. More concretely, this study explored how pregnant and parenting youth came to construct their health related knowledge and views, and how these perceptions fit with their expectations and experiences. This qualitative case study revealed that the environment influenced both learning and perceptions of health, that the perinatal period was a time of reflection and re-envisioning, that pregnancy was a catalyst for change, and that varied resources were used to inform health related knowledge and views. In this chapter, I build on the within and cross-case findings presented in chapter four and five, and situate these findings within the current literature to address the two overarching research questions: 1) how do pregnant and parenting youth come to understand maternal health? and 2) how do the meanings they construct relate to their lived experiences and contexts. Next, I identify and explore the implications and recommendations these findings have for theory, practice, and research. Finally, I discuss the limitations of the study and finish with concluding thoughts.

Experiential Threads

The women in this study shared stories that were diverse in nature and while participants' life experiences leading up to their most recent pregnancies varied greatly, there were notable commonalities across narratives. The experiential threads discussed in this section provide important context for understanding the health-related meanings constructed by participants. These areas link to several social determinants of health, impact health both directly and indirectly, and are known to influence health-related knowledge, attitudes, and beliefs (Braveman, Egerter, & Williams, 2011). For example, health and related behaviours are directly

shaped by living and social conditions, and indirectly shaped by the health-related choices available to individuals and their families.

Above all, poverty and recent loss in terms of family connections, home, or peer group were key points of intersection in the lives of participants. In terms of commonalities that emerged during pregnancy, all of the women in this study shared a sense of optimism and agency about the future, and were very focused on creating better outcomes for themselves and their children. Some research contends that pregnancy is an ideal opportunity for added support in order to build on the sense of hope and optimism reported by youth at this time (Koniak-Griffin, Anderson, Verzemnieks, & Brecht, 2000). The women in the current study drew heavily on their past experiences, and their stories were rife with examples of resilience and the aspiration to overcome adversity.

In terms of other threads, pregnancies were largely unplanned and unintended, though the inconsistent use of birth control was acknowledged by a number of participants. This trend is consistent with national data from the United States reporting that 82% of pregnancy among women aged 15 to 19 years, and 64% of pregnancies among women aged 20 to 24 years, were unintended (Finer & Zolna, 2011). The majority of the participants grew up in single-parent families in which the mother was primary caregiver and financial supporter. All of the women in the current study discussed growing up in poverty and living in areas they didn't feel safe or secure in. Housing instability was rampant, with 10 of the 11 participants reporting precarious housing or frequent moves in the year preceding their pregnancy. This finding of unstable living situations in the year preceding their pregnancies was not unexpected for this group of participants, as instability in terms of housing was one of the admission requirements for living at the residence. What was surprising, however, was the number of moves that occurred in the five years preceding their most recent pregnancies (mean of 28 moves). This speaks to a longer

history of instability and precarious housing, and for some a sense of transience that stemmed from childhood into adolescence. FP even started to frame her ability to cope with frequent change and uncertainty as a descriptor and strength: “I’m a mover.” For some, their relationships rather than ties to any physical place or location defined their sense of home.

Neighbourhood conditions shape the types of social exposures experienced by youth (Diez Roux & Mair, 2010), and the social and physical characteristics of neighbourhoods are increasingly viewed as contributors to health disparities (Diex-Roux & Macintyre, 2007). Research supports the assertion that living in areas with higher levels of poverty, violence, and crime increase adolescent sexual risk behaviours (Calrson, McNulty, Bellair, & Watt, 2017; Cubbin, Santelli, Brindis, & Braverman, 2005) and that housing instability impacts sexual and reproductive health outcomes (Brahmbhatt et al., 2014). Living in urban poverty and experiencing housing instability are also associated with higher rates of sexually transmitted infections (Mosher, Deang, & Bramlett, 2003; Ford & Browning, 2014; Grieb, Vey-Rothwell, & Latkin, 2013).

Education is linked to health in a number of ways, and greater educational attainment has been associated with health-promoting behaviours and earlier adoption of health-related recommendations (Barbeau, Krieger, & Soobader, 2004; Cutler & Lleras-Muney, 2006). Being in school is a known protective factor for delaying pregnancy; research suggests that young women who remain in school are less likely to engage in sexual activity and become pregnant (Perper, Peterson, & Manlove, 2010), and those that do engage in sexual activity are more likely to use condoms consistently (Blum & Nelson-Mmari, 2004). When discussing educational attainment and goals, trends were also noted among participants. At the time of their most recent pregnancy, five participants had dropped out of high school, three had completed high school, and three were enrolled in and attending high school. The women in this study had completed a significant

amount of education, which may account for their resourcefulness while pregnant as they had all found their way to the outreach centre and recourses. Further, many were engaging in prenatal educational programs and services before they moved into the residence; indeed, this was mandated.

In terms of prospective educational goals, most participants voiced a desire to return to school in order to build a stable foundation for themselves and their children. Mason enrolled in an alternative high school for young parents after the birth of her baby, and two participants were in the process of submitting college applications. These goals and plans to return to studies differ from the published literature on educational attainment following early childbearing. Two of the mothers (Lila and PA) even traveled great distances, took multiple buses from the residence, and spent several hours in transit per day in order to complete their high school education. In fact, it is acknowledged that youth who become pregnant are less likely to complete high school or college (Basch, 2011; Hoffman, 2006; Maynard, 1996; Hofferth, Reid, & Mott, 2001; Levine & Painter, 2003), even when they are on this trajectory prior to becoming pregnant (Manlove, 1998). A possible explanation for these differences could be that participants attending school for young mothers and programs at the outreach centre had access to free, on-site daycare. This meant that they could feed their infants, be close by if needed, and check-in with them during their breaks. They also appreciated that their peers in the programs were young mothers who could relate to their experiences. Thus, the experiences of the women in this study may not reflect those that do not have access to similar services and supports.

Histories of mental health issues were prevalent in this group and a majority of participants disclosed engaging in mental health care at some point before pregnancy. For some, mental health issues worsened while pregnant and three women disclosed having had episodes of severe depression while pregnant that involved suicidal ideations. The prevalence of mental

health issues among Canadian youth are on the rise, with recent literature reporting that as many as 34% of Ontario high-school students experience a moderate-to-serious level of psychological distress (symptoms of anxiety and depression), and 14% experience a serious level of psychological distress (Boak et al, 2016). For the vast majority of mental health issues (70%), the onset is childhood or adolescence (Government of Canada, 2006). In a recent study of high-school students in Ontario, 12% reported having seriously contemplated suicide in the preceding year (Boak et al., 2016). Pregnancy occurs more commonly among women aged 18-20 with baseline depression, and women with co-occurring stress and depressive symptoms have over twice the risk of pregnancy compared to those without symptoms (Corcoran, 2016; Hall, Kusunoki, Gatny, & Barber, 2014). Similarly, depression emerged as an individual risk factor for adolescent pregnancy in an Australian prospective cross-sectional cohort study (Quinlivan, Tan, Steele, & Black, 2004). However, in this study, other environmental factors examined during multivariate analysis also had significant independent associations with younger age of motherhood including, in order of magnitude: a history of parental separation/divorce, exposure to family violence in early childhood, illicit drug use, idealization of pregnancy, low family income, a positive score of depression or anxiety on a standardized scale, and a low level of education. Again, many of these factors link with the social determinants of health.

A history of pre-pregnancy alcohol and illicit drug use was reported by almost all study participants, with several having used illicit drugs while pregnant due to a late recognition of the pregnancy and one participant discussing harm reduction measures at length. Two participants discussed addictions in depth, including their experiences in drug rehabilitation programs. Substance use, including a higher prevalence of smoking, alcohol, and drug use, are significant adolescent risk factors for unintended pregnancy (Finer & Zolna, 2014; Albrecht et al., 2006). Drug use isn't uncommon for this peer group, as in Canada, youth aged 15-24 have the highest

self-reported rate of illicit substance use in the past year (Health Canada, 2010). According to the Canadian Alcohol and Drug Use Monitoring Survey (CADUMS), the top five substances used by youth in 2012 were alcohol (71.5%), marijuana (25.1%), hallucinogens (4.6%), ecstasy (3.8%) and cocaine (2.7%) (Canadian Centre on Substance Abuse, 2013).

A history of physical or intimate abuse also emerged as a common topic of discussion during participant interviews, though none of the interview questions were designed to explore violence or abuse specifically. Overall, participants discussed abuse openly and candidly, though some hinted at abusive dynamics without describing the circumstances in depth. Participants shared stories of abuse that occurred prior to and during their pregnancies. The literature supports that multiple forms of abuse are common experiences among Canadian pregnant adolescents, including intimate partner abuse, abuse from former partners, and high rates of abuse by family members (Kingston, Heaman, Fell & Chalmers, 2012; Renker, 2002). In fact, pregnant adolescents are six times as likely to report being abused by a family member, and the rates of physical abuse are significantly higher among adolescents (41.0%) compared with adult women (8.2%) (Kingston, Heaman, Fell, Chalmers, 2012). Pregnant adolescents face greater vulnerability to coercive relationships, which may speak to these higher rates of abuse (Wiemann, Agurcia, Berenson, Volk, & Rickert, 2000). That said, while these experiential threads create a concerning image of young parenthood in this group, the women in this study refused to be solely defined by their circumstances, past trauma and crises, poverty, or previous experiences. The women in this study spoke frankly and acknowledged many of the challenges they faced in early life very matter-of-factly, as these challenges formed components of their life stories rather than defining characteristics.

Understandings of Health

Adolescence is a transformative time featuring complex cognitive, emotional, and physical maturation, and this transition is rendered even more challenging for youth experiencing poverty, prejudice, and a lack of strong role models (Agosto & Hughes-Hassell, 2006). Cognitive development also plays an important role in understanding the unique characteristics of adolescent mothers, as their continuing brain development influences thinking and reasoning (Weinberger & Elvevag, 2010). Given that adolescence in itself is a time of transition, PPY experience these transitions two-fold. Pregnancy that occurs during adolescence further compounds these transformations and challenges, as young women learn about and integrate new roles and activities that accompany motherhood. The female adolescent journey is typically marked by questions they ask about who they are relationally, physically, intellectually, culturally, and sexually (Johnson, 2014), whereas the transition to new motherhood is typically marked by questions about coping, ability and competence (Tarkka, Paunonen & Laippala, 1999). Maternal health is a multidimensional construct that represents how individuals think, feel, and behave with regard to their own health while pregnant and parenting. The current study revealed that understandings of maternal health were dynamic and evolved over time. The meanings attributed to maternal health were influenced not only by the strengths and vulnerabilities of the individual women, but also by the environments they engaged in, with many reporting notable changes in perspective once they relocated to the residence.

