

Nova Scotia Health Promotion & Protection

**Prenatal Education & Support
Needs in Nova Scotia**

October 1, 2008

Prepared by: Research Power Incorporated



Finding the solution is simple when you know how

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Executive Summary

Introduction

In spring 2005, the *Prenatal Education and Support Standards for Public Health* were released. The document, written by the Prenatal Education and Support Working Group, presented a new provincial prenatal education and support framework which supported a broader population health approach to prenatal education and support including 13 Prenatal Education and Support Provincial Standard Statements.

After the release, the Prenatal Education and Support Working Group was tasked with supporting the implementation of these standards. In 2006, the Prenatal Education and Support Working Group decided that prior to the implementation of the statements, additional information was needed to determine the prenatal education and support needs of women in Nova Scotia as well as opportunities with moving forward using a health promotion/population health framework. The purpose of this report is to provide a synthesis of the findings from the information gathered from women and providers as well as the highlights from the literature on prenatal education and support needs in Nova Scotia.

Methodology

Qualitative strategies were used to gather data from multiple stakeholders. The data collection methods included interviews with key informants, focus groups with women across the province as well as a literature review.

Focus Groups

During the first wave of data collection, focus groups were conducted with 44 pregnant and postpartum women (n= 4 focus groups). Recruitment took place through Family Resource Centres in Bridgewater, Amherst, Sackville and Spryfield. Recruitment at Family Resource Centres was done purposefully to increase the likelihood of gathering the perspective of women who may be living in more challenging circumstances and those who were less likely to access traditional prenatal education and support services such as those offered through Public Health Services.

A second wave of focus groups (n= 4 focus groups) were conducted with 31 pregnant and postpartum women through Public Health Services offices in Halifax, Antigonish, Sydney Mines and Yarmouth. The purpose of the second wave was to explore prenatal education and support needs in locations not

previously covered during wave 1 as well as with women who were likely to make use of, or have easy access to, services such as Public Health Services prenatal classes.

☞ Interviews

One on one telephone interviews were conducted with ten key informants (health care providers and prenatal educators) working with prenatal and post partum women to explore their perceptions around prenatal education and support needs.

☞ Literature Review

A synthesis of a literature review presented in a document by Best Start Ontario entitled 'Prenatal Education in Ontario: Best Practices' was conducted.

Key Observations & Conclusions

☞ Effectiveness of Prenatal Education and Support & Current Needs

Pregnancy

- Prenatal education and supports are effective at providing information to help increase women's confidence, knowledge and awareness around pregnancy and alleviate fears about pregnancy and birth. However, prenatal education can create fear, anxiety, and a sense of pregnancy being unnatural as some women may interpret the information as inflexible and directive versus recommendations.
- Traditional prenatal education and supports (e.g., those provided through Public Health Services) may not be utilized by women in most need. However, partnering with Family Resource Centres is effective at reaching these women. More work could be done to target women who often 'fall through the cracks' (e.g., women in the sex trade, women with issues of substance use, etc.).
- Prenatal education information and methods of delivery may be provider versus participant driven, and may not always be based on the needs of women (e.g., oversimplified, redundant with self-directed learning, repetitive information if attending for a second pregnancy, etc.).
- There appears to be a lack of prenatal education and support related to mental health issues such as depression, feelings of loneliness, guilt, indifference towards the pregnancy and inability to bond with the baby.
- Timing of prenatal classes often did not align with women's stage of pregnancy. Information presented on a week by week basis would enhance the effectiveness of prenatal education as it increases the relevance of the information and helps to minimize women becoming overwhelmed with too much information at one time.

Birth

- Women and providers noted that the information about birth is medicalized with a focus on intervention and pharmacological pain relief. There is a need for more information around holistic options and services (e.g., doulas and midwives).
- There is variability in how much information women wanted related to birth with some women noting there was too much of a focus on birth and others indicated they liked the focus of prenatal education to be on birth, perhaps due to a lack of confidence or nervousness about birth.
- Women felt that prenatal education and support did not provide adequate information on pain management, complications (e.g., induction, cesarean section) and post birth recovery. Information pertaining to these areas and others (e.g., infant feeding) should be presented in a non-judgmental, unbiased manner to allow women to make informed decisions.

Newborn Care & Parenthood

- Providers felt that prenatal education and supports about newborn care centred on the immediate (often physical) needs of the newborn, and information is lacking on growth and development, infant cues, attachment, and social interaction.
- Women indicated that information about common problems in the care of a newborn (e.g., sleeping, breastfeeding, gastrointestinal issues, colic, etc.) would be useful.
- Prenatal education, information and supports are currently lacking around formula feeding for women who chose not to or are unable to breastfeed.
- A gap in the provision of prenatal education and support includes the emotional aspects of newborn care and parenting such as depression and the emotions of adapting to parenthood. Further, information is lacking on personal care for women after having a baby.
- Supports are also required for partners and support people to assist women through emotional changes and caring for the newborn.

∞ Access to Prenatal Education and Support

Sources

- Common sources of prenatal education and support include health care providers, Family Resource Centres, prenatal classes, hospitals, online/websites, books, television and support people.

Facilitators

- An important facilitator to women accessing prenatal education and support is an environment that is personally comfortable (e.g., judgment free, safe, welcoming, open to diversity and social inclusion, respectful, accommodating to non-traditional ‘support people’, etc.). This type of environment is more commonly found in Family Resource Centres.

- Supports and services such as child care, transportation, free internet access and incentives also facilitate access to prenatal education and support.

Barriers

- A fear of judgment and prejudice because of issues such as lifestyle, life circumstance, literacy, language, etc. are obstacles which prevent some women from accessing traditional prenatal education and supports. It appears some women also face judgment and stigmatization around their decision to formula feed rather than breastfeed.
- A barrier preventing women from accessing prenatal education and support is a lack of awareness regarding what is available. Opportunities such as those through Public Health Services and Family Resource Centres are not well promoted to women, especially by physicians. Building awareness of available resources would help to empower women so that rather than waiting for their primary care provider to tell them about resources, they proactively inquire themselves. Further, media and advertising may help to further promote local resources.
- Another common barrier to accessing information was inconsistent or mixed messages. Establishing consistent key messages for all providers to promote is critical. Given the diverse range of information sources, the reliability and accuracy of information obtained by women is a concern. A compiled list of reliable high quality resources may help to overcome this issue.
- Obstacles such as transportation (especially in rural and remote communities), isolation (physical and social), lack of child care, cost concerns, access to technology and lack of space in classes also prevent some women from accessing prenatal education and support.

Coordination of Programs & Services

- In terms of coordinating prenatal education and support resources, strengthening linkages between community organizations and providers; building stronger linkages with physicians; networking, sharing and communication between providers; and the creation of a central list of resources are recommended.

☞ Learning Styles & Approaches to Prenatal Education & Support

Public Health Services classes

- Common reasons for attending Public Health Services prenatal classes include: to receive social support; to have questions and issues addressed; to facilitate partner involvement, support and education; referral to the class by a health care professional; and serving as a refresher for those who had children several years ago.

- Suggested changes/areas of improvement to the classes include providing opportunities for participants to ask anonymous questions; providing hands-on practical education and realistic information in a non-judgmental manner; having smaller class sizes; and providing information in a timely way so it aligns with a woman's stage of pregnancy.

Preferred learning styles

- The preferred learning style includes facilitated discussion, participant driven approaches, and multiple strategies (visual and print material). Key elements of such approaches include:
 - A semi-structured environment with a facilitated group discussion as it creates an opportunity for women to share experiences, ask questions, and express opinions while still having the support of a professional to provide accurate information.
 - A 'women centred' or 'participant driven' approach where issues discussed are those that are important and relevant to the participants rather than driven by the provider/educator. This type of approach helps to facilitate group engagement as well as improve the uptake and understanding of information.
 - Providing additional information, follow-up and supports via multiple methods including supplemental print or visual materials. However, providing print material alone is not an ideal education method as it can be easily ignored and its effectiveness is limited by literacy levels. Further, videos and hands on models need to be realistic to provide useful prenatal information.
- The strengths of online learning include the ease of access (24/7), the anonymity and ability to ask questions anonymously, and access to topical information (week by week information).
- Critical aspects of online resources include ensuring ease of use, ensuring the credibility of information, and providing a forum to ask questions and links to resources.
- The strengths of face to face learning include the ability to share and learn from others, opportunity to socialize with other parents, and hands on learning.
- A telephone hotline similar to what is available in other provinces would be beneficial for providing prenatal education and support.

Conclusion

This report provides a synthesis of the findings from the information gathering with women and providers in Nova Scotia as well as the highlights from the literature on prenatal education and support needs. The report presents several strengths of current prenatal education and supports, as well as areas and opportunities for improvements. Incorporating the findings of this report into new and existing prenatal education and supports will help to improve their effectiveness including ensuring that they are meeting the needs of diverse women across Nova Scotia. A first step will be a review and discussion of the

findings with key stakeholders in November 2008 to help inform future planning related to the development and implementation of prenatal education and supports.

Introduction

In spring 2005, a document entitled *Prenatal Education and Support Standards for Public Health* was released. The document, written by the Prenatal Education and Support Working Group using best practice and evidence, presented a new provincial prenatal education and support framework which supported a broader population health approach to prenatal education and support. The framework included the following 13 Prenatal Education and Support Provincial Standard Statements:

Public Health Services, with partners:

1. Provides leadership for a coordinated, community approach to prenatal education and support
2. Reflects the principles of the Baby Friendly Initiative throughout prenatal education and support services
3. Ensures awareness of the benefits of prenatal education and support services for pregnant women, as early as possible in their pregnancy
4. Facilitates equitable access to prenatal education and support for all pregnant women
5. Ensures the early identification of pregnant women who are at risk of not achieving healthy pregnancy outcomes
6. Provides services that are responsive to the diverse needs of pregnant women, whose life circumstances may place them at risk of not achieving healthy pregnancy outcomes
7. Offers prenatal education and support through a variety of approaches to address the learning needs of pregnant women and their families
8. Enhances women's capacity and self-efficacy in the prenatal period
9. Delivers consistent key messages to the perinatal population
10. Supports and maintains competencies to achieve the expected outcomes for prenatal education and support services
11. Implements and utilizes data collection processes to improve and/or support prenatal education and support services
12. Improves prenatal education and support services, based on provincial program evaluations
13. Encourages realistic, positive and accurate representation of birth, breastfeeding and parenting in local and provincial media

After the release of this report, the Prenatal Education and Support Working Group was tasked with supporting the implementation of the prenatal education and support standards including the development of key prenatal

messages and supporting resources for consumers and professionals, development of a provincial prenatal education and support evaluation framework as well as a provincial prenatal education and support social marketing strategy. In 2006, the Prenatal Education and Support Working Group met and decided that prior to the development of key messages and modalities of delivery, additional information was needed to determine the prenatal education and support needs of women in Nova Scotia.

In February 2008, Nova Scotia Health Promotion and Protection (NSHPP) contracted a consultant to explore with women and health care providers across Nova Scotia prenatal education and support needs as well as opportunities in moving forward using a health promotion/population health framework. The exploration continued in August-September 2008 to gather information from a greater range of perspectives.

Purpose of the Report

The purpose of this report is to provide a synthesis of the findings from the information gathering with women and providers as well as the highlights from the literature on prenatal education and support needs in Nova Scotia.

Methodology

The following section describes the methodology used to explore prenatal education and support needs in Nova Scotia. The methodology used for the two waves of focus groups and interviews including the sample, recruitment strategies, data analysis, trustworthiness and limitations of the findings are presented, as well as the literature review procedures.

Focus Groups

The following describes the methodology used to gather information through two waves of focus groups with pregnant and post partum women to explore their prenatal education and support needs.

☞ Sample & Recruitment

Wave 1: Family Resource Centres

During the first wave, four focus groups were conducted between February and March 2008 with pregnant and postpartum women (up to six months post partum). Recruitment took place through Family Resource Centres across the province including Bridgewater, Amherst, Sackville and Spryfield. Key contacts at each Family Resource Centre were tasked with recruiting participants and providing a room at the Family Resource Centre to hold the focus group. Recruitment at Family Resource Centres was done purposefully to increase the likelihood of gathering the perspective of women who may be living in more challenging circumstances and those who are less likely to access traditional prenatal education and support services such as those offered through Public Health Services. An honorarium was provided to women who participated in the focus groups. A total of 44 pregnant and post partum women participated in the first wave of focus groups at Family Resource Centres.

Wave 2: Public Health Services

A second wave of focus groups was conducted between August and September 2008 with pregnant and postpartum women (up to six months post partum) through Public Health Services offices around the province. The purpose of the second wave was to explore prenatal education and support needs in locations not previously covered during wave 1 as well as with women who are likely to make use of or have easy access to services such as Public Health Services prenatal classes. For wave 2, focus groups were held in Halifax, Antigonish, Sydney Mines and Yarmouth. Key contacts at these Public Health locations were tasked with recruiting participants and providing a room to hold the focus

group. Similar to the first wave, an honorarium was provided to women who participated in the focus groups. A total of 31 pregnant and post partum women participated in the second wave of focus groups.

Table 1 provides a profile of focus group participants from both waves including their locations and number of participants.

Table 1: Focus Group Locations & Participants

Wave	Location	Participants
WAVE 1	Amherst	n = 10
	Bridgewater	n = 10
	Sackville	n = 11
	Spryfield	n = 13
	<i>TOTAL</i>	<i>n = 44</i>
WAVE 2	Antigonish	n= 7
	Halifax	n= 6
	Sydney Mines	n= 9
	Yarmouth	n = 9
	<i>TOTAL</i>	<i>n= 31</i>
TOTAL = 75 Participants		

☞ About the Participants

To gather some basic demographic data, a short survey was completed by women prior to the focus groups (a copy of the survey is provided in Appendix A). The following table presents the age categories of the women who participated in the two waves of focus groups:

Table 2: Age Category of Participants

Age Category	Wave 1: # of Participants*	Wave 2: # of Participants
Under 18 Years	3	0
18-24 Years	17	4
25-34 Years	15	20
35-44 Years	7	7
45 Years and Over	0	0

*Note: Does not total 44 as two women choose not to fill out the survey.

At the time of the focus group, 20 women in wave 1 indicated that they were currently pregnant. During wave 2, nine women were pregnant and 22 were post partum. The following table presents the number of children the participants had, excluding their most recent/current pregnancy:

Table 3: Number of Children (excluding most recent/current pregnancy)

Children	Wave 1: # of Participants*	Wave 2: # of Participants
0	16	15
1	15	9
2	10	4
3	1	2
4 or more	0	1

*Note: Does not total 44 as two women choose not to fill out the survey.

