



Reducing the Impact

working with pregnant
women who live in
difficult life situations



BEST START: ONTARIO'S MATERNAL, NEWBORN AND
EARLY CHILD DEVELOPMENT RESOURCE CENTRE
c/o OPC
180 DUNDAS STREET WEST, SUITE 1900
TORONTO, ON, M5G 1Z8
Phone: 1-416-408-2249 or 1-800-397-9567 **Fax:** 1-416-408-2122
Email: beststart@beststart.org www.beststart.org

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RESOURCE DEVELOPMENT:

Dennise Albrecht, Children's Hospital of Eastern Ontario
Wendy Burgoyne, Best Start
Pam Carr, Healthy Babies, Healthy Children, Kingston
Wendy Christopher, Better Beginnings Better Futures
Suzanne Davidson-Noel, Canada Prenatal Nutrition Program, Nipissing
Kelli Dilworth, Canadian Institute of Child Health
Betty Ann Horbul, Canada Prenatal Nutrition Program, Cochrane District
Colleen Logue, Nutrition Resource Centre
Nancy MacNider, St Mary's Home
Jennifer Medves, Queens University School of Nursing
Monica Pedzolt, MotherCare
Wendy Reynolds, AWARE
Dianne Rogers, Canadian Institute of Child Health
Shawna Scale, Healthy Beginnings, Healthy Babies
Marci Swazey, AWARE
Julie Voorneveld, Canada Prenatal Nutrition Program, Health Canada
Judy Watson, Canada Prenatal Nutrition Program, Health Canada
Barb Willet, Best Start
Margaret Zubert, Health Canada

KEY INFORMANTS:

Cheryl Booth, Brighter Futures, Port Colborne
Jennifer Corbiere, Aboriginal Children's Programs, Health Canada
Katie Dilworth, Canada Prenatal Nutrition Program, Toronto
Sue Hubay, Babies First, Peterborough
Wendy Kelen, North Kingston Community Health Centre
Joanne King, Killaloe Community Resource Centre
Margaret Leslie, Breaking the Cycle
Louise Picard, Sudbury and District Health Unit
Cindy Scythes, York Region Health Services
Diane Shrott, Healthiest Babies Possible, Toronto
Rebecca Sutherns, University of Guelph

FOCUS GROUP PARTICIPANTS:

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introduction



“Poor conditions lead to poorer health. An unhealthy material environment and unhealthy behaviour have direct harmful effects, but the worries and insecurities of daily life and the lack of supportive environments also have an influence.” (Wilkinson & Marmot, 1998)

The impact of low socio-economic status on infant and maternal health is well documented, both in the research and in anecdotal reports from service providers. Low socio-economic status is associated with low birth weight and other complications prior to and following delivery. The use of hospital days for the treatment of pregnancy-related complications is nearly four times greater for women in the lowest versus women in the highest income group (Mustard et al, 1995). However, the ramifications for pregnant women and their children who live in poverty extend beyond birth weight issues and include a range of health concerns, in addition to social and psychological impacts.

Many programs have been developed across Ontario to support pregnant women and their children. Most were specifically designed to address the needs of women with low socio-economic status. The results of these innovative interventions have been impressive. National and provincial evaluations have shown significant improvements in maternal and newborn health for program participants. However, the rates of poverty are still high and the depth of poverty, in particular for women of childbearing age, is alarming.

SOCIO-ECONOMIC STATUS AND THE DETERMINANTS OF HEALTH

A person's socio-economic status is usually defined by their income, level of education, and occupation. Socio-economic status is clearly a determinant of health. Research shows that people with higher levels of education and income generally have better states of health than those with low income and less education (Mustard et al, 1995). In addition to income and education, the term socio-economic status can include issues related to housing, cultural background and material possessions. It also includes the perception of having a meaningful role in social life, which those of low socio-economic status may struggle to achieve in the eyes of the community. Pregnant women of low socio-economic status are likely to be negatively affected by social and other determinants of health. It is incumbent upon service providers to understand the complexity of socio-economic status. Living with low socio-economic status is difficult. Receiving inappropriate consideration worsens the situation.

Pregnant women of low socio-economic status are a varied group with a range of abilities and challenges. Some populations of particular interest and concern are:

- pregnant teens
- women living in poverty
- women living in rural areas
- new immigrants
- women with low levels of literacy
- the working poor
- unemployed women
- single parents
- women with little social support
- women living in violent situations
- women struggling with substance use
- homeless women
- women in poor housing conditions

To reach and support this wide range of audiences, many different strategies must be used. Great care needs to be taken to ensure that programs and service providers are respectful, inclusive and welcoming.

A woman's health goes well beyond her individual "lifestyle choices". The determinants of health include the entire range of individual and collective factors and their interactions that affect people's health. These factors include income and social status, social support networks, education, employment and working conditions, social environments, physical environment, personal health practices and coping skills, healthy child development, culture, health services, gender, biological and genetic endowment (Health Canada, 1999).

The World Health Organization (Wilkinson & Marmot, 1998) expands the determinants of health to

include the impact of economic and social policies on health. Social and economic conditions may be even more important to health, than access to medical care. The World Health Organization looks at ten different, but interrelated aspects of the determinants of health, including:

- the need for policies to prevent people from falling into long-term disadvantage
- how the social and psychological environment affects health
- the importance of ensuring a good environment in early childhood
- the impact of work on health
- the problems of unemployment and job insecurity
- the role of friendship and social support
- the dangers of social isolation
- the effects of alcohol and other drugs
- the need to ensure access to supplies of healthy food for everyone
- the need for healthier transport systems

IMPACTS OF LOW SOCIO-ECONOMIC STATUS FOR PREGNANT WOMEN

Pregnant women who live in poverty are as varied as any other group of people. Many are on social assistance. Some are the “working poor” while others are homeless and without income whatsoever. They may be happily married, living in an abusive situation or raising a family on their own. Similarly, low education is linked to poverty but not all pregnant women living in poverty have lower education. In fact, many have higher education but find themselves, through a variety of life events, living in financially distressed circumstances.

Unfortunately, once a woman finds herself in a situation of poverty, regardless of other conditions that determine socio-economic status, she may find it very difficult to emerge. Irrespective of education level or previous job experience, women are likely to find moving out of poverty, off social assistance, or out of badly paid jobs to be challenging, perhaps overwhelming. Public perceptions and impressions of women in these situations can contribute to feelings of worthlessness and can generate resentment towards low-income women.

Service providers can be overwhelmed when confronted by the many issues related to pregnancy and low socio-economic status. Many pregnant women who live in poverty have a complex variety of interconnected concerns. Part of the service provider’s role is to try to minimize the impact of poverty, where possible. This resource manual will provide information and support in a practical, evidence-based fashion to service providers who deal with pregnant women of lower socio-economic status.

Socio-economic status is broader than poverty, however, poverty is linked to most aspects of socio-economic status. Therefore, the impact of poverty on pregnancy, and program strategies for responding to poverty, will be important components of this resource.

HOW TO USE THIS RESOURCE MANUAL

This resource was written with a wide range of service providers in mind. The objective of this manual is to help service providers re-think the ways in which they work with pregnant women of low socio-economic status in order to provide more effective programs and initiatives. The service providers may work in programs that were specifically established to meet the needs of low-income pregnant women or in programs that may have low-income pregnant women as part of their larger participant group. Pregnancy support programs, drop in programs for parents, in-home support services and a range of health care and social service providers will benefit from an increased understanding of the issues and effective strategies related to low socio-economic status. The range of information presented in this manual will be valuable to those with experience working with women of low socio-economic status and those who are not yet aware of the issues and available information. It will assist staff in:

- selection and development of additional programs or services
- evaluating and re-defining existing services
- increasing knowledge and understanding
- training new staff
- reviewing the way individuals work with women
- finding relevant resources

This resource manual contains a variety of information, including current research, strategies and recommendations. Where appropriate, the words of service providers or women living in difficult life circumstances are used to convey a concept. The sections are divided by issue area, according to pertinent determinants of health. Each issue area contains information you can use in a variety of ways, such as staff training, program development, or where to turn for more ideas and information. At the end of the resource you will find best advice and top tips from women and from service providers, a list of relevant resources and services and a glossary.

the research



OVERVIEW OF PREGNANCY AND POVERTY

POINTS TO PONDER

- the number of pregnant women living in poverty in Canada is unknown
 - women in the lowest socio-economic group are four times more likely to have pregnancy related complications that require hospitalization
 - low income pregnant women may not be a special needs group: instead, some research shows they are, in fact, the mainstream maternity population
-

It is difficult to estimate exactly how many pregnant women are living in poverty in Canada. For example, Statistics Canada collects information about income but does not collect specific information about the income of pregnant women. The issue is further complicated by the fact that there are different ways to measure poverty. Despite some controversy over the best method, the most widely used measure of poverty in Canada is the low-income cut-off, also known as LICO. The method used to calculate LICO is quite complex but, generally speaking, LICO marks the level where people have to spend most of their income on food, shelter, and clothing.

Furthermore, there has been little published research on poverty in Ontario since the 21.6% cuts to social services in 1995. Many of the figures in this review are from the period immediately after the social assistance reforms. The data reported may be positively skewed and may not represent the true experiences of

Ontario families living in poverty since the cuts to social assistance. It is also important to remember that the issues of low socio-economic status extend beyond those of poverty. When including all women living in difficult life circumstances, the numbers are higher than numbers of women living in poverty.

In Canada, research has shown that health is affected by socio-economic status. People with the highest levels of education and income generally have better states of health than those with less education and a lower income. The link between socio-economic status is particularly evident during pregnancy. For example, a Manitoba study found that use of hospital days for the treatment of pregnancy-related complications was almost four times greater for women in the lowest income group as compared with women in the highest income group (Mustard et al, 1995). An American study examined the poverty rates among childbearing women. Researchers found that two thirds of all women in their childbearing years had low incomes and almost half (46%) were poor. In many communities, low-income women are the mainstream maternity population, not a small 'special needs' group (Braveman et al, 1999).

POVERTY RATES IN CANADA

POINTS TO PONDER

- fewer Canadians live in poverty than 10 years ago, but the depth of poverty has increased
 - women are more likely than men to live in poverty
 - single mothers with young children have the highest rate of poverty
 - young single mothers have the greatest depth of poverty
-

In 1998 it was reported that 16.4% of Canadians lived in poverty. A harsher reality is that most people living in poverty live thousands of dollars below the poverty line. The number of people at less than 50% of the poverty line has grown dramatically in recent years from 143,000 Canadian families in 1989 to 233,000 in 1998 (National Council of Welfare, 2000).