Conceptualizations of motherhood. Becoming a mother represents a transition in a number of significant personal, social, and physiological ways, and ultimately results in changes in identity (Choi, Henshaw, Baker, & Tree, 2005). Participants in the current study came to understand health through reflections on their own experiences, while trying to integrate new experiences and information. Pregnancy emerged as a time of contemplation and re-envisioning.

Drawing on past experiences and fuelled by the desire to avoid repeating childhood trauma, many participants considered what it meant to be mothers and what motherhood meant for their lives. When sharing stories, they shifted effortlessly from discussions of their past histories, to daily lives, to imagined futures. Participants described pregnancy as a period of great introspection and reflection, rendering the perinatal period as a time when greater emphasis was placed on issues of timing, health, and identity.

The women in this study questioned what it meant to be adults and mothers, and what motherhood meant for them and their lives. Some found themselves caught in a liminal, ‘in-between’ space, with the abrupt loss of their adolescent lifestyle described in terms of a fast track to adulthood. Some were regarded or self-identified as girls (e.g. I’m a 17 year old girl) up until the point they became pregnant or when their pregnancies became visible to others, at which time they were suddenly deemed women (e.g. I am a pregnant woman). Pregnancy rendered them too mature to be girls, but commonly regarded as too young to be mothers. PPY in the current study sensed that they occupied a liminal space, not fully accepted as adult but no longer fitting comfortably into youth. Participants tended to define adulthood in terms of behaviours and responsibility rather than chronological age. Once pregnant, they felt more mature than their childless peers, often making a decision to shift peer groups towards other PPY. Throughout our interviews, descriptions of youth lifestyles emphasized individual autonomy and freedom whereas descriptions of motherhood emphasized required tasks and lack of choice. Motherhood was characterized as a time of responsibility, selflessness, and struggle – something youth weren’t supposed to have to experience so soon.

Common cultural representations of motherhood (Choi, Henshaw, Baker, & Tree, 2005) depict women as natural mothers, immediately able to care for their babies, and ultimately fulfilled in the role of carer and nurturer (Woollett & Marshall, 2000). This representation of

motherhood was not inclusive of the experiences of many of the PPY in this study, as the discovery of pregnancy was often described as a time of crisis and upheaval. These dominant representations of good mothering are also recognized to operate beyond the belief systems or choices of individual women (Goodwin & Huppatz, 2010); as social constructs that place pressure on women to conform to particular standards or ideals. Once pregnant, the women in this study had to make sense of being outside of the ideals of 'good motherhood' and come to terms with what motherhood would mean for them.

Participants in the current study engaged in the discourse of good motherhood when asked about maternal health, perhaps as a means to stabilize their social identities, establish a sense of deeper meaning, and place themselves into an acceptable social category. A sense of stigmatization can extend from social settings (e.g. streets, parks, malls, and public transit) into health care, with some PPY feeling that their health care providers engage in stereotyping based in inaccurate media portrayals (Harrison, Clarkin, Rohde, Worth & Fleming, 2017; Harrison, Clarkin, Worth, Norris, & Rohde, 2016). As such, young mothers are vulnerable to normalizing measures (Rudolfsdottir, 2000), such as expectations about proper motherhood and pregnancy, including the behavioural expectations and lifestyle choices of pregnant woman. These normalizing measures may hold greater influence on young mothers, as adolescence is recognized as a time when social norms are particularly influential (Wise, 2015; Sayer, Afifi, Bearinger, Blakemore, et al., 2012). Thus, pervasive social constructions of good motherhood exert influence on how PPY form understandings of motherhood, maternal health, and health behaviours.

Women who do not fit within the representation or construct of good mothers, including young mothers and mothers experiencing poverty, often bear a stigma of unworthiness or deviance (Neiterman, 2013; Brubaker 2007). All participants reported encountering stigma and

judgement related to early pregnancy, and some felt stigmatized due to their status as a single, young mother. For some, this impacted their comfort to engage socially while pregnant and left them feeling conflicted when trying to make sense of their pregnancies. Stigma refers to the attributes of an individual or group that provoke negative evaluation of one's social identity (Crocker, Major, & Steele, 1998). Adolescent mothers who identify as experiencing stigma are also more likely to isolate themselves from friends (Wiemann, Rickert, Berensen, & Volt, 1999). In an American study exploring the experience of stigma during pregnancy in a sample of 925 low-income youth, 39% of participants reported feeling stigmatized by their pregnancy (Wiemann, Rickert, Berenson, & Volk, 2005). The perception of stigma was widespread in the current study, with all participants citing life examples.

In Canada, the stigma associated with adolescent motherhood remains pervasive (Kelly, 1996), and is linked to a range of perceived disadvantages for mother and child. Youth may be particularly attuned to social evaluation with implications for physical and mental health (Weed & Nicholson, 2014). Stigma towards PPY may constitute an ongoing social evaluative threat that directly impacts their developing self-concept and identity (Eisenberger, Lieberman, & Williams, 2003; Fulford & Ford-Gilboe, 2004; Somerville, 2013), as well as negative consequences on the social, affective, and cognitive dimensions of their lives (Whitley & Kirmayer, 2008). Participants in the current study discussed select environments that made them feel particularly vulnerable to judgment and stigmatization, including public transit. For some, this was distressing and the desire to avoid the perceived judgment on city buses was so intense that they refused to take public transit while pregnant, which greatly limited their mobility. This sentiment was also uncovered in a study conducted by Whitley & Kirmayer (2008), which explored the psychosocial experience of mothers of varying ages and ethnic backgrounds in Montreal using a grounded theory approach. This study explored perceptions of social exclusion

that participants associated with the perceived stigma of young parenthood. One study participant, a 24-year old single mother with a 3-year old child, spoke about the sense of rejection from unknown members of the public, including the perceived judgement while riding the city bus. This study supported that the sense of stigma contributed to social exclusion and negative rumination. The experience of negative perception while taking public transit may not be limited to a Canadian context. A study by Ellis-Sloan (2014) explored the experiences of stigma and self-presentation in a group of parenting youth in South East England. In this study, several young mothers also reported experiencing sneers and comments from strangers while taking the bus.

Conceptualizations of maternal health. Pregnancy influenced how participants felt about themselves, their bodies, and the choices they were presented with. When discussing maternal health, descriptions were largely behavioural in nature and focused on the individual. Some participants framed these discussions in terms of the absence of dangers or the protection of self and child (e.g., being healthy means having a safe place for my baby to grow up), while others described ongoing decision-making based on what they perceived as healthful choices (e.g., maternal health means not smoking or drinking while pregnant, eating healthy food, and getting enough sleep). Common to both, whether focused on the reduction of potential harms or engagement in new healthful behaviours, was the process of active change. When participants decided to continue their pregnancies and become mothers, they uniformly wanted to provide stable, healthy, happy environments for their children. They were committed to making lifestyle changes in order to achieve these goals. This suggests that early pregnancy may engender resilience, which is the capacity to adapt and grow in the face of adversity (Fulford & Ford-Gilboe, 2004).

When describing maternal health, participants first listed known expectations of health behaviours in pregnancy. They showcased their understandings of health by reciting common

pregnancy recommendations. Participants were quick to list weight gain, prenatal vitamins, and adherence to nutritional guidelines; recommendations about physical activity; attendance at prenatal care and ultrasound appointments; and smoking, alcohol and illicit drug cessation as markers of maternal health. Participants were reminded about these recommended healthful behaviours again and again throughout pregnancy. Formal discussions of healthful maternal behaviours tended to occur during prenatal classes and at health appointments; informal comments were received in daily life, at the residence, and with peers, family members, and sometimes even by strangers. Participants felt that, when enacting these healthful and recommended behaviours, they were optimizing their maternal health and perceived as responsible mothers.

In terms of conceptualizations of maternal health, beyond noting areas where they achieved or fell short of recommended behaviours, very few discussed what these new behaviours meant for their lives. Participants were much more inclined to speak to what these behaviours meant for their babies, signifying a sense of responsibility to safeguard their growing fetuses. Some participants even positioned discussion of health in pregnancy with fetus as subject (i.e. my baby is healthy and that's all that matters) rather than themselves as central in their accounts of health. The link between a mother's behaviours and fetal health is echoed in previous research with adolescent mothers (Klima, 2003), and it is common for young mothers to focus on self-care by not drinking, reducing or stopping smoking, eating properly, and minimizing self-destructive behaviours in order to create optimal conditions for their unborn child (Rentschler, 2003; Rutmas, Strega, Callahan & Dominelli, 2002; Spears, 2001). Several participants, particularly those receiving mental health counseling and support, discussed emotional health, stress and mood in pregnancy. For several participants, pregnancy was a catalyst to seek mental health diagnoses, treatments and medications. When discussing health, one participant discussed

the links between spiritual wellbeing and maternal health, as she felt that a healthy pregnancy was a combination of her actions, her doctor's, and the will of God.

Given this openness to positive change, pregnancy presents a unique opportunity to support women to reevaluate and possibly improve their health, including efforts to decrease or stop substance use (Nathoo, et al., 2015). Several participants framed their descriptions of health in terms of harm reduction by outlining decisions and strategies to avoid or reduce known dangers (Leslie, 2008). The language and philosophy of harm reduction were initially applied to substance use in adults and then youth (Toumbourou, Stockwell, Neighbors, Marlatt, Sturge & Rehm, 2007), though in recent years it has broadened to include contexts beyond drug use (Berridge, 1999). For instance, harm reduction approaches have been used with adolescents in regards to sexual risk-taking behaviours (Parsons, Halkitis, Bimbi & Borkowski, 2000), alcohol use (Larimer, 2013; Marlatt & Witkiewitz, 2002; Tevyaw & Monti, 2004), and problem gambling (Dickson, Derevensky & Gupta, 2004). In this study, harm reduction efforts were evidenced in a number of ways, including two participants who worked to develop coping mechanisms other than self-injury and cutting, three participants who reduced the number of cigarettes smoked daily and one who successfully quit smoking while pregnant, and the intentional tapering of drug and alcohol use during pregnancy. Mason discussed harm reduction measures at length, and the tapering of her daily alcohol and crack cocaine consumption during her first term pregnancy, which resulted in eventual sustained sobriety during her second term pregnancy. In a recent American study conducted with 213 women with a past or present history of addictions, those that received care in a comprehensive prenatal clinic that espoused a harm reduction approach had high rates of engagement in services and very high rate of drug abstinence during pregnancy, despite not mandating an abstinence-only approach (Wright, Schuetter, Fombonne, Stephenson & Haning, 2012).