Interviews

This section describes the methodology used to gather information through interviews with key informants working with prenatal and post partum women.

☞ Sample

One on one telephone interviews were conducted between February and March 2008 with ten key informants (health care providers and prenatal educators) working with prenatal and post partum women to explore their perceptions around prenatal education and support needs. The following key informants were interviewed as part of the information gathering process:

- ◆ A representative from the Dartmouth Family Resource Centre
- ◆ A Public Health Manager
- ◆ A Midwife
- ◆ Two Public Health Nurses
- ◆ A Doula
- ◆ A Representative from 'Kids First' Family Resource Centre
- ◆ A Community Outreach Worker
- ◆ A Family Physician
- ◆ A perinatal nurse from the IWK Health Centre

Literature Review

A synthesis of a literature review presented in a document by Best Start Ontario entitled ‘Prenatal Education in Ontario: Best Practices’ was conducted.

Data Analysis

Data collection was completed by experienced research consultants from Research Power Inc. and a lead researcher then analyzed and compiled the data from the interviews, two waves of focus groups and literature review into the final report. Each focus group and interview lasted approximately 60-90 minutes and were audio-recorded and then transcribed verbatim. Interview and focus group guides were developed by the research consultant to guide the discussions. The guides were reviewed by the Prenatal Education and Support Working Group with adaptations made based on their feedback. The original guide was adapted slightly during wave 2 to cover some additional areas of interest around Public Health prenatal classes as well as online learning approaches. A copy of the interview guide is presented in Appendix B and the focus group guides (wave 1 and 2) in Appendix C.

Once transcribed, the interview and focus group data was coded, that is, broken into meaningful pieces related to emerging themes and categories. Coding was done using the qualitative software package NVivo (version 7), which is frequently used in qualitative health research. Sub-themes that illuminated the data in ways not provided by the main codes/themes were created as needed and attached to the main nodes/themes. The data from the transcripts were analyzed independently by the research consultant and were then compared and contrasted to field notes. Emerging themes and categories were discussed with Project team members. The findings from the two waves of focus groups were compared and contrasted, with similarities and differences reported.

The focus group and interview results are presented and organized by the main categories of the guide including: prenatal education and support needs; access to prenatal education and support; and prenatal education learning styles and approaches. Findings from the literature review are highlighted in boxes throughout the report.

Trustworthiness of the Findings

Trustworthiness of the findings was assured through several methods including:

- Independent and systematic coding and data analyses;
- The use of direct quotations from focus group and interview participants to substantiate the findings; and
- Peer review and debriefing between the researchers conducting the analyses.

Qualitative methods including focus groups and interviews are exploratory in nature and thus provide rich and valuable insights into people's views and feelings, but is not intended to be generalized or quantified. Verbatim quotations from respondents are used throughout the report to illustrate the findings.

Limitations

Although this exploration and information gathering of prenatal education and support needs captured data from multiple stakeholders around the province, there are limitations that need to be considered. During wave 1, recruitment efforts were made through Family Resource Centres to target women living in more challenging circumstances and those less likely to make use of traditional prenatal education and support services. In an effort to gather the perspective of women who may not face such circumstances and those more likely to make use of traditional prenatal education supports recruitment for wave 2 took place through Public Health Services. However, there is no guarantee that participants fell into either of these categories. Other than age, the survey conducted with women prior to the focus group did not ask specific questions about other demographic information such as education, income, marital status, etc. Further, the focus groups were held exclusively with pregnant and post partum women. Therefore, information on prenatal education needs of their support people (e.g., family, friends, partners, etc.) were not captured and may require additional focus groups to determine their specific needs.

Despite these limitations, multiple data collection methods were used and input was obtained from multiple sources (i.e., there was triangulation of data sources and methods) which helps to ensure the credibility and trustworthiness of the findings.

Findings

The following presents the findings related to prenatal education and support needs based on the focus groups with pregnant and postpartum women (waves 1 and 2), key informant interviews and literature review. The findings from each method (e.g., focus groups, interviews and literature) are organized within the following sections:

- Effectiveness of Prenatal Education and Support & Current Needs
- Access to Prenatal Education & Support
- Learning Styles & Approaches to Prenatal Education and Support

Effectiveness of Prenatal Education and Support & Current Needs

This section presents the findings surrounding the effectiveness of prenatal education and supports in the following areas:

- Pregnancy
- Birth
- Care of a Newborn & Parenthood

Effectiveness of Prenatal Education & Support for Pregnancy

Increased Knowledge, Awareness & Confidence

Many providers interviewed noted that current prenatal education and supports were generally effective during the pregnancy stage at providing information to help increase women's knowledge and awareness. Some providers discussed informal evaluations and the feedback received from their prenatal education and support services as positive. For example one provider described an informal pre/post-test evaluation conducted at a Family Resource Centre that showed increases in knowledge of pregnancy and awareness regarding available supports.

Literature:

- ♦ The literature has shown significant positive differences in behaviours including tobacco use, alcohol consumption, attendance at prenatal appointments, pet care/hygiene practices (toxoplasmosis) between prenatal class attenders versus non-attenders

[We did our] own pre- and post-test [through] questions ...a lot of the answers to these questions initially were 'don't know' [or] 'where can I get support'. ...When we looked at the post-test, we could see that the knowledge had increased. They actually had answers rather than "don't know." Or we could see that they now knew of several places to get support, rather than one place. (Provider)

From the evaluations that I personally receive and the work that I do with prenatal classes and Public Health, the vast majority of the time people will say yes they found them very helpful [during their pregnancy]. (Provider)

During the focus groups, many women from wave 1 reported that prenatal education and supports were generally effective in terms of increasing their knowledge around pregnancy. Some felt that the prenatal education and supports received helped to alleviate their fears and increased their confidence as they approached the end of their pregnancies and birth. While a few women in wave 2 noted that the education received increased their knowledge, a few others indicated that the prenatal education had created some fear, anxiety, and a sense of pregnancy being unnatural as the information was presented as directives rather than recommendations.

I've also had some fears that have been relieved by reading [and attending] class [before] I would think, Oh my God, I [don't know if] this might be harmful to my baby. (Wave 1)

I feel more confident entering into the later stages of my pregnancy and looking forward to the birth just because I know what to expect. (Wave 1)

[Prenatal education and support] needs to be delivered in a way that it's not undermining whatever self-confidence you might have built up in yourself. I found, especially the first few classes, prenatal class seemed to take away everything that felt natural about having a baby and replaced it with fear and anxiety. ...having a baby is a natural thing and you don't really want to be scared to death of it. (Wave 2)

Resources & Support Not Used by Women in Need

Although many providers described current prenatal education and supports as generally effective, it was consistently noted that they were not being utilized by women in need (those women who may benefit the most). Many providers felt that women who were minorities, marginalized or living in challenging circumstances (e.g., low income, abusive relationships, etc.) do not commonly access traditional prenatal education and support opportunities, such as those offered through Public Health Services. However, many providers commended the work of Family Resource Centres for providing much needed prenatal education and support services specifically to women living in more challenging circumstance. It was believed that additional services and supports were needed to further address and help pregnant and post partum women who commonly do not access prenatal education and supports and often 'fall through the cracks' (e.g., women working in the sex trade, women with issues of substance use/abuse, etc.).

I think what's provided is great support. [However] I think the thing is we may not be getting the population of women who need it the most. And by that I mean women living in extreme poverty, women with substance use issues in their lives, those sorts of things. I think anecdotally we know that the women who face many life challenges don't often attend the more mainstream programs. (Provider)

We're certainly seeing more women who face challenges come to groups like [Family Resource Centres]. But I still think we're missing some of the women who may engage in prostitution or who are addicted to drugs. (Provider)

Too Provider Driven

As noted above, many providers felt that prenatal education and support were beneficial in increasing women's knowledge and confidence around pregnancy. However, some providers felt that the information provided and method of delivery were often too provider driven and were not based on the needs of women. Some providers described the information delivered to women as 'oversimplified' and redundant. It was suggested that although core topics should be covered during prenatal education, the bulk of the information should be centred on the learning needs and style of the target audience.

Literature:
Studies suggest that 50% of the time prenatal education topics do not match the topics of interest by women

I think that we underestimate [women's] capacity in terms of what they know in many situations, even in vulnerable situations. I think we really need to understand what they know about pregnancy ... as opposed to just coming from 'What do we think all women should know' and then give it to them. (Provider)

... many of the modalities that we use are maybe not in tune with the generation that's having babies right now. I think that our modalities of support and education are more provider-driven as opposed to really looking at how pregnant women and their families learn now. We don't have a lot of multimedia- interactive [prenatal education and supports]. It's pretty [much] in my mind traditional in terms of classes, print materials. ... using things like Facebook I just think that could be a huge opportunity. (Provider)

A few women in wave 1 felt that some of the information provided during prenatal education was beneficial but some of it was redundant and boring as it was information which they were already aware of through self-directed learning (e.g., books, internet, etc.). This was also noted in wave 2, with these women adding that the information became especially repetitive during their second pregnancies. These women suggested that separate educational materials and classes were needed for women who had a previous pregnancy to serve as a brief refresher of the basics but primarily focus on new topics such as sibling jealousy, etc.

I mean there are some things that honestly I didn't know. And then other things were to me it was a little bit boring because I had already known about them. (Wave 1)

I found that I read most of what I learned in the prenatal [class]. Some of the classes I found it boring because I read so much before. I think the prenatal class I should have taken earlier. (Wave 1)

I went the first time. I probably could have benefited [for] my second and the third [pregnancies], but not from the things that they teach you for the first time. There should be [information] for [having] another child, and it should be more focused on new issues [like having more than one child], rather than just the first one. So I didn't bother going [to the classes for my] second or third [pregnancy]. (Wave 2)

A lot of [the pregnancy information] was information I already knew. I took [the Public Health prenatal classes] when I had my first, but not second [pregnancy]. (Wave 2)

[For my second pregnancy] I just did it myself, I knew what to expect, and I felt comfortable. (Wave 2)

Lack of Mental Health Support

Several women from wave 1 and 2 described a lack of prenatal education and support related to mental health issues during their pregnancies. Many women in wave 1 described experiencing depression during their pregnancies but were unaware or not informed on what it was or why they were feeling that way. These women also described feelings of loneliness and guilt associated with feeling indifference towards the pregnancy and inability to bond with their baby during pregnancy. A few women in wave 2 felt that many prenatal education and support resources did not address 'hard topics' such as miscarriage and that local resources and supports to address and cope with these issues were not well promoted.

Another thing people don't know is that you can actually get depressed while you're pregnant... I was very depressed when I first found out about this [baby]. I didn't bond with this baby. I didn't get attached to this baby until I was almost 22 weeks. I had no feelings. I didn't care one way or the other, as cruel as that sounds. It's just your hormones, that's what it was. But [during] my whole pregnancy I think right up until like three weeks before I delivered, I was totally indifferent that I was pregnant. But nobody told me that this was not okay [and] nobody ever asked. (Wave 1)

You can have the baby blues while you're pregnant, right? I cry all the time for nothing. I just sat there and cried. Like people looked at me like, 'Why are you crying?' [and] I [did] not know why. (Wave 1)

I was definitely not prepared for the baby blues. I ended up on medication and everything. (Wave 2)

Timing of Information

A few women in both waves of focus groups noted that the timing of prenatal classes often did not align with their stage of pregnancy and therefore the information was less helpful and/or relevant to them. During wave 2 some women indicated that they enjoyed information which was presented on a week by week basis regarding their pregnancy and the development of their baby. They preferred receiving pregnancy information in this style as it did not overwhelm them and because the information was current and relevant to their stage of pregnancy.

I used [resources] online, every week they send you updates on baby's development, and I enjoyed that. I found it was nice to get, instead of having it all at once. Every week, what's going on with my body and with the baby. (Wave 2)

... the week to week information. So it's not a whole lot of information all at one time. (Wave 2)

The information that we got from prenatal classes has been great [but] sometimes it hasn't been as timely as you'd want it to be. [For example] you got information in your second trimester that you really should have gotten in your first trimester. The information's all really good, but some of the information that you're getting at 20 weeks you should have gotten at 8 weeks. It's like, okay great, now I can't turn back my time, I can't turn back the clock. (Wave 2)

Effectiveness of Prenatal Education & Support for Birth

Lack of a Holistic Approach

Several providers felt that although there was a great deal of emphasis in prenatal education and supports about birth, this information was too medicalized with a focus on intervention and pharmacological pain relief. Providers felt that it was important to inform women about their options around a more holistic approach to birth including the services of doulas and midwives. Several providers indicated that they did not feel that women received adequate information about their options in order to make informed decisions around birth. A few providers felt that prenatal education and supports about birth are currently too focused on fear and risk and do not promote the normalization of birth.

What I hear from women attending classes is that they hear all about what possible interventions could be done for them but not necessarily much about how to actually work with labor and with their bodies to avoid these. [They do not] promote how a normal labor and birth could happen. There are some doulas that provide prenatal classes or yoga who work towards normal birth and with women to increase their confidence. But it doesn't seem to be happening within Public Health or the Medical system. ... I think there are women who want epidurals, that want all these [interventions], but there is also a huge group of women who say I would like to try to minimize interventions. (Provider)

I think what women these days lack is information and supports that increase their confidence and addresses their fears that is holistic in nature ... I think women need a lot more [education and support] that pregnancy and childbearing are natural healthy processes I think we focus on risk, that's not very helpful for women because it instills an atmosphere of fear of these risks. (Provider)

Similar to providers, several women expressed interest in prenatal education and support around birth from alternative providers. Many women during wave 1 and a few women in wave 2 felt they wanted a holistic birthing experience but were unaware of their options in terms of alternative services/providers such as midwives or doulas. During wave 2, a few women noted that their questions around alternative providers were addressed during prenatal class, however the information was not volunteered upfront.

[You] go straight through the medical system, especially if it's your first time and [if] don't happen to be hooked up with a [Family Resource Centre] like this, which I wasn't, you can get a fairly narrow approach to having kids. It's like an assembly line. (Wave 1)

I don't think [doulas] would have been brought up in [prenatal] class if we hadn't asked the question. I don't think that we would have voluntarily been given information about if their services were available. (Wave 2)

Too Birth Focused

It was consistently noted by providers that often the focus of prenatal education and support was primarily on birth rather than newborn care and parenting. Several providers attributed the focus of prenatal education and supports, and women themselves, on the actual birth rather than newborn care and early parenting to medicalization and the perceived risk and fears associated with the birthing experience. Many providers felt that a shift in focus in terms of prenatal education and support was needed towards both the physical and emotional aspects of taking care of an infant and parenting (e.g., attachment, healthy parental relationships, etc.)