Even though the poverty rate was at a near low in Canada in 1998, women in prime child bearing years are at great risk of living in poverty. Those between 18 and 24 years of age have a poverty rate of 24.9% and women between 25 and 34 years of age have a poverty rate of 18.5% (National Council of Welfare, 2000).

Overall, single mothers and their children fare the worst. The National Council on Welfare's Poverty Profile 1998 indicates that family type is the most important indicator of the risk of poverty (National Council on Welfare, 2000). Overall, single mothers with children under 18 have the highest poverty rate. More than half (54.2%) of families headed by single parent mothers live in poverty. However, age is also a factor. The Profile

notes that the poverty rate for families led by a single mother less than 25 years of age was an “abysmal” 85.4%. Translated to numbers, this means that, in Canada in 1998, 83,000 single mothers were living at less than 50% of the poverty line. In fact, overall, single mothers with children under 18 have the largest depth of poverty. On average, they lived \$9,230 below the poverty line in 1998 (National Council of Welfare, 2000).

Generally, the risk of poverty decreases with increasing education. The poverty rate for families led by single mothers with less than high school education was 74.7%. The highest rate was seen among those who did not graduate from high school. Single mothers who did graduate had a poverty level of 48.4%. This demonstrates that family type and level of education influence a person’s risk of poverty (National Council of Welfare, 2000).

CONSEQUENCES OF LOW SOCIO-ECONOMIC STATUS FOR PREGNANT WOMEN

POINTS TO PONDER

- there have been improvements in the past 20 years: however, low socio-economic status still negatively affects pre-natal, newborn and maternal health, despite universal health care
 - there are many factors that contribute to poor birth outcomes (such as discrimination, lack of food security, stress, violence, lack of support, alcohol and drug use) that, when combined with low socio-economic status increase the risks for the infant and mother
-

The risks are high for pregnant women living in poverty. Socio-cultural factors such as poverty and social deprivation are as important as biological and nutritional factors during pregnancy. All must be addressed to promote healthy birth weights (Gama et al, 2001). Despite universal health care, socio-economic status remains a primary determinant of prenatal health. In 1991, the infant mortality rate of those in the lowest income groups was 1.6 times greater than that of the highest income groups (Health Canada, 2000a).

The risks increase with other demographic factors, such as culture and geographic isolation. Infant mortality among First Nations, Metis, and Inuit populations is about double that of the Canadian average. Infant mortality rates among the Inuit in the Northwest Territories are about 2.5 times higher than national rates (Health Canada, 2000a).

Many circumstances leading to poor birth outcomes are connected to poverty and low socio-economic status. The risk factors for low birth weight include smoking, alcohol and drug use, poor nutrition, age, stress, violence and lack of support. All of these risk factors are more prevalent among pregnant women living challenging lives. When exploring solutions, strategies must address the larger context of the community, instead of merely addressing each risk factor on an individual basis as a ‘lifestyle’ factor (Marquis & Butler, 2001).

PRENATAL CARE

POINTS TO PONDER

- low income pregnant women who have other distressed life circumstances are least likely to enter prenatal care
 - most of these women, however, are aware of the benefits of prenatal care but many barriers exist that lead to late or no entry to care
 - distressed life circumstances (including poor housing conditions, substance use, high stress levels, lack of social support, mistrust of professionals and lack of childcare and transportation) may prevent women from entering prenatal care
-

An important predictor of healthy pregnancy and positive birth outcomes is the provision of and attendance at prenatal care, or regular education, medical assessment and intervention during pregnancy. While the majority of women seek prenatal care in the first trimester of pregnancy, those most likely to live in poverty do not. Teenagers, single women, smokers and women who use alcohol and other drugs generally seek care later in pregnancy and attend for fewer visits (Marquis & Butler, 2001). There are interconnections between pregnancy, poverty, distressed life circumstances and poor pregnancy outcomes. For example, one study reported that 15% of pregnant women entered prenatal care late and that the strongest determinant of late entry was living in a distressed urban neighbourhood (Perloff and Jaffee, 1999).

Women living in poverty describe both personal and structural reasons for not obtaining early prenatal care. Personal problems are often considered to be the biggest barriers to care and drug use is one of the most common personal reasons cited. A number of structural barriers also need to be addressed. Barriers to prenatal care have been linked to decreased use of services and poor health outcomes of mothers and infants (Omar et al, 1998). Although structural barriers to prenatal care have been identified and extensively studied, these barriers continue to persist, despite new approaches and programs (York et al, 1999).

The range of individual issues and structural barriers that may prevent early and regular attendance for prenatal care include:

- living in poor housing conditions
- using alcohol and other drugs
- smoking
- elevated stress levels
- lack of transportation
- difficulty scheduling an appointment
- long waiting time
- program restrictions such as mandatory attendance, geographic boundaries, and number of weeks pregnant
- discomfort with health care professionals and institutions

- having too many other problems
- language and or cultural barriers
- exhaustion and fatigue
- fear of medical examination
- the belief that prenatal care is not necessary
- the belief that they already know how to have a healthy pregnancy
- lack of childcare
- poor support systems
- domestic violence
- isolation
- not knowing where to go
- not wanting anyone to know about the pregnancy (Pagnini & Ruchman, 2000; Sable & Wilkinson, 1999; Mikhail, 1999; Cook et al, 1999; York et al, 1999; Gazmararian et al, 1999).

Even when no barriers are identified, women may still receive less than adequate prenatal care. Service providers may believe that pregnant women do not access prenatal care consistently because the women do not value prenatal care. Instead, pregnant women say they do not have adequate information about availability and eligibility for services. Service providers must ensure that they are aware of actual issues effecting women's ability to access prenatal care (Omar et al, 1998).

Women who planned their pregnancies are most likely to enter prenatal care early as opposed to women with an unplanned or unexpected pregnancy. The overall "intended-ness" of a pregnancy has a great impact on when the pregnant woman seeks prenatal care (Pagnini & Ruchman, 2000).

Pregnant women living in poverty have many problems, which also reduce the likelihood that they will be able to access prenatal care. Women who receive inadequate prenatal care are more likely to say that they almost always felt stress during pregnancy. Intervention for stress reduction for pregnant women may lead to improved prenatal care (Sable & Wilkinson, 1999).

Living in a rural area can also be an issue and a barrier. Access to adequate health care is a problem not only because of greater distances but also due to economic, social and cultural factors (Watt, 1999). Other barriers include weather, isolation (no public transportation, distance between neighbours, lack of social supports), cost of travel (gas, only one car per family) and lack of confidentiality. Rural women are confronted with additional systemic barriers to prenatal care. The barriers include high poverty rates, health care provider shortages, and a health care system unresponsive to the needs of poor women (Pistella et al, 1999).

Minority and immigrant women who are pregnant and living in poverty encounter additional barriers. Often, women are unaware of existing health programs and services. Even when women are aware of prenatal services, other barriers exist. Lack of trust of service providers, severe isolation, lack of understanding of the health care

system, and language or cultural barriers can prevent meaningful interchanges and effective service delivery. In fact, one study reports that many immigrant women who are pregnant are marginalized due to cultural, linguistic and economic barriers. The same study goes on to report that there are “tragic” stories of unsatisfactory and discriminatory treatment by health and social service providers, uninformed consent, and misunderstood instruction and health information (Chiu, 1996).

Despite knowing the importance of prenatal care and having access to affordable care, many low-income women still did not participate in prenatal services. The gap between attitudes about prenatal care and participation in prenatal care indicates that both system and personal factors must be addressed to ensure that pregnant women with lower socio-economic status receive adequate prenatal care (Gazmararian et al, 1999).

STRESS AND LACK OF SOCIAL SUPPORT

POINTS TO PONDER

- the conditions that prevent access to prenatal care also predict high levels of stress and lack of social support
 - half of all pregnant women say their lives are moderately or extremely stressful
 - those whose lives are extremely stressful are more likely to be young and single, have low socio-economic status and low social support and to smoke heavily
 - they are also more likely to move frequently and are less likely to access available services
-

Stress, lack of social support, poverty and pregnancy are closely linked. The factors that predict negative birth outcomes and poor access to prenatal care also predict high levels of stress and lack of social support. Lack of emotional support accompanied by higher levels of social isolation negatively impact on a pregnant woman’s health and well being. There is also a link between stress and impaired fetal growth and preterm birth. Almost one in ten pregnant women report high stress levels and another 40% rate their life as moderately stressful. Pregnant women who experience high levels of stress are more likely to be less than 20 years old, single, have less than Grade 11 education, have a low income, receive low social support and to smoke heavily (Best Start, 1998; Marquis & Butler, 2001).

Another source of stress can be high levels of mobility. Forty-two percent of pregnant teens in one study had moved at least once between the first and second interviews, a period of a few weeks. High mobility creates and contributes to elevated levels of personal stress and to increased financial concerns (van de Sande, 1999). It is common for teen mothers to have little or no support from the father (van de Sande, 1999). Adult pregnant women living in poverty also have lower levels of social support. Lack of support makes it more difficult for pregnant women to access services and to improve their health. For example, Motherisk, a

program sponsored by the Hospital for Sick Children in Toronto, offers free information and advice about substance use during pregnancy. They acknowledge that the pregnant women who use their services are unlikely to be representative of all pregnant women who drink. Women who do not have easy access to a telephone, such as women living in isolation, in poverty, or who are homeless, are much less likely to contact Motherisk (Health Canada, 2001).

Effective intervention approaches can enhance social support for pregnant women living in poverty. Several research studies have shown the many ways that social support can reduce stress during pregnancy, including enhancing feelings of well being and reducing unhealthy behaviours such as smoking and alcohol use. Furthermore, the research indicates that single mothers, teen mothers and pregnant women living in poverty are at elevated risk for reduced social support and will require more intensive interventions (Weber, 1999).

ABUSE AND VIOLENCE

POINTS TO PONDER

- violence often starts during pregnancy
 - the frequency and severity of domestic violence often increases during pregnancy
 - pregnant women who live with the threat of violence are more likely to be depressed, to use substances and are less likely to eat well
-

Abuse and violence during pregnancy are not uncommon, although it is difficult to determine the extent of the problem. For example, the Society of Obstetricians and Gynaecologists of Canada estimates that 4 to 17% of pregnant women experience violence. These percentages may be low, as many pregnant women do not report abuse. For many women, pregnancy creates a state of vulnerability. Of women who are physically abused, many report that the abuse began during pregnancy. The frequency and severity of abuse often increases during pregnancy (Marquis & Butler, 2001). Young women are most at risk for abuse in pregnancy and often have few supports.