Medicalization of pregnancy. In North America, medicalization exerts a powerful force that shapes women's experiences of pregnancy and health (Parry, 2008). Inhorn (2006) defines medicalization as the "biomedical tendency to pathologize otherwise normal bodily processes and states. Such pathologization leads to incumbent medical management" (p. 354). A known impact of medicalization is that pregnancy becomes conceptualized similarly to a disease condition, with a focus on morbidity rather than being viewed as a natural state (Firoz et al., 2013; Rudolfstottir, 2000). It has even been suggested that women's experiences with pregnancy epitomize the process of medicalization (Zadoroznyi, 1999). Interestingly though, the women in this study had a tendency to describe health in biological and individual ways, but did not frame their understandings of health in pregnancy as a dangerous time wherein a woman and her fetus are unwell or at risk. Generally speaking, participants viewed pregnancy as a natural process that presented opportunities for change rather than a pathological condition. Conceptualizations of health were not described in terms of the absence of disease, even when the pregnancy was deemed high risk and required increased medical monitoring. For instance, MichMich, whose pregnancy was designated high risk due to fetal placement and fetal heart rate irregularities found this label worrisome but, even in the presence of increased risk, considered herself a healthy mother, carrying a healthy baby. This suggests that PPY may resist some facets of the medicalized view of pregnancy. That said, all participants were receiving care from obstetricians, were delivering in hospital, and were completing the suggested medical monitoring.

Regardless of how participants conceptualized maternal health, whether described as the optimization or introduction of new behaviours deemed healthful, or the reduction or elimination of potentially harmful ones, pregnancy was overwhelmingly viewed as a turning point. That said, accounts tended to focus on behaviours stemming from medical recommendations. I'm reminded of a discussion I had with Kat Minou about healthful behaviours she'd adopted during pregnancy.

She commented that she often forgot to take her prenatal vitamins and quipped: “I’m not worried about it. The doctors are, but I’m not.” To me, this spoke to the notion of medical monitoring and the pressures to conform to recommended health behaviours, which were acknowledged but seemed to be somewhat resisted in Kat’s account.

Some argue that medicalization objectifies pregnancy as a condition distanced from personal experience, and a time when women temporarily become an incubator or “containers for a developing fetus” (Young, 2001, p. 274). This framing of maternal health can create some problematic dichotomies regarding decision-making and medical recommendations. For instance, Mitchell (2001) describes acts such as a woman’s decision to refuse prenatal testing or to drink coffee while pregnant as being potentially interpreted as a sign that the woman has made the “wrong” choice or lacks the “right” information. Pregnant women who engage in activities considered taboo might be at risk for negative labeling, and may be subject to increased surveillance, restrictions, and instruction (Mitchell, 2001). Some posit that the medicalized view of pregnancy may be even more influential for youth, as Rudolfsdottir (2000) notes that to reach the aims set by health care, young women tend to internalize the medical gaze in order to make themselves better, more acceptable, healthier mothers. Some participants expressed this sentiment, particularly when in non-specialized settings for young mothers, as many were fearful that failure to comply with medical recommendations would result in their children being apprehended by social services. Participants spoke about “doing all the right things” in order to retain custody of their children, which swayed some to learn how to “work the system”, while dissuading others from asking questions or engaging closely with those they perceived as monitoring them. This is an example of how the presence of an external influence resulted in both purposeful and incidental learning.

Social contexts of pregnancy. During our interview sessions, participants shared stories and histories that helped me appreciate some of the social complexities in their lives. While social contexts were at the fore of many of our discussion, I was surprised that these factors were rarely linked with discussion of health. It is now widely acknowledged that health and optimal development are influenced by a variety of factors, many of which are outside of traditional health system (Health Canada, 2011; Keating & Hertzman, 1999). Health care alone cannot adequately improve health overall or reduce the disparities without also addressing where and how people live (Braverman, Egerter, & Williams, 2011). Factors such as income, social status, education, employment, social and physical environment, early childhood development, and biology all influence health and development (Public Health Agency of Canada, 2011; Keating & Hertzman, 1999; Marmot & Wilkinson, 2006; Berkman & Kawachi, 2000). Moreover, social contexts, social status, and the social determinants of health have long been acknowledged as significantly shaping experiences of pregnancy and mothering (Neiterman, 2013; Edin & Kefalas 2005; Fox 2006). That said, most of our discussions of maternal health centered around lifestyle and individual choices rather than the influence of social, economic, and environmental factors on the decisions they made about health. The women in this study often spoke of social contexts when we discussed their life experiences, families, and relationships, but these areas were never identified or discussed as significant issues to be addressed to achieve health in pregnancy and while parenting. For example, when discussing informational needs, finances and housing were at the forefront as all participants had started planning for when they would leave the maternity home and take on all of the care and costs for themselves and a newborn. While some women were concerned about bad credit and insufficient funds, only one discussed what ongoing impact this could have on their health or capacity to make healthful choices. Equally, all participants acknowledged the importance and value of healthy eating, however only one of them discussed

strategies for maintaining healthful choices when they moved out of the residence. When living independently, healthy eating may conflict with food choices based on cost, availability of options from food banks, and proximity to grocery stores. The link between larger dynamics and health remained largely unrealized and unarticulated.

Opportunities to Learn. The current study demonstrated that factors in the environment could either facilitate or constrain learning, including the accessibility of content and approaches, timing of teaching, access to resources, and relationship between educator and learner. All participants yearned to feel actively involved in youth-focused education rather than to be passive participants in generic programs. Participants were quite resourceful in their approaches to learning about maternal and fetal health, pregnancy, and parenting. Belenky, Clinchy, Goldberger, and Tarule (1997) posit that giving birth is a major life event that involves intellectual development initiated by listening to others and is often accompanied by an “epistemological revolution” (p. 35). Due to the transitional nature of adolescent development, and concurrent cognitive development, PPY may experience greater learning curves during this period (Lawson & Rhode, 1995). Some literature suggests that all first-time mothers benefit from services, companionship and support; however, the needs of pregnant youth differ in urgency (Lawson & Rohde, 1995).

The current study demonstrated that learning preferences during the perinatal period were highly personal and prone to change over time. However, learning preferences tended to align with how participants liked to learn before pregnancy. For instance, participants that did not respond well to didactic teaching continued to prefer hands-on methods and individual or small group sessions once pregnant. In an exceptional case, though, a participant that did not read much before her pregnancy became an avid reader while pregnant due to a new interest in learning about her body, pregnancy, and health. Other changes were noted, for example, in the type of

content that participants typically accessed even when the methods were unchanged. For example, a participant that self-identified as a reader of fiction found herself reading non-fiction health and pregnancy materials, and participants that reported watching makeup tutorials online in their leisure time found themselves searching pregnancy sites more often. These findings contribute to the body of knowledge as they offer a contrasting view to other research examining learning in pregnancy. Rentschler (2003) conducted an interview-based study with 20 women in their second or third trimesters of pregnancy to gain a clearer understanding of youth perspectives on pregnancy and parenting. In this study, only two of the 20 participants spoke to reading about baby care and baby development. Further, while participants were thinking about the meanings of motherhood, very few of them actively sought information. The participants described in this study and those in the current study are different for a number of reasons. Participants in the current study had access to multidisciplinary, youth-specialized services and were living in a home with other PPY. They were surrounded by opportunities to learn, from posters on the walls and bulletin boards at the residence, to cohabitating with a peer group at varying stages of pregnancy and parenting and with varied levels of experiences, to classes and services offered by providers specialized in youth work. The resource-rich environment participants in the current study were immersed in likely influenced their learning behaviours.

A study by Svensson, Barclay, and Cooke (2008) explored the learning processes best suited to expectant and new parents, and found that first-time parents wanted a range of programs to choose from. These first-time parents suggested grouping programs into three formats of education: “hearing detail and asking questions” using a formal structure and pre-set topics; “learning and discussing” featuring closed group mini-lectures and discussions; and “sharing and supporting each other” with an informal structure and high participant facilitation (p. 37). These parents also highlighted the importance of learning by seeing and hearing the real experience,

which was emphasized as a powerful and important method of learning. This was also reported in the current study, as PPY were very intent on learning about factual norms, as well as the experiences and authentic insights of other mothers, recognizing the distinct value of stories and statistics. While participants in this study spoke distinctly of these types of knowing, they did not privilege one over the other. Rather, they sought a balance between what they viewed as “real” information received from other women or their own bodies, and “factual” information they received from educators, texts, and diagnostic imaging such as ultrasounds. Participants sought education and information stemming from personal experience and medical knowledge, viewing both as resources to be used selectively, and often as a means to triangulate their learning.

Timing, readiness, and the pacing of learning were also major considerations for participants, particularly those with unplanned pregnancies. Participants wanted to retain a sense of control over their learning, and some chose to defer learning about select topics until the timing was more immediately relevant. An illustrative example of this was a participant hesitating to watch the public health nurse’s labour and delivery videos until close to the due date rather than when the nurse had initially scheduled the viewings. This is an interesting finding because so much of the prenatal literature regarding topics like nutrition (Wise, 2015; Skinner, Carruth, Ezell & Shaw, 1996) and weight gain (Neilsen, Gittelsohn, Anliker, & O’Brien, 2006; Seed, 1993) focus on ‘how’ or ‘what’ adolescents want to learn but much less emphasis is placed on ‘when’. Breastfeeding educational literature is the exception, as the new framework for delivering breastfeeding-supportive prenatal care is based on flexible preparatory guidance that is responsive and focused on ‘teachable moments’ as they emerge (Merewood, 2014).

The careful consideration of timing, pacing, and readiness may be as important as the content and delivery methods for youth, as learners that were exposed to content before they felt ready tended to disengage from learning. Participants reported feeling most involved with

prenatal education when it was directly relevant and applicable, in that it aligned with their present circumstances or gestational stage. Further, when exploring learning best suited to young mothers, materials and resources used for education should be tailored and differ from the ones given to older pregnant women. Research on nutritional educational materials revealed that these resources often portray married women in their twenties and thirties, and address the health, emotional, and educational needs of an audience quite different from that of pregnant adolescents (Skinner, Carruth, Ezell, & Shaw, 1996). Participants voiced that being able to relate to and apply what they learned was key, bridging the theoretical with the practical and real life aspects of pregnancy and parenting.