I think that even from my own experience with doing one-on-one care, a lot of women prenatally are only marginally thinking about baby care. A lot of them are thinking a lot more about the day of the birth. (Provider)

... its very hard for people to focus on raising a child when you're pregnant and getting ready to give birth and you're frightened of giving birth. ...I think in other cultures the nine months of pregnancy is preparing to be a parent [and] we don't do that in this culture. We terrify women on how terrible child birth is going to be and so that's what they focus on and then they suddenly get home and say 'oh my god, I've got a baby [to] take care of.' (Provider)

Like providers, a few women during wave 1 also felt there was too much emphasis placed on the birth stage and many felt unprepared for the task of parenting and taking care of a newborn (e.g., lacked information, were unaware where to get support, etc.).

I didn't find a lot of it very helpful. Like the prenatal classes I'm taking, I think they concentrated too much on things that weren't [important]. They spent four out of eight days talking about birth and showing birth videos instead of talking about more important things... like about how to take care of the baby ... not just birth. (Wave 1)

I thought I was prepared, even leaving the hospital, I didn't know how unprepared I was, until I'm at home, my boyfriend went to work, Public Health didn't call because it was a Friday afternoon, so I had all weekend home by myself, and I spent two days, home alone, crying, with this baby, because I didn't know what to do. (Wave 1)

Unlike women in wave 1, those who participated in wave 2 were most interested in prenatal education and support that centered on birth. Several women described feeling adequately prepared for pregnancy through the reading they did independently; however, they felt less confident and/or nervous with the birthing process. As such, many appreciated the prenatal education and supports which focused on birth. A few women noted that they were so fixated on birth that information on the care of newborn only became of interest after the baby was born.

I'm more worried about the birth. There are so many books out there now, that when you get pregnant I got about 20 books and start reading them all, so you find out a lot of information. (Wave 2)

The hospital prenatal class was very informative, because it dealt with more issues towards the birth and the delivery as opposed to early prenatal education. ... I wanted more information on birth. I didn't realize what I was getting into the first time around as the second time. I even went out and got a doula, because I was that nervous. I found the focus wasn't on birth really, and that's what I was looking for. (Wave 2)

I remember them talking about [newborn care] in the [Prenatal] classes, but at that point, I think all my focus was on labor and delivery, and how this baby was going to come into the world. (Wave 2)

Lack of Information on Pain Management

Women in wave 2 consistently noted that they did not receive adequate information regarding pain management options for birth. Many women indicated that they were not able to make informed decisions regarding pain management and felt unprepared and pressured to make a decision in the middle of labour. Of those women who received information regarding pain management, some described a sense of judgment if their decision did not align to the beliefs of providers.

You're not a bad person for wanting pain management. There's lots of options out there, but it was almost like you were not doing yourself a favor or your baby a favor if you didn't have a natural delivery. (Wave 2)

[We should be told] both sides of it, the drug side [and] the natural side, and let you make the decision rather than have you in there in the midst of labor and delivery, and they're calling the shots rather than yourself. ...[I wish] they'd have given me the information ahead of time, to make a decision. So [I could] go in prepared. (Wave 2)

I think that people should have more information about the epidural too. I never opted to have it, but I guess I was scared of it. ... here, people don't push it, they're not pro-epidural from what I hear from some people. Women should just really be educated about it. (Wave 2)

Lack of Information of Birth Options/Complications

Several women from both wave 1 and 2 indicated that they wanted to know their options around birth including the benefits and risks in order to make informed decisions and a birth plan. Similar to many providers (see page 14), women also felt that too much focus on risk and possible complications created fear; however, many women were still interested in being informed of common complications during birth (e.g., c-sections, inductions, etc.). Especially in wave 2, several women described feeling unprepared and afraid of having a c-section because they did not receive adequate education and support prior to complications arising.

Literature:

- ◆ Studies have found that after attending prenatal classes women often feel prepared for a normal vaginal delivery, but inadequately prepared of complications (e.g., prolonged labour, c-sections, etc.)

I just think they should talk about different things that could happen ... like birth with and without drugs and then cesarean.... because I ended up needing a C-section. I was completely floored because I didn't even read the chapter in the book about C-sections. I knew what it was but I didn't really know anything about it. I didn't know that I wasn't supposed to drive after a C-section. ...Nobody told me about all the things that you have to be careful of. [There should be] a booklet or explain the different [births], like C-section, natural birth. (Wave 1)

I ended up getting no information on cesareans, and then I ended up having one. So that was a huge thing. I got very little [information] on inductions, and I was induced....the stuff about induction just got left out, and I freaked out when they told me I had to get induced. (Wave 2)

Post-Birth Recovery

A few women in wave 2 noted that more information was needed around post birth recovery. Reflecting on the birth process, these women felt that they would have benefited from information around recovery from a c-section, birth of the placenta and post birth pain.

The after birth. I was in so much pain for a month after, I just didn't really know too much about the after birth, no one really ever said that, the details. (Wave 2)

... the after birth pains, which again you weren't told about, I was shocked I had such pain after. (Wave 2)

Effectiveness of Prenatal Education & Support for Newborn Care & Parenthood

Lack of Information on Development, Attachment & Social Interaction

It was often noted by providers that prenatal education and supports which were not birth focused often were centred on the immediate (often physical) needs of the newborn. Many providers felt that there was a gap in prenatal education and supports related to information about growth and development such as infant cues, attachment, social interaction, etc.

Literature:

- ◆ Studies indicate that attendance at prenatal classes is associated with a 75% increase in the likelihood that the baby will be breastfed
- ◆ Less than half of parents report feeling prepared for parenthood prior to the birth of their first baby
- ◆ The literature suggests that women perceive a lack of information around the realities of caring for a newborn

... so bathing, feeding, some of that basic newborn care, I think that that's done well. But to me, caring for a newborn is much more than that. To be caring for a newborn is absolutely that attachment piece ...how that attachment promotes brain development and promotes, social development, cognitive development, I think that in terms of caring for the newborn we need to broaden that more than just basic hands on feeding, changing diapers and bathing, it needs to be more of that attachment and learning infant cues. (Provider)

Lack of Information on Common Problems

Many women in both waves of focus groups felt that information was lacking about common problems associated with newborns and their care. Many were interested in knowing some basic signs and symptoms related to common problems so they were able to determine the severity of the issue and ways to treat it as well as coping skills. Some areas of interest included:

- ◆ Issues with breastfeeding (e.g., pain, mastitis)
- ◆ Sleeping (e.g., infant sleep patterns, sleeping in the same bed as parents versus a crib)
- ◆ Infections (e.g., thrush)
- ◆ Pain (e.g., hernia)
- ◆ Gastrointestinal issues (e.g., constipation, acid reflux, lactose intolerance, diarrhea, etc.)
- ◆ Jaundice
- ◆ Multiple children (e.g., jealousy, time management, etc.)
- ◆ Nutrition (e.g., vitamin supplements, fluid requirements, formula feeding)
- ◆ Sleeping positions
- ◆ Colic
- ◆ Fever
- ◆ Rashes
- ◆ Product recalls (e.g., BPA)
- ◆ Teething

Lack of Information & Supports for Formula Feeding

Several women in wave 2 noted that prenatal education, information and supports were currently lacking around formula feeding. Many of these women recognized that breastfeeding was best; however, for those who choose not to or were unable to breastfeed there was little information and support available to assist them with formula feeding. Some women noted that it was positive that breastfeeding mothers have options such as breastfeeding support groups; however, these types of services and supports were desired but not available to those who cannot breastfeed and have to formula feed.

...[information] about formula or bottles [there's] nothing, because they just assume you're going to breastfeed. But for me it didn't work out, like I tried and tried for weeks, and it just didn't work. So I ended up just having to learn [about formula feeding] all on my own. (Wave 2)

... information that I would have liked from Public Health is, I know that their push right now is for breastfeeding, but some people try, and try, and try, and you just can't do it. So I would have liked some information on, if you do have to use formula, what to do. (Wave 2)

My Public Health nurse was telling me they have breastfeeding support groups, and I breastfed for the first two months, I had a lot of troubles and I ended up having to put her on formula ... I kind of wanted my own support, for like people who can't breastfeed, support for those mothers. ... I'm not going to go to a breastfeeding support group with my baby, and take a bottle out. (Wave 2)

Lack of Emotional Support

A few providers noted that there was a gap in provision of prenatal education and support in terms of the emotional aspects of newborn care and parenting. A few providers felt that issues such as depression and the emotional aspects of adapting to parenthood were currently lacking and should be incorporated into prenatal education and support.

I think it's important to educate around the Mom's own emotions. [Dealing] with Moms who've had a history of depression that have had some emotional issues of their own who are now facing becoming parents and may have had emotional conflict with their partner, may not understand at all the whole attachment piece emotionally to the child and what that means. So that's an area that we could certainly do a lot better but that could be woven throughout all the education, not just a stand alone section but sort of linking that emotional and attachment piece throughout all the [prenatal] education. (Provider)

It was commonly noted by women in wave 1 and 2 that prenatal education and support around emotional aspects of parenting and taking care of the newborn were lacking. Several women were interested in knowing more about the emotional changes/stresses associated with parenthood as well as the signs and symptoms of post partum depression and where they could seek support and help. A few women in wave 2 suggested that the information regarding post partum depression be presented early, prior to the possible onset of symptoms.

I think there should be more information made available about postpartum depression. So even through the classes [and in the] pamphlets, you get this whole thick book... [and] you've got one page on postpartum depression. ...they should offer something to your partner if they want it. ...because [my partner] had no idea what I was going through. (Wave 1)

I didn't think that was post-partum depression I said to the doctor, when I finally did go to the doctor, I said, 'I don't know how much of this is just normal, this is what you're supposed to feel like after you have a baby, or how much of this just isn't right. I can just tell you, it doesn't feel like something's right'. It's supposed to be the happiest time of our life, not the scariest. (Wave 1)

I got a lot of information [on post partum depression] when I did my home visit. They gave me a lot a lot of pamphlets on it. I think it was within three days they come and visit you, two days after you go home, but the baby blues for me ...by the time I had the visit, I was a mess. But I was ashamed or afraid to say that I was a mess, so when she gave me the pamphlets it really helped because I realized I'm not crazy, but maybe some of that information needs to be really out there [sooner]. (Wave 2)

Lack of Information on Personal Care

Some women in wave 2 noted that there was not enough information or support around their own personal care after having a baby. Many of these women agreed that the focus of education and support should primarily be on the new baby; however, it was noted that there were some topics around their own personal care in which they were interested such as incision care, nipple care, nutrition and birth control after having a baby.

... not neglecting your own health, because it's so easy for me to focus on [the baby]....you should also be taking care of your own things, because I don't think we talked about... if you have to have stitches or your nipple care. (Wave 2)

I think things about your own body, and your own after care... I think because everybody focuses so much on the baby, which is a good thing, and how to care for the baby, it's the fact that you forget about [yourself]. (Wave 2)

Lack of Supports for Partners/Support People

Women in both wave 1 and 2 felt that education and supports were also needed for their support people (e.g., fathers, partners, family, etc.) in order to assist them through emotional changes and the task of caring for a newborn. This finding was especially pronounced in wave 2 where women felt their partners were unprepared for supporting them through pregnancy, birth and taking care of a newborn. Many felt that prenatal education and supports were often too focused on the women and often neglected their partners. Further, several women

Literature:

- ♦ Fathers report being prepared for the birth of their baby, but not for post natal life (e.g., changes to their relationships, lifestyles, etc.)
- ♦ Fathers who attend father-focused prenatal classes (as opposed to traditional prenatal classes) have fewer symptoms of stress and improved spousal relationships

noted that efforts to provide prenatal education and supports to partners were often ineffective. It was also noted that efforts were needed to ensure that prenatal education and support was provided to partners in a manner in which they feel comfortable. A few women noted that focus groups are needed to determine what type of information partners are seeking and effective delivery.

I know my husband, he was the youngest of his brothers and sisters, and has never changed a diaper ever, so I'm sure that's going to be a big concern for him. (Wave 2)

I think a little bit more for spousal support. My husband had a hard time with things. They're kind of blown over, they need a little bit of support. ...They have pamphlets now that you give to the father that's expecting, but you leave them on the table and say, here, if you want to read it. [Husbands] are not going to [read them]. It's almost like you're a wimp if you read them. (Wave 2)

My boyfriend didn't feel very comfortable in the prenatal classes. He didn't feel like he got anything really out of it. ...the guys [in the class] didn't really talk that much. (Wave 2)

I disagree with [this] focus group not having any dads in it. ...especially if [the dad] did attend the Public Health classes. ... I think if you're [looking at] prenatal education, dads should have been [included in this] the focus group....my husband takes care of my kids as much as I do. (Wave 2)

Access to Prenatal Education & Support

The following section provides an overview of the findings from the focus groups, interviews and literature regarding access to prenatal education and supports including:

- Sources of prenatal education & support
- Facilitators to accessing prenatal education & support
- Barriers to accessing prenatal education & support
- Opportunities for promotion and coordination of prenatal support resources.

☞ Sources of Prenatal Education & Support

Women and providers were asked where they felt women primarily access prenatal education and supports. Both providers and women discussed similar means in which women access prenatal educating and supports. These are highlighted in the following table:

Literature:

Studies have found that that primary source of prenatal education and support include: friends, physicians, partners, books and magazines.