Violence during pregnancy puts the fetus at risk, with risks ranging from preterm birth to low birth weight to physical injury (Marquis & Butler, 2001). Violence is often targeted to specific areas of the body, including the breasts, genitals and the abdomen.

Again, the factors leading to negative birth outcomes are intertwined. Depression and suicidal thoughts are common in women who live in abusive situations. Women with histories of sexual and physical violence have significantly higher levels of general distress and anxiety (Martin et al, 1998). These women are also more likely to use substances (including alcohol, tobacco and other drugs) and less likely to eat well. More

than 40% of women enrolled in a combined prenatal care/substance use treatment program had been victims of both sexual and physical violence and one third had been victims of physical violence (Martin et al, 1998). There is also a connection between violence and rapid repeat pregnancy.

There is a need for extensive screening for the occurrence of violence among pregnant women in addition to the need for follow-up safety planning and support in combination with pregnancy prevention interventions (Jacoby et al, 1999). A woman is most at risk of being killed or seriously injured just before and just after she leaves an abusive situation. This is a very dangerous time for a woman. Care should be taken not to increase the risk for the woman.

Service providers cannot ignore the high incidence of violence and abuse in pregnant women living in poverty. Women who live in violent or abusive situations are at elevated risk of experiencing many of the factors that lead to negative birth outcomes. The situation is complex. Pregnant women who leave abusive situations may enter a situation of increased poverty, risk to personal safety and barriers to prenatal care. Multidisciplinary approaches are most effective when they address the range of factors presented by the pregnant woman experiencing abuse or violence (Health Canada, 2001). Pregnancy is also a window of opportunity for women experiencing violence. During pregnancy women often have increased contact with health care providers and may be more willing to disclose their situation and reach out for help.

DEPRESSION

POINTS TO PONDER

- there are many connections between depression, low social support, substance use, and low socio-economic status
 - the social circumstances that lead to depression are similar to those that lead to other problems, such as substance use
-

There are many interconnected issues related to depression among pregnant women living in difficult life circumstances. Depression during pregnancy is associated with low education, being unmarried and/or unemployed, having poor support from a partner (if present), and being in a second or subsequent pregnancy. Women with good support networks report lower levels of depression, before and after delivery. These women also have babies with healthier birth weights. Conversely, women with low social support report higher levels of depression and are more likely to have low birth weight babies. There are significant physical and psychological benefits to social support, especially for women who are socially disadvantaged (Weber, 1999; Dasilva et al, 1998). Provision of social support during pregnancy may decrease the risk of depression among pregnant women.

Depression and social isolation are also common among pregnant teens. Depression is an important factor in determining health and developmental outcomes of teen mothers and their infants. Higher levels of depression are linked to stressful life events and a lack of social support (Zuckerman et al, 1987).

There has been little research examining prenatal depression and the factors that may predispose many low-income women to elevated levels of depression during pregnancy. The social circumstances that lead to depression are similar, if not identical, to those that lead to other problems, such as the overuse of alcohol, tobacco and other drugs. Service providers must be prepared to deal with many interconnected concerns related to depression.

TOBACCO USE

POINTS TO PONDER

- although smoking rates have decreased in the general population, rates have increased among women who live in poverty
 - smoking is most common in women who have other risk factors for negative birth outcomes
 - if a pregnant woman can't quit smoking, reducing the amount she smokes will help improve the infant's birth weight
 - telling women to quit smoking isn't enough
 - pregnant women need advice about how to quit or reduce smoking
 - stages of change based interventions work well with pregnant smokers
-

Overall, Canadian smoking rates for the general population have declined dramatically over the past 25 years. However, in the past decade, there has been an increase in smoking among women, teenagers, and adults living in poverty. About 28% of Canadian women smoke; however, the Canada Prenatal Nutrition Program indicates that 45% of participants smoke during pregnancy (Canada Prenatal Nutrition Program, 2001). In Ontario, a survey of teens indicated that 35% of teens smoke and that rates of tobacco consumption are higher among young women than among young men (Centre for Addiction and Mental Health, 1999).

Smoking rates are high among pregnant women living in poverty, which leads to unfortunate outcomes. The most clearly established risk factor associated with low birth weight is maternal smoking. Maternal smoking increases the risk of preterm birth and small for gestational age babies. Exposure to second hand smoke may cause similar problems (Marquis & Butler, 2001).

The difficulties faced by many pregnant women have enormous impacts on infant health. It is difficult to separate the effects of substance use from the effects of other life circumstances (Health Canada, 2000a). A Canadian study noted that differences in socio-economic status may prove even more important than the tobacco consumption itself (Kramer et al, 2000).

The reasons that women give for smoking are many and varied. Smoking can play an important role in a woman's life, particularly if she is facing many challenges. Women state that smoking helps them cope with stress, depression, fear, anger and frustration and that it is often the one thing that they do for themselves. They say it helps them relax, gives them pleasure and helps them control their weight. In order to help women quit smoking we need to carefully consider the reasons why women smoke and the role that smoking plays in their lives.

While quitting smoking is always preferable, even a decrease in tobacco consumption during pregnancy will improve the infant's birth weight. The earlier in pregnancy the woman is able to reduce or quit smoking, the greater the improvements in birth weight. Most women who stop smoking in pregnancy do so as soon as they find out they are pregnant. This is a "teachable moment", an opportunity when many women are most ready to change smoking behaviour (St. Mary's Home, 1992). Unfortunately, cessation is least likely for those most at risk. Women who continue to smoke during pregnancy are more likely to be teenagers, unmarried and have less education (Marquis & Butler, 2001).

Ways and means, or providing information and supports on quitting smoking, are necessary. Information about the harmful health effects of smoking during pregnancy is usually insufficient to produce change in women living in difficult life circumstances. Women also need information on the process of stopping smoking as well as support and encouragement. Strategies based on the stages of change are effective with this group (Ruggiero et al, 2000).

ALCOHOL AND DRUG USE

POINTS TO PONDER

- alcohol and drug use by pregnant women are not isolated phenomena nor merely "poor lifestyle choices"
 - alcohol and drug use in pregnancy is associated with poverty, with partners who are substance abusers and with domestic violence
 - pregnant women who use substances must feel services offer safety and security, without fear of reprisal for their substance use
 - services must be meaningful and responsive to the complex life circumstances of pregnant women living in difficult life circumstances
-

While alcohol consumption rises with socio-economic status, problem use of alcohol is higher among lower socio-economic groups (Centre for Addiction and Mental Health, 1998; University of Health Network Women's Health Program, 1999). With respect to alcohol and other drugs, the combination of substance use

and poverty is a particular danger to pregnant women. Alcohol and other drug use can lead to preterm delivery, low birth weight, complications during pregnancy as well as brain damage and birth defects in the newborn. Studies of women who have given birth to a child with fetal alcohol syndrome or other alcohol related effects have shown that women who have low levels of literacy, are of minority status, or are living in poverty are over-represented (Health Canada, 2001). Certain groups of women, including Aboriginal women and women on income assistance, are over-represented in addiction treatment programs (Tait, 2000).

Some American surveys have reported that the prevalence of prenatal illicit drug use is about 5% of all pregnant women in the United States, with higher rates for selected subgroups. Illicit substance use is not an isolated phenomenon or a poor lifestyle choice. Substance use is associated with poverty, with partners who are substance users and with domestic violence.

Successful treatment outcomes for women who use alcohol or drugs are associated with length of time in treatment (or retention) and an acknowledgement of the many factors that lead to treatment. Retention is increased when a woman's other needs are addressed and support services (such as childcare, parenting classes and vocational training) are provided (Howell et al, 1999).

Service providers need to address, not only use of drugs and or alcohol, but also the range of issues facing a pregnant substance-using woman. The effects of substance use during pregnancy are well known, including an increase in risk of fetal alcohol syndrome and/or effects, low birth weight and other infant health problems. Women who use substances have an elevated risk for a range of obstetrical complications that may increase perinatal morbidity for the woman and the infant. These women also face other risk factors such as poverty and single motherhood; therefore, service providers must pay attention to the complexity of all risks involved (Bishai and Koren, 1999).

In addressing substance use during pregnancy, there are implications for service provision for women with low socio-economic status. As with tobacco consumption, ways and means, or supports and services are needed. Information on health risks is not enough to meet the needs of most of these women. Lack of knowledge and intention to harm are not the issue; provision of appropriate service is.

“This study found that pregnant women who are at risk of misusing substances do not do so because they are unaware of the public health message, or because they are indifferent to the potential harm to their fetuses. Rather, the contributing factors to substance misuse by pregnant women are complex and varied, and therefore call for services and programs which reflect this reality.... the service needs of pregnant women who struggle with problems of substance misuse will not be fully addressed by any single service or program women reported overwhelmingly that the most valuable asset a service can offer is a supportive and non-judgmental environment ...” (Tait, 2000).

External factors that contribute to substance use, in particular by low-income women, must be addressed:

“Researchers increasingly view smoking and substance abuse not simply as a negative lifestyle choice but as a rational response to real pressures associated with gender and class inequity. Physical, sexual, or emotional abuse and stressful life events such as divorce,... social isolation, family violence, and economic uncertainty ... all lead to higher rates of smoking and substance abuse among women living in poverty”. (University of Health Network Women’s Health Program, 1999)

Pregnant women at risk of using substances must be able to access services with a sense of safety and security. Services must provide care that is meaningful to the women and responsive to the complexity of their circumstances. Regardless of the substance in question, there are multiple interconnected reasons why pregnant women, especially those who live in poverty, will use those substances. Successful outcomes are dependent on the service provider’s recognition of these factors, their ability to respond to them and the attitude with which the response is made. The role of the service provider is critical. The commitment of the service provider to help pregnant women is a key factor in successful outcomes (Zapka et al, 2000; Miller, 1999).

NUTRITION AND FOOD SECURITY

POINTS TO PONDER

- most low-income pregnant women are aware of the need to eat well during pregnancy, but lack the financial resources to follow recommendations
 - access to good affordable food makes more difference to what women eat than education about nutrition
 - for women on fixed incomes, the food budget is often an expendable or “unfixed” item, unlike rent
-

Nutrition information has benefits for pregnant women living in poverty; however, information alone is insufficient. The challenges of food security and the consequences of being unable to obtain adequate nutrition are on going concerns for women living in difficult life circumstances. Pregnant women do not ignore advice to eat well during pregnancy. They are often unable to afford the healthy food they know they should be eating. For pregnant women living in poverty, the food budget is an expendable or “unfixed” item, unlike rent. Often, women living in poverty report that food expenses come last in the monthly budget. One report describes the difficulties some pregnant teens have in achieving appropriate prenatal nutrition:

“The teens generally spoke of eating less junk food, more fruit and vegetables and milk but gave frequent examples of how poverty made it difficult to eat healthy foods. Several complained of not having enough money for food, especially for milk, fresh fruits and vegetables which are more costly... the situation was frequently worse at the end of the month when they were waiting for their next cheque... some were

unsuccessful in accessing nutrition support services that did exist, sometimes through lack of knowledge of services, or in some cases, lack of access... some teens limited their food intake because of insufficient finances” (van de Sande, 1999).

