



**Listening to the Voices of Mothers
and Public Health Nurses:
Personal, Social, and Institutional
Aspects of Early Home Visits**

A QUALITATIVE RESEARCH STUDY

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Research Team

Dr. Megan Aston RN PhD

School of Nursing, Dalhousie University
Halifax Nova Scotia
megan.aston@dal.ca

Dr. Sheri Price RN PhD

School of Nursing, Dalhousie University
Halifax Nova Scotia

Dr. Josephine Etowa RN PhD

School of Nursing University of Ottawa
Ottawa Ontario

Dr. Adele Vukic RN MN PhD

School of Nursing, Dalhousie University
Halifax Nova Scotia

Linda Young BSc MPA

Director of Public Health Services, Capital Health
Dartmouth Nova Scotia

Christine Hart RN BA BScN IBCLC

Public Health Nurse, Public Health Services, Capital Health
Dartmouth Nova Scotia

Emily MacLeod BACS MA

Research Coordinator
School of Nursing, Dalhousie University
Halifax Nova Scotia

Patricia Randel BA MSc

Research Coordinator
School of Nursing, Dalhousie University
Halifax Nova Scotia



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Executive Summary

This study provides an in-depth examination of public health nurses' (PHNs), mothers' and managers' experiences of postpartum home visiting programs offered by Public Health Services, Capital Health in Halifax Nova Scotia. The narratives of PHNs and mothers provide detailed accounts of their experiences during home visits which are often invisible or misunderstood by other health care professionals and the general public.

A purposive sample of 36 participants including PHNs (n=16), mothers (n=16) and managers (n=4) was used to collect personal in-depth experiences about two home visiting programs, enhanced (targeted) and early (universal). Individual interviews were completed with each participant. The findings have been organized under three main themes: 1) The Role of Relationships in Home Visiting 2) Health Outcomes 3) Targeted and Universal Home Visiting

Relationships: Through the use of feminist poststructural methodology and discourse analysis we found that PHNs used a range of skills and tools to screen and assess families in both programs. They did this by building supportive relationships with mothers through the provision of positive and non-judgmental interactions. The way PHNs provided information and support was instrumental to facilitating positive relationships and health outcomes. An overwhelming majority of mothers said they felt more confident and reassured because of the relational support and expert knowledge they received from their PHNs. This was foundational to assisting women to quickly and effectively transition into their new role as mother.

Health Outcomes: PHNs and mothers also challenged the meaning associated with historically, institutionally and socially constructed 'softer' health outcomes including self-confidence and reassurance which have been prioritized as 'less important' than other health outcomes such as breastfeeding rates and readmissions to hospitals. The outcomes of maternal self-confidence, empowerment, attachment and positive mental health are important indicators of a new mother's ability to adapt to parenting and cope with the transformative impact of a baby, yet they are often not included in program data or monitoring. Through supportive relationships and meaningful interactions PHNs were able to better observe and assess these indicators.

Targeted and Universal: Targeted and universal programs have been historically constructed through global stereotypes and stigma which affected the experiences of mothers and PHNs. PHNs and mothers were aware of the stigma associated with different groups of mothers and because of this awareness, PHNs were able to purposefully shift relations of power to ensure their interactions were supportive and non-judgmental.

The stories shared by mothers, PHNs and managers provide ample evidence of the critical importance of services provided by PHNs. Despite this evidence, PHN's expressed concerns that their work continues to be underappreciated, invisible and poorly understood. These findings highlight the importance of considering a range of health outcomes when planning, implementing and evaluating public health services and post partum care provision to new mothers and families.

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Introduction

Health care provided by public health nurses (PHNs) for mothers, babies and their families has been a long standing practice in Canada and aligns with The World Health Organization (WHO) priority area on maternal child health (WHO, 2013). The Public Health Agency of Canada (PHAC) also considers maternal and infant health to be a priority area and therefore an essential service for all mothers who may need support (PHAC, 2013).

While the early postpartum period is often considered to be an exciting and positive time for mothers, newborns and their families, it can also be a time filled with complex psycho-social and physical changes that may be stressful for mothers (Darvill et al., 2010; Forster et al., 2008; Simkin, 1991, 1992; Teeffelen et al., 2011). To address such concerns, Public Health Services across Canada have created a variety of programs and services for mothers, babies and their families during this time of transition that are predominantly provided by highly skilled (PHNs) with specific expertise in postpartum.

Nova Scotia Public Health

Nova Scotia Public Health Services is committed to supporting mothers and children and offers a range of services throughout the province for families through the Healthy Beginnings program. At the time of this research new mothers were screened in hospital using the Parkyn Screening Tool (Public Health Services, 2013) to determine their need for postpartum support. After discharge follow-up phone calls were also made within 72 hours of the mothers' returning to their home. The Healthy Beginnings program also offers parents the option of home visits and parenting "drop in" clinics (Nova Scotia Public Health, 2013). During the time this study was taking place there were two home visiting programs. One of these programs was the 'Enhanced' Home Visiting also known as the 'targeted' program which was created for families who had been assessed by a PHN to be at higher risk for poor health outcomes. As a result, these mothers were eligible to have additional support offered to them in the form of unlimited home visits by PHNs as well as visits by specially trained community home visitors for up to three years (Nova Scotia Public Health, 2013; Public Health Services, 2013).