Table 4: Common Sources of Prenatal Education

Source of Prenatal Education	Examples
<i>Health Care Providers</i>	<ul style="list-style-type: none"> ◆ Primarily cited physicians and nurses ◆ Some alternative providers such as midwives and doulas were also noted
<i>Resource Centres</i>	<ul style="list-style-type: none"> ◆ Family Resource Centres ◆ Single Parent Centres
<i>Prenatal Classes</i>	<ul style="list-style-type: none"> ◆ Public Health Services classes ◆ Prenatal classes offered through local resource centres ◆ Prenatal classes offered through local hospitals
<i>Hospitals</i>	<ul style="list-style-type: none"> ◆ Hospital facility tour
<i>Online</i>	<ul style="list-style-type: none"> ◆ Websites from companies such as “Pampers”, “Gerber”, etc. ◆ Government websites such as “momsanddads.ca” ◆ Other sites such as “babycentre.com”, “fertility.com”, “babyzone.com”
<i>Books</i>	<ul style="list-style-type: none"> ◆ Public Health’s “Healthy Pregnancy, Healthy Baby....A New Life” ◆ “What to Expect When your Expecting” ◆ “The Pregnancy Bible” ◆ Week by Week Pregnancy Guide
<i>Television</i>	<ul style="list-style-type: none"> ◆ Reality television programs (e.g., “A Baby Story”, “Birth Days”, “Bringing Home Baby”, etc.)
<i>Support People</i>	<ul style="list-style-type: none"> ◆ Family ◆ Friends

On the survey conducted prior to the focus groups, 76% of women (n=32 - of those who completed the survey) in wave 1 and 84% in wave 2 (n=26) indicated that they had attended a prenatal education program including: Public Health Services prenatal classes, teen prenatal classes (in Ontario), programs at the IWK Health Centre, community prenatal programs (e.g., at churches, Family Resource Centres), and hospital tours. Women indicated that they also received prenatal education from their physician, books/ magazines, internet, naturopaths, midwives, doula services and friends. Women were asked to rate on a scale of 1 to 10 the importance of prenatal education and support (1 being not important and 10 being critically important). On average, women rated the importance of prenatal education and support as an 8.3 during wave 1 and 9.0 in wave 2. The following table illustrates the levels of importance of prenatal education rated by the women:

Table 5: Importance of Prenatal Education & Support

Rating	Wave 1: # of Participants	Wave 2: # of Participants
Not Important (rating 0-3)	0% (n=0)*	3% (n=1)
Somewhat Important (4-7)	17% (n=7)*	6% (n=2)
Critically Important (8-10)	83% (n=35)*	90% (n=28)
TOTAL	n=42	n=31

*Calculations based on those who completed the survey- 2 of the 44 participants did not complete survey

Facilitators to Accessing Prenatal Information & Support

The following section describes the facilitators or what helped women access prenatal information and support. The facilitators identified included a comfortable and open environment, and free services and supports.

Comfortable & Open Environment

During the interviews, it was consistently noted by providers that a critical facilitator to women accessing prenatal education and support was an environment that was perceived to be personally comfortable to them including open to diversity and social inclusion. Many providers highlighted that a fear of stigma and judgment often prevents women from accessing prenatal education and supports, therefore, environments which are welcoming, safe, and convey a sense of respect and openness are ideal. This was perceived as especially important for women living in more challenging circumstance or adolescents who may not access mainstream services (e.g., Public Health Services classes) out of fear of judgment. For example, Family Resource Centres often encourage women to bring “support people” (e.g., boyfriends, partners, mothers, friends, etc.) and rather than assume that a traditional partner is involved (e.g., husband) as this is not always the case, especially for women living in more challenging circumstance or adolescents. Further, providers noted that women in more challenging circumstances commonly express discomfort with the “formality” and structured settings of mainstream services (e.g., outside of their immediate community, classroom type setting, paid parking, etc.).

Literature:

Best Start Ontario suggests that a critical facilitator to prenatal education and support is a comfortable environment including a tone of tolerance and acceptance

We hear all the time about how they're not treated with respect by people in institutions. And that's a big thing that we've worked very hard on [at this Family Resource Centre] is trying to show that we are respectful. It doesn't really matter what your life circumstances, you are a valued person just for being who you are. I think that really comes across in community-based organizations. (Provider)

Right now all of the prenatal classes that are happening with Public Health Services are actually happening at the local Family Resource Centre. So that breaks down that barrier of having to drive to the hospital and go up three flights of stairs into the sterile hospital boardroom to get the programs. [Our] coordinator also works with Public Health Services and they deliver the programs in the school. (Provider)

Women in the focus groups did not discuss facilitators to support participation in prenatal education in great detail. However, one woman in wave 1 described the prenatal education and support she received at her local Family Resource Centre compared to those at Public Health as “*more personable*”.

Free Services & Supports

A key facilitator consistently noted during the interviews with providers was the provision of free supports and services to women. This was primarily discussed in the context of Family Resource Centres, which often provide free supports and services such as child care and transportation to enable women to more easily access prenatal education and supports. Some providers described incentives such as free grocery gift cards, refreshments/meals, and baby showers to encourage women to attend prenatal education sessions. It was noted by providers that transportation is an issue, especially for women living in more challenging circumstances who may not have access to a car, or for women living in rural and remote communities, therefore facilitators such as home visits and transportation options were critical. Providers discussed services such as free computers, internet community access sites, and local libraries as important supports to improve access.

We're able to offer a \$10.00 grocery gift card ...for each week that women attend. So we think that that's a pretty big draw for women. We give them a great snack each week, little gift bags like a couple times in the class. We end every group with a group baby shower because we know that some women who come may not have a baby shower ever. (Provider)

In terms of prenatal support, what Family Resource Centres have been able to do is provide supports like transportation, child care for older children, when the women are in programming. So that has broken down some of the barriers that prevent women from accessing programs. (Provider)

Similar to providers, women in the focus groups also noted that the provision of free services and supports was a critical enabler for them to access prenatal education, especially for women in wave 1. Many women in wave 1 and a few in wave 2 felt that a key support was the provision of child care which allows women the opportunity to participate, without having to worry about costs and

logistics of child care. Other services such as transportation were also highlighted as enablers. Further, a few women in wave 1 described accessing prenatal education through free services such as those offered by their local library as useful.

A lot of the information, I got free from the library. I didn't buy any books. I just borrowed them. I mean you can go to the library. It's free. (Wave 1)

I think babysitters [are important] when you don't have anybody to take care of your other kids. [this] Family Resource Centre also provides transportation. If you're doing a program here your children can be upstairs. (Wave 1)

☞ **Barriers to Accessing Prenatal Information & Support**

Several barriers were identified to accessing prenatal education and support including fear of judgment and prejudice, transportation and isolation, lack of awareness of available resources, inconsistent information, lack of child care, cost concerns, reliability and accuracy of information, access to technology and limited class space.

Fear of Judgment & Prejudice

It was consistently noted by providers that a key barrier which prevents women from accessing prenatal education and support was a fear of judgment and prejudice. Several providers indicated that women fear stigma and discrimination (e.g., racism, socio economic status, age, etc.) while accessing traditional services (e.g., Public Health). One provider described this discrimination as a subtle attitude which has led to some women living in more challenging circumstance or of a minority group feeling uncomfortable. Further, providers also felt that some women are uncomfortable receiving prenatal education and support through traditional resources because of a fear of judgment due to their current situation or lifestyle (e.g., women who are unmarried, adolescents, lesbian couples, etc.). Several providers indicated that issues related to language and literacy may prevent women from feeling comfortable accessing prenatal education and support services.

Literature:

- ◆ Women least likely to attend prenatal class: under 25 years, have not finished secondary education, single, low income, and no health insurance
- ◆ Socio-demographic disparities have been found between women who attend prenatal classes and those that do not
- ◆ Caucasian women are twice as likely to attend prenatal class compared to African American women
- ◆ Adolescent specific classes help to increase attendance and reduce stigmatization

... often very young [women] for example, will not come to prenatal education classes, typical because everybody is old. They just feel uncomfortable.... The smokers won't come often because they think you're going to tell them ... 'oh you're a bad person because you smoke'. (Provider)

Women who have maybe been to Public Health, the more mainstream classes will often tell us, 'I just didn't feel comfortable there, it was all couples and I went with my mom so I felt really left out'. (Provider)

I think most of the Public Health classes seem to be really dominated by middle class couples and so people who don't fit into that demographic feel alienated and they don't want to go back [like] lesbian couples and teen couples. (Provider)

... discrimination and racism.. Because we no longer live in world where racism is overt, it is covert. ... Present day in the [hospital], the black women in particular that I have worked with feel that they routinely experience racism in that institution. ... It's being overlooked, , it's attitude, it's people rolling their eyes, it's people making comments like your black skin is tougher than white skin. [Its] subtle things that the average person in the dominate culture would not interpret as being racist. ... you have a double whammy if you are poor and of a minority. (Provider)

A few women in wave 1 noted that they did not access traditional prenatal education and support services such as those through Public Health due to fear of judgment and misconceptions that this service is linked to child protective services.

I grew up in a place where my mother always told me that Public Health would come in and examine your house and take your child. The house has to be spot clean because Public Health [would take] the baby. I never was told that Public Health was an actual resource. So during all my pregnancy, all the problems I had during my pregnancy I felt alone. (Wave 1)

Women in wave 2 described feelings of judgment primarily around their decisions to formula feed rather than breastfeed. Several women who chose to formula feed indicated that they felt stigmatized by prenatal education resources and supports which promoted breastfeeding. Although these women recognized that breastfeeding is ideal, many felt this notion was 'pushed' too strongly and has inadvertently caused those who do not (or tried and could not) breastfeed to feel inadequate in their role as a new parent.

I know that [breastfeeding] is best for your baby, but some people choose not to, and you do feel very alienated... I left the Public Health classes feeling almost like I was going to harm my baby by giving him formula. There's a real stigma against people who choose to bottle feed or have trouble breastfeeding and can't talk about it. (Wave 2)

Especially on the breastfeeding. I never liked breastfeeding. ... some people are really intimidated by it, and just don't want to do it. And they come out of the hospital feeling like an inadequate mother. (Wave 2)

There was a pamphlet that they gave us at both the hospital tour and at our Public Health classes, which I totally didn't agree with because the title of it is, something, why formula feeding is dangerous. ... And when I read that pamphlet, I was like, well I'm planning to bottle feed, I'm bad, it's dangerous... If you decide in the hospital not to breastfeed, the nurses pretty much don't even speak to you anymore...they get upset, and they blame you for bottle feeding your child. (Wave 2)

I watched other people have their babies just freaking out, and mom literally walking the hallway balling their eyes out trying to breastfeed....it's so overwhelming, and you feel so bad if you don't. (Wave 2)

Transportation & Isolation

It was consistently noted by providers that issues of transportation were common barriers preventing women from accessing prenatal education and support. In rural and remote communities issues of transportation were described by providers as even more pronounced. Providers also describe issues of social isolation which was prominent in both rural and urban contexts. Social isolation was described among women who have limited social supports within their community (e.g., family, friends, etc.), especially among those who are marginalized or living in challenging circumstances.

Literature:

According to the literature, common reasons why first time mothers do not attend prenatal class includes: feeling the classes would not help them, classes being offered at inconvenient times, transportation and child care issues, cost and being unaware that the classes were available

A lot of the gaps have to do with rural program delivery. Women [maybe] isolated for many different reasons, whether they're isolated because of geography, lack of transportation, [or] they're isolated because of age or income. All of those factors can attribute to a woman not seeking the support. (Provider)

... maybe transportation is not possible for her to even get into a town or a city where there is prenatal classes. So she doesn't feel that she has access to services. Someone who's suffering mental health concerns, depression or women that are in violent situations where their movements are being controlled. They may be suffering isolation. There's a lot of different forms of how people feel isolated. (Provider)

... many women find it really hard, people come here they have no community supports or they have no personal supports and to access community supports takes a lot of courage for women ... seeking out a parent resource center can be quite scary. (Provider)

Similar to providers, some women in wave 1 and 2 also discussed transportation as a barrier to accessing prenatal education and supports. A few women described instances where transportation was not available and prenatal education and support services were being offered in areas not accessible via public transportation. Women in wave 2 added that transportation was especially challenging in rural areas.

Transportation, for some ... like my cousin, she's not on a bus route, she doesn't have a car, she can't [get to] any of the groups. (Wave 1)

Transportation would be a big issue. I know [its challenging] in Digby and Shelburne where our prenatal clinic is in Yarmouth, people out in Digby and Shelburne don't tend to access the services much, because of the distance. Can you imagine living on Brier Island, that's a two or three hour drive. (Wave 2)

You can't do [prenatal classes] here, you have to do it all over in Sydney. And that probably discourages a lot of young people too, because some of them don't travel. (Wave 2)

Transportation, definitely. I was thinking that today when I was coming [to this focus group] what if I didn't have a car? This would have been tough. (Wave 2)

Lack of Awareness of Available Resources

It was often noted by providers that a key barrier preventing women from accessing prenatal education and support was a lack of awareness regarding what is available. Many providers highlighted that current opportunities such as those through Public Health Services are not well promoted to women, especially by physicians (lack of referrals). Further, some providers felt that more promotion is needed to make accessing prenatal classes a 'normal' part of pregnancy. A few providers felt that building awareness of available resources would help to empower women so that rather than waiting for their primary care provider to tell them about resources, they proactively inquire about them themselves.

Literature:

Best Start Ontario suggests that additional promotion may be needed to reach certain groups of women such as those who do not have a Family Physician or those new to the community

I've met lots of women [who say their] doctor doesn't tell them about prenatal classes. They don't really know about Public Health if they've never interfaced. And unless they're vulnerable they're not really accessing Family Resource Centre-type avenues. I think if you try to find out about them on web sites it's very difficult. (Provider)

...for example, there is a program locally through the CPNP where they can qualify for a monthly food box to offset the cost of groceries So I'll say to folks 'did you know that this is available and that you can ask for it and they can self refer, you can call and ask for it yourself' and they have no idea. So if people don't know what's available then they're not going to ask for it. If they have a general sense of the supports available, [they maybe] able to ask for [them]. (Provider)

Like providers, some women in both waves also felt that available resources were not well promoted, especially their by family physicians. Many women in wave 1 described being unaware of the services available through Family Resource Centres until after they had their baby or during their second pregnancy. Further, women desired more information of available prenatal education and supports services of non-traditional providers such as doulas and midwives. A few women felt as though the traditional route of having a baby was their only option and many desired the education and emotional support these non-traditional providers could provide.

I wish someone had told me about prenatal resources. I wish my doctor had [let me know about them] because I had nothing. (Wave 1)

I would like to have known about doulas before I had my first child. I didn't know about them until my second... (Wave 1)

I think knowing where to go to get the information. We live at [name of community], and there's a PACT, Parents and Children Together, and I just happened upon that looking through some leaflets from the hospital. When I started going there, the Public Health nurse actually came and did a six week series after the baby was born, on feeding, on teething, on really tangible things. I just happened upon that by mistake. (Wave 2)

Inconsistent Information

A few providers noted that a common barrier to using prenatal information and support is inconsistent messages. It was noted that due to the range of prenatal education and support sources (e.g., providers, organizations, internet, books, etc.) and the lack of consistent messaging, women are often getting contradictory information. Several providers felt that establishing consistent key messages which all providers promote to women was critical to effective prenatal education and support.