Prenatal vitamins may also be beyond the budget of a woman who is struggling to make ends meet. About one third of the pregnant teens (29%) in one study reported taking prenatal vitamins irregularly throughout their pregnancy. Thirteen percent did not take them at all because the vitamins either caused stomach upset or they were too expensive (van de Sande, 1999).

While food supplements alone may be beneficial to birth weight, a combination of services such as social support, access to food and information, is better than food supplements alone. A World Health Organization report, sums up this issue succinctly:

“...there is solid evidence affirming that friendship, good social relations, and strong supportive networks improve health including pregnancy outcomes; access to good affordable food makes more difference to what people eat than health education; and there is social value in preparing food and eating together.”

(Wilkinson & Marmot, 1998)

TEEN PREGNANCY

POINTS TO PONDER

- pregnant teens who live in poverty experience many of the same distressed life circumstances as their adult counterparts (such as lack of social support, no food or financial security, and elevated stress levels)
 - there is a social tendency to moralize and blame pregnant teens for “irresponsible” behaviour
 - what is needed is a supportive approach that nurtures young mothers and cares adequately for their needs
-

There were 42,161 pregnant teenagers (aged 15 to 19) in Canada in 1997. This is the lowest rate in 10 years (Statistics Canada, 2000). The majority of pregnant teens come from the poorest income groups. Adolescent mothers are at a significantly higher risk of preterm birth and small for gestational age babies (Marquis & Butler, 2001). With early and appropriate supports, teen mothers can have babies that, on average, approach the health status of children of older mothers.

Pregnant teens have a number of concerns in common with other pregnant women living in poverty, plus a few concerns unique to their age group. The basic needs of food, shelter, and safety are often unmet for teen mothers and their children. Teens who report inadequate nutrition are more than twice as likely to have low

birth weight babies than those who report that they eat well (van de Sande, 1999). The range of concerns for pregnant teens includes:

- financial stress
- obtaining adequate nutrition and prenatal vitamins
- access to prenatal care
- safe, affordable housing
- mobility issues
- inability to prepare for the baby
- isolation from peers and communities
- lack of accurate information and helpful supports (Best Start, 1997).

Specific concerns about financial problems were identified and include:

- the importance of support and assistance from family
- inadequate levels of support from social assistance
- the humiliation and frustration of applying for and receiving social assistance
- limitations of social assistance benefits
- strategies for saving money
- lack of support from the biological father of the baby (van de Sande, 1999).

Young women express genuine concern and try to do what is best for the baby, however, 63% of pregnant teens rate their lives as stressful or very stressful. A genuine concern for their baby's health and well being can result in a situation that produces more stress. Some pregnant teens noted that their stress levels were elevated because they worried about the effects of poverty on the fetus (van de Sande, 1999).

Pregnant teens understand the value of prenatal care, however, they are often unable to access care early in the pregnancy and regularly during pregnancy. In one study, 58% reported attending at least one prenatal class. The remainder reported that finances, transportation or time off work were barriers to prenatal care (van de Sande, 1999).

Pregnant teens express desire to continue their education so that they can get jobs to support their family but the barriers (lack of transportation, childcare, social/emotional support and academic inflexibility) are often insurmountable. There is a need for co-ordinated services from many sectors to enable them to stay in school and learn to be effective parents (van de Sande, 1999; Best Start, 1997).

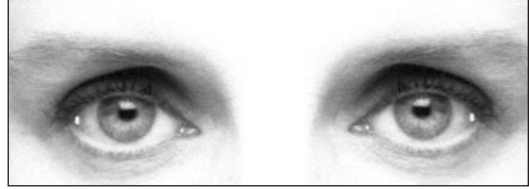
The prevailing blaming attitude towards pregnant teens that focuses on "irresponsible" behaviour and other morality issues, makes the situation worse. A shift in attitudes to a supportive approach that nurtures young mothers and cares adequately for their needs, would help teens who face the challenges of an early pregnancy (Health Canada, 2000b; van de Sande, 1999).

IMPLICATIONS

1. The debate over the issue of poverty continues. Regardless of exact numbers, a significant percentage of Canadians live in poverty and a significant percentage of poor Canadians are pregnant women.
2. Given gender differences and the impact of family type on poverty levels, pregnant women who live in poverty may not be a sub-population of pregnant women, but rather, the “mainstream” pregnancy population. Women in prime childbearing years are women at great risk of living in poverty. The situation has not changed substantially in the last quarter century. In addition, low socio-economic status is a broader category than low income.
3. The reality for many pregnant women living in poverty includes:
 - infant mortality rates 1.6 times higher than their higher income counterparts
 - increased chance of negative mother/infant birth outcomes
 - late or no entry into prenatal care
 - little social and paternal support
 - high stress levels
 - increased chance of domestic violence and abuse
 - higher rates of depression
 - higher rates of tobacco, alcohol and other drug use
 - lack of food security and poor nutrition
4. For many pregnant women with low socio-economic status, there are interconnected factors and complex issue that lead to negative effects on maternal/infant health. One issue cannot be dealt with in isolation from the others.
5. An important predictor of healthy pregnancies and positive birth outcomes is early and adequate prenatal care. However, pregnant women who live in poverty or in other high-risk situations are less likely to engage in early or regular prenatal care. It is important that service providers do not make assumptions about the women’s needs, level of knowledge or the context of their lives.
6. Pregnant women with lower socio-economic status may have high levels of stress and very low social support (including little or no paternal help). High mobility, in particular with the teen population, has also been shown to contribute to elevated stress levels. Maternal/infant health and well being are negatively impacted by lack of emotional support and by high levels of social isolation.
7. Pregnancy creates a state of vulnerability with respect to domestic abuse and violence. The situation is complex and compounded by the reality that danger can increase when women leave an abusive situation. Pregnant women also face increased financial hardship after leaving a relationship.

8. Depression is associated with low socio-economic status and disadvantaged situations. Depressive symptoms can lead to and result from low social support and use of drugs and alcohol.
9. The use of alcohol, tobacco, and other drugs by low-income women during pregnancy, cannot be separated from their distressed life circumstances. It is not a straightforward situation. Distressed life circumstances contribute significantly to the use of alcohol, tobacco, and other drugs. In turn, substance use contributes to distressed life circumstances and negative birth outcomes. Pregnant women who use substances do not intend to cause harm. Most women know that substance use can be harmful. They require the “ways and means” or the tools to implement the information. Factual, non-judgmental information accompanied by appropriate, meaningful implementation strategies will greatly increase the likelihood of reduction or cessation of substance use. The attitude of the service provider is critical to successful outcomes. Service providers must remain caring, non-judgmental and non-threatening in regards to substance use during pregnancy.
10. Delivery of nutrition information to low-income pregnant women is important; however, equally or more important is the issue of food security. Many low-income pregnant women cannot access enough high quality food and therefore cannot realistically implement the nutrition information being delivered to them. Access to good affordable food makes more difference to nutrition than health education.
11. Some pregnant women living in poverty are more at risk than others. Pregnant low-income teens deal with the same issues as adult pregnant women who live in poverty; however, their experience is intensified by moralistic, blaming attitudes and fewer supports.

misconceptions



There are a wide range of values and beliefs about women of lower socio-economic status, and an equally wide range of misconceptions and misleading statements about pregnancy and poverty. Inaccurate facts and unsupportive approaches are not helpful to women who are struggling to meet their basic needs. If you are working with pregnant women, you may need to redirect inappropriate comments or provide accurate information to people who are misinformed about poverty. Here are some common misconceptions about pregnancy and poverty.

Low-income people don't know how to budget.

- In fact, the problem is not mismanagement of money. Most low-income people receive less money than is needed to provide the basic necessities of life.

You don't need money to bond with your child.

- In fact, while families living in poverty may raise happy, healthy children, it is much more difficult to be a positive, supportive parent when you are constantly worrying about money. In general, the children of parents with lower incomes are less healthy than children of parents with higher incomes.

Teens get pregnant so that they will have enough money for their own apartment.

- In fact, most pregnant teens do not intend to get pregnant. Some may be trying to leave a difficult situation at home, but for most teens, the pregnancy is unexpected and not intended.

Supporting pregnant teens condones sexual activity and teen pregnancy.

- In fact, providing supports to pregnant teens helps them raise healthier children. Not only are there compassionate arguments for helping teens during pregnancy, it is also an investment in our future. Increasing supports to pregnant teens and improving access to birth control have not been shown to increase rates of sexual activity or teen pregnancy.

We managed without, they can too.

- In fact, it is much more difficult to manage than it used to be. Extended family and community supports are more scarce and it now takes two incomes for most families to make ends meet.

Spending money on supports takes money away from worthwhile programs.

- In fact, there are many different programs that money can be invested in. Providing supports during pregnancy is one valuable way to invest money in our children and our communities.

People on welfare are too lazy to work.

- In fact, most people on welfare are unable to work or can't find work.

“I worry about money from the time I get up in the morning to the time I go to bed at night.” Program Participant

feedback from pregnant women



There is great value in gathering information from women in your community, before you begin to address the complex issues of low socio-economic status. In order to make a difference, it is important to determine the needs and concerns of women who are facing the challenges on a daily basis. Effective approaches are based on actual needs as defined by the women, not service provider's perception of the issues involved.

To write this resource, many women who lived in poverty during their pregnancies were consulted about their experiences and their thoughts regarding what makes a difference. The women were asked to share their ideas about the kinds of information that should be available to health care and other service providers so that providers can better understand the experience of living in poverty while pregnant. While the women included in this study lived in communities in southern Ontario, their concerns were consistent with the themes of similar studies in other areas of the province.

The pregnant women were a diverse group with varied experiences. Some received social assistance; others were "working poor". Some were teens, others older. Some participants lived in a rural area, while other women lived in an urban setting. A few had supportive family members, but many had no supports at all.