Interpersonal relationships. Participants developed implicit hierarchies of trusted information, and these hierarchies varied by person and by topic. The youth in this study often triangulated information between sources to determine the most reliable or accurate response before acting on it. In previous studies of young mothers (aged 20 or less), family members were cited as strong preferences for informational support, particularly the maternal mother (Cronin, 2003; Mercer, 1986; Conway, 1999; Folkes-Skinner & Meredith, 1997). This was not the case for participants in this study, largely due to absent or strained relationships with their families of origin. Participants tended to turn to peers, other mothers, their birth companions, extended family members, and educational or health care providers for direct information.

Given that youth were developing trusted networks of information, the importance of interpersonal relationships emerged as a notable finding. Youth sought out information when they felt comfortable confiding in and asking questions of providers. For some, this was their public health nurse, prenatal teachers, or doctors, and for others their birth companions and peers. Fear and the loss of trust were detrimental to relationships and carried significant implications for learning. Most often, the loss of trust was related to perceived judgment, a heightened sense of

monitoring and surveillance, and an overarching fear of having their children apprehended. Oh Henry! and Mason described how detrimental the mistrust of their providers and educators became as it inhibited question asking, authentic interactions, and access to resources. This is echoed in previous research with PPY, where some young women felt that health care providers held them to a less tolerant and more judgemental standard than their adult counterparts (Harrison, Clarkin, Worth, Norris & Rohde, 2016). Research examining the experiences of social workers that provide care for PPY touch on the complexities of these relationships, as they describe struggling to bridge the gap between their roles as parent/guardian/helper and their reporting responsibilities to child protection (Rutman, Strega, Callahan & Dominelli, 2002).

Digital landscapes. When exploring commonalities regarding learning preferences, technology-mediated sources emerged as powerful educational tools for independent learning. Technology has redefined and reshaped the way adolescents express themselves and how they learn. Youth in the current study reported using the Internet to learn about health, pregnancy, and parenting because it facilitated learning without authority figures and lectures. Online networks range from small and intimate to global, and adolescents have access to information much more rapidly than ever before (Gross, 2004). A benefit of widespread access to computers, Internet, and mobile devices is the ability to network with similar individuals, and the option to remain anonymous while accessing information (Hiller & Harrison, 2007; Valkenburg & Peter, 2011). Conversely, accessibility and the accuracy of information were concerns raised by participants in this study. Researchers have long examined social media, such as online forums (Love, Crook, Thompson, Zaitchik, Knapp, LeFebvre, et al., 2012; Welbourne, Blanchard & Boughton, 2009), Wikis and podcasts (Boulos & Wheeler, 2007), and blogs (Miller & Pole, 2010; Boulos, Maramba & Wheeler, 2006; Oomen-Early & Burke, 2007) as places for peer social support and

health education but less far emphasis has been placed on how these digital environments contribute to prenatal learning.

It is important to note that the delivery of information online doesn't necessarily make it more appealing or relatable to youth. While exploring government-created prenatal information available online, including the current health promotions content published on the Public Health Agency of Canada website, this content echoed many of the narrowly focused behavioural descriptors of health in pregnancy; largely the same behaviours listed by participants in this study when they were asked about maternal health. For instance, the 2014 publication entitled the 'Sensible Guide to a Health Pregnancy', outlines lifestyle choices and individual interventions, including: prenatal nutrition, folic acid, alcohol abstinence, physical activity, oral health, and emotional health. This guide offers a series of guidelines about healthy pregnancy without context or case examples, or, as stated on the website: "key information about certain lifestyle choices you can make to help ensure a healthy pregnancy" (The sensible guide to a healthy pregnancy, 2014). Although public health professionals recognize the importance of social and cultural influences on health and health outcomes, the website focuses solely on what a lone individual can do. This type of messaging narrows the responsibility for maternal and child health to the individual instead of acknowledging the need to address and change the socioeconomic challenges and conditions that some young mothers face. This may be a reason why the women in this study sought information from less formal sources that combined stories and facts, such as the popular paperback, "What to Expect When You're Expecting" (Murkoff & Mazel, 2010), as well as websites, apps, and vlogs to round out their learning.

Videos are a presentation style with which young women identify, relate to, and find interesting (Skinner, Carruth, Ezell & Shaw, 1996). Research exploring healthy eating in PPY also emphasizes that both hands-on and video formats are preferred methods of learning (Wise,

2015). Video blogging (vlogging) is a new method of pregnancy and birth storytelling that many participants welcomed. Birth storytelling is a well-documented way for expectant mothers to learn about birth (Drake, 2002; Leight, 2002; McHugh, 2001), and vlogging may be a modern and accessible means of engaging in storytelling. Vlogging can take on a number of forms and includes text-based blogs that have links to videos (Parker & Pfeiffer, 2005), video-based commentaries that are typically housed on social media sites like Youtube (Molyneaux, O'Donnell, Gibson & Singer, 2008), or a series of shorter video updates on a video-sharing platforms such as Instagram or Snapchat (Subrahmanyam & Lin, 2007; Valkenburg & Peter, 2009; Yang & Brown, 2013). Youth tended to respond to vlogs and online discussion boards when they found them interesting and interactive. They often chatted about specific vloggers by name and as though they were personal friends.

Technology-based methods have unique applications for prenatal education, particularly for those who may be hesitant about school-based or group learning environments or those who do not have access to youth-specific education and services. Social media use is also widespread in this cohort. In fact, over 70% of adolescents have a social media account (Shapiro & Margolin, 2014), and users tend to check their accounts daily for an average of one hour per day (Vitak, Ellison, & Steinfield, 2011). In the current study, technology facilitated communication and allowed participants to communicate with family members and partners in different countries. The capacity to connect and receive ongoing support throughout the pregnancy was of critical importance for some participants, as it allowed them to celebrate gestational milestones with geographically dispersed family.

Lived Experiences and Contexts

The findings of this study suggest that learning and meaning-making in the perinatal period are complex, contextually situated, and fundamentally influenced by environment, experience, culture, and activity. While participants spoke openly and candidly about past experiences and everyday life challenges, they were not always able to access informational sources to help address these challenges. This may be because the pathways linking social disadvantage to health are complex, and seeking a single solution is not always realistic (Braveman, Egerter, & Williams, 2011). Context and environment emerged as important factors that profoundly shaped how participants came to understand their pregnancies, bodies, and maternal roles. Neiterman (2013) conducted research with PPY to explore how social interactions shift the perception of the stigmatized body of an underprivileged mother to an acceptable body depending on the social setting. This was evidenced in the current study. Neiterman's research also suggested that the label of deviant mother could reappear when young mothers were subjected to public perception. It would follow that meanings and understandings about pregnancy would also be somewhat fluid and context-specific. In this study, bioecological systems theory helped provide a broader picture of other contextual factors influencing learning and development, as this theory reinforced the interconnectedness of person and context, as well as behaviour and environment.

The young women in this study moved in and out of numerous settings every day, including the residence where they lived, educational environments at the outreach centre and school where they attended classes, institutional settings during appointments, informal settings with peers and family members, and virtual landscapes while engaging online and with social media. Research confirms that development is significantly influenced by the formal and informal contexts in which it unfolds (McNeely & Blanchard, 2010). During the interviews,

participants discussed influences on their lives and learning across the bioecological systems, with greatest influence noted in terms of proximal processes (Bronfenbrenner, 1979), or routinely occurring interactions with persons, objects, and symbols in their immediate environment over an extended period of time (Jackson, Zhao, Fitzgerald, von Eye, & Harold, 2006). Participants learned primarily from those who surrounded them, as well as the activities and tools they used regularly. Examples of proximal processes included, but were not limited to, peer-to-peer interactions, interactions within the residential home and outreach centre, discussions with health care providers, learning during pregnancy and parenting classes, watching vlogs and commenting on discussion boards, and engaging with information technology.

When exploring context at the microsystem-level, all participants themselves in need of a stable and safe living environment while pregnant, and the residential program became a temporary home for them. They shared this experience, even though the events and motivations that precipitated the transition to residential life were quite individual. For some, a sense of stability in terms of a physical home was largely unknown to them and others experienced a longstanding history of precarious housing. Living in a state of transience, whether prolonged or intermitted, is a known barrier that prevents youth from engaging with important sources of meaning and identity such as the education system, workforce, and leisure (Farrugia, 2011). There is broad acknowledgement within the homelessness literature that youth who experience housing instability are positioned as vulnerable in day-to-day life (Toolis & Hammack, 2015; Bullock, 2008), that and this can lead to an overall reduction in life prospects (Ferrell, 1997; Gaetz, 2004; White, 1993). Moreover, homeless youth are more likely than their peers to experience trauma, neglect, and physical and mental illness (Chicago Coalition for the Homeless, 2011), which can significantly impact educational opportunities. However, residential living

provided stability, food, shelter, structure, resources and support so that the youth could focus on other aspects of their pregnancy and parenting trajectories, such as their health and education.

Many participants experienced enhanced mood and general wellbeing while living at the residence, with some reporting improvements in health soon after moving in. Residential living promoted the development of a sense of collective identity and social integration, and a setting where young motherhood was accepted and normalized. The sharing of communal space, meals, rituals, and responsibilities fostered a sense of group membership that insulated the women from the commentary, scrutiny, and gaze of strangers. Living alongside other pregnant and parenting peers also provided a convenient and accessible source of support and opportunities for role modeling, as the women learned together and from one another. Some participants also shared examples of how they assumed mentorship roles among their peers in the residential and outreach settings. Social support, particularly from family and friends, is recognized to positively influence first time mothers' mental health and wellbeing in the postpartum period (Leahy-Warren, McCarthy, & Corcoran, 2012). Living in the residence with other PPY offered opportunities for enhanced social support, and research conducted on the importance of peer support and wellbeing among PPY suggests that young mothers who experience pregnancy together have an increased sense of closeness due to the shared experience (Sherman & Greenfield, 2012; Stevenson, Maton, & Teti, 1999). A metasynthesis of 18 qualitative studies on homeless motherhood reported that adult mothers living in a shelter relied on each other for support (Meadows-Oliver, 2003). In the current study, role modeling emerged as a powerful educational influence that shaped perceptions and understandings of parenting, and as such living in a maternity shelter where role modeling opportunities were maximized was key. That said, there were notable tensions inherent to this environment too, including the rules and regulations

in place, flux of residents, and requirement for surveillance, monitoring, and oversight. Learning was, at times, both enhanced and inhibited by the residential environment.