We do hear again some women saying, "My doctor said it was okay for me to have a few drinks." I don't know if that's the complete truth but that's what's being reported to us. Another example is some women report that their doctors are telling them it's more stressful to quit smoking during pregnancy than to cut down. ... So I think the information there is really inconsistent. (Provider)

I think sometimes the messaging overall is inconsistent. So for example around feeding your baby. So with Public Health we do a lot of work around promoting the benefits of breast feeding, however, often Moms will say ... the family doctor has told them it doesn't really matter one way or the other whether you breastfeed or formula feed, really it makes no difference to the baby. (Provider)

During the focus groups, women in waves 1 and 2 also described several instances in which they received mixed, inconsistent or contradictory information from various health care providers. Some described feeling upset

and confused when they followed newborn care recommendations and then were confronted by a provider who informed them that they were not caring for their newborn properly. Further, some women felt that print information also contained inconsistent information (e.g., Canadian versus American books). Some women also noted that information received through friends and family did not always reflect current recommended practices.

... you've got one person telling you this and somebody else telling you [that]. [For example] the Public Health Nurse told me that she can sleep on her belly during the day as long as she was being watched. Now the doctor tells you, 'No, no, no, they're not allowed on their belly at all'. (Wave 1)

With my son, he was a little bit big. So the nurse came over she told me I was feeding him too much. So she told me to give him water. So I'm like 'okay'. So then I went back to my doctor, she was mad that the Public Health nurse told me to give him water. She tells you not to give him water. That was a mixed message I got. (Wave 1)

... in the hospital I wasn't told that he needed vitamin D drops. It wasn't [until] the first one month check-up before my doctor said 'Well how's she doing with the vitamin D?' I'm like 'What vitamin D?' And then you feel bad because a whole month without getting that vitamin that supposedly they were supposed to have. (Wave 1)

Might be [good] to get some consistency ... even doctors, one doctor will tell you something and then another doctor will tell you something totally different. (Wave 2)

I had a family doctor tell me to put my baby on rice cereal at two months in a bottle. And they told us in Public Health, never to do that. I asked him, why does Public Health tell you not to do this and [the doctor] couldn't answer that. He just said, he did that himself with his own kids, so that's why I should do it. [There's] definitely inconsistency. (Wave 2)

Lack of Child Care

Some providers noted that a lack of child care was an issue that prevents women from accessing prenatal education and supports. This was especially true for women who were financially unable to pay for child care services.

Someone who already has children at home and is a single mom may not be able to afford child care to be able to get to the support or classes available. So they might be falling through even though they could really use the emotional and social support of a group. (Provider)

A few women in wave 2 also thought that a potential barrier for some women might be a lack of child care to attend classes.

[Some women might] have kids at home, and don't have anybody to take care of them. (Wave 2)

Cost Concerns

A few providers felt that the perceived costs associated with prenatal education were a deterrent, especially for low income women. It was thought that many women believe that classes, especially those through Public Health will cost them a fee.

... when we talk about prenatal education classes, one of the questions is 'how much is it?' ... [because] they might not be able to access that. But when we tell them it's already paid for by our tax dollars, they are more likely to make the phone call. (Provider)

Reliability & Accuracy of Information

Some providers expressed concern regarding the quality of information being accessed by women. Although many felt that women were actively using self-education resources such as those online and through books, some providers expressed concern regarding the reliability and accuracy of information available through these mediums as well as women's ability to critically judge the quality of the information.

There definitely are women who are accessing the Internet to find out some information regarding prenatal as well as parenting. The challenge with that is whether it's the appropriate information or whether it's the right information. (Provider)

... parents use the Internet a lot. So we just try to caution them to try to stick to a known Canadian site like Health Canada because there's a lot of misinformation out there. There's a lot of information maybe from the United States that we don't do here. (Provider)

In both wave 1 and 2, women also noted the challenges of accessing information that was reliable and accurate. Many women expressed a desire to have a compiled list of reliable high quality resources (e.g., websites, books) which they can feel confident accessing on a range of prenatal topics/issues.

If you Google 'prenatal support' you get 16,000 pages. It would be nice if they just narrowed it down to the important stuff. Or if prenatal classes or places here just have a list of Web sites, the best ones to go on. (Wave 1)

I'm having problems with knowing what Web site to go to ... I don't know which site to go on. (Wave 1)

... you wonder if the internet is accurate, you want to hear it from somebody that's local, is it relevant to me in Nova Scotia and Canada, not Joe Blow who's got his own webpage. (Wave 2)

...you don't know if you're getting information from the UK or Canada. So I think if you get the information online, it's hard to tell if it's real or not. (Wave 2)

Access to Technology

Some providers noted that for some women, access to technology to utilize online prenatal education and support resources was a barrier. Several providers noted that access to a computer and the internet was challenging for some women. However, it was noted that free internet access sites such as those available at Family Resource Centers and local libraries help to improve access. Some providers noted that even if women have access to a computer and internet in their communities, the use of these resources was limited to the user's literacy (reading literacy and computer literacy) levels. Further, it was noted that in some rural communities high speed internet service was unavailable which further challenged use of online resources.

Well [a barrier is not] having a computer at home. It's being in a community where you don't have high-speed Internet so you're tying up your phone lines...most Internet sites these days are designed for high speed. (Provider)

Everybody talks about the internet and some people certainly do use it but again, in our population, most people don't have access to a computer and the literacy level here is pretty limited. ... we have adults who are at a grade three reading level. So the internet is not really 'available' to them. (Provider)

Similar to providers, a few women in wave 1 also cited lack of access to technology as a barrier to accessing online prenatal education and support resources. These women described a lack of access to home computers; however, some described using computers at local libraries or schools to find information of interest. Like providers, women also noted that access to online resources was limited to the women's ability to use computers and the internet.

If you don't have a computer and Internet like me, [that's a barrier to accessing information online]. Or if you didn't know how to use it. (Wave 1)

Limited Space & Timing of Classes

Some providers noted that women interested in prenatal education and supports such as those offered through Public Health Services may face barriers accessing these classes due to lack of space. This may be particularly challenging for women who wish to access prenatal classes later in their pregnancy.

I know Public Health gets a lot of calls ... from women who are very late in their pregnancy... and haven't attended any prenatal classes and are now thinking 'Okay, now it's time. I need to sign up now.' ... But I know the Public Health classes fill up very quickly. And you basically have to call like the day you find out you're pregnant... to be able to get into their classes. (Provider)

... we don't have resources to do anything more than we're doing. I mean our classes are full. We're only tapping into so much of the population. But right now if we even kept our model status quo, we couldn't do more. (Provider)

A few women in both waves also described issues around access to prenatal education classes due to limited space. A few women in wave 2 noted that they could not access prenatal education classes due to when they were offered.

I know that it's really difficult to get into the classes at the hospital because they're all really booked up in advance. (Wave 1)

I think in the prenatal class, one of the reasons that I didn't go was because the hours that I was working. (Wave 2)

☞ Promotion of Prenatal Education & Support

During the focus groups and interviews, women and providers were asked to discuss the most effective methods to promote prenatal education and support opportunities. Promotion strategies suggested included physician referrals, media and advertising as well as word of mouth. Each is described in greater detail below.

Literature:

Best Start Ontario suggests that ideally women should be referred to prenatal education and support resources by their primary care provider (e.g., family physician, nurse practitioner, midwife, obstetrician, etc.) as this is the most effective way to reach a large number of women

Physician Referrals & Promotion

As previously described, a barrier to women accessing prenatal education and supports was a lack of awareness of available resources and opportunities. It was consistently noted by providers that physicians play a critical role in the promotion of prenatal education and support opportunities, however many providers felt that physicians were unaware of what was available locally. Many providers noted that the majority of women will go see their family physician at one point during their pregnancy, therefore family physicians provide an ideal opportunity to promote local resources to a large group of women. Providers highlighted that recommendations and referrals made by family physicians were also powerful and are more likely to be followed through by women. Several providers

described local efforts to build stronger relationships and awareness with family physicians to promote and encourage them to refer women to local prenatal resources and opportunities.

We know most women are at least seeing their physician. So the physician is key in terms of getting the other supports in place for women. It is a critical link.... Physicians are busy so perhaps they don't have the information about what community supports are available. So it's making the link between the physicians getting the knowledge that they need in order to make referrals. (Provider)

I think some times doctors are confused as to what exactly is available. Are physicians aware that there are these CPNP programs for Moms that provide transportation, that provide supplements? Maybe they don't know and maybe if they knew they would refer. (Provider)

Several women in both waves of focus groups also discussed the importance of physicians, particularly family physicians, providing referrals to community based programs and services. Many women indicated that their family physician provided no referrals to any prenatal education or support resources. A few women felt that a simple brochure at the physician's office may be effective at promoting available local resources and supports recognizing that family physicians may be busy and have limited time to promote these types of resources.

I have a great physician. I think she's wonderful. I really trust her. But I found ... they're interested in your blood pressure and what's in your pee cup, but the rest of it, it's kind of skimmed over as if it's almost like it's somebody else's responsibility to tell you the other stuff. (Wave 1)

...when you go to the doctor, say you're pregnant, that's when the doctor should give you all this information. That'd be great. Because that's the first [person] you're going to see when you're pregnant, is your doctor. Some of the doctors don't really have time. ... [so they could] just pass pamphlets. (Wave 1)

The doctors aren't telling you about prenatal education, where you can get it. They didn't tell me.The doctors aren't promoting prenatal classes, and they should be. (Wave 2)

Media & Advertising

Several providers suggested that prenatal education and resources should be promoted through advertising and the media. This could include social marketing campaigns to build awareness around the benefits of prenatal education. Many providers felt that consistent key messages were needed and should be promoted by providers and through social marketing strategies. In addition, providers felt that local resources and supports (e.g., Public Health Services, Family Resource Centres, etc.) needed to be advertised in the community (e.g., physician's offices, walk in clinics, etc.) so that women know who they could contact for prenatal information and support.

There's nothing in terms of marketing [for prenatal education and support]. There should be media blitzes whether it's TV, radio, beautiful billboards for women in terms of 'are you aware these services are available, did you know that it's as easy as calling your Public Health office and finding out what best suits you and literature is available and classes are available'. (Provider)

Promotion. [Something like those] provincial campaigns around quitting smoking, for example. So you see TV ads, ads in paper. ... I think we also need that coordinated approach to prenatal care. I think provincially to have that kind of social marketing or public awareness campaign if you're pregnant call this 1-800 contact line/hot line and find out where the nearest classes are to you or where you could go. (Provider)

Women in waves 1 and 2 of the focus groups also felt that media would be an effective means to build awareness regarding prenatal education opportunities and resources. Many women described not accessing local supports because they were unaware that they were available. Some women suggested that promoting these opportunities through local media (e.g., local grocery stores, newspapers, flyers, community television channels, etc.) would be an effective way to promote and build awareness of opportunities.

Advertise. Even if you just...put out flyers, [if] you're grocery shopping... just stop and read the bulletin boards. Or maybe take out a small ad in the newspaper just to let people know that [these resources are] here. (Wave 1)

... even if on channel eight, the TV guide, they have Public Health and their number. I would have called, if I had seen it anywhere, any type of media, but I didn't see anything. (Wave 1)

TV is a big, it reaches most people....It depends on your target, for some women you'd have to go with maybe grocery stores, so they can get information there. (Wave 2)

Word of Mouth

During the interviews with providers, word of mouth was described as a way in which prenatal education and support opportunities and resources are currently being promoted locally. Word of mouth was especially powerful at promoting programs and services of Family Resource Centres as comfortable, judgment free places to obtain prenatal education and support.

It's by word of mouth, so people who are comfortable here talk to their neighbors, talk to other people and if you find it comfortable and its welcoming amongst people that you know, then you're more likely to go here. (Provider)

If you make it so that it's valuable to people, then people will seek it out and then you don't really have to advertise the local grapevine gets around and likewise if it's not appropriate and people don't like it, the same thing, it will get around very quickly that this is not working and we're not going there. (Provider)

Like providers, women in the wave 1 focus groups also felt that word of mouth was an effective way to promote prenatal education and supports. Women commonly described not knowing about the programs and services of their local Family Resource Centre until they were told by friends or members of the community.

I didn't know about this [Family Resource Centre] until this pregnancy, [but I found out through]... friends in town. (Wave 1)

Even the taxi drivers here in this town will tell you if they know you're pregnant, 'Oh, you should go check out [this Family Resource Centre].' (Wave 1)

☞ Coordination of Programs and Services

During the interviews, providers were asked how prenatal education and support resources could be better coordinated. In some cases, the focus groups with women also revealed some information around coordination of program s and services. Strengthening linkages between community organizations and providers; building stronger linkages with physicians; networking, sharing and communication between providers; a central list of resources were highlighted. Each is described in greater detail below.

Strengthening Linkages between Community Organizations & Providers

A few providers felt that strengthening the linkages between community organizations and providers would help improve coordination of prenatal education and support programs and services. For example, although many providers highlighted the value of Family Resource Centres in providing prenatal education and support to traditionally under served women, it was noted that among providers the level of respect and appreciation for their community based expertise was low. It was also noted by a few providers that the system of prenatal and post natal care is fragmented. It was suggested that greater emphasis on community based care by providers in the community and improved collaboration between providers would help to improved continuity of programs and services.

I think if we break down the barriers between those that have designated themselves as professionals and those community-based organizations that are doing good work. ...in terms of not appreciating the expertise that is sitting in community-based organizations. (Provider)

I'm a firm believer in decentralization... it's one of the challenges of our Public Health system. To have a Public Health Nurse who has this huge territory ...who goes knocking on doors to people [they've] never met before. So that that Public Health role is a wonderful one, I don't think it's all that effective. We used to have community Public Health Nurses they worked in a neighborhood and they got to know that neighborhood quite well and the local agencies. When you think about women [they] go to see somebody for their prenatal care, they go to somebody different for their prenatal education [and] go to a third place to actually give birth and then they're turfed off back home to see a fourth individual afterwards. I mean the family physician is probably the single most continuous piece, I think you need a community based [system], same providers, who would provide support across, prenatal and post natal until your kids are school aged. (Provider)

Building Stronger Linkages with Physicians

It was consistently noted by providers that a key aspect of improved coordination would include building stronger linkages between providers, especially with family physicians. It was noted that as the first point of contact for many women, the family physician plays a critical link in the promotion and referral of prenatal education and support opportunities and resources.