However, in many important aspects, the women had very similar life experiences. All reported problems accessing healthy food during their pregnancies. Lack of transportation was a barrier to service use and to connecting with other supports. The women perceived much of the advice they received from health and other service providers to be unrealistic. They reported few, if any supports from within their family and social networks. They perceived community and structural barriers that limited their ability to access care. They spoke eloquently of their needs, what works for them and what does not.

- *“Don’t lecture me about do’s and don’ts. I already know them. If I could do them, I would. If I’m not, there’s a reason. Usually I try, but when there’s no money, there’s no money.”*

This section of the report incorporates information gathered from pregnant women of low socio-economic status. The main areas of concern for the women were access to healthy food and prenatal vitamins; sleep, rest, and relaxation; access-ibility and transportation; lack of support networks; lack of information about community resources; and structural barriers and attitudes. The women identified these as the most difficult issues they faced. The women were also asked to identify helpful and unhelpful interactions with health care and other service providers. Themes that emerged were grouped around provider attitudes, provision of “ways and means”, and information/referral. The women’s feedback is grouped thematically.

ACCESS TO HEALTHY FOOD AND PRENATAL VITAMINS

Women understand the need to eat healthy food and take prenatal vitamins while pregnant; however, they either lack the means or do not have the right information to do so.

- *“When they give advice on eating better food, getting more rest and exercise, they have to be sensitive about us not having the funds to access these needs and having low energy because we’re not able to eat better.”*
- *“I needed realistic ways to eat healthy with less money.”*
- *“Lots of them think you can go to the Food Bank whenever you want. But I could only go to the food bank three times a year when I was pregnant - I couldn’t drop in anytime I was hungry. And the food bank doesn’t provide meat. When I was pregnant, I was anaemic and the doctor told me to eat more meat and to take iron pills. I couldn’t afford either. I was so run down and I needed to get my energy up to handle other things.”*

The women did not perceive advice about budgeting and meal planning to be helpful. They believe the root of the problem is lack of money, not lack of information or skills.

- *“There’s never enough money. We’re under incredible financial stress. It doesn’t help when they give us those nutrition and budget classes. They have to understand that we can’t do everything they tell us to do. It’s just not possible.”*

The women’s perception that some service providers do not appreciate the profound impact of poverty on this aspect of their lives, leads to feelings of anger and frustration.

- *“It would be better if they told you where to get the food, not just that you needed to eat more.”*

This, in turn, creates barriers to accessing care. Women report feeling misunderstood and judged. They would rather not disclose their true needs to these caregivers.

- *“There’s the embarrassment, you don’t want those people to know that you can’t take care of yourself when you’re pregnant.”*
- *“If you finally get up the nerve to ask for help, and then the person doesn’t understand your situation, it doesn’t feel like they really want to help. It makes you not want to get involved in the first place.”*

SLEEP, REST, AND RELAXATION

As with food and vitamins, the women understand the need for good sleep, hygiene and rest periods during pregnancy; however, the reality of their lives makes it difficult to follow through on this advice.

- *“They kept telling me to rest more but I worked into my eighth month, 5 days a week from 3PM to 3AM. Then I was bed ridden in the ninth month.”*

Many women do not have the support in their lives that would enable them to rest when they should.

- *“I was told to put my feet up and relax - but how could I? When I got pregnant the second time, my daughter was 4 years old and she needed lots of attention. I was on my own. There was no time to rest because there was no one to watch over her.”*

Of course, the presence of a partner does not guarantee support; indeed, the partner can often be a hindrance to self-care. Service providers need to communicate an understanding of the complexity of the lives of pregnant women living in poverty.

- *“They [service providers] seem to offer lots of simple advice but it’s hard to implement. I had no time or money to take care of myself. I had to take care of my kids - there was no one else around to help out because my husband was useless. Plus I had to keep my house clean when I was pregnant. If my husband came home and it was messy, it would mean trouble.”*
- *“My ex was so selfish - so I finally got up the courage and asked him to leave.”*
- *“I went to welfare to get maternity clothes. They sent me a cheque to buy some and my husband found the cheque and spent the money on himself because the cheque was in his name. I went back to welfare but they couldn’t help me a second time.”*

ACCESSIBILITY AND TRANSPORTATION

All of the women who participated in the focus groups had attended prenatal classes or had accessed some other form of prenatal care. However, even women who are knowledgeable about the benefits of prenatal care, and are motivated to engage in it, identify accessibility and transportation as potentially overwhelming barriers.

- *“They need to know that just getting to prenatal classes isn’t easy. When I was pregnant I couldn’t even afford the bus - I had to walk everywhere in the middle of the winter. I was so sick with morning sickness that I would walk a little bit and then dig a hole in the snow and throw up. I would cover it over with snow and walk some more.”*
- *“It was difficult getting back and forth to work and appointments. I couldn’t afford transportation so I was walking on really hot days when I was eight months pregnant.”*

The women also recognize the need for community responsibility in supporting some of their accessibility issues. They perceive a social class divide as well.

- *“They could set up a special seat on the bus for pregnant women. You know, they now have special parking spots in all the parking lots for pregnant women who drive. None of us can afford to have our own cars. So we have to take the bus. But it’s hard to get someone to give up their seat for you, even when you’re nine months pregnant! I had to stand on the bus when I was really pregnant - no one would move to let me sit down even though I was really showing.”*

Another accessibility issue for pregnant women living in poverty is centred on their childcare needs. Whereas higher income women may be able to afford paid assistance, these women could not.

- *“There aren’t enough resources to help me deal with my other kids while I was pregnant.”*

SUPPORT NETWORKS

All of the women who participated in the focus groups shared a common history, in that they lacked supportive people in their lives. All identified this as one of the most important challenges faced by pregnant women living in poverty. Absence of support could manifest itself as a problem in terms of practical needs and realities.

- *“If I go into labour today, is there someone there for me who can help me get to the doctor?”*

- *“When I was pregnant, I didn’t know who to call. I was so isolated until she [my daughter] was born.”*

Women also identified another pressing issue that succinctly expresses the day-to-day reality of their lives.

- *“You may not have a phone to call for help.”*

The women also report less tangible supports that satisfy their emotional needs as very important.

- *“You need someone to rub your feet.”*
- *“You need someone to love you.”*
- *“You need to be able to say, “I’m here alone, I need someone to help.””*
- *“It’s like you need a volunteer surrogate mother who can check up on you [while you’re pregnant].”*
- *“Everyone said, “Call if you ever need a babysitter”. Of course, when I do need one and call, they’re not available.”*
- *“When you’re pregnant, you find out who your friends are - because I could no longer go out drinking or to clubs - some friends were supportive, others weren’t.*

KNOWLEDGE OF COMMUNITY RESOURCES

The women feel strongly that health and service providers should be better referral agents. Again, this issue has both practical and interactional implications for the women. On the practical side, they believe they are not given enough information about community resources to help them during their pregnancies.

- *“They should know of and inform us about support groups and other resources in the community that could help us.”*

On the interactional side, they feel the way in which service providers deliver information can be improved, which would make it easier to hear.

- *“When they talk down to us or don’t understand our lives, this doesn’t help. Be friendly and open with us. Don’t be judgmental.”*
- *“I was only 17 years old with my first. When I went to the hospital, they induced me and didn’t tell me what was going on. They didn’t ask me what I needed. Everyone needed to put in their two cents when*

I got pregnant. You always hear, “Babies having babies”. I didn’t need to hear that. I lost my confidence because of people saying things like that.”

Assumptions made by health and service providers determine the amount and kind of information and services made available to the women.

- *“My doctor didn’t give me any information - I think she thought I knew everything because I was older and married - but I didn’t!”*
- *“I think they gave me too much information because I was so young. They didn’t trust me with anything. But you know, when she was born, no one came to help or check things out - no one! But when I had my next child and I was older and more experienced, then they sent a social worker to the hospital!”*

STRUCTURAL BARRIERS AND ATTITUDES

The women reported several structural barriers faced by pregnant women, which may be amplified by the reality of living in poverty.

- *“My work discriminated against me when I told them I was pregnant. I had been a little emotional when I first found out (I was pregnant) so I told my supervisor why. Then they cut my hours way down - from 5 days a week to one day per week. They said they did this because I was hired as casual help - which wasn’t true - they denied it had anything to do with me being pregnant. I was in good spirits - I could do my job!”*
- *“Being in school was really tough. The college discouraged me from continuing when they found out I was pregnant.”*

Societal attitudes constitute another barrier for these women. They report feeling judged, inadequate and unsupported by the community as a whole.

- *“I was young and a lot of people noticed I was pregnant and were judgmental.”*
- *“People really looked down on me because I was a pregnant woman and I was poor. It destroyed my self-confidence. I needed to be around people who believed in me - who thought I could be a good mother!”*

Judgmental attitudes can foster fear of reprisal in some of the women.

- *“My biggest fear is that they’re [CAS] going to take him from me because I’m not a good enough mom.”*

HELPFUL INTERACTIONS WITH SERVICE PROVIDERS

Generally speaking, the women identified three main themes when asked what was beneficial for them in their interactions with health and service providers: provider attitude, appropriate referrals, and “ways and means”.

The approach taken by service providers, or the community at large, is of critical importance.

- *“Supportive and enlightened people were helpful because they treated me with respect even though I was young.”*
- *“It was helpful when they understood where we were coming from, when they knew more about our situations, and when they were able to direct me to the proper places to go for help.”*
- *“It was very stressful making sure I had everything ready for the baby. I had two part time jobs to make sure everything was in place. My Ontario Works case worker was very supportive - she told me not to get another job, that I had to rest. I was so tired that I couldn’t sleep well anyway.”*
- *“One nurse in the hospital was great with me when I tried to breast feed. She stayed with me and showed me how to hold the baby. It made a huge difference that she was willing to help and wanted to help.”*
- *“It all depends on the way someone says things to you. I go to church every week and a woman there offered to pick me up in the mornings to drive with her to church. She said to me, “It would be a pleasure to drive with you in the morning.”*

Furthermore, practical supports to implement advice (known as the “ways and means”) will ensure that pregnant women living in poverty can turn suggestions into action.

- *“I had help with pills [prenatal vitamins], milk and other things with my second pregnancy. I felt a lot healthier than with my first child.”*

When ways and means are combined with appropriate referral, the results for the women are extremely positive.

- *“I was going to Better Beginnings for my second pregnancy so I got a home visitor and went to a parent support group - it made a real difference.”*
- *“I had a home visitor, too. She brought me vitamins and milk coupons - that made it easier.”*

UNHELPFUL INTERACTIONS WITH SERVICE PROVIDERS

The women indicated a number of issues that get in the way of helpful service provision. These include provider attitude, lack of information and referral and advice without the appropriate means of implementation.