The second program was the 'Early' Home Visiting Program that was considered to be a more 'universal' program created for all new mothers and newborns that had been assessed by a PHN to need services but were not considered to be at a higher risk for poor health outcomes. Upon returning home from hospital these mothers were eligible to receive follow-up telephone support and one or more home visits.

Purpose

The purpose of this research project was to explore how universal and targeted home visiting programs for mothers and babies were organized, delivered, and experienced through the everyday practices of PHNs, mothers, and managers in Capital District Health Authority Public Health Services. Findings focus on how the two home visiting programs were embedded in and affected by social and institutional discourses.

Research Questions

- 1) How were universal and targeted home visiting services organized and delivered within public health services?
 - What were the institutional and professional practices?
 - What were the categorization practices?
 - How were needs assessed?
 - How were home visiting services communicated to PHNs, managers, mothers, and other health professionals?
- 2) How were universal and targeted home visiting services understood and experienced by PHNs, mothers and managers?

Background

History and Context of Postpartum Home Visiting in Canada

Public health nursing has a century long history in Canada that began with a focus on health promotion and illness prevention for mothers and children through both home and school visiting (Stamler & Yiu, 2012). Although PHNs have been practicing for over a century they have only recently been recognized as a specialty within nursing (CHNAC, 2003). Indeed, the invisibility and misunderstanding of the work of PHNs with mothers and children has been a constant theme both historically and presently. In previous research conducted in Nova Scotia by Meagher-Stewart et al., (2004) there were numerous examples of how the work of PHNs was collaborative and participatory. Yet, it was also found that these practices continued to be invisible and not well understood. Yiu and Horsburgh (2007) also write about the misunderstanding of the work of PHNs.

It is important to recognize the significant shift in public health discourse that took place in the 1990's from a socio-ecological to a more bio-medical perspective (Hall and White, 2005; Olds, 1999; Stamler and Yiu, 2012). This created some conflict with PHNs' practice that had previously and for many years focused on social justice, health equity and social determinants of health. Although focusing on targeted populations could be interpreted as attending to issues of social justice, the use of bio-medical measures predominantly shifted assessment away from a social lens that was needed to understand the social and institutional complexities of a mother's situation. This shift in focus to a more behaviour oriented health outcomes focus was interpreted as a reductionist method used to address health and led to debates about most appropriate models for programs and services. Ultimately, practice shifted from a general to a more targeted health needs approach (Hall & White, 2005; Meagher-Stewart et al., 2004; Olds, 1999; Stamler & Yiu, 2012) and focused practice on 'health needs' (Meagher –Stewart et al., 2004). This included challenges in identifying and implementing appropriate needs assessments in everyday practice. Emerging research during this time continued to provide evidence of health inequalities, and the importance of social determinants of health (Ashton & Seymour, 1988; PHAC, 2011).

Postpartum Home Visiting Today

The National Collaborating Centres for Determinants of Health and Aboriginal Health (NCCDH and NCCAH) in Canada held a national conference in 2008 that focused on the impact of postpartum home visiting programs on childhood development (NCCDH, 2014; NCCAH, 2014). At this conference there was consensus among PHNs, community home visitors, other health care professionals, and government employees that home visiting programs had measurable long lasting effects on developmental and health outcomes, which enabled children and their families to develop and live more productive and healthier lives. Globally, other countries were also concerned with effective delivery of postpartum programs for mothers and babies including home visiting programs in the UK (Appleton & Cowley, 2003) as well as Central and Eastern Europe and the Commonwealth of Independent States (Davidson, Smith, Socha, Aston & Etowa, 2010). While many authors and health care professionals believe that most new mothers will experience difficulties during the postpartum period as part of a universal experience of becoming a mother, there has been a global shift to primarily support 'vulnerable' populations that usually focuses on determinants of health such as poverty, low socioeconomic status, single parent households, food insecurity and homelessness. Globally, this has created dichotomies and tensions when targeted and universal programs are compared.

Universal and Targeted Home Visiting

There is a plethora of research that has been conducted globally confirming that mothers identified as 'at risk' or 'targeted' who receive postpartum home visits from PHNs and other home visitors will experience positive health outcomes such as reduced hospital admissions, successful breastfeeding, positive parenting, and increased self-esteem (Haroon et al., 2013; Kersten-Alvarez et al., 2010; Nievar et al., 2010; Sadler et al., 2007; Schaffer et al., 2012; Vanderburg et al., 2010). However, fewer studies have been conducted for mothers considered to have 'less risk' and receive 'universal' services. As a result, there is a significant gap in understanding whether a focus on targeted or universal home visiting or a combination of both provides the best outcomes for all families. At the

time of the study Public Health Services in Nova Scotia provided both. A discussion paper highlighting Nova Scotia's combined home visiting program can be found on the NCCDH website (NCCDH, 2014).