I know it's been quite a challenge to have physicians to be part of this and from our perspective from Public Health we see them as huge in terms of providing referrals and informing people of ways to access But I think because Physicians have such a demanding role themselves ... I'm not sure that they see the importance that they play, I'm not sure they're aware of how important their role and their input is with these clients. (Provider)

At your first point of access, so what do you do when you find out you're pregnant? I don't know what you did, but I called my doctor, that would be that first time that you accessed health care, that would be the time that it'd be important to be given the information of, this is where you get really good information, and this is how you access it. (Wave 2)

Networking, Sharing & Communication between Providers

Many providers noted that coordination of programs and services may be improved through communication among providers as well as networking and sharing opportunities. Many providers felt that there was a lack of awareness among various providers regarding the types of programs and services being offered in local communities. Several providers highlighted committees (e.g., maternal and child health committees, early years committees, prenatal community support networks, etc.), which have been effective as a forum among providers to share and build awareness regarding prenatal programs and services.

...[we had] a great workshop and a lot of interest from community providers. [It was good to] come together. It was a great information sharing session. It was a whole day of mini workshops and information sharing. So out of that came a committee called the Prenatal Community Support Network. And it's open to anybody who provides prenatal care to women. ... that has been really wonderful for keeping us all in touch and on top of what's happening in other places...and now we are so much more aware of all of the services within [our District and] knowing who to call, who to refer [women] to. (Provider)

...a mode of communication amongst providers so that the left hand knows what the right hands doing. ... Physicians are some of our greatest partners and we hardly ever get referrals from physicians (Provider)

Central List of Resources

A few providers felt that a list of local prenatal education and support resources and opportunities would build awareness among providers of what is available locally as well as facilitate referrals to services by primary care providers. Further, this list could be distributed to women to also build their awareness of what is available to them in their communities.

I don't think that women are necessarily aware that Public Health does provide these service ... Services are not necessarily [found] in one place. Where I used to work there was one flyer that a [health care provider] could give out at the beginning of pregnancy. It included all prenatal classes in town including prenatal yoga, prenatal fitness courses, all on one page. I think that was a really useful resource for providers. (Provider)

...provide a whole list of resources in the community... [like] mental health, addictions, all the Family Resource Centre numbers, the library. (Provider)

Some women in wave 1 and 2 focus groups also suggested that a central list of resources would be beneficial to them. Several women described not knowing what types of resources and supports were available to them locally and therefore felt that a local list of prenatal education and support resources and opportunities would be helpful.

...it would be great to have a list of all the agencies and groups that deal with pregnancy, birth and child care in [my community]... Well I just live up the street and I didn't find out about this [resource centre] until after I went to the hospital to give birth. (Wave 1)

... if there was just a one page sheet of where to go for prenatal exercise, where to go for yoga, where to go, the LaLeche League, all those kinds of [resources]. (Wave 2)

Some local supports ... it would be nice to know where you could go, what ones are free. There's lots of services here that are free, right? It's nice to know where you can go. (Wave 2)

Learning Styles & Approaches

The following section provides an overview of the findings from the focus groups and interviews regarding learning styles and approaches to prenatal education and support including:

- Public Health Services classes
- Preferred learning styles
- Other considerations

☞ Public Health Services Classes

Aspects of the Public Health Services prenatal education and support classes were explored in greater detail in the focus groups with women in wave 2. These findings are presented in this section including why women choose to participate in classes and what they would like to see done differently.

Reasons for Attending

Women in wave 2 were asked why they chose to attend Public Health Services prenatal education and support classes. The detailed reasons for participating in Public Health Services classes are summarized in Table 6 along with supporting quotes.

Table 6: Reasons for Attending Public Health Prenatal Class

Reason	Explanation	Quote (wave 2)
Social Support	<ul style="list-style-type: none"> • Being around other new mothers and fathers • Sharing and learning from others experiences 	<i>Being with other people that are pregnant in different stages in the prenatal classes is what I find really valuable. Being surrounded by people in the same situation.</i>
Addressing Questions	<ul style="list-style-type: none"> • Opportunity to ask questions and get professional answers • Listen and learn from the questions of others 	<i>You don't know necessarily what to ask, and that's where in the class it's really nice because somebody else might ask the question that you would have never thought to ask.</i>
Partner Involvement, Support and Education	<ul style="list-style-type: none"> • Opportunity for partner involvement in the pregnancy and information on how to provide support • Social support from other father's-to-be 	<i>I think my husband, he's very nervous, and to see the other guys in the class too...so he can kind of talk to [them] on the side too, and I know that's made him feel better. So I think there's that support for him as well as for me.</i>
Referral to the class	<ul style="list-style-type: none"> • Referred to or recommended by a health care professional 	<i>I was going to be a first time parent, and hadn't spent a lot of time with an infant. I had no one to talk to about my pregnancy, and I was scared.</i>

		<i>So when I went to the hospital for my ultrasound, they suggested going to these classes</i>
Refresh Information	<ul style="list-style-type: none"> Serves as a re-fresher of information for those who had children awhile ago 	<i>It's been eight years since I had a baby, I don't remember. Just the more information the better.</i>

What Worked Well

Overall, there was variability in women's (from wave 2 focus groups) perceptions regarding the effectiveness of Public Health classes. Some women indicated that they chose to attend prenatal class to access social support and have the ability to ask questions of experts and their peers. These women indicated that those expectations were met and therefore they were satisfied with the classes.

What Should be Done Differently

In wave 2, women who participated in a Public Health Services prenatal education and support class were also asked what they would have liked to have been done differently. The following table provides a summary of these responses along.

Table 7: Suggested Changes to Public Health Prenatal Class

Change	Explanation	Quote (wave 2)
Anonymous Questions	<ul style="list-style-type: none"> Opportunity for questions to be asked anonymously by those who may be uncomfortable asking in the classroom setting 	<i>I find that when you have questions...I'm a quiet person, [I'd like it if] I could write it down on a piece of paper.</i>
Hands on & Practical	<ul style="list-style-type: none"> More hands on activities (e.g., changing diapers, bathing a baby, etc.) 	<i>... do more hands-on things, like changing a diaper, bathing a baby. And they could probably even have volunteers that would come in with their babies and show them.</i>
Class size	<ul style="list-style-type: none"> Large class size prevented discussion Some discomfort asking questions in a larger class Some topics not covered due to a lack of time with larger class size 	<i>I know when we started our group, it was a huge group. ... It was probably 15 couples, and that was just way too much. Like it took an hour just to go around the room and introduce yourself.... I was really hoping for more discussion opportunity....The second time around our group was quite small. So we're able to talk a lot more amongst each other, and I like that. You're more comfortable to ask questions.</i>
Timing of Information	<ul style="list-style-type: none"> Alignment of information with women's stage of pregnancy Suggest having classes with women in similar stages of pregnancy 	<i>She was in second trimester, I was in third, and she was – so it was kind of like it was a little hard, just some of the [topics] that we were talking about was probably freaking her right out, right?</i>

	(homogeneity within classes)	
More Realistic Information	<ul style="list-style-type: none"> Provide a more accurate, realistic portrayal of the pregnancy, birth and newborn care experience (e.g., real life videos, etc.) 	<p><i>I feel that the video that they showed during our class ... what I took away from it, was you were going to go into early labor and you were going to lay on the couch and watch a movie with your husband, and everything was going to be wonderful.... they showed actually a video of a lady having a birth with no pain medication, and she didn't even scream once. And I was like, wow, that's not what I've seen on TV.</i></p>
Judgment	<ul style="list-style-type: none"> Need to provide information in an unbiased non-judgmental manner to allow women to feel comfortable in making informed decision (especially true around newborn care in terms of infant feeding and pain management) 	<p><i>[At the prenatal classes] when they did talk about pain management, it was kind of like, 'you can have this but we don't recommend it'. Like I found that there was quite a judgment on if you were going to choose to have an epidural, [because] it might cause trouble with your labor and delivery, it might cause troubles with your baby in the long run. I found there was a lot of judgment on having that option [or] any kind of pain management.</i></p>

☞ Preferred Learning Style

During the focus groups and interviews, providers and women were asked to describe what they felt the most effective learning style was to disseminate prenatal education and support. The interviews and focus groups suggest that the preferred learning style includes facilitated discussion, participant driven approaches, and multiple strategies (including visual and print material).

Facilitated Group Discussion

It was consistently noted during the interviews with providers that the most effective learning style for delivering prenatal education and support was through facilitated discussion. Many providers felt that the semi-structured environment of a facilitated group discussion was ideal (compared to classroom style teaching or self-directed learning) as it creates an opportunity for women to share their experiences, ask

Literature:

- ◆ Best Start Ontario suggests that discussion groups are the preferred method for delivering prenatal education and support
- ◆ Best Start Ontario recommends that discussion groups be based on adult learning principles and facilitated by a provider who uses the knowledge and skills of the participants to create an open environment that meets the needs of the participants
- ◆ The literature suggests using an 'empowerment' model (interventions that foster the autonomy of parents and confidence in their decisions)
- ◆ Best Start Ontario describes online prenatal education and support as 'promising'; however, additional research around effectiveness (e.g., 100% online versus blended with face to face) is needed.

questions, and express their opinions while still having the support of a professional to provide accurate information. Providers noted that groups who regularly meet build greater trust and form stronger social supports compared to groups which only meet occasionally. It was noted by a few providers that facilitated discussion was most effective when women of similar life stage and circumstance were brought together as this also facilitated openness and sharing among the group as well as comfort and social bonding without fear of judgment.

We've had people say 'it's nice to have a place to go where you can say anything you want to say'. I think a really semi-structured environment where [women] feel like what they have to say matters. They get a chance to offer their opinions, ask questions... it's really the relaxed, facilitated discussion. It's not us up there doing a lecture style or teaching about something. It's nice [for women to] come and be able to say what [they] want and ask questions in a non-judgmental atmosphere. (Provider)

[Having the women] leading it. [For example, we had a discussion] about marijuana and the effects of smoking marijuana during pregnancy. People were offering different opinions and stories. And one mom said 'I smoked marijuana with my first baby and I can see that she has different learning needs at 3 years old. She doesn't learn the way other kids do.' I think is so much more powerful coming from a mom, like their peer, than me standing up there saying "you shouldn't smoke marijuana." (Provider)

The most effective style is group [discussion]. It's bringing a group of women with similar lifestyles and values together to seek support from each other in an atmosphere where they're getting the appropriate information. (Provider)

Similar to the providers, women in wave 1 also consistently discussed facilitated group discussion as their preferred learning style. Several women noted the group discussion was ideal as it gave them an opportunity to discuss common issues with other women with whom they could relate. Further, a few women in both waves also felt that classroom style teaching (especially in large groups) did not provide a comfortable environment for asking questions or voicing opinions.

I [like] sitting in a group like this and just discussing stuff with other people, [women] who went through it. (Wave 1)

Even talking with people who've recently given birth, their experiences...that would probably be very beneficial to talk to people who had recently gone through it. But the prenatal classes weren't geared towards that... wasn't really a discussion. It was more a nurse up at the front telling you things. I didn't find I learned a lot from other people. I don't even know if I opened my mouth during the prenatal classes really. (Wave 1)

... because it's easier to ask questions when people aren't staring at you [in a class], and it feels embarrassing if you ask [questions] (Wave 2)

Participant Driven

It was consistently noted by providers that a critical component to prenatal education and support was a ‘women centred’ or ‘participant driven’ approach where issues discussed were those that were important and relevant to the participants rather than driven by the provider/educator. Many felt that this type of approach would facilitate group engagement as well as improve the uptake and understanding of information. Further, the information should be geared specifically to the needs of the individual or group which includes building an understanding of their social context and adapting information so it is relevant and appropriate to the participants.

[Prenatal education and support] *has to be driven by the participants in that particular group because there may be burning issues that people want addressed. If you haven't built that into your program and haven't asked the participants what information they want to have, then they're not going to get anything out of it.* (Provider)

[Learning] *in groups [is most effective] but a learning style where the participant sets the agenda because what they bring up [will be] things that they want to know or are interested [and the information] will actually stick in their minds.* (Provider)

Multiple Strategies (including visual and print material)

Although it was noted by providers that facilitated group discussions were the most effective method to deliver prenatal education and support, some also felt that a multi-method approach was also needed. Some providers noted that along with facilitated group discussion it was important to also provide additional information, follow-up and supports via multiple methods to suit the individual learning styles and needs of women. This may include facilitated discussion which also provides supplemental print or visual materials or providing forums outside of the group discussion for women to connect on specific issues.

Literature:

- ◆ Studies have found that visuals and videos are most effective when paired with opportunity for discussion, debriefing and questions.
- ◆ Print materials provided prior to classes help women to feel comfortable and informed

Providers felt that print material alone was ineffective because it could be easily ignored and its effectiveness was limited by the literacy levels of the user. Most felt that the combination of visual and ‘verbal’ approaches with supporting print material for later reference was ideal, especially in situations like classes and discussion groups.

I think [there should be] many different strategies and have options available for different learning styles, we should be open to having and facilitating online forums or [sessions], for example for same-sex couples. I think there should be opportunity for people to get together, should they want to get together. I think there should be things in between [so they can] go back and reflect and access other [resources] like blogs or Facebook. (Provider)

I think you need a combination. I think you need both facilitated discussion and I think you need to provide some visuals for some people in terms of media like the DVD's, or videos. [Or] somebody to come in with past experience, like a breastfeeding mom can sit in on [the group] or someone to come in and discuss openly what is it like really to have a baby at home. I think there are all kinds of different ways that people learn and it's a real challenge to meet everybody's needs in a couple of hours. (Provider)

I think that's very individual really. You know because our mind set is such that we know that people learn in a variety of ways. We [should provide a variety like] handouts and have people come in and sit and listen, there are internet sites that people can access and there's TV shows people can watch. I think that sometimes it's very beneficial for many people to hear the information and then to have the literature to support it to take home to review and reflect on and to refer back to. I'm not really sure if there's one best way. (Provider)

Similar to the providers, a few women in wave 1 also noted that a multi-method approach would help with learning. Most women felt that group discussion was the most effective way to provide prenatal education and support, however, some women indicated that along with group discussion they also wanted supplemental material which they could refer to. A few women noted that prenatal education print materials should also include lay terminology or a glossary of terms as few women understood medical terminology. In wave 2, print materials such as “A New Life” (i.e., Healthy Pregnancy, Healthy Baby) was described as helpful when combined with the class.

It's nice to go to one of these [handouts]. [It's good to get] handouts after talking because then if you can't remember something, you can just look back and refresh your memory. (Wave 1)

... for all the big words like words in your body, like [a definition] that tells you what it exactly is...because you can read it and then you're like ‘Well I don't know what this part is.’ (Wave 1)

My friend is pregnant and she's trying to figure out if she [wants to] do the prenatal classes or not. I said, at least do the first one and get the book. (Wave 1)

Women in wave 1 and 2 of the focus groups felt that videos and hands on models were not realistic enough to provide useful prenatal information. It was consistently noted by the women that they preferred seeing real life demonstrations such as watching a mother breastfeeding and changing and bathing a real baby. Further, a few women in both wave 1 and 2 indicated that they enjoyed doing real life hospital tours in order to build awareness and familiarity of the equipment and alleviate some fears.