If the women perceive that a service provider does not have a good understanding of the context of their lives, then they are less likely to act on suggestions or advice and more likely to perceive the interaction as negative.

- *“The woman I dealt with told me to eat more fresh fruits and vegetables. The way she said it got my back up. So I just ignored what she said. If I could afford fresh fruits and vegetables, I would have bought them. It would have been more helpful if she’d talked to me about what it’s like to struggle to feed yourself and your family and then referred me to the Good Food Box - I only found out about it later from a friend.”*

The women often note lack of advice and referral to appropriate supports. In retrospect, they believe that insufficient information contributed to their difficulties during pregnancy and beyond.

- *“During my pregnancy I was really isolated and didn’t know who to call for help - it would have been a lot easier if I had known where to go to get support. The supports are out there but no one tells you about them.”*
- *“My doctor assumed I didn’t need extra support because I was married and older - she didn’t talk to me about where to go for help.”*
- *“My daughter had milk in her breasts when she was first born. I took her to the doctor and THEN she told me it was normal. I would have liked to have known this earlier.”*

Advice without the appropriate means of implementation leads to resentment. Again, the women see this as lack of understanding of the realities of their lives.

- *“I resented being told to quit smoking because there wasn’t any information or support given to help me. I knew I should quit - if I could quit, I would. What I needed was help to quit, not being told to quit.”*
- *“I didn’t reach out to service providers until my child was born. When I did, they told me to take care of myself and the child - but that was easy advice that wasn’t so easy to follow.”*
- *“Everyone kept saying rest but I couldn’t - I worked until my ninth month. I had too. I couldn’t afford not to.”*
- *“Eat properly. If I could, I would.”*

- *“Doctors always tell you about Canada’s Food Guide. On my income there is no way I can afford to follow it - there is just not enough money. But I did try to do the best I could.”*

One woman summed up this point effectively when she said:

- *“Suggestions are welcome, commands are not helpful.”*

The issue of quitting smoking during pregnancy emerged as a hot topic. Overwhelmingly, the women view advice to quit without the backup means to do so as disempowering.

- *“They told me to quit smoking, but didn’t give me any ideas about how to do it.”*
- *“Advice about quitting smoking was hard to follow because I was living with others. Even though I didn’t smoke everyone in my house did - I couldn’t escape it!”*
- *“I wish my doctor would have helped me quit smoking instead of just lecturing.”*

Misinformation about the effects of smoking is also an issue that needs to be addressed, both in terms of educating professionals and educating pregnant women themselves.

- *“My doctor said, “Don’t quit – don’t go cold turkey - nicotine withdrawal is bad for the baby.””*
- *“When I returned from the hospital, I made myself and others smoke outside so my house would be smoke-free. But then the winter came and we began smoking inside again. But we only smoke in the basement.”*

THE ROLE OF THE COMMUNITY AT LARGE

The women were asked to identify supports that could ease the life of a pregnant woman living in poverty. Again, their ideas ranged from attitudes to information to practical supports.

- *“Neighbours and people walking down the street could make things a lot easier by just saying, “Hi, how are you?”*
- *“You [service providers] could let pregnant women know what they can do that doesn’t cost a lot. I’d also like to see you standing up for all low-income pregnant women and helping us change the way people see us.”*
- *“It would help if everyone understood - like the whole community!”*
- *“A supportive partner is so important.”*
- *“Let people in the community know how difficult it is to be pregnant and not have any money.”*

IMPLICATIONS OF FEEDBACK FROM PREGNANT WOMEN

In order to present a wide range of experiences of pregnant women, the implications drawn here include information from the participants in this study as well as the experiences of the teen participants from both the Voices and the Sudbury reports (Best Start, 1997; van de Sande, 1999).

1. Women believe it is imperative that service providers understand the context of their lives. They describe the range of barriers and issues that make life difficult for a pregnant woman living in poverty. Included in their descriptions are lack of food security, elevated stress levels, lack of rest, lack of transportation and other accessibility issues, social isolation and lack of support from family and social networks, lack of relevant information about available resources and services, community and structural barriers to receiving the same level of care that higher income women receive, and unrealistic advice from health and other service providers.
2. The women understand the importance of good nutrition and the value of taking prenatal vitamins while pregnant; however, they either lack the means or do not know how to implement suggestions and advice from service providers. The women articulate that the root of the problem is lack of money, not lack of information or skills. They feel misunderstood and judged by service providers who do not appreciate the profound impact that poverty has on food security. This leads to feelings of anger and frustration and creates barriers to accessing care. The women reported that they would rather not disclose their true needs to service providers who do not understand the context of their lives.
3. The women report leading stressful lives with little opportunity for sleep and self care. While they understand the need to do so, the reality of their lives hampers their efforts to relax and take care of themselves. They do not have the social and family supports to ease some of the burdens in their lives.
4. Accessibility (including not having a telephone or a permanent residence) and lack of transportation and childcare can be potentially overwhelming barriers to accessing prenatal care, even for women who are knowledgeable about its benefits and are motivated to engage in it.
5. Pregnant women living in poverty identified lack of support and social networks as important difficulties. Absence of support can leave both the emotional and practical needs of the woman unmet while simultaneously increasing her stress levels.
6. The women's experience with many service providers has been that advice (which is often unrealistic to implement) is offered but referrals to appropriate services or community supports are not as forthcoming. The women believe they do not receive enough information about community resources. As a result, they do not have information about many of the practical supports that were made available to other women to help them during their pregnancies. Also, the way in which service providers deliver advice and information can be improved so that women will be more receptive to implementation. Interactions

should be non-judgmental and not condescending. Service providers should not make assumptions based on age or other characteristics about the amount and kind of information women need.

7. Another major barrier is societal attitudes towards pregnant women living in poverty. The women report feeling judged, inadequate and unsupported by some service providers and the community as a whole. Judgmental attitudes can foster fear of reprisal and perceived threat of apprehension of this child or others. These fears in turn lead to late or no entry into prenatal care and failure to disclose concerns to service providers.
8. The women had many helpful interactions with service providers and were specific about what helped. The service provider's attitude (non-judgmental, contextually based, and caring), appropriate referral and provision of "ways and means" lead to successful interactions from the women's perspective.
9. Unhelpful interactions and advice were also problematic for the women. Perceived negative attitudes (condescending, judgmental, or uninformed) on the part of the service provider, lack of information and referral, and advice without the appropriate means of implementation were identified as extremely unhelpful. Women were less likely to act on suggestions or advice and more likely to perceive the interaction as negative if they felt that a service provider did not have a good understanding of the context of their lives. Resentment towards the advice given by service providers is the result of these interactions.
10. The women believe that the community at large has a role to play in supporting low-income pregnant women. They also see the important role service providers play in advocating on behalf of pregnant women living in poverty.



effective strategies

This section provides information on helpful strategies and approaches to addressing low socio-economic status and pregnancy. The information was gathered from a variety of sources, including interviews with staff that provide services to pregnant women living in poverty. For each topic area, or issue, you will find tips, best advice, ideas and questions to consider. Example programs are outlined in order to provide you with a wide range of ideas, tools and suggestions. Service providers must explore the individual elements of each program in order to determine the relevance to their own audiences, programs and services.

Many of the overall strategies discussed in this section concern what we can do for women who may be struggling to meet their daily needs. It is important to remember that while we provide key services and resources, our underlying role is to increase women's ability to cope and to help establish an improved sense of self worth. It is not always easy to find a way to meet women's very basic needs (for example by providing groceries) while also empowering women to better face their challenges. Look for ways to involve women, to increase participation and to find roles for women, rather than automatically doing things for them.

“Whenever you can, help her make things possible for herself.” Joanne King, Community Resource Centre, Killaloe

THE ISSUE - PRENATAL CARE

Many low-income pregnant women either enter prenatal care late or don't enter prenatal care at all. The reasons for this are varied, as discussed in the research section of this resource (Braveman et al, 1999; Cook et al, 1999). Addressing the personal and structural barriers to prenatal care can increase attendance and the quality of the service. Prenatal care is often one service offered as a part of a larger organization. While a woman may access prenatal care through a medical or health centre, prenatal care is also offered at many prenatal support programs. Often the context of the prenatal care will have an influence on how the woman perceives and is able to access the prenatal care. The following examples pertain, not only to aspects of prenatal care, but also the context in which it is offered and to associated programs and services.

Helpful approaches

Here is what some low-income women have said about prenatal care and what made it easier for them to access prenatal care. Their ideas include:

Incentives – Programs can offer transportation, free milk, prenatal vitamins, prepared food and grocery gift certificates.

A wide range of issues – Programs can address other issues in a woman's life such as substance use, domestic violence, food security and financial concerns.

A comfortable, knowledgeable environment – A good program environment is based in staff who are non-judgmental, supportive, caring and maintain confidentiality; create an atmosphere of fun and mutual support and make informed referrals to other support services.

In-home supports – Options for in-home support can include family visitors, telephone contact and services offered through computer technology.

School programs for teen moms – Consider prenatal classes delivered in school, provision of school credits for prenatal attendance and extended supports for new mothers to continue their schooling.

Culturally sensitive programs – Some examples of cultural sensitivity include prenatal information made available in many languages, pictures and educational models that represent different cultural groups, translators, staff who understand cultural differences and support from elders.

Access to other support services – Support services can be offered on-site (such as food cupboards, clothing exchanges, toy lending libraries, prenatal/parenting information lending libraries, one-on-one counselling, other group supports and computer access) or through informed referral to appropriate community supports. Referrals can be made directly (face-to-face) or indirectly (posters in the halls and washrooms, easy-to-read listings of community resources and information bulletin boards).

Unhelpful approaches

Here is what some low-income women have said about their negative experiences in prenatal care, which included:

Assumptions based on age, marital status, and socio-economic status – Information delivery might not include the context of the lives of low-income pregnant women (such as lack of food security, high stress levels, lack of support and emotional issues), prenatal classes geared to couples only, or prenatal classes geared to older mothers, leaving teen moms feeling excluded.

Restrictions based on length of pregnancy – Some prenatal programs exclude women whose pregnancies are beyond the first trimester.

Lack of accessibility – Barriers to accessibility can include lack of transportation, childcare, or geographic location and program costs associated with participation.

No menu of options – Some programs may lack options regarding pregnancy alternatives such as adoption and abortion, birthing experiences such as use of medications, midwives and other support people, or infant feeding practices.

Lack of information – Information about available resources, community supports and the experience of being pregnant might not be available or accurate.

An uncomfortable environment – Biased and judgmental staff, lack of confidentiality, or impractical advice that doesn't take into account the circumstances of living in poverty can make a program uncomfortable for some women.