Influences at the exosystem level, such as the educational system, medical system, community services, and social services also shaped perinatal learning. For some, these influences were strongly felt, including those engaging with child protective services, as the fear of losing of their children was a recurrent theme in many narratives. Given the presence of the CAS in their lives, some women opted to improve their chances of retaining their children by participating in therapy and attending prenatal and parenting classes. A condition of living at the residence was attendance at classes and/or services at the outreach centre located down the street. An advantage of a site that offers clustered, multidisciplinary support to young mothers, such as the outreach centre, is that care providers are specialized to work with youth and ideally positioned to facilitate educational approaches that are age and developmentally appropriate (Klima, 2003). The literature supports that PPY value medical and social services provided in youth-focused environments, and given the choice, prefer consistent doctors for their children and social supports for themselves (Cox, Bevill, Forsyth, Missal, Sherry & Woods, 2005).

Through the outreach centre, participants frequently interacted with components of the health, educational, and social systems at a single site and on a regular basis. These links to broader systems offered consistent supports to participants. Previous research exploring the health-informational needs of pregnant youth recommends the involvement of various health care providers in the planning and provision of education, as well as programs that explore topics that extend beyond the medical aspects of pregnancy to include the broader informational needs of youth (Gilblin, Poland & Sachs, 1986).

Implications and Recommendations

Contributions to theory. The findings of this study demonstrate that environmental forces can act as catalysts for improved health and wellbeing during pregnancy and in the post-partum period. Youth are strongly influenced by risk and protective factors in their environments and throughout their development. Bronfenbrenner's bioecological systems theory was useful in highlighting the complex, multidimensional world in which adolescents live and learn, as well as adolescents' personal characteristics. Guided by the bioecological system's theory, several key characteristics and influences were recognized while exploring how this group of PPY, living in a temporary maternity residence and accessing community services, came to understand maternal health. As described in Bronfenbrenner's theory (1977), and noted in this study, the relationship between the individual and their immediate setting had the most direct effect. Participants shared numerous personal accounts of how their environments, both past and present, either enhanced or constrained their sense of health, wellbeing, and capacity to learn.

With regards to person, relevant individual characteristics across cases included age, attitudes, socioeconomic status, educational attainment, health status, gestational stage, parity, learning needs and disabilities, and histories of trauma. As seen in figure 2, other individual-level characteristics such beliefs about pregnancy, motherhood, and health also shaped learning in the perinatal period. Proximal processes and influences at the microsystems level were perceived as the most influential in shaping health-related knowledge and views. Notable influences at the microsystems level included the living environment of the residence as it acted as a micro-community, the outreach centre which offered prenatal education and multidisciplinary health services, school or work, peer group, and "family" as defined by participants and not limited to biological family members. Several participants also noted the influence of their church or church groups during their pregnancies. Notable influences at the exosystems level included mass media

and technology, social services, Children's Aid Society, health care system, and educational system. Participants also spoke to influences at the macrosystems level, primarily in terms of dominant cultural values, stigma, and notions of 'good' mothering. Influences at each of the levels of the bioecological systems theory contributed to understandings and shaped meaning related to maternal health.

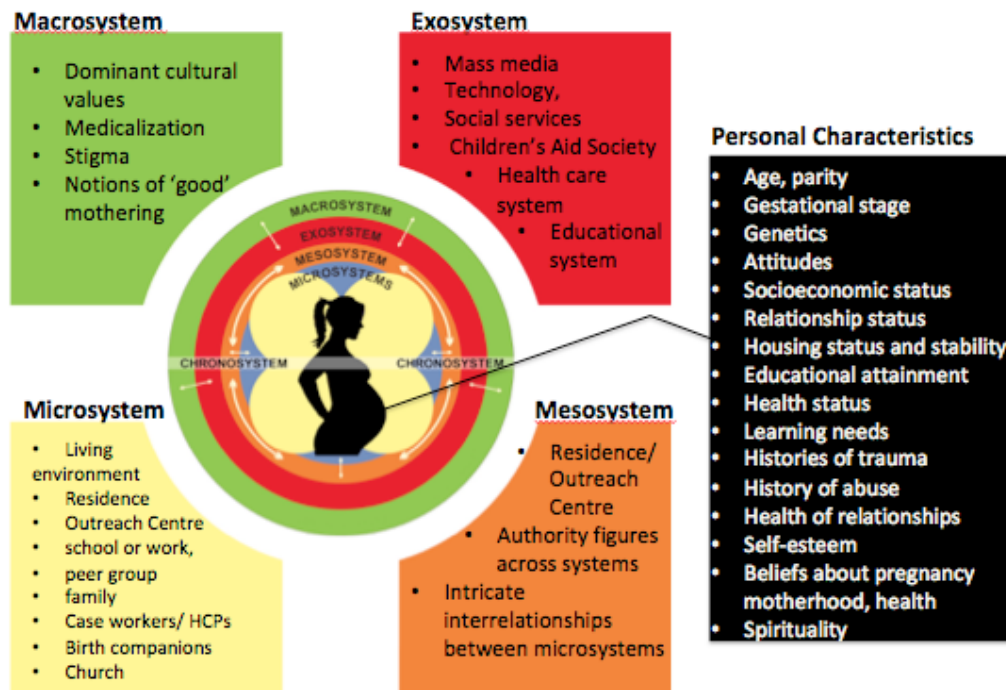


Figure 2. Modified version of Bronfenbrenner's Bioecological Systems Based on Study Findings

While the literature acknowledges that negative health interactions can contribute to disengagement, stress, fear, and mistrust of the health care system (Harrison, Clarkin, Rohde, Worth, & Fleming, 2017), the current study revealed that the impacts of negative experiences could extend much further than their system of origin. The bioecological systems theory allowed for a greater appreciation of interrelationships at the mesosystems level, which consists of two or more microsystems in the participant's life. For example, negative experiences with social services contributed to broader disengagement and mistrust within other systems, including

education and health care. Participants that felt as though they were under scrutiny or surveillance in one system tended to distance themselves from their providers, hesitated to ask questions about health, and felt deeply mistrustful of authority figures in other environments such as their teachers, workers at the residence, and their health care team. The current study contributes to the literature by highlighting the highly interrelated nature of the systems PPY engage with. The quality of relationships and experiences, whether negative or positive, can have far reaching impacts in other systems and settings. Services for youth tend to be fragmented and under-resourced in Canada (Child and Youth Mental Health, 2002), and the findings of this study speak to the importance of maintaining awareness and communication between the interdependent systems.

Recommendations for practice. The findings of this study lead to three main recommendations for health education: 1) the importance of accessible services; 2) the value of prenatal services that allow for time and continuity to promote the development of trusting relationships between practitioners and youth; and 3) prenatal assessments that incorporate an exploration of the contexts and environments of learning, including proximal processes. These three recommendations are elaborated on below.

First, accessibility emerged as one of the central components of prenatal education, with accessibility denoting both convenience of service acquisition and use of educational methods and materials tailored to learner characteristics. In the current study, the provision of clustered services reduced logistical barriers related to time, travel, and scheduling. Participants could walk to most of their appointments, classes, and services, given that they were located on the same street. They had access to youth-specialized medical checkups, dental work, prenatal education, childcare (while completing programs or credits towards high school equivalence), therapy, and drug counseling at a single site, on the same street as the residence they lived in.

A history of trauma, violence, mental health issues, and substance use were common threads in the stories shared by the participants in this study and shaped how they came to engage with services. Research suggests that most general obstetrician-gynecologists and family doctors, that is, those who do not provide obstetric services in tailored settings for PPY may be reluctant to inquire about a woman's experience with violence or mental health issues (Fortier & Foster, 2017). Practitioners specialized to work with PPY are positioned to deliver the most comprehensive care. Providers that are generalists may not have the specialized training or awareness of the resources available to support young mothers, signalling that potential health needs could remain unmet.

Education is made more accessible through an appraisal of the learning preferences, needs, disabilities, and goals of PPY. Key features identified by participants as enhancing their willingness to learn included the availability of multiple teaching methods, the use of accessible language, examples they could relate to, and the establishment of shared decision-making when possible. Four participants in the current study disclosed having diagnosed learning disabilities that impacted their capacity to concentrate and recall information; they did not respond well to didactic teaching methods or large group learning environments. Research supports that youth with learning disabilities are routinely challenged because they access services from providers who are unaware of their learning needs (Jones, Woolcock-Henry, & Domenico, 2005). When youth with unique learning needs are provided with the same information by community service agencies, in the same manner as youth without learning disabilities, it may prevent them from understanding, remembering, or using this information (Shapland, 1999). A benefit of receiving ongoing care from a single, multidisciplinary centre is the continuity of providers and the capacity to build tailored educational plans together.

Timing and a sense of readiness to learn were also key factors in making health education accessible. Participants voiced enhanced learning when the content was perceived as directly applicable and well aligned with their gestational stage or present circumstances. This signals the importance of linking education to real life examples, rendering it less abstract and more immediately relevant to learners. In terms of general preferences, participants enjoyed opportunities for active learning, learning delivered in a longitudinal way and revisited over time, and the provision of methods, tools and resources to facilitate integration of education into daily practice. Positive learning experiences featured open discussions, small group sizes, the availability of varied materials, hands-on learning opportunities, rich descriptions and storytelling, coaching, and role modeling.

Second, PPY reported learning from a variety of sources outside of their peer group or families, including their health care providers, public health nurses, teachers, and counsellors. During interactions with providers, learning was optimized in the presence of therapeutic relationships, and trust and safety emerged as prerequisites for information seeking. Interestingly, trust and safety are prominent components of trauma-informed perspectives (Muskett, 2014), and research supports that trust and respect are paramount for relationship building between nurses and pregnant youth (Rentschler, 2003). A positive therapeutic relationship is of great importance in the treatment of multiply abused or traumatized individuals, including youth. This is relevant to the study population as all participants reported some degree of crisis or trauma in the years preceding their pregnancies, including physical abuse, volatile family relations, loss, and chaotic circumstances in their childhood homes.