It would also be nice to have a mom come in and watch her breastfeed, watch her get the baby to latch on, because you can't see that with a doll ... actually see somebody do it properly like in the flesh and watch a mom change a baby or watch a mom bathe a baby, not just a doll. (Wave 1)

One thing that helped me is we went for [the hospital] tour ... they showed you everything I had an idea of what was going to happen and what all the different instruments were and it didn't scare me so bad. So when they were moving me to the next room and all the tubes were hanging around, I knew it was just the oxygen and stuff. (Wave 1)

I think the tour of the labor and delivery room is probably the best so far. By really getting in there and talking about it, and seeing where I'm going to be and what things are going to be used and to really be familiar with it, so it's not going to be as scary when I go. (Wave 2)

Online Versus Face-to-Face

During wave 2, women were asked which learning style they would prefer for prenatal education and social support. Women reported mixed responses with the majority preferring having both online and face-to-face support available. Table 8 provides some of the findings about preferences for face-to-face versus online education and support, including supporting quotes.

Table 8: Perspectives on Online versus Face to Face Learning and Support

Online		Face to Face	
Theme	Quote	Theme	Quote
<u>Easy Access</u> <ul style="list-style-type: none"> Ease of accessing online resources at women's convenience (e.g., 24/7) 	<p><i>It's easy to access [any] time. You don't have to have an appointment.</i></p> <p><i>...if you have any questions then you've got the [chat] room, which is just a click away and that's 24 hours.</i></p>	<u>Learning from others</u> <ul style="list-style-type: none"> Ability to share and benefit from questions of others 	<p><i>Face-to-face. I think it's that people in class ask questions you may not have thought of or may not be comfortable asking, so there's the feedback not just from the instructor, but from the rest of the class.</i></p>
<u>Anonymity</u> <ul style="list-style-type: none"> A preference and comfort in the ability to ask questions anonymously 	<p><i>...because it's easier to ask questions when people aren't staring at you, and it feels embarrassing if you ask things.</i></p>	<u>Socialization</u> <ul style="list-style-type: none"> Opportunity to get out and socialize with other parents 	<p><i>It's great to have the full year off...but the year can be really long if you don't have support. You don't have places to go and people to meet up with...the days get really long if you're just home all day with your baby.</i></p>
<u>Topical Information</u> <ul style="list-style-type: none"> A wealth of information available on a wide variety of topics 	<p><i>They've got one room – the site is actually designated to help people who can't get pregnant. So you've got the trying to conceive chat room, and then you have the already conceived chat room.</i></p>	<u>Hands On</u> <ul style="list-style-type: none"> Ability to learn through hands on learning 	<p><i>Face-to-face [because it's] hands on. I just think the hands-on you remember more.</i></p>

<ul style="list-style-type: none"> Information presented on a week by week basis (applicable to the women's stage of pregnancy) 			
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Considerations for Online

The women who participated in the focus groups as part of wave 2 were also asked what key aspects or components are critical to ensuring that online prenatal education and support resources are useful. Some key aspects included the following:

- Easy to use

Easy to use. I think that just having very simplistic titles, so an easy flow of how to get there, back button, so you can get out of where you're at, if you're in the wrong place. And then a search option ...that [would be] helpful. (Wave 2)

- Credibility

Information from experts, and listing them there, like what their credentials are. Make sure the credibility is there for the experts [on the site]. (Wave 2)

- Ability to ask questions

Sometimes you just have a little question that you just want to throw it out there to women [in a forum] that have been through it, and I've done that, and get your answers that way. (Wave 2)

- Links to Resources

I think giving [the links] the resources that are out there in the community. (Wave 2)

Other Considerations

Realistic Information

As previously noted, several women in wave 1 and 2 noted that regardless of the method of delivery, many wanted the information to be a realistic portrayal of the experience. Several women in wave 1 and 2 described their experiences with watching videos at prenatal classes and described them as not “realistic”. Many described watching television programs which they preferred due to their real life portrayal of pregnancy, birth and newborn care. Although a few women in wave 2 noted that the realistic portal may create some fear, they still would prefer to have realistic and honest information.

Well we watched a couple of videos, but they just don't really show what's actually going to happen. You want something realistic. Like the videos we watched, she's talking on the phone during contractions, that's not realistic. You think when you're in labour and you're screaming 'what's wrong with me?' (Wave 1)

One thing that the instructor of this class I attended that kind of freaked me out a bit, but I'm glad she said it was, 'it's going to hurt a lot, it's going to hurt more and when you think it can't hurt anymore, it's going to hurt even more'. I'd rather it not be sugar-coated. (Wave 2)

The same problem that they have with labor, they had with breastfeeding...[the] pain and discomfort associated with it, it was glossed over. ...They could have gone into a bit more detail. But I think they're afraid to tell people about pain. (Wave 2)

Preferred Provider

During wave 2 women were asked which provider they were most comfortable or preferred receiving prenatal education and support from. Generally, most women indicated that their family physician played a minimal role in their prenatal education and support. Most indicated that they would prefer to receive prenatal education and support from a nurse (e.g., family practice nurse, nurse practitioner, Public Health nurse, etc.) rather than their physician. Most felt that nurses were generally better listeners and educators, and also noted that they had more time to address prenatal education and support compared to the family physician.

...my physician was great, but the nurses are so much more informative, and they do take their time. (Wave 2)

The medical system, the way it's set up right now, you're going to go and wait in a waiting room for an hour, and then you're going to get three minutes worth of questions. It's more acute rather than your fears, or concerns, or issues – it's more, okay, what is the problem? (Wave 2)

Sometimes it feels like when you go down to see the doctor, they kind of want to get you out the door as fast as possible... you feel that they're rushing you. And I get kind of uncomfortable and I don't want to sit there and take up time and ask questions... [Nurses], they may have a better way of explaining something too, like more lay terms. (Wave 2)

Telephone Hotline

It was also suggested in one focus group that a telephone hotline similar to what is available in other provinces would be highly beneficial for providing prenatal education and support. These women agreed that a telephone hotline would allow them to easily access professional and reliable information and answers to questions.

In Ontario, ...they have a call-in line where people can phone in if something is wrong with your baby, and you can actually talk to a nurse on the phone, and she'll say, try such and such, and if that doesn't work, call a doctor, so that you don't end up constantly in Emergency if you're maybe dealing with something that's confusing to you.

Key Observations & Conclusions

Key Observations

☞ Effectiveness of Prenatal Education and Support & Current Needs

Pregnancy

- Prenatal education and supports are effective at providing information to help increase women's confidence, knowledge and awareness around pregnancy and alleviate fears about pregnancy and birth. However, prenatal education can create fear, anxiety, and a sense of pregnancy being unnatural as some women may interpret the information as inflexible and directive versus recommendations.
- Traditional prenatal education and supports (e.g., those provided through Public Health Services) may not be utilized by women in most need. However, partnering with Family Resource Centres is effective at reaching these women. More work could be done to target women who often 'fall through the cracks' (e.g., women in the sex trade, women with issues of substance use, etc.).
- Prenatal education information and methods of delivery may be provider versus participant driven, and may not always be based on the needs of women (e.g., oversimplified, redundant with self-directed learning, repetitive information if attending for a second pregnancy, etc.).
- There appears to be a lack of prenatal education and support related to mental health issues such as depression, feelings of loneliness, guilt, indifference towards the pregnancy and inability to bond with the baby.
- Timing of prenatal classes often did not align with women's stage of pregnancy. Information presented on a week by week basis would enhance the effectiveness of prenatal education as it increases the relevance of the information and helps to minimize women becoming overwhelmed with too much information at one time.

Birth

- Women and providers noted that the information about birth is medicalized with a focus on intervention and pharmacological pain relief. There is a need for more information around holistic options and services (e.g., doulas and midwives).

- There is variability in how much information women wanted related to birth with some women noting there was too much of a focus on birth and others indicated they liked the focus of prenatal education to be on birth, perhaps due to a lack of confidence or nervousness about birth.
- Women felt that prenatal education and support did not provide adequate information on pain management, complications (e.g., induction, cesarean section) and post birth recovery. Information pertaining to these areas and others (e.g., infant feeding) should be presented in a non-judgmental, unbiased manner to allow women to make informed decisions.

Newborn Care & Parenthood

- Providers felt that prenatal education and supports about newborn care centred on the immediate (often physical) needs of the newborn, and information is lacking on growth and development, infant cues, attachment, and social interaction.
- Women felt that information about common problems in the care of a newborn (e.g., sleeping, breastfeeding, gastrointestinal issues, colic, etc.) would be useful.
- Prenatal education, information and supports are currently lacking around formula feeding for women who chose not to or are unable to breastfeed.
- A gap in the provision of prenatal education and support includes the emotional aspects of newborn care and parenting such as depression and the emotions of adapting to parenthood. Further, information is lacking on personal care for women after having a baby.
- Supports are also required for partners and support people to assist women through emotional changes and caring for the newborn.

☞ Access to Prenatal Education and Support

Sources

- Common sources of prenatal education and support include health care providers, Family Resource Centres, prenatal classes, hospitals, online/websites, books, television and support people.

Facilitators

- An important facilitator to women accessing prenatal education and support is an environment that is personally comfortable (e.g., judgment free, safe, welcoming, open to diversity and social inclusion, respectful, accommodating to non-traditional 'support people', etc.). This type of environment is more common in Family Resource Centres.
- Supports and services such as child care, transportation, free internet access and incentives also facilitate access to prenatal education and support

Barriers

- A fear of judgment and prejudice because of issues such as lifestyle, life circumstance, literacy, language, etc. are obstacles which prevent some women from accessing traditional prenatal education and supports. It appears some women also face judgment and stigmatization around their decision to formula feed rather than breastfeed.
- A barrier preventing women from accessing prenatal education and support is a lack of awareness regarding what is available. Opportunities such as those through Public Health Services and Family Resource Centres are not well promoted to women, especially by physicians. Building awareness of available resources would help to empower women so that rather than waiting for their primary care provider to tell them about resources, they proactively inquire themselves. Further, media and advertising may help to further promote local resources.
- Another common barrier to accessing information was inconsistent or mixed messages. Establishing consistent key messages for all providers to promote is critical. Given the diverse range of information sources, the reliability and accuracy of information obtained by women is a concern. A compiled list of reliable high quality resources may help to overcome this issue.
- Obstacles such as transportation (especially in rural and remote communities), isolation (physical and social), lack of child care, cost concerns, access to technology and lack of space in classes also prevent some women from accessing prenatal education and support.

Coordination of Programs & Services

- In terms of coordinating prenatal education and support resources, strengthening linkages between community organizations and providers; building stronger linkages with physicians; networking, sharing and communication between providers; and the creation of a central list of resources are recommended.

☞ Learning Styles & Approaches to Prenatal Education & Support

Public Health Services classes

- Common reasons for attending Public Health Services prenatal classes include: to receive social support; to have questions and issues addressed; to facilitate partner involvement, support and education; referral to the class by a health care professional; and serving as a refresher for those who had children several years ago.
- Suggested changes/areas of improvement to the classes include providing opportunities for participants to ask anonymous questions; providing hands-on practical education and realistic information in a non-judgmental manner; having smaller class sizes; and providing information in a timely way so it aligns with a woman's stage of pregnancy.

Preferred learning styles

- The preferred learning style includes facilitated discussion, participant driven approaches, and multiple strategies (visual and print material). Key elements of such approaches include:
 - A semi-structured environment with a facilitated group discussion as it creates an opportunity for women to share experiences, ask questions, and express opinions while still having the support of a professional to provide accurate information.
 - A 'women centred' or 'participant driven' approach where issues discussed are those thatn are important and relevant to the participants rather than driven by the provider/educator. This type of approach helps to facilitate group engagement as well as improve the uptake and understanding of information.
 - Providing additional information, follow-up and supports via multiple methods including supplemental print or visual materials. However, providing print material alone is not an ideal education method as it can be easily ignored and its effectiveness is limited by literacy levels. Further, videos and hands on models need to be realistic to provide useful prenatal information.
- The strengths of online learning include the ease of access (24/7), the anonymity and ability to ask questions anonymously, and access to topical information (week by week information).
- Critical aspects of online resources include ensuring ease of use, ensuring the credibility of information, and providing a forum to ask questions and links to resources.
- The strengths of face to face learning include the ability to share and learn from others, opportunity to socialize with other parents, and hands on learning.
- A telephone hotline similar to what is available in other provinces would be beneficial for providing prenatal education and support.

Conclusion

This report provides a synthesis of the findings from the information gathering with women and providers in Nova Scotia as well as the highlights from the literature on prenatal education and support needs. The report presents several strengths of current prenatal education and supports, as well as areas and opportunities for improvements. Incorporating the findings of this report into new and existing prenatal education and supports will help to improve their effectiveness including ensuring that they are meeting the needs of diverse women across Nova Scotia. A first step will be a review and discussion of the findings with key stakeholders in November 2008 to help inform future planning related to the development and implementation of prenatal education and supports.

Appendices

Appendix A: Survey

Thank you for taking the time to participate in this focus group. If you could take a moment to fill out a couple quick questions it would be greatly appreciated. This information is intended to be completed anonymously, please DO NOT write any personal information, such as your name on this sheet.

1. What is your age?

- Under 18 years
- 18-24 years
- 25-34 years
- 35-44 years
- 45-49 years
- 50 years and over

2. Are you currently pregnant?

- Yes
- No

3. How many children do you have excluding (not including) your most recent pregnancy/delivery?

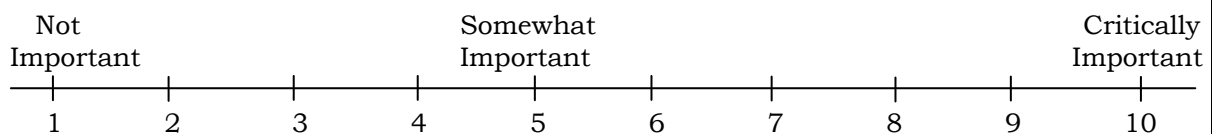
- 0
- 1
- 2
- 3
- 4 or more

4. Have you ever attended a prenatal education program?

- Yes
- No (skip to question #6)

5. Please describe some of the prenatal education programs you have used or participated in:

6. Overall, how would you rate the importance of prenatal education and support (please circle your rating)?



Appendix B: Interview Group Guide

Interview Guide

PURPOSE OF THE INTERVIEW

The purpose of the interview is to gather the perspective of health care providers to discuss the education and support needs of prenatal and post partum women. Specifically the interview will gather data to assess issues related to prenatal education and support needs; access to prenatal education and support; and learning style.