Public Health Nurses Make a Difference

As the research literature demonstrates, there is overwhelming evidence of positive health outcomes associated with home visits by PHNs with targeted high-risk mothers from both quantitative and qualitative studies (Armstrong, Fraser, Dadds & Morris, 1999; Aston et al. 2006; Eckenrode et al., 2000; Hedges et al., 2005; Jack, DiCenso & Lohfeld, 2005; Jansson, Peterson & Uden, 2001; Kitzman et al. 2000). The focus however, has primarily been within the home visit itself and has not included a broader systems approach. No studies were found that focused on institutional decision making with regard to either targeted or universal home visits.

An extensive review of the literature on home visiting programs for mothers and their families revealed that there were few studies that focused specifically on the work of PHNs and even fewer that focused on universal home visits. Most of the research focused on paraprofessionals or a combination of paraprofessionals and PHNs. The studies that do include PHNs are primarily about targeted programs for high-risk or vulnerable mothers (Olds, 2007; Olds et al., 2002) with virtually no studies on universal programs. This indicates a significant gap in our understanding of postpartum home visiting.



Methodology

The guiding theory and methodology for this research was feminist poststructuralism (Butler, 1992, 2005; Cheek, 2000; Foucault, 1983; Scott, 1992). The use of this methodology enabled the researchers to conduct an in-depth examination of personal experiences of PHNs, mothers and managers about two home visiting programs that had been constructed through institutional policies as well as social practices of mothering. Feminist poststructuralism was used to critically explore the social and gendered construction of the work of PHNs with new mothers, babies, and their families as well as examine power through a relational lens. This particular understanding of relations of power (Foucault, 1983) enabled the research team to examine a variety of social and institutional discourses that affected the participants' experiences of home visits. In other words, relations between people that were based on their beliefs, values and practices were analyzed through a particular concept of power. Power was NOT understood as simply 'power over a person', rather, power was understood to be ever

changing, contextual and dependent on how individuals perceived their situations. By exploring the personal experiences of PHNs, managers, and mothers within the context of public health using feminist poststructuralism we were able to gather in-depth evidence about how home visiting programs were personally, socially and institutionally experienced and constructed.

Discourse analysis (Butler, 1992, 2005; Cheek, 2000; Scott, 1992) and the concepts of language, practices, beliefs, and values provided an important frame to understand the experiences of participants. For example, we purposefully used open-ended questions to enable participants to share their personal experiences and perspectives and allow for as many different 'discourses' or ways of understanding targeted and universal home visits as possible. We wanted all perspectives to be equitably heard. We wanted to be open to the possibility of new or invisible practices and experiences. There were a variety of discourses that emerged from the data.



The concepts of subjectivity and agency were used to understand each participant's perspective of their own personal and social location. Because the 'lived experience' of individuals is considered to be the embodiment of beliefs, meaning, and practices that are personally, socially, and institutionally constructed, we paid close attention to the language and practices of all participants and how they perceived their relations with others they interacted with within the health care system. In other words, their subject position or subjectivity.

The concept of agency assumes that individuals have potential control over their lives and the ability to make changes (Butler, 1992, 2005; Scott, 1992). Therefore, we were able to examine how participants were self-reflexive, conscious of their own social locations, and questioned and challenged some home visiting practices.

Setting

At the time of the study in 2011 Nova Scotia Public Health Services offered universal screening by PHNs for all mothers to determine if they were eligible for extra support through the 'Enhanced' or 'targeted' Home Visiting program. This 'targeted' program provided services from both PHNs and community home visitors for up to three years. Mothers who did not screen in as high risk for the targeted program instead received services from the 'Early' Home Visiting or 'universal' program. Both programs were voluntary.

Participant Recruitment

A large qualitative study was conducted with 36 participants. Over the course of 6 months, we recruited 16 PHNs (5 in the targeted program, 9 in the universal program and 2 in both programs), 16 first time mothers (6 in the targeted program and 10 in the universal program) and 4 managers.

All PHNs who conducted early home visits in either the targeted or universal programs were sent letters inviting them to participate in the research study. They were also asked to provide letters of invitation to mothers they met during home visits. All potential participants interested in participating in the study or who had questions were asked to contact the research coordinator to obtain additional information and set up a mutually agreeable time and place to conduct the interview. Eligibility criteria included

1) ability to speak and understand English, 2) PHNs who had been in their position of work for a minimum of six months, 3) managers of home visiting teams who had worked in their position for a minimum of one year within the past three years and 4) first time mothers who had received a minimum of one home visit in either of the programs.

PHN participants were 32 – 59 years old with an average age of 44. They had worked in post partum home visiting programs from 2.5 – 12 years. All PHNs had a Bachelor of Science in Nursing with some PHNs having additional education. All managers had worked at Public Health for a minimum of one year.