Program example

- **MotherCare** (Canada Prenatal Nutrition Program Drop-in, Barrie) aims to reduce barriers and increase understanding for pregnant women and new mothers. The MotherCare motto is accessibility, flexibility, empowerment and mutual trust. They provide concrete supports including food (such as milk, juice, bread or other grains, fruit, and vegetables), vitamins, and a clothing and baby furniture exchange; educational supports on topics related to pregnancy and parenting; social and emotional supports including peer support and information on lifestyle and social relationship issues; and social integration by involving program participants in planning activities.

Tips

- **Ask** low-income women what worked for them. Ask, “What would make you never come out to a prenatal program? What would make you never come back? What would make you interested in a program and want to attend regularly?”

- **Involve** women in program planning. Ask them to review your publicity campaign. Pay them for their time.
- **Offer** free childcare, transportation and food. Promote these as integral parts of your prenatal program.
- **Advertise** in laundromats, shopping centres, corner stores, drugstores and other places frequented by low-income women.
- **Avoid** overuse of the word “free”. Instead, say, “Come help yourself to groceries”.
- **Provide** incentives. Make your program incentive package available in many non-threatening locations, such as drugstores, libraries and doctors’ offices.
- **Find** co-facilitators. A good choice is a graduate of previous prenatal classes. You also might want a co-facilitator who represents a specific population. For example, a teen mom co-facilitator might help increase the comfort level of other teens in your prenatal program.

Ideas for community action and advocacy

- **Involve the community.** For example, involve local agencies and businesses in the development of your incentive package. Then ask local businesses and services to help distribute it.
- **Partner with other service providers.** This way, you can more easily and cost effectively fill gaps in service. For example, partner with the childcare resource centre for childcare support during programming. Or ask other community services to donate staff time to address the important issues identified by women, such as domestic violence, substance use and food security.
- **Take your program on-line.** There are some interesting, innovative examples of community wide programs accessible through the Internet. For example, Cybermoms in Sudbury. This is also a good way to find new partners, such as employment services and continuing education facilities.

Best advice

“Be flexible. Tailor prenatal programs to the needs of the community. Ask women to tell you what they need. Involve them in decision making.” Katie Dilworth, Canada Prenatal Nutrition Program, City of Toronto

Questions to consider

- How can we attract low-income women to our prenatal program as soon as they find out they are pregnant?
- Would I feel comfortable as a participant walking into our program? What would I change to make participants more comfortable?
- Have I eliminated as many barriers to attendance as possible? Are there incentives I could provide?

THE ISSUE - FOOD SECURITY

Many low-income pregnant women consider lack of food security to be the number one barrier that interferes with a healthy pregnancy. It is important to provide nutrition information; however, information alone is not sufficient. These women need access to high quality food. Without food security, they cannot realistically be expected to implement the nutrition information being delivered to them. As one mom said, "I don't need to know five different ways to cook chicken. I need the chicken."

For all of us, food holds many meanings and serves many functions. This is no less true for pregnant women who live in poverty. The main difference is lack of food security. Women living in poverty lack adequate means to meet the nutritional, social, and emotional purposes served by food. Here are some of the food security issues encountered by pregnant women living in poverty:

- Unlike rent, utilities, and other fixed monthly expenses owed to other people, food purchase is often relegated to a place of less priority.
- In an emergency, the food budget is often the first to go.
- Low-income mothers will often report that they feed the others in their family first and only eat after the others are fed, if there is food remaining.
- Some mothers will not disclose that their families are in need of food to service providers for fear of reprisal or reports to child protection services.
- There is a widespread community perception that the food needs of low-income people are well looked after by food banks and other food programs. The reality is that these services were long ago stretched beyond their capacity and can now only meet the needs of participants in limited, usually emergency, situations.
- Most food banks are not equipped to meet the most pressing food needs of low-income pregnant women; that is, their need for milk, fresh fruit and vegetables, and other perishables such as meat.
- There is a stigma associated with using food banks and other food programs. Some women will not access the services because they feel ashamed.
- Good nutrition is known to be an important determinant of healthy birth outcomes, however, nutrition information is not enough. Access to high quality food is more important and often unavailable.
- Despite attempts made by service providers to provide for food security needs, some women (in particular, pregnant teens) may be falsely concerned about weight gain during and after pregnancy. Body image issues and their connection with tobacco consumption need to be considered in the development of food security programs.

Helpful approaches

Here is what some low-income women have said about food security and what made it easier for them to achieve food security. Their ideas include:

Food as incentives - Snacks or meals can be a part of every program. Snacks and meals can be used to attract women to the programs. Grocery store gift certificates can be used as incentives to program participation.

“Food to go” – Food can be taken home in a variety of ways. Consider providing ingredients or whole meals as part of food preparation activities, access to food through food cupboards and freezers and providing prenatal vitamins.

Kitchen table discussions – Prepare meals as a group. Discuss life issues over a meal without a staff person acting as facilitator. Share food tips in an informal non-teaching environment.

Access to perishable food - Creative programs find ways to offer fresh foods, whether through grocery gift certificates, donations from grocery stores, or program budgets that build in purchase of perishable food for program participants.

Knowledgeable referrals - Service providers can find out about other food programs (such as the Good Food Box) and make this information widely available.

Advocacy - Service providers can take a proactive stance in securing food for low-income pregnant women from other food programs, can reduce barriers for women when they need to access other food programs and can highlight food security needs within their communities.

End of the month programs - Service providers need to recognize that food security needs of pregnant low-income women are greater from the middle to the end of each month given the timing of distribution of social assistance cheques.

Unhelpful approaches

Here is what some low-income women have said about their negative experiences in achieving food security, which included:

Advice without capacity - Service providers who only provide advice about budgeting and meal planning. Many low-income pregnant women believe they have adequate information and skills, but what they need is money to purchase healthy, nutritious food.

Not understanding customary tastes - There may be differences in culture, family history, or personal tradition in food selection leading to reluctance to try unfamiliar foods.

Assumptions about knowledge - Service providers may assume pregnant low-income women need to be “taught” how to budget, menu plan and follow Canada’s Food Guide.

Assumptions about living conditions - Service providers might not understand the reality of a life in poverty. Women may have no access to useful appliances such as freezers or blenders. Acquiring food can be time consuming if you are poor.

Uninformed service providers – Some service providers do not know about the service restrictions of food banks and other food programs.

Unaware of the issues - The concept of “good nutrition” is secondary to food security.

Program examples

- **Babies First** (Canada Prenatal Nutrition Program Prenatal Drop-In Program, Peterborough) is a drop-in at a family resource centre. It provides the following program components: transportation, childcare, a morning snack and lunch, a \$15 per week voucher for food, access to a pound of frozen ground beef, a bag of frozen vegetables, orange juice from an on-site freezer, and access to a cupboard of canned goods for participants to use when needed. Before Babies First began, staff consulted with women (and paid them for their time) to find out what they wanted and developed the program and budget to suit those needs. Once they knew the women’s needs, they sought out partners who could work together as a multidisciplinary team. They were able to hire a community development worker to co-ordinate the project and undertake the important task of outreach to women, since the nurse and dietician were already part of the team.
- **Higgins Method** (Montreal Diet Dispensary, Montreal) is a food supplementation program whose philosophy is to “add on” to the mother’s existing diet. Low income women are given 1 litre of whole milk per day and one dozen eggs every two weeks. However, the Higgins Method is described as a global one and takes into account all of the woman’s needs. The evaluators of the project believe its effectiveness lies in the provision of tender loving care. The pregnant woman’s difficulties are eased wherever possible so that she can focus on giving birth to a healthy baby. Furthermore, the program’s developers recognized that their staff needed special training over and above their formal education to work with groups of women considered “at risk”. Therefore, all Montreal Diet Dispensary dieticians have at least four weeks of training on the Higgins Method prior to meeting any women.

They also receive continued in-service training in psychology, helping relations, and various subjects related to high-risk pregnancies, such as substance use. The Higgins Method has been shown to reduce the incidence of low birth weight. However, the evaluators point out that it is successfully implemented because they consider all of the woman's needs.

- **The Food Mentoring Project** (Single Mothers Support Network, Kingston) is geared towards low-income single mothers but could be adapted for pregnant women. The project links older women as mentors with low-income single mothers. The goals of the project are not focused on nutrition, menu planning, or budgeting, but rather to identify food security issues, share skills, develop an action plan and network with existing provincial food security groups. The emphasis, however, is on sharing the “lost arts”, such as preserving, canning, and dehydrating harvest fruits and vegetables. The women also look to their mentors for ideas on sharing quick and easy recipes, cooking with low-cost everyday ingredients that they like to use, and big batch recipes for freezing. The moms and mentors meet once a month for a half-day of sharing and cooking. Transportation, childcare, and food preparation costs are all covered by the project, as are any costs for special equipment. Most of the equipment is donated, so that moms can take needed supplies home with them.

Tips

- **Start** a bulk-buying club and a lending “library” of cooking equipment, cookbooks, and uncommon spices or condiments.
- **Use** gift certificates from grocery stores instead of food vouchers. Some people are badly treated when they present vouchers.
- **Make** sure that gift certificates and packages of information do not indicate they are for pregnancy. The women may not want other people to know that they are pregnant.
- **Facilitate** information sharing through displays or demonstrations rather than “teaching”.
- **Stimulate** informal learning as opposed to leading formal presentations.
- **Cook** a meal together.
- **Invite** participants to choose a favourite recipe from a range of cookbooks each month. Review the women's choices and pick the most popular and affordable. Make the recipe as a group and have a meal together. Give women the ingredients so they can make the recipe at home. Where possible, give them any needed utensils, such as pie plates for quiche.
- **Spend** your program funding where it's needed - on food, meals and grocery gift certificates. Remember, if you are low-income, you can't afford to eat well.
- **Emphasize** personal tastes in food. Work with those tastes. Don't impose your tastes on the women.
- **Take** a “help yourself” approach to the food you make available to women. The word “free” is over used and inaccurate.

Ideas for community action and advocacy

- **Start or join a local food security council.** Make sure this group addresses the needs of low-income pregnant women.
- **Spearhead innovative community projects.** Start a community garden for low-income women. Try food mentoring. Think of any other imaginative ideas that will put more food on the tables of low-income pregnant women.
- **Promote food security issues in your community.** Start a myth busting campaign. Work with the local food bank to relay accurate information about its capabilities and limitations to your community.
- **Find out about local food security programs** and advocate for special considerations to meet the needs of pregnant women.