Key components to building therapeutic relationships with known trauma survivors include communication styles that reinforce trust and safety, the patience and time required to develop a sense of trust and safety, and sensitivity regarding issues of power and authority (Green

et al, 2015). Provider attributes that create safe environments include: consistency, reliability, predictability, availability, honesty, decision-making that include youth perspectives, and transparency (Bath, 2008). A study exploring the health care engagement experiences of PPY found that positive health care interactions featured mutual respect, support, open dialogue, and nonjudgmental attitudes (Harrison, Clarkin, Rohde, Worth, & Fleming, 2017). In the current study, trust, safety, continuity, and time emerged as facilitators for learning during the perinatal period. I would posit, however, that the related attributes of trauma-informed approaches would also have a positive influence on learning.

Barriers to the formation of therapeutic relationships include: a sense of less respect for youth health concerns, a sense of being rushed, poor communication skills, and a limited understanding of confidentiality issues (Jacobson, Richardson, Parry-Langdon, & Donovan, 2001; Fox, Philliber, McManus, & Yurkiewicz, 2010). In reviewing the literature about trauma-informed practice in educational settings, teachers had some concerns about how to apply these approaches in a classroom setting (Alisic, 2012). In the current study, participants attended classes and accessed services at the outreach centre, where providers had resources about trauma and systems in place for onsite crisis management and referrals. This may not be the case for PPY in areas that do not offer youth-specialized services or sites that have not adopted a multidisciplinary approach to care and education. Given the prevalence of trauma in PPY, the widespread implementation of trauma-informed training and practice would likely benefit both educators and learners. Sustainable strategies for the implementation of trauma-informed prenatal and parenting services comprising health care and/or education would involve the development of a trauma-aware organizational culture that includes students and staff (i.e., health care providers, policymakers, educational administrators, teachers, and other personnel) as equal

stakeholders (West, Day, Somers, & Baroni, 2014; Hummer, Dollard, Robst, & Armstrong, 2010).

It is acknowledged that outcomes for adolescent mothers and their babies are fundamentally linked to the quality, amount, and type of support available to them (Logsdon, Hertweck, Ziegler, & Pinto-Foltx, 2008). The health and life circumstances of adolescent mothers and their children are improved when social supports match their desire for support (Logsdon, Birkimer, Ratterman, Cahill, & Cahill, 2002; Polomeno, 1996). The current study also highlights the importance of establishing a balance between the type of education that is desired and delivered.

Lastly, health care and education aimed at helping women prepare for pregnancy, childbirth, and parenting should incorporate an appraisal of the life experiences, strengths, and contexts of PPY. The findings from the current study frame pregnancy as a catalyst and perhaps a pivotal opportunity to reevaluate health understandings and goals. Changes initiated in pregnancy could have longstanding implications for health, and educators and providers are well positioned to encourage the continuation of healthy lifestyles initiated during pregnancy. This would likely involve ongoing strategies to maintain healthful choices when social, economic, and environmental circumstances change. During assessments and interactions, providers would benefit from a greater understanding of the closest influences and relationships to each youth (i.e. proximal processes), as these emerged as highly influential and could support the development of strategies to sustain healthful choices. Exploring contexts and relationships may be a way for educators and providers to bring the social context of each young pregnant woman to the forefront. This study found that when discussing health in pregnancy, the young women limited their discussion to elements of health commonly reinforced through medicalized prenatal care, despite their complex social needs and challenges. Given that social determinants of health have

significant influence over health outcomes (Lightman, Mitchell, & Wilson, 2008; Wilkinson & Marmot, 2003), incorporating these broader determinants of health into prenatal and parenting services could improve their effectiveness.

At a systems level, the current study contributes to the literature by highlighting the importance of establishing an awareness of the different systems youth engage in and the relationships within these systems, as they are highly interrelated. Services for youth tend to be misaligned and under-funded in Canada, which is problematic given the interdependence between systems. A recent review of youth services in Ontario demonstrated that the lack of a shared, global vision for youth has produced limited-scope policies and programs, with funding and operating structures that are not coordinated. This results in initiatives competing with each other and not providing the necessary complementarity to best meet the full range of youth needs (Government of Canada, 2017). This is particularly challenging for PPY, as they are navigating multiple systems and benefit greatly from cohesive and coordinated care.

Recommendations for research. The findings of this study revealed several areas for future research. First, the young women in this study tended to conceptualize maternal health as largely individual with a focus on choices and behaviours rather than broader social interactions. Given that both the stories shared during interviews and the literature support that PPY encounter numerous social challenges, future research could explore young women's perceptions of the social and economic realities of early parenthood, and how these impact their health perspectives and behaviours. Additionally, given the prevalence of trauma in this population and that some of the prerequisites for learning they reported aligned with known attributes of trauma-informed care, further research into their perceptions of whether and how this influences their health experiences and learning is also warranted. Young mothers engage in health care two-fold, for themselves and as the gatekeepers of their children's health. It would thus be valuable to examine

their perceptions of the social determinants of health to gain a more fulsome understanding of their experiences. The use of longitudinal research designs would allow for insight over time, which is a current gap in the literature.

Second, during the data collection phase of this study, I was struck by how eager the participants were to share their stories with me. I also realized how powerful and compelling the stories and perspectives were when shared directly. Participants also discussed the important role of story and storytelling in their understandings of health in pregnancy, motherhood, labour and delivery, and parenting practices. Some participants gave equal weight to educational materials and anecdotal stories. Many resources targeting pregnant women, including educational resources created by Health Canada, appear to privilege facts and while neglecting stories, let alone examples inclusive of the contexts and realities of young pregnant and parenting women. This warrants further exploration, namely asking youth to share their health stories and experiences, as their perspectives are largely absent from the literature to date. Research focused on eliciting and sharing the narratives of young mothers could be a first step in addressing this gap. Moreover, inclusive representation of diverse experiences of motherhood, including youth voice, could help broaden commonly accepted perceptions of ‘good mothers’ and challenge some of the stereotypes and stigma associated with young parenthood. This might be of particular importance for youth who become pregnant and do not have access to role models, pregnant peer groups, and specialized programs and services accessed by the women in the current study.

Lastly, participants discussed digital landscapes and learning from other young mothers online. Participants in the current study lived in a residential environment with other PPY, creating a community that insulated them from some negative perceptions of early parenting. However, other youth may not have similar supports and settings available to them. In the absence of a pregnant and parenting peer group, digital landscapes may emerge as a pseudo peer

group and become even more influential in the development of understandings of motherhood, maternal health, and the realities of parenthood. Little is known about the influence of online learning environments, and future research could explore how digital landscapes contribute to learning in the perinatal period.

Limitations of the study

This study provides insights in to a participant population that is understudied and typically difficult to access. In terms of approach, the use of qualitative methods facilitated the exploration of experiences and contexts, and the narrative descriptions featured verbatim quotes whenever possible to honour the words and voices of participants. I am not a mother and have never been a pregnant youth, however, I spent considerable time at the residence with the women outside of the interview sessions in order to learn from them and become a less foreign presence. I made the deliberate decision to eat at the youth tables at lunch hour rather than eating with the administrators and residential staff in order to gain familiarity among the women. Many of the participants became comfortable with me, as evidenced by them remaining in the room to chat once the interview sessions ended and the recorders were turned off. That said, this study also has a number of limitations, including sampling, interview schedules, and issues related to possible bias.

First, I used a combination of convenience sampling and snowball sampling to recruit participants into the study. All of the women who participated in this study were recruited from a single community-based residential program, thus each woman was accessing a number health and/or social services during pregnancy and the post-partum partum period. To be eligible for study participation, young women had to be aged 13-20 years at the time of pregnancy, pregnant or in the first 6 months of the post-partum period at the time of enrollment, accessing community

services, available to complete two interview sessions, and able to communicate in English.

Additionally, while not all participants were native English speakers, those who could not communicate in English (or in one case, a combination of English and occasional French) were excluded from the study and their experiences are thus not reflected in these findings.

While the purpose of qualitative research is not to generalize findings, it is nonetheless important to acknowledge that the results of this study may not be transferable across settings or contexts. The women in this study may have experienced a higher level of risk, instability or trauma than the general population of pregnant youth, as this was a prerequisite for moving into the residence. Once they moved into the residence, these women were immersed in a very unique micro-community that offered added resources and support, mandated ongoing prenatal education, created a live-in peer group of pregnant and parenting youth, and offered opportunities for informal learning and role modeling. This study offers insight into the experiences of a group of women who are engaged in very specialized and unique circumstances.

Second, all of the participants in this study were recruited during the same season, thus findings regarding the residential environment offer a snapshot versus perceptions of the setting over time. Each participant completed two in-depth interview sessions that were conducted at least two weeks apart. The first interview was designed to focus on life histories and experiences; the second interview focused more on meaning-making and was designed recursively to elaborate on emergent themes and responses from the first interview. Scheduling two interview sessions helped establish rapport with participants; however, two sessions may not have been enough to adequately delve into the participants' experiences. In hindsight, the addition of a third, more reflective interview conducted 1-2 months later could have provided valuable insights, particularly if these women experienced transition during that timeframe such as labour and delivery or moving out of the residential environment. One participant, Mason, completed her

second interview two months after the first, and in this span of time she moved from the residence and into her own apartment, and enrolled in alternative high school. The timing of these interview sessions allowed her to reflect on her new experiences and contexts, and to discuss how these contributed to her understandings of health, education, and parenting.

Lastly, while the interviews were semi-structured and communication was very open and candid, there is still the potential for participants to perceive certain answers as more appropriate or desirable than others. Throughout my time at the residence, I never positioned myself as an expert and made it very clear that I was looking to learn from and with the young women in this study. I was surprised that participants were curious about me as both a researcher and a person, and asked questions about my past, interests, likes, dislikes and motivations. The desire to learn about me took me off-guard because it was unlike any of my other research experiences. The difference may speak to the intimate and in depth sharing inherent to 1-on-1 interviews, the importance of establishing trust and rapport. It was, indeed, sharing versus collecting data. I believe that these young women viewed the sharing of their stories as an investment in me, and in turn wanted to know that I would treat their words and stories with great care.