Six mothers in the targeted program and 10 in the universal program agreed to participate in the study. They had an average age of 28 years and ranged between 18 and 38 years of age. All mothers had completed grade 12, 9 had an undergraduate degree and 2 had a college diploma. Twelve mothers lived in urban areas and all were first time mothers. No economic data was collected for any participants.

Data Collection

Ethical approval was obtained through appropriate Research Ethics Boards prior to initiating contact with potential participants. PHN and PH Manager interviews took place at the individual's place of work and all interviews with mothers were conducted in the mothers' homes. Interviews were 60-90 minutes, audio taped and transcribed verbatim. Pseudonyms were used and all identifying information removed.

Data Analysis

Interview transcripts were initially coded using ATLAS.ti qualitative software. After coding the Principal investigator (PI), research coordinator (RC) and co-investigators used discourse analysis to identify relations of power, institutional discourses and moments of subjectivity and agency. The first few transcripts were analyzed with the full research team to identify initial emerging discourses and themes. The PI and RC continued with discourse analysis. All transcripts were analyzed separately as well as compared in order to find common themes. This was done consecutively.

FINDINGS

The Role of Relationships in Home Visiting

Importance of Relationships

All PHNs discussed the importance of developing positive and trusting relationships between themselves and the mothers they visited. They spoke about how it was essential to develop a respectful and genuine relationship in order to effectively support mothers, babies and their families.

I think that's probably the most important thing we do, is try to establish relationships with our clients. (Targeted PHN)

Many PHNs in both programs spoke about the uniqueness of the home visit and how it provided an opportunity to focus more on the mothers' perspectives. Because the PHNs were guests in the mothers' homes, it shaped the relationship in a particular way that shifted towards and better fostered a client led relationship. PHNs could also include the mother's personal environment in their assessment.

Everyone can look the same potentially in the hospital. When you go into their home then you see where they live and who's around them or not around them, and the supports. (Universal PHN)

Shifting Relations of Power

PHNs in this study offered numerous examples of how they were very skilled at building relationships. Many described how they had to be attentive to and dispel the negative construction of health professionals as authority figures. They described, either directly or indirectly, that a large part of their relationship development was centred on shifting negative power relations that had been socially, institutionally and historically created.

The perception is that our goal is to take babies away from families. When in fact, our goal is just the opposite – How can these parents be the absolute best that they can be [...] (Universal PHN)

Many PHNs described how they challenged the traditional hierarchical and socially constructed nurse/client relationship by purposefully relating in a more 'personal' or 'human' way without charts, books or checklists.

Instead of getting in there and saying this and this and this. I would just be like, 'okay, how is it going?' And just kind of slowly establish that relationship. Because I don't want to scare anybody away. (Targeted & Universal PHN)

A chart will rarely come out of my bag during a visit. I'm very cognizant that me sitting with a chart again gives that kind of power authority role and I'm not going to make a relationship with somebody who probable doesn't trust the healthcare system. (Targeted PHN)

Many PHNs in both programs recognized their position of authority as a nurse and more specifically as a health care professional within the institution of Public Health. They attempted to shift this dominant and hegemonic relation of power to create a more collaborative relationship where the mothers felt they were taking the lead and were in control of their decisions rather than feeling judged or watched over. This positive approach to interacting with new mothers allowed the mothers to feel supported by their PHN and be more accepting of their help.

Once I saw how she was interacting with her and she was very open about what she's there for [...] She was very understanding, and that made me really open up to her. Like it made me realize why she was there. (Targeted Mother)

Recognizing and Removing Judgment

The majority of mothers in both programs were nervous about having a PHN come to visit them as they believed their mothering practices might be judged. However, the majority of mothers also spoke about how they felt a sense of relief, or were relaxed after meeting the PHN because she was personable, friendly or cheerful. It was important to most mothers in the study that the PHNs were friendly and easy to talk to.

She made me feel a lot more secure. And because I knew that if I was doing something wrong, she wouldn't yell at me. She would actually take the time to teach me. (Targeted Mother)



Fostering comfortable communication has become an invisible nursing practice, but is considered by nurse educators and practitioners to be foundational to establishing therapeutic and effective relationships and assessments. Being friendly is predominantly seen to be a 'soft' skill and has historically been associated with women's work that has been devalued. The PHNs and mothers in this study challenged this oppressive stereotype as they made evident how important and powerful 'soft' and friendly communication was to creating positive health outcomes such as building confidence.

Strengths Based Relationships

The majority of PHNs in both home-visiting programs described employing a strength-based approach to care, choosing to avoid negative criticisms of a mother and instead focus on positives and "building up" the mothers' confidence. This was an essential aspect of their practice and PHNs understood its importance for relationship development.