Best advice

“Recognize that women cannot afford to eat well so you need to offer food or grocery gift certificates so they can buy food.” Sue Hubay, Babies First, Peterborough

Questions to consider

- Do I ensure the “ways and means” to implement the advice and information I provide to women?
- Can I think of innovative ways our community can put more food on the tables of low-income pregnant women?
- Do I consider how difficult it may be for women to talk freely about food security?

THE ISSUE - SOCIAL CONDITIONS AND ADDICTIONS

There are a variety of circumstances that can impact the lives of pregnant women living with low socio-economic status. These circumstances include: increased risk of depression, high levels of stress and low levels of social support, increased risk of tobacco and other substance use and greater risk of domestic violence. The social conditions and personal characteristics that lead to any one of these concerns are similar, if not identical, to those that lead to all of the other problems; furthermore, they are likely to occur in combination and as such the consequences for the women are intensified. The intertwined concerns can lead to negative birth outcomes for both mother and infant. Therefore, service providers must be prepared to address interconnected concerns when dealing with pregnant women of lower socio-economic status.

Unhelpful approaches

Here is what some low-income women have said about these issues and what made it easier for them to cope. Their ideas include:

Practical information – Pass on easy-to-manage advice or ideas that are realistic considering the conditions encountered by pregnant women. Provide factual, non-judgmental information.

Ways and means – Incorporate practical supports to implement advice or information, such as a taxi chit to enable a woman to get to an appointment you made on her behalf.

Empathic interaction – A service provider who listens, not tells, who doesn't jump to solutions but lets a woman tell her story, who doesn't shame or blame.

Good referrals – A service provider who is knowledgeable about community services and lets a woman know about them in a timely and confidential manner.

Holistic approach – A service provider who doesn't deal with one issue in isolation but who recognizes the links with other life events.

Honour the woman – A service provider who expresses interest in and support for the woman as a woman, not only as a mother or mother-to-be.

Unhelpful approaches

Here is what some low-income women have said about their negative experiences related to these issues, which included:

Simplistic advice – A service provider who says, “You should quit smoking” or, “You should eat more nutritious food”.

Inappropriate reactions – A service provider who expresses disapproval either in words or in body language.

Failure to deal with multiple issues – A program that focuses on one issue only, such as quitting smoking, without recognizing how this is connected to all other issues in a woman's life.

Assumptions about available support – Not recognizing that practical supports might not be available, such as access to transportation or a partner who is willing to provide tender loving care.

Program example

- **Breaking the Cycle** (CAP-C pregnancy and substance use program, Toronto) is a community-based early identification and prevention program designed to reduce risk and enhance the development of substance-exposed children (prenatal to 6 years). The program addresses maternal addiction issues and the mother/child relationship through an integrated, cross-sectoral model. Breaking the Cycle operates through the efforts of a provider partnership of 6 service organizations that, in addition to other efforts, donate staff time to Breaking the Cycle. Services are offered through a single access model in which mothers and children can access addiction, health, developmental, and parenting services through an integrated trans-disciplinary approach at one location in downtown Toronto. Breaking the Cycle evaluations have demonstrated that women's participation has resulted in healthier birth outcomes, better maternal health ratings, fewer health concerns, fewer parenting breakdowns resulting in separation of children from their mothers and fewer maternal development concerns.

Tips

- **Develop** a comprehensive list of resources for referrals. Post the list where women can see it. Make photocopies and leave them in common areas for women to pick up.
- **Use** available local resources. Ask others to do in-service training on topics such as substance use, depression, or domestic violence.
- **Ask** about difficult life issues routinely, privately and sensitively. Be willing to bring up and discuss uncomfortable topics in a non-judgemental manner.
- **Provide** ongoing, consistent support. Ask the difficult questions routinely and repeatedly. This time, a woman might trust you enough to disclose.
- **Let** the woman tell her story in her own time. Avoid offering too many solutions too quickly.
- **Offer** advice only when asked. Make sure she has factual information so she can make informed decisions.
- **Integrate** discussions of the social determinants of health into all programming.

Ideas for community action and advocacy

- **Get involved.** Join a community group or coalition that addresses issues of violence, substance use or depression in the lives of pregnant women. Make sure these issues are on the agenda of any group you are part of.
- **Tap into existing special events or awareness weeks**, such as National Non-Smoking Week or Violence Prevention Month. Highlight the issue's relationship to pregnant women.
- **Foster professional education.** Invite people working in any of the multidisciplinary areas to provide training in your work setting. Attend educational programs or workshops available in the community. Develop educational resources, policies, programs and training around these issues.

- **Highlight the interconnectedness of these issues** through a public education campaign, in-service training or cross training events.

Best advice

“There are many small changes a pregnant woman can make when it comes to substance use. It’s better to focus on small change than on complete abstinence. She should be congratulated for the little things along the way.” Margaret Leslie, Breaking the Cycle, Toronto

Questions to consider

- Have I been impacted personally by any of these issues?
- If I have been impacted, does this affect my ability to work with pregnant women who are affected by these issues?
- Do I have access to accurate information about these issues and the effects on pregnant women?
- Am I able to remain non-judgmental, empathic, respectful and supportive when I encounter a pregnant woman who is affected by these issues?
- Can I overcome my personal beliefs about a woman’s need to change? Can I support her self-determination and plans to change in a non-coercive and caring fashion?
- Can I stay hopeful while finding ways to encourage hope in a pregnant woman affected by these issues?

THE ISSUE - HOUSING AND MATERIAL POSSESSIONS

Some of the most pressing concerns during pregnancy are related to housing and material possessions. This is especially true for pregnant teens and women who are leaving an abusive relationship. With little notice, they may have to find a new place to live, along with necessary furniture, supplies and cooking equipment. Pregnancy also is a time when women need new clothing and equipment, such as maternity clothing, baby clothing, diapers and other baby supplies. When the budget is limited these increased needs result in higher levels of stress and concern about wellbeing and the perception of others. While it is rarely within program mandates to go beyond basic needs such as food provision, there are many simple ways that programs can address concerns related to housing and material possessions.

Program examples

- **Parkdale Primary Prevention Parenting Project** (Canada Prenatal Nutrition Program, Toronto) is a drop-in style pregnancy support program. Many participants are new immigrants to Canada. A world wall map indicates the places of origin of the participants. Basic needs such as housing, food, knowledge of services and material possessions are important concerns for participants. Flannel material and yarn are donated to the program, and then supplied to participants interested in making maternity and baby supplies.
- **Healthy Mothers: Healthy Babies** (Sandwich Community Health Centre, Windsor) is an innovative, incentive-based prenatal program offered at a Community Health Centre. The program offers many of the same services provided by other prenatal programs. It also welcomes women to the program by providing an attractive prenatal canvas tote bag package. The tote bag's contents include information about the program's prenatal services, nutrition, parenting and breastfeeding. It also includes a baby bath thermometer, safety information, recipes, free samples, "free" coupons to attend prenatal programs, prenatal exercise classes, home visits, cooking classes, and other programs offered by the Community Health Centre, free milk and egg coupons, free video rental, free skin and makeup demo, free prenatal vitamins, and a coupon for a free smoke alarm from the local fire department.

Tips

- **Subscribe** to newspapers. Help women look through the rental sections of the paper.
- **Find out about** rights for renters and landlord regulations. Link women to advice and information if they are having problems.
- **Post lists of crisis housing and shelter** information and services.
- **"Loan out"** material supplies needed for daily living such as pots and pans.
- **Have supplies** and patterns on hand and encourage those experienced in making items such as breast pads, baby blankets or outfits, to share their knowledge with interested women.
- **Maternity and baby supplies** can also be shared. Find ways to loan car seats, or breast pumps. Have a clothing exchange cupboard for maternity and baby clothes. Encourage participants to trade or pass on baby toys. Link women with places that sell second hand, rent or loan baby and maternity supplies.
- **Celebrations** may be rare occasions for the families in your program. Think about ways to welcome a new baby or to celebrate a milestone or success, for example, a participant quitting smoking. Consider asking for donations of handmade baby outfits. The outfit you give to a new baby may be the only baby gift received by the family.

Ideas for community action

- **Join or participate** in municipal housing committees or tenant groups.

- **Sit on the board** of shelter or crisis housing program.
- **Encourage retailers** and community groups to donate maternity and baby supplies to your program. Let them know the types of supplies that are most needed in a family emergency, for example, diapers and non-perishable foods.
- **Ask for donations** of children's books, handmade baby outfits, or baby quilts.
- **Partner with** a local or mobile library or toy library that will loan books or toys.
- **Invite local businesses** to use the program as a site for their mandatory volunteer program whereby staff provide facials, massage, makeup sessions, manicures or other related services.

Best advice

"You can help women carry the load, but you can't carry it for them." Monica Petzoldt, MotherCare, Barrie

Questions to consider

- Do I know how to help someone who is looking for housing? What if they have limited finances and do not have money for first and last month's rent?
- Do I know the most pressing concerns of my clients? Have I asked the women in my program about the material possessions they need?
- If there is no space to store donated items such as maternity and baby clothes, have I thought about other ways to meet women's needs?
- Have I involved retailers and community groups in helping to meet my clients needs?

THE ISSUE - EDUCATION AND OCCUPATION

Women living in difficult life circumstances may have been unable to complete high school or to get the training or higher education that they wanted. Some may have difficulty reading or writing. Others may be learning a new language in order to function in their new community. Some program participants may have higher education, but due to unfortunate circumstances, are unemployed or under-employed. While many program participants will rely on social assistance, others who are employed may still have great difficulty making ends meet.

Participants with low levels of literacy may have difficulty finding out about existing services, understanding written information about pregnancy and acquiring and keeping a job. Low literacy levels present barriers at multiple levels and can be a social stigma. Program participants may feel uncomfortable telling others that they have difficulty reading instructions, written materials or completing forms. Service providers should be sensitive to the fact that women may need someone to help them go through written materials,

in a non-judgmental manner. For some women it will be enough to provide information in simple, clear language (“plain language”), focussing on the most important information. Other women may require verbal explanations of materials.

Programs and services for women should respect that the issues of education and employment are important components of socio-economic status. There are many strategies available for providing assistance and supports related to education and employment. Pregnancy is not always a time when women are planning for future education or changes to employment. However, service providers should be aware of sources of information and programs for interested participants and can also help to bridge to future opportunities.

Program example

- **Stop 103** (Toronto) is a support program that offers a range of services for pregnant women. They have a partnership with a local literacy program. A staff member from the literacy program attends the weekly pregnancy drop in program and works with interested women. Services include helping individuals learn to speak English, helping women with