During my time at the residence, I selectively disclosed information about my life and told all participants about my background as a health care professional. While I approached the interviews very collaboratively and from the lens of a woman first, learner second, and a researcher last, the fact that I am a health care professional may have heightened the potential for social desirability response bias. To minimize this potential limitation, I discussed confidentiality often and I maintained a non-judgmental approach throughout all interactions. While drafting my early research proposals, I read about the role of researcher as instrument in qualitative research, but until I conducted this study, I was a little unclear about what exactly this meant. This study made me acutely aware that who I am as a person, and how I engaged in this process, mattered; it

mattered not only to my participants as they gauged my level of trustworthiness, but it also mattered in all aspect of this study from conceptualization to analysis.

Conclusion

The purpose of this study was to elicit, explore, and interpret the experiences of a group of pregnant and parenting youth living in a residential maternity shelter. This study examined how pregnant and parenting youth came to construct their health-related knowledge and views, and how these perceptions fit with their expectations and experiences. The findings of this study suggest that environment influences both learning and perceptions of health, that pregnancy is a catalyst for change, and that young pregnant women are quite heterogeneous in terms of the resources that shape and inform their health-related knowledge and views. While these young women may be subject to many of the same influences and expectations in pregnancy as the general pregnant population, they differ due to a combination of their educational needs and preferences, the intensity and frequency of stigmatization they face, the multifaceted transitions they are negotiating, as well as their relative lack of resources. Thus, the findings of this study illustrate the importance of understanding the experiences of young pregnant women in order to support their health and educational experiences. The findings of this study also demonstrate the significance of integrated, interprofessional education and health services for pregnant and parenting youth.

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Appendix A. Study Information Letter

[INSERT UNIVERSITY OF OTTAWA LETTERHEAD]

Research Team:	Chantalle Clarkin, PhD (candidate)	Angus McMurtry, PhD (advisor)
	Faculty of Education	Faculty of Education
	University of Ottawa	University of Ottawa
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We invite you to be interviewed by Chantalle Clarkin for our study. The purpose of the study is to find out what young pregnant and parenting women think about pregnancy-related learning and health. I am really interested in hearing your stories and will ask questions about your life, experiences and preferences.

What will I have to do?

If you agree to join the study, you will take part in **two**, one-on-one interview sessions with Chantalle Clarkin. The initial interview will take place in person, at a time that is convenient for you. The 2nd interview can be in person, or by Skype or telephone. The second interview could take place at the centre or at a location that is more convenient for you (your home or a local spot that is quiet and private). The interviews will be scheduled **2-3 weeks** apart. During the interviews, I will ask you questions and we will talk about your answers. The questions will focus on your past experiences, current life, how you like to learn about your health, and the types of information that have been most helpful to you while pregnant. Each interview will last roughly **1 hour**. During the first interview, there is also a short questionnaire that will collect some background information about your life. You can complete this questionnaire independently or I can read it to you. With your consent, the interview will be audio-recorded and transcribed for analysis by Chantalle Clarkin. Following the completion of the study, you and [insert name of centre] will receive a summary of the findings in [insert timeframe for delivering results].

What are the risks?

There is little risk associated with your involvement in this study. In addition to your time commitment, the only risk to you could be a feeling of personal vulnerability associated with the information you choose to share during the interviews. However, no adverse emotional effects are anticipated. It is possible that some of questions in the interview may make you feel uncomfortable at times. You do not have to respond to any questions that make you feel uncomfortable. Your involvement at the Centre or any other facility will NOT be affected by your interview responses or your agreement or refusal to participate in the study. If you would like to speak with someone further following the interview session, [Insert Name] is a counsellor at the Outreach Centre that would be willing to talk to you. He/she can be reached at: [Insert address and phone number].

What are the benefits?

You may or may not benefit directly from this study. The findings of the study will be used to better understand and potentially improve education and programs for pregnant and parenting teens. For the in-person interview, refreshments will be provided. During each of the interview sessions, you will receive an honorarium for your time in the form of a \$20 gift. Any transportation costs (parking fees or public transit fares) for travel to interview sessions will be paid for.

Will my information be kept confidential?

The information that you share in the interview will remain strictly confidential. Because the interview will be conducted in person or by telephone, Chantalle Clarkin will know who you are. But only Chantalle Clarkin will know your identity and you will never be asked to say your name during the interview. During our first meeting, in order to help protect your identity, you will be asked to select a study name (a name other than your actual name) that will be used to identify you on all study-related materials. Any information that could potentially reveal your identity (e.g., school or program you attend) will be changed or removed so that you cannot be identified in published reports or presentations.

Where will my information be kept?

The digital audio-recording of the interview will be downloaded onto a computer and erased from the audio-recorder immediately after the interview. All audio-recordings will be stored on a password-protected computer in a research office at the University of Ottawa. Only Chantalle

Clarkin and her advisor Angus McMurtry will have access to the data. Data will be kept for five years after the publication of research findings. After this time, data will be erased, shredded and appropriately destroyed.

What if I change my mind?

It isn't a problem if you decide to change your mind. Your participation in the study and interviews are *voluntary*. You can withdraw from the study at any time and/or refuse to answer any questions that make you feel uncomfortable without any negative consequences. You can change your mind at any time and decide not to take part in the study. If you complete the first interview but not the second one, the information you shared during the first session will be included in the study.

If you are interested in participating in the interviews for this study, please contact Chantalle Clarkin at [REDACTED] by [insert date] to schedule your first interview.

Your written consent will be obtained prior to the interview.

If you have any questions about the study please contact Chantalle Clarkin or Angus McMurtry (see phone numbers and email addresses listed above). If you have any questions regarding the ethical conduct of this study, you may contact the Protocol Officer for Ethics in Research, University of Ottawa at:

Tabaret Hall

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Sincerely,

Chantalle Clarkin, PhD (candidate)

Angus McMurtry, PhD (advisor)

Appendix B. Study Poster

Research Study :

Becoming Teenage Mothers: A Qualitative Study

ARE YOU...

- 13 to 20 years old?
- In your final trimester of pregnancy or first 6 months post-partum?
- Willing to share your stories and talk about your health and perinatal experiences?
- Available to participate in two interview sessions that will each last about an hour?

If you answered 'Yes' to all of these questions you are eligible to take part in a study. Chantalle Clarkin is conducting this study as a part of her PhD in Education from the University of Ottawa.

To learn more about the study contact Chantalle:

by email  or
phone/t 



Appendix C: Consent Form

[INSERT UNIVERSITY OF OTTAWA LETTERHEAD]

Research Team:	Chantalle Clarkin, PhD (candidate)	Angus McMurtry, PhD (advisor)
	Faculty of Education	Faculty of Education
	University of Ottawa	University of Ottawa
	████████████████████	████████████████████
	████████████████	████████████████
	████████████████	████████████████
	████████████████	████████████████

Invitation to Participate: I am invited to participate in **two** one-on-one interviews for the above-mentioned research study conducted by Chantalle Clarkin, a PhD candidate from the University of Ottawa under the supervision of Professor Angus McMurtry.

Purpose of the Study: The main purpose of the study is to explore the stories and experiences of a group of pregnant and parenting teens. The goal of the study is to find out what young pregnant and parenting women think about their pregnancy-related learning and health. During the interviews, I will be asked questions about my life, experiences, opinions, and preferences.

Participation: My participation will consist of taking part in **two**, one-on-one interviews with Chantalle Clarkin. The initial interview will take place in person. Subsequent interviews may take place either in person, or by Skype or telephone, at a time that is convenient for me. The second interview could be conducted at the centre or at a location that is more convenient for me (in my home or somewhere local that is quiet and private). The interview sessions will be scheduled **2-3 weeks** apart. The interview will be structured as a question and discussion session. In the interview, I will be asked a range of open-ended questions focusing on my past experiences and health, health decisions, and learning preferences. During the first interview, there is also a short questionnaire that will collect some background information about my life. I can complete this questionnaire independently or the researcher can read it to me. Each interview

will last roughly **1 hour**. With my consent, the interview will be audio-recorded and transcribed for analysis by Chantalle Clarkin. Following the completion of the study, I will be offered a summary of the findings, and so will [insert name of centre], in [insert timeframe for delivering results]. I will select the option below if I would like to receive a summary of study findings after the study is done and the researcher will confirm the choice with me at the of the second interview.

Risks: There is little risk associated with my involvement in this study. Other than the time commitment to take part in the study, the only risk to could be a feeling of personal vulnerability associated with the information I choose to share during the interviews. However, no adverse emotional effects are anticipated. It is possible that some of questions in the interview may make me feel uncomfortable at times. I do not have to respond to any questions that make me feel uncomfortable. If I would like to speak with someone further following the interview session, [Insert Name] is a counsellor at the Outreach Centre that would be willing to talk to me. He/she can be reached at: [Insert address and phone number. My involvement at the Centre will NOT be affected by my interview responses or my agreement or refusal to participate in the study.

Benefits: I may or may not benefit directly from this study. The findings of the study will be used to better understand and potentially improve educational interventions and programs for pregnant and parenting teens. The researcher has explained that refreshments will be provided during the interviews. During each of the interview sessions, I will receive an honorarium in the form of a \$20 gift card to thank me for my time. Any transportation costs (parking fees or public transit fares) incurred to attend interview sessions will be paid for.

Confidentiality and anonymity: I have received assurance from the researchers that the information I will share will remain strictly confidential. Because the interviews will be conducted in person or by telephone with Chantalle Clarkin, my anonymity cannot be protected. Only Chantalle Clarkin will know my identity and I will not be asked to state my name during the interviews. Before the first interview, I will be asked to pick a name other than my own. This name will be used to identify me in all study documents and recordings. Any information that could potentially reveal my identity will be changed or removed so that I cannot be identified in published reports or presentations.

Conservation of data: The digital audio-recording of the interview will be downloaded onto a computer and erased from the audio-recorder immediately after the interview. All audio-recordings will be stored on a password-protected computer in a research office at the University of Ottawa. Only the Chantalle Clarkin and her advisor Angus McMurtry will have access to the audio recordings and transcripts. Data will be conserved for five years after the publication of research findings. After this time, data will be shredded and appropriately destroyed.

Voluntary Participation: I don't have to participate in this study. If I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions that make me feel uncomfortable without any negative consequences. I understand that I am free to change my mind at any point.

Acceptance: I _____, agree to participate in the above-mentioned research study conducted by Chantalle Clarkin, PhD candidate from the Faculty of Education, University of Ottawa under the supervision of Professor Angus McMurtry.