[...] the positive reinforcement I'm very big on [...] 'you're doing a good job on this' and focusing on building capacity instead of just focusing on anything negative. (Targeted & Universal PHN)

The majority of mothers discussed the importance of the notion of strength-based practice. They repeatedly identified never being told that they were doing things wrong and instead were continuously praised and positively supported.

I know she was very supportive and she used very positive words all the time. There was never any talking down. (Targeted Mother)

It was very reassuring, very much positive reinforcement. Like 'you're doing a great job.' (Universal Mother)

Conclusion

The majority of PHNs in this study gave examples of how they challenged the dominant medical discourse that situated patients as passive knowledge receivers rather than active health care participants. PHNs chose to shift the dominant hierarchical relationship to ensure mothers felt comfortable and open to developing a relationship with a PHN – this was done through the forming of relationships. The repeated mention of relationship development and the impact that relationship development had on the mothers home visiting experience highlights the importance of this aspect of postpartum care. Mothers and PHNs also challenged the negative perception of 'soft' skills by telling us over and over again how therapeutically important it is to be kind, genuine, friendly and nice.

I don't have family here, I needed somebody that I can call and I can trust and feel comfortable asking her anything [...] and I do with her now. (Targeted Mother)

FINDINGS

Health Outcomes Defined by Mothers and PHNs

Mothers from both home visiting programs described similar health outcomes associated with their home visit. These included outcomes such as confidence, reduced stress, increased self-esteem, feeling normal and reassurance.

It made me feel much more confident. It made me feel more secure. It made me feel that I didn't have to worry as much [...] they kind of calmed my mother instincts to the point where I could cope with it [...] (Targeted Mother)

I guess she reassured me that I was doing everything right and, you know, gave sort of that support that I needed. (Universal Mother)

It wasn't any kind of, you know, magical thing that she said or any kind of secret but it was more of a reassurance that it's okay. (Universal Mother)

All of the mothers in the study had some doubts and concerns about how they were taking care of their baby. They wanted to make sure they were "doing it right" and looked to the PHN for reassurance.

Especially because it was my first baby [...] just if somebody could come and reassure me that yes, I'm doing something right. (Universal Mother)

PHNs were aware of the tumultuous transitional feelings that new mothers often experienced and felt that providing reassurance was central to attain positive health outcomes.

[...] if a nurse is able to get in there and instill confidence in a mom in those first 3 and 4 and 5 days, it can make all the difference in the world [...] (Universal PHN)

Transitioning into the role of motherhood can be a time of challenge, excitement, joy and fear. Mothers may feel bombarded with information from multiple sources and overwhelmed by their new role. Therefore, it was important that PHNs not only provided information to mothers, but they also needed to address and be supportive of the unique needs of each mother depending on where she was at in her journey.

We're so by ourselves. Families are at the other end of the country or they're working, not able to support moms. So it's the support that she needs. And it's to get good support early and get her feedings, good quality feedings, and get things into a pattern of confidence. (Universal PHN)

There's resources out there that I would have never known without these home visits. So it's very reassuring. (Targeted Mother)

Overwhelmingly, both PHNs and mothers in both programs prioritized health outcomes such as confidence, reduced stress and self-esteem over other health outcomes. While specific issues such as breastfeeding, bottle feeding, bathing, cord care, etc. were cited by mothers to be of importance to discuss with a PHN during the home visit, they primarily spoke about their need to first feel confident and reassured so that they could effectively take care of their baby.

Breastfeeding Support

PHNs identified breastfeeding support as being a central reason for many of their home visits although prioritization of breastfeeding did shift within groups at times.

[...] the challenges of breastfeeding is usually the number one reason why I'm there [...] so that she can actually continue on that duration of breastfeeding without saying, 'You know what, this is too painful and I'm giving up. I'm just going to do what the media says. I'm going to give the bottle and be done.' (Universal PHN)

Several mothers described receiving breastfeeding support from their PHN during the home visit. Many identified that this support enabled them to continue to breastfeed.

[...] the nurse was really helpful in showing me different positions and latches, and kind of teaching me how to calm down while I was doing it so that he would calm down. And that was really helpful because otherwise I'd be bottle feeding him. (Universal Mother)

PHNs did identify a difference in how the mothers prioritized their health needs. For example when mothers were experiencing low-income, food insecurity, or mental health issues they often shifted focus from breastfeeding to more imminent concerns such as housing, finances or food.