PURPOSE OF THE GUIDE

This document will be used by the interviewer to guide the interview discussion on prenatal education and support needs.

INTRODUCTION & CONSENT (5 Minutes)

Nova Scotia Health Promotion and Protection (Public Health Services and other Departments) who provide supports to pregnant and post partum women are conducting focus groups with women and providers to gather information to help develop more effective support for prenatal and post partum woman and their partners. We are conducting focus groups with women and interviews with providers who work with prenatal and post partum women such as physicians and providers working with Public Health Services, Youth Health Centres, etc. The information and learnings from the interviews will be analyzed and compiled into a report as part of the information gathering of prenatal education and support needs in Nova Scotia.

Participation in this interview is voluntary, all the information provided will be kept confidential and answers will not be associated with any names in any reports written. To help with the analysis of the information, I would like to audio-record and transcribe this interview. The responses provided will only be reported in aggregate, and although individual responses may be used as quotations, no one will be personally identified. Do you have any questions?

Do you consent to participate in the interview?

Yes No

Do I have permission to audio-record this interview?

Yes No (If no, ask if notes can be taken)

PURPOSE OF THE INTERVIEW

The purpose of the interview is to gather the perspective of health care providers about the education and support needs of prenatal and post partum women in Nova Scotia.

Section 1: General Prenatal Education & Support Needs (20 minutes)

In this first section, I would like to begin with questions related to women's prenatal education and support needs in general. For the purpose of this interview prenatal education and support includes: books/ magazines; internet such as websites, social networking sites, discussion forums; health care professionals such as physician, nurse, pharmacist, dietitian, midwife, etc.; prenatal classes; videos; friends/family; high schools; Youth Health Centres; community resources/organizations such as Family Resource Centres, prenatal yoga, recreation centres, etc. The supports provided may address a range of issues including physical and emotional health, financial needs, connecting women to community resources, etc.

1. Do you feel the prenatal education and supports available for women are effective in terms of:
 - Helping them with their pregnancy?
 - Preparing them for the birth of their baby?
 - Preparing them for caring for their newborn?
 - Preparing them to be ready for parenthood?

Each of the above areas will be explored and the following probes used for each of the above "themes":

Probes:

- If yes, how? In your opinion, what is helpful? What support is most beneficial? What could be done to improve the support?
 - If no, why not? What other support do you feel women need?
2. Currently there are a range of providers and organizations providing prenatal education and support. In your opinion, how can these supports be better coordinated (if at all) or what is required to better coordinate these resources and supports to ensure a systems approach to prenatal education and support?

Section 2: Access to Prenatal Education & Support (20 Minutes)

I would like to now discuss issues related to women accessing (e.g., finding and using) prenatal education and supports.

3. Where do you think most women obtain prenatal education and support?

Probes:

- In your opinion, is the support easy to access (e.g., find and use)? Why or why not? (e.g., comfortable setting to get information, feeling welcomed, getting there, time of day it was offered, etc.)
- What is helping women to access (e.g., find and use) prenatal education and support?

4. What do you think are some of the barriers or challenges preventing women from accessing (e.g., finding and using) prenatal education and support?

Probes:

- How do you think these barriers can be overcome?

5. What types of supports are needed to help women access (find or use) prenatal education and support?

6. What is the most effective way to reach and promote prenatal education and support opportunities and resources to women?

Probes:

- Recommendations from health care professionals, media promotion, etc.

Section 3: Learning Styles/Approaches and Information (10 minutes)

People learn in different ways so in this last section I would like to discuss what types of learning styles or approaches and information are most effective for delivering prenatal education and support to women.

7. What type of learning styles/approaches do you think are most effective for delivering prenatal education and support?

Probes:

- Classroom style teaching by a health care professional, self-directed learning, online learning such as websites, online courses, one on one counseling, peer support, etc.
- What types of materials do you feel are most effective at providing prenatal education for women (e.g., print material, videos, online resources, etc.)?

8. What will help to ensure that prenatal information is understood and used by women?

Probes:

- Considerations around reading/ literacy levels, visual/graphic information, size of print, etc.

CLOSING (5 minutes)

That is the end of the formal questions.

9. Do you have any other feedback and/or input that you would like to add to help improve prenatal education and support for women in Nova Scotia?

Thank you for your time and thoughtful input.

Appendix C: Focus Group Guide

Wave 1 Focus Group Guide

PURPOSE OF THE FOCUS GROUP

The purpose of the focus group is to gather the perspective of pregnant and post partum women to discuss their prenatal education and support needs. Specifically the focus group will gather data related to prenatal education and support needs; access to prenatal education and support; and learning style.

PURPOSE OF THE GUIDE

This document will be used by the facilitator to guide the focus group discussion on women's prenatal education and support needs.

INTRODUCTION & CONSENT

Nova Scotia Health Promotion and Protection (Public Health Services and other partners) who provide supports to pregnant and post partum women are conducting focus groups with women and health care professionals to gather information to help develop more effective support for pregnant and post partum woman and their partners. The information and learnings from the focus groups will be analyzed and made into a report and used to improve current prenatal resource, programs and services..

Participation in this focus group is voluntary, all the information provided will be kept confidential and answers will not be associated with any names in any reports written. To help with the analysis of the information, I would like to audio-record and transcribe this focus group. The responses provided reported all together, and although individual responses may be used as quotations, no one will be personally identified. Does anybody have any questions?

The facilitator will review guidelines for the focus group (e.g. what is said in the focus group is confidential and should not be shared outside the group, all views/feedback is welcomed, respectful of all opinions, etc.)

Do you consent to participate in the focus group?

Yes No

Do I have permission to audio-record this focus group?

Yes No (If no, ask if notes can be taken)

FOCUS GROUP QUESTIONS

The facilitator will begin the focus group using the scripts and questions outlined below. Items printed in italics are scripts for the facilitator.

Section 1: General Prenatal Education & Support Needs (30 minutes)

In this first section, I would like to begin with questions related to women's prenatal education and support needs in general. For the purpose of this focus group prenatal education and support includes: books/ magazines; internet such as websites, social networking sites, discussion forums; health care professionals such as physician, nurse, pharmacist, dietitian, midwife, etc.; prenatal classes; videos; friends/family; high schools; Youth Health Centres; community resources/organizations such as Family Resource Centres, prenatal yoga, recreation centres, etc. The supports provided may address a range of issues including your physical and emotional health, financial needs, connecting you to community resources, etc.

10. Do you feel the prenatal education and support you received or are receiving:

- Helped or is helping you with your pregnancy?
- Prepared you for the birth of your baby?
- Prepared you for caring for your newborn?
- Prepared you to be ready for parenthood?

Each of the above areas will be explored and the following probes used for each of the above "themes":

Probes:

- If yes, how? What was helpful? What was/is most beneficial? What could have been done to improve the support?
- If no, why not? What other support did or do you need?

Section 2: Access to Prenatal Education & Support (30 minutes)

I would like to now discuss your experiences related to accessing (e.g., finding and using) prenatal education and supports.

11. Where, if anywhere, did you obtain prenatal education and support during your current or other pregnancies?

Probes:

- Was the support easy to access (e.g., find and use)? Why or why not? (e.g., comfortable setting to get information, feeling welcomed, getting there, time of day it was offered, etc.)
- What helped you to access (e.g., find and use) the support?

12. What do you think are some of the barriers or challenges preventing you or other women from accessing (e.g., finding and using) prenatal education and support?

Probes:

- How do you think these barriers can be overcome?
13. What types of supports are needed to improve women's access (e.g., find and use) to prenatal education and support?
 14. What is the most effective way to reach and promote prenatal education and support opportunities and resources to women?

Probes:

- Recommendations from health care professionals, media promotion, etc.

Section 3: Learning Style/Approach and Information (10 minutes)

People learn in different ways so in this last section I would like to discuss what types of learning styles or approaches and information are most effective for delivering prenatal education and support to women.

15. What type of learning styles/approaches do you think are most effective for delivering prenatal education and support?

Probes:

- Classroom style teaching by a health care professional, self-directed learning, online learning such as websites, online courses, one on one counseling, peer support, etc.
 - What types of materials do you feel are most effective at providing prenatal education for women (e.g., print material, videos, online resources, etc.)?
16. What will help to ensure that prenatal information is understood and used by women?

Probes:

- Considerations around reading/ literacy levels, visual/graphic information, size of print, etc.
17. What types of information, topics, or activities are you most interested in receiving?

CLOSING (5 minutes)

That is the end of the formal questions.

18. Do you have any other feedback and/or input that you would like to add to help improve prenatal education and support for women in Nova Scotia?

Wave 2: Focus Group Guide

PURPOSE OF THE FOCUS GROUP

The purpose of the focus group is to gather the perspective of pregnant and post partum women to discuss their prenatal education and support needs. Specifically the focus group will gather data related to prenatal education and support needs; access to prenatal education and support; and learning style.

PURPOSE OF THE GUIDE

This document will be used by the facilitator to guide the focus group discussion on women's prenatal education and support needs.

INTRODUCTION & CONSENT

Nova Scotia Health Promotion and Protection (Public Health Services and other partners) who provide supports to pregnant and post partum women are conducting focus groups with women and health care professionals to gather information to help develop more effective support for pregnant and post partum woman and their partners. The information and learnings from the focus groups will be analyzed and compiled into a report and used to improve current prenatal resource, programs and services.

Participation in this focus group is voluntary, all the information provided will be kept confidential and answers will not be associated with any names in any reports written. To help with the analysis of the information, I would like to audio-record and transcribe this focus group. The responses provided reported all together, and although individual responses may be used as quotations, no one will be personally identified. Does anybody have any questions?

The facilitator will review guidelines for the focus group (e.g. what is said in the focus group is confidential and should not be shared outside the group, all views/feedback is welcomed, respectful of all opinions, etc.)

Do you consent to participate in the focus group?

Yes No

Do I have permission to audio-record this focus group?

Yes No (If no, ask if notes can be taken)

FOCUS GROUP QUESTIONS

The facilitator will begin the focus group using the scripts and questions outlined below. Items printed in italics are scripts for the facilitator.

Section 1: General Prenatal Education & Support Needs (30 minutes)

In this first section, I would like to begin with questions related to women's prenatal education and support needs in general. For the purpose of this focus group prenatal education and support includes: books/ magazines; internet such as websites, social networking sites, discussion forums; health care professionals such as physician, nurse, pharmacist, dietitian, midwife, etc.; prenatal classes; videos; friends/family; high schools; Youth Health Centres; community resources/organizations such as Family Resource Centres, prenatal yoga, recreation centres, etc. The supports provided may address a range of issues including your physical and emotional health, financial needs, connecting you to community resources, etc.

19. Do you feel the prenatal education and support you received or are receiving:

- Helped or is helping you with your pregnancy (probe for specific topics of interest, what areas/issues did this help with and how)?
- Prepared you for the birth of your baby (probe for specific topics of interest, what areas/issues did this help with and how)?
- Prepared you for caring for your newborn (probe for specific topics of interest, what areas/issues did this help with and how)?
- Prepared you to be ready for parenthood (probe for specific topics of interest, what areas/issues did this help with and how)?

Each of the above areas will be explored and the following probes used for each of the above "themes":

Probes:

- If yes, how? What was helpful? What was/is most beneficial? What could have been done to improve the support?
- If no, why not? What other support did or do you need?

Section 2: Access to Prenatal Education & Support (30 minutes)

I would like to now discuss your experiences related to accessing (e.g., finding and using) prenatal education and supports.

20. Where, if anywhere, did you obtain prenatal education and support during your current or other pregnancies?

Probes:

- Was the support easy to access (e.g., find and use)? Why or why not? (e.g., comfortable setting to get information, feeling welcomed, getting there, time of day it was offered, etc.)
- What helped you to access (e.g., find and use) the support?

21. How many of you have attended prenatal classes such as those through Public Health Services or your local hospital?

Probes:

- Why did you want to attend these classes? What were you hoping /anticipate gaining? Did you receive Healthy Pregnancy, Healthy Baby...A New Life"? Did you find it useful?
- Did the classes meet your expectations? Why or why not?
- What, if anything, would you have liked to have seen done differently in the classes (e.g., topics, learning approach, etc.)?

22. What, if any, role has your family physician played in your prenatal education and support?

Probes:

- What role would you like to, or would have liked, to see your family physician play in your prenatal education and support?
- Would you consider/ be comfortable receiving prenatal education and support through other providers such as family practice nurses or nurse practitioners? Why or why not?

23. What do you think are some of the barriers or challenges preventing you or other women from accessing (e.g., finding and using) prenatal education and support?

Probes:

- How do you think these barriers can be overcome?

24. What types of supports are needed to improve women's access (e.g., find and use) to prenatal education and support?

25. What is the most effective way to reach and promote prenatal education and support opportunities and resources to women?

Probes:

- Recommendations from health care professionals, media promotion, etc.

Section 3: Learning Style/Approach and Information (20 minutes)

People learn in different ways so in this last section I would like to discuss what types of learning styles or approaches and information are most effective for delivering prenatal education and support to women

26. What type of learning styles/approaches do you think are most effective for delivering prenatal education and support?

Probes:

- Would you prefer to learn face-to-face (e.g., one on one sessions, classroom style teaching through multiple sessions taught by a health care professional, etc.) or would you be more comfortable learning online (e.g., online fact sheets, interactive lessons), or a combination of both? Please explain.
- What about support (e.g., social support), would you prefer to receive prenatal support face-to-face (e.g., group setting, etc.) or online (e.g., chat rooms, social networking sites, etc.)? Please explain.

- If an online prenatal education and support program were to be developed, what would be the key elements of this program to make it a success (e.g., interactive, visual, reputable site/information, ability to ask questions, ability to connect with other women in the program, etc.)?
- What types of materials do you feel are most effective at providing prenatal education for women (e.g., print material, videos, online resources, etc.)?

27. What will help to ensure that prenatal information is understood and used by women?

Probes:

- Considerations around reading/ literacy levels, visual/graphic information, size of print, etc.

28. What types of information, topics, or activities are you most interested in receiving?

CLOSING (5 minutes)

That is the end of the formal questions.

29. Do you have any other feedback and/or input that you would like to add to help improve prenatal education and support for women in Nova Scotia?

Thank you for your time and thoughtful input.