If I have any questions about the study, I may contact Chantalle Clarkin or Angus McMurtry at:

Chantalle Clarkin, PhD (candidate)
Faculty of Education
University of Ottawa

████████████████████
████████████████
████████████████
████████████████

Angus McMurtry, PhD (advisor)
Faculty of Education
University of Ottawa

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████████████████
████████████████

If you have any questions regarding the *ethical conduct* of this study, you may contact the Protocol Officer for Ethics in Research, University of Ottawa at:



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

If you would like to receive a written summary of the study findings once the study is finished (sent either by email), please check the box below:



I want to receive a written summary of the study findings after the study is finished.

Participant's signature: _____

Date: _____

Researcher's signature: _____

Date: _____

Appendix D: Contact Information Form

Name: _____

Study Name (please select a name other than your own): _____

Phone number: _____

Email Address: _____

How would you like to be contacted to arrange interview details?

- Contact me by phone. Best time to reach you by phone: _____
- Contact me by text message.
- Contact me by email.

How would you like to complete your second interview?

- In person
- Over the phone
- By Skype or Facetime

Would you like a reminder call or text message a day before our interview to remind you of the place and time? Yes No

Appendix E: Ethics Approval Notice

File Number: 06-14-37

Date (mm/dd/yyyy): 07/14/2014



Université d'Ottawa **University of Ottawa**
 Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

Ethics Approval Notice**Social Sciences and Humanities REB****Principal Investigator / Supervisor / Co-investigator(s) / Student(s)**

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Angus	McMurtry	Education / Education	Supervisor
Chantalle	Clarkin	Education / Education	Student Researcher

File Number: 06-14-37**Type of Project:** PhD Thesis**Title:** Teenage motherhood: A qualitative study describing prenatal health education experiences of young mothers.

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
07/14/2014	07/13/2015	Ia

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

Special Conditions / Comments:

N/A

Appendix F: Interview Guide

Interview One

One of the goals of this first interview is to get to know you better by learning about your life and your experiences. I want to spend some time talking about things that are important to you, and would love to hear about your opinions, feelings, goals, relationships, family, and friends.

A) Background (person, process, context, time) *We will spend roughly **15 minutes** talking about your background and then we will move on.*

1. Tell me a little about some of the most important aspects of your life right now.

Prompts

- Where did you grow up? What was your neighbourhood like?
- Where are you living now?
- Are you still living with your family? Can you tell me about them?
- Do you have a job? If so, tell me about it.
- What do you like to do for fun? Has this changed since you became pregnant?
- How and where do you spend most of your time? Are you involved in any groups/clubs?

2. Who are some of the most important people in your life right now? Tell me about them.

Prompts

- Have these people changed since you became pregnant? If so, how?
- If the baby's father involved with the pregnancy/parenting? If so, are they accessing any services at the centre?
- Tell me about the people who are involved in your pregnancy.

B) Pregnancy experiences (person, process, context) *We will spend roughly **15 minutes** talking about your pregnancy experiences and then we will move on.*

3. What has this pregnancy been like for you?

Prompts

- How have you been feeling lately?

- What was it like when you first found out you were pregnant? Who was the first person you told?
- Do you have friends that are pregnant/parenting too? When/where did you meet them?

4. What types of stories do you hear about pregnant and parenting teens in the media (newspapers, news, tv show, magazines)?

Prompts

- How do you feel when you see TV programs like ‘Teen Mom’ or ‘16 and Pregnant’?
- Do you watch pregnancy and parenting reality TV programs? Have you ever learned something from watching this type of program?
- Do you think these types of show influence how people see you? How so?

5. How do you feel when you’re out in public (city bus, mall)?

Prompts

- How has being pregnant influenced how you spend your time and the things you do? Can you give me some examples?
- Has the way you use social media (like facebook, twitter, instagram) changed?

C) Health services (person, process, context, time) *We will spend roughly 15 minutes talking about your health experiences and then we will move on.*

6. How far into your pregnancy were you when you went to see a health care provider (HCP)?

Prompts

- What was that like?
- What made you decide to go?
- Did you see a HCP regularly before this pregnancy? What was your health like then?
- How often are you going to medical appointments now?
- Are you comfortable asking questions about your pregnancy and health?

7. How did you end up coming to the residence? Did you know about it before you were pregnant?

Prompts

- Tell me a little more about the centre. What services do you use here?
- What do you like most about it? Is there anything you would change if you could?

8. Have you made any health or lifestyle changes since becoming pregnant (e.g. quitting smoking, stopping alcohol, changes to nutrition, sleep patterns, living arrangements, taking vitamins)?

Prompts

- What made you decide to make these changes? How has it been?
- Do you think you will keep up the changes once you've had the baby?

D) Prenatal Education (person, process, context) *We will spend roughly **15 minutes** talking about your pregnancy-related educational experiences and then we will move on.*

9. Have you taken any classes about pregnancy or parenting?

- If so, tell me more about these (Who teaches them? Who is in the class with you? What sort of things are you learning about? Do you like going to them? Would you recommend them to other teens?) If you have not yet taken any classes, do you plan on going? Why?

10. What sort of questions about pregnancy, your health or your baby have you had so far?

- What are your main pregnancy or parenting concerns?
- What are the things about pregnancy and parenting that you feel confident to handle?
- How did you find the answers/learn more about it?
- What are the topics that you still want to know more about?
- If you started to feel sick or concerned about your health, what would you do?

11. What's your favourite way to learn about your pregnancy or baby? (e.g. TV, videos, from friends/family who have been pregnant before, books, internet sites, blogs, your doctor, medical pamphlets)

Prompts

- Where do you get most of your health information or advice from?

- How can you tell if the information or advice you're getting is any good?

Additional questions for interview 2:

- 1) How was the experience of participating in this study for you?
- 2) Is there anything that you would change or do differently?
- 3) Are there any important questions that I didn't ask or topics that I might have missed?
- 4) Are you interested in having an anonymized form of your personal reflection activity (your words or images) included in the final product of my thesis?
- 5) Are you interested in having an anonymized form of your personal reflection activity (your words or images) included in presentations?
- 6) I know that you answered this question when you signed the informed consent form, but I wanted to double check whether you're interested in receiving a summary of the study findings after the study is done. Would you like me to send you this summary by email?

Appendix G. Demographics Questionnaire

Selected study name: _____

1. Are you currently *pregnant*? Yes No

If yes, how many months pregnant? _____

2. Are you currently *parenting*? Yes No

If yes, age of your children: _____

3. Highest school grade completed? _____

4. Are you currently attending school? Yes No

If yes, are you enrolled: Full-time or Part-time

5. Do you currently have a job outside the home? Yes No

If yes, are you working: Full-time Part-time Maternity leave

6. Who are you currently **living with**? Family Partner Friends Community home (like St Mary's)

Other, *please describe*: _____

7. How many times have you moved in the **past year**? _____ In the past **5 years**? _____

8. How many years have you been living in: Canada _____ City (Ottawa): _____

9. How would you describe your current relationship status: Single Dating In a relationship
 Engaged Married Living together Common Law It's complicated

10. Age: _____

11. Since your most recent pregnancy, has the amount of your media use *changed*? **Yes** **No**

a. If **yes**, please select **all of the following that apply**:

TV	<input type="checkbox"/> I am watching <i>more</i> hours of TV now	<input type="checkbox"/> I am watching <i>less</i> hours of TV now	<input type="checkbox"/> No change
Internet (websites, streaming, Netflix, Youtube)	<input type="checkbox"/> I am using the Internet <i>more</i> now	<input type="checkbox"/> I am using <i>the</i> Internet less now	<input type="checkbox"/> No change
Social Media (Facebook, Twitter, Chat groups)	<input type="checkbox"/> I am using <i>more</i> now	<input type="checkbox"/> I am using <i>less</i> now	<input type="checkbox"/> No change
Print Sources (newspapers, books, magazines, pamphlets):	<input type="checkbox"/> I am reading <i>more</i> now	<input type="checkbox"/> I am reading <i>less</i> now	<input type="checkbox"/> No change
Other sources, please describe:			

12. Since your most recent pregnancy, have your television viewing and internet browsing habits *changed* in any of the *following ways*?

b. Please select **all that apply**:

- I am watching *more* TV shows with **pregnant/parenting teenagers** (e.g., Teen Mom, 16 and Pregnant)
- I am watching *less* TV shows with **pregnant/parenting teenagers** (e.g., Teen Mom, 16 and Pregnant)
- I am watching *more* TV shows that provide **health information** (e.g., Dr. Oz, The Doctors)
- I am browsing *more* Internet sites that provide information about **general health issues** (e.g., nutrition, illnesses, prevention)
- I am browsing *more* Internet sites that provide **information about pregnancy**
- I am browsing *more* Internet sites that provide **information about newborns or baby care**
- I am browsing *more* **discussion forums or chat groups for pregnant or parenting youth**

Other, please specify

13. What are some of the names of websites, books, TV shows or other sources that you use to find information about your health, pregnancy or baby?

Appendix H: Confidentiality Agreement

The study: **Teenage motherhood: A qualitative study describing prenatal health education experiences of young mothers**, is being undertaken by Chantalle Clarkin at the university of Ottawa, under the supervision of Professor Angus McMurtry.

The findings generated from this study will inform maternal-child health theory and offer insight into ways of actively engaging pregnant and parenting teens to help them build links between perinatal health education and their day-to-day lives.

I, (name of peer debriefer), agree to:

1. Keep all the research information shared with me confidential by not discussing or sharing the research information in any form or format with anyone other than the Principal Investigator(s);
2. Keep all research information in any form or format secure while it is in my possession;
3. Return all research information in any form or format to the Principal Investigator(s) when I have completed the research tasks;
4. After consulting with the Principal Investigator(s), erase or destroy all research information in any form or format regarding this research project that is not returnable to the Principal Investigator(s) (e.g. information sorted on computer hard drive).

Peer debriefer:

(print name)

(signature)

(date)

Principal Investigator:

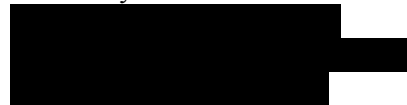
(print name)

(signature)

(date)

If you have any questions or concerns about this study, please contact:

Chantalle Clarkin, PhD (candidate)
Faculty of Education
University of Ottawa



This study has been reviewed and approved by the Research Ethics Board at University of Ottawa (**File Number:** 06-14-37). For questions regarding participants rights and ethical conduct of research, contact the University of Ottawa Research Office at [REDACTED].

Note: The peer debriefer will be given a copy of this form to retain for her/his records