[...] if you asked them what the Public Health Nurse did for me, they're probably not going to say anything. Because what these people are all looking for is shelter, they're looking for money, they're looking for food. (Targeted PHN)

So for EHV [Enhanced targeted], what I find, you don't normally get to see them the same day or even the next day. You might not get to see them until the next week because, 'Yeah, I'm doing okay.' Right? But we do see them. Whereas the Early Team is a little bit different because it tends to be more if they need to be seen, they need to be seen right away [...] because it's breastfeeding. Whereas the reason we are visiting [Enhanced targeted] people, it's not usually for breastfeeding. (Targeted PHN)

Challenging and Redefining Health Outcomes

Identifying health outcomes is an important component of the assessment process when working with mothers individually or from a population focus. Health outcomes that have been associated with new mothers have been developed over a century, however, more recently continue to be institutionally constructed from a predominantly biomedical perspective. While health outcomes such as confidence and self-esteem are cited in

the health literature to be important, they often continue to be prioritized as 'less important' when compared to issues such as breastfeeding, food security and hospital visits. While physical and urgent health needs of mothers and babies must take priority over other health needs that are not life threatening, we must also question the ways in which 'other' health outcomes have been and continue to be perceived and prioritized and how this affects the overall health of mothers and babies. Perhaps a more fluid and non-hierarchical framework would better meet the needs of mothers and allow them to prioritize their needs themselves.

Conclusion

Although PHNs work from a primary health care perspective and much of their practice is focused on prevention, it is also complex and not always easy to evaluate. Therefore, prevention due to confidence becomes invisible and less valued. This social and institutional construction of health outcomes needs to be further assessed, particularly when PHNs and mothers in both programs in this study overwhelmingly prioritized confidence and self esteem as very important. This alerts us to the need to challenge systemic assumptions about health outcomes. We need to ask what health outcomes are important, to whom and in what context. Accepting different interpretations will enable us to better understand what mothers value the most and what they need to ensure they experience positive health for themselves and their babies.



FINDINGS

Targeted vs. Universal: The Great Divide

As the PHNs in the study described their experiences it became evident that a division had been constructed between the targeted and universal programs. PHNs who worked in the 'Early' universal program described situations that made them feel their program was valued less than the 'Enhanced' targeted program.

[...] they're not going to fill the vacancies that are on the Universal Team. So the message that tells me, the Universal Team is not important. Because if it was important, if both teams were equally important, we're going to split the gaps in service to both teams. We're not. We're filling all of the EHV positions. (Universal PHN)

The positioning of the targeted and universal programs as oppositional and in tension was not unique to this public health unit. In fact, this dichotomy has been written about and debated around the world for many years. At the time of the study, this particular health unit was one of few in Canada that continued to incorporate both programs. PHNs in both programs were clearly aware of the tensions between the two programs and gave examples of how they challenged what they believed were misperceptions about the universal program. For instance, these PHNs shared examples of mothers in the universal program who experienced many difficulties including isolation and postpartum depression that were also experienced by 'targeted' mothers.

[...]If you've got a mom who is low risk [...] the phenomena of postpartum depression is totally unpredictable. So she might have had some component of postpartum depression in her first and second, after those deliveries. But after the third, she could possibly just bottom right out. (Targeted PHN)

PHNs were concerned that mothers considered to be 'universal' would fall through the cracks and not have access to health promotion and illness prevention interventions unique to home visits.

There's a lot of anxiety with the clients that I work with in the Early Team [...] I think they put a lot of expectations on themselves to know everything and to be perfect moms and do all that kind of stuff. (Targeted & Universal PHN)

PHNs in the 'Early' universal program described feeling unsupported and devalued at times. This was further exacerbated when they believed the universal program might be cut.

[...] it's just frustrating because first of all to be told that your work doesn't have a lot of meaning is a big blow within the Early Team. (Targeted & Universal PHN)

[...] there's comments made that 'many of these individuals in the Universal program have access to resources. So they are going to find the resources whether you go out and do your initial visit or not. They're resourceful people. They have the income. They'll search the internet. They'll travel to where they need to travel to get whatever services they happen to need.' So personally that makes me feel devalued. (Universal PHN)

However, some PHNs who worked in the 'Enhanced' targeted program agreed that more focus should be given to their program because mothers in the 'Early' universal program would be able to find support elsewhere on their own.

We've seen that the Enhanced Home Visiting Program is [...] it's where we need to focus our efforts for those people in the community who really need that extra support [...] there will be more of an emphasis put on this program, with cutbacks and everything. (Targeted PHN)

I think it [targeted program] is finally being seen as a priority [...] and I'm not to take away from breastfeeding. I value breastfeeding. I really do. But when you look at a young mom who hasn't had a great life and now she has this baby, this is the opportunity to break that cycle. (Targeted PHN)

These diverse beliefs and discussions about the programs created an institutional divide between the two home visiting programs. PHNs in the 'Early' universal program believed and felt that their practice and the services they provided to the mothers in their program was highly effective and led to positive health outcomes as seen in the previous Health Outcomes section. However, many PHNs said they believed their work was often 'invisible' to managers and other nurses because their work focused



more on preventing poor health outcomes and therefore was not as easy to measure. Ultimately these health outcomes were less visible.

Well, to me, it's that whole dichotomy between the Early Visiting piece and looking at the determinants of health and community development. Why can't they be moved somehow together? [...] They're being put at odds. (Universal PHN)

Assessing Risk and Health Needs

To determine a mother's eligibility for participating in either of the home visiting programs, the Parkyn Screening Tool was used to assess a mother's risk for poor health outcomes.

So if you've scored technically a 9 or above on our screening tool, for the majority of the situations you would come to the Enhanced Home Visiting Program. Less than that then you're seen as having the supports and the abilities to manage a little easier or a little bit better. So in that case, you would go to the Early Home Visiting Program. (Targeted PHN)

Many of the PHNs in this study had concerns about the use of a screening tool. They questioned whether this tool was able to gather all of the information required to correctly identify a mother's level of need.

You may be university educated, you may have a very well support system, you may have everything else going well for you but because you have a history of anxiety from when you were a child and you smoke then that may give you a 9 on our screening tool. So our screening tool is not ideal. (Targeted PHN)

The PHNs discussed their reservations using the screening tool because they believed it could not capture many important nuances about a mother's situation that could only be identified with a thorough assessment conducted by a PHN. Because the screening was conducted in the hospital and was outside of a mother's home and therefore 'out of context' PHNs were concerned that certain issues were being missed.

[...]it's only a snapshot so it's not ideal because you're not in the home. (Targeted PHN)

In other words, while the screening tool did capture some important issues, a home visit enabled PHNs to conduct more extensive and in-depth assessments. Home visits also offered the opportunity for mothers and PHNs to develop trusting relationships that could then lead to a more genuine and comprehensive assessment where mothers might feel more comfortable to share more information that they did not feel comfortable sharing in the initial screening process with a PHN in the hospital.

Many PHNs spoke about how they included assessments beyond the screening tool to make decisions to recommend or not recommend either program. One nurse used the term "flip" whereby she would shift a mother to the other program if the score was borderline for either program.

[...] sometimes that client may go to the Early Home Visiting nurse and then at that point in time, if the nurse goes in, that nurse can reassess and can always flip that client back to us if need be. (Targeted PHN)

The following examples provide scenarios in which a mother who screened in on paper as high risk with a score of 9 or above may be shifted to the universal program because of a more wholistic needs assessment completed by a PHN in the home.

So that mom would get a 9 because she smokes outside and because she has a previous history of a depression or anxiety but things are going okay now. Then that nurse may write Early Team. (Targeted PHN)

[...] even though mom had a high score, she may go in for Early Home Visiting because we hear that she has lots of supports and things around her. (Universal PHN)

There appeared to be some confusion about how mothers were being identified as either at risk or lower risk.

[...] we're having this struggle between what people are perceiving as an EHV [enhanced targeted] client and what's listed on the tool as being a client. So if you are a middle class woman who has a premature baby who was probably going to have developmental delays or something like that [...] the people in EHV, I find, will look and go, 'She doesn't need us. She's not good for the program. We want all the low income, low educated moms that are on Social Assistance.' And I go, 'but part of her struggle is going to be how do I access resources and how do I get some support around that, and being able to just have someone to talk to?' And so we don't always see eye to eye on what's EHV. It's kind of morphed into something that it never was intended only to be. (Universal PHN)

This last quotation highlights how the socially constructed category of 'mothers on social assistance' who are considered to be 'at risk' influenced PHNs' understandings of the two programs. Many PHNs and managers believed that all new mothers in both programs were vulnerable in some respect and needed support. However, there were differing opinions about how to prioritize vulnerabilities within the 'Early' universal program particularly in relation to the 'Enhanced' targeted program. This confusion was primarily associated with a lack of information or stereotypes about certain groups of mothers. No one disputed the need for mothers in the targeted program to receive home visits. However, PHNs in the universal program felt they needed to give examples of why mothers in the universal program also needed home visits. They understood that these mothers had been positioned as 'other' and therefore fought to support and advocate for their health care needs.

We as Public Health and nursing and a society could say she'll be fine. [...] she's got a university degree, the husband owns his own business, they've got a big beautiful home, it's her third baby. You may even think that when going home from the hospital, she may not even need any support in any way [...] She could still experience postpartum depression [...] I don't think we should ever for a moment look at a picture and think that 'okay, I've got this figured out.' (Targeted PHN)

All PHNs and managers agreed that there were different levels of risk and all mothers experienced some form of vulnerability. However, vulnerability was understood and interpreted in different ways. PHNs did not use the term 'at risk' or vulnerable very often. The term 'health need' was used more often which signified an interesting challenge to the use of the negative term 'risk'. PHNs predominantly chose to use the term 'health need' as a way to shift the focus to be more strength-based rather than deficient.

These challenges to using different terms not only signified how tensions and divisions have been constructed between the two programs and groups of mothers, these moments of tension also give us valuable information and the opportunity to critically discuss the issues of health risks and health needs as they pertain to different groups of mothers.

Challenging Stereotypes and Reducing Judgments

The majority of PHNs expressed concern that mothers would feel judged during their home visit and acknowledged a need for being non-judgmental in their practice.

I always make sure that I tell them, you know, we're here to support you, we're not here to judge you, and that kind of stuff. (Targeted & Universal PHN)

Mothers from both programs often described an initial fear of feeling judged about their parenting abilities prior to their home visit. Mothers in the 'Enhanced' targeted program were more likely to articulate judgements associated with having their child taken away while those in the 'Early' universal program spoke about judgements associated with providing incorrect baby care or not having a clean house.

Here I am with this little baby just afraid that somebody outside is going to recognize that I'm struggling and they're just going to take my baby. (Targeted Mother)

What if she thinks that I'm a horrible mom or doing things completely wrong, those kind of feelings too. (Universal Mother)

PHNs also described how some of the mothers who were identified and ultimately labeled as poor and single, felt judged by other mothers who had higher incomes, were financially secure, and were married.

Often at drop-ins, I'm overhearing conversations about the best cloth diapers, the best blended baby foods, the best things to buy for your baby, where you can get the best nursing tops. My clients feel like outsiders in those environments. (Targeted PHN)

The 'Enhanced' targeted program was developed to support mothers at risk such as women experiencing low income or low education. The historical, social and institutional construction of mothers into these risk categories leads to labels and stereotypes that ultimately position them as "less than" through relations of power. Using categories of social determinants of health and creating targeted groups can also have the inadvertent effect of perpetuating negative stereotypes.

[...] the resource centres are geared towards the folks who would be in the Enhanced Home Visiting Program [...] and the folks that sometimes need those services as well are not going because of the stigma or the identifying themselves as having to need a resource centre for support. (Universal PHN)

The majority of PHNs indicated that they were aware of how certain groups of mothers were negatively stereotyped and judged. They gave many examples of how they purposefully worked with mothers to ensure they did not feel judged.

So the more you know about the culture and why they do the things you do. I know that my way is only my way. It's not the only way. (Targeted PHN)

Mothers from both programs also described how PHNs they met effectively eliminated their fears of being judged. This was accomplished through positive, friendly and strength-based practices.

I know that feeling when someone, I guess, in a position is more knowledgeable than you and they do make you feel like you don't know what you're doing. But she didn't make me feel like that. (Universal Mother)

Our place was kind of a mess at the time because we had just got home and didn't have time to, or energy, to really clean up or whatever. And she said, 'You know what, it doesn't bother me that your place is a mess [...] it looks like it's all about the baby here and nothing else.' Which it basically is. It's all about him. He runs the show. (Universal Mother)

Conclusion

The practice of dividing targeted and universal postnatal programming is not unique to Canada and is discussed and debated throughout the world. We suggest that this division between programming has many unintentional side effects that ultimately lead to barriers and obstacles for the individuals who access the services and the PHNs who provide the services. By creating two streams of programming and prioritizing one of those streams a dichotomy is created and a power relation is established. It is this institutional power relation that was described by both PHNs and Mothers in the present study. PHNs from the universal program described feeling as though their practice was often invisible and underappreciated because it was not the priority program and mothers described their anticipation of being judged by other mothers and PHNs based on their programming stream.



Final Outcomes and Recommendations

The present research study allowed us to see both challenges and successes associated with the postpartum home visiting program in Nova Scotia. PHNs described their purposeful practice of challenging a mother's feeling of judgment by communicating and interacting in a certain way and mothers described anticipating judgment but overcoming this through relationship development and trust.

We saw the types of health outcomes that mothers and PHNs valued and prioritized such as confidence, reassurance and reduced stress and how PHNs supported mothers to attain these health outcomes. The belief in the importance of these health outcomes were consistently voiced among all PHNs and all mothers regardless of their individual programming stream, however some differences between the targeted and universal programming were described.

PHNs expressed their concern with the use of the Parkyn screening tool and highlighted the need for comprehensive assessments to take place in the home in order to gather a true understanding of the mothers' needs. All PHNs and managers agreed that there were different levels of risk and that all new mothers experienced some level of vulnerability.

Recommendations

- 1) Healthcare professionals need to recognize the invisibility and stereotyping of motherhood.
- 2) Healthcare professionals need to recognize the invisibility and stereotyping of public health nursing.
- 3) Organizational practices that perpetuate judgment need to be eliminated. Healthcare professionals and society need to understand that new mothers often anticipate judgment from others and healthcare practices need to be tailored to eliminate this feeling of judgement. Building foundational positive relationships can eliminate this judgment and create an atmosphere where trust and respect are engendered. In such situations healthcare professionals can conduct needs based assessments collaboratively with new mothers.
- 4) Home visits provide the best environment to conduct a thorough and accurate needs based assessments.
- 5) Health outcomes should be prioritized from mothers' perspectives (both individually and collectively) rather than prioritized through a dominant institutional perspective.
- 6) The impact of organizational divisions that categorize women into either targeted or universal programming needs to be acknowledged, explored and further questioned with an emphasis on examining its' societal implications for new mothers using the lens of relations of power.
- 7) The restrictive nature and limitations of self-report using instruments such as the Parkyn screening tool need to be recognized and ideally only used in conjunction with a holistic home visiting assessment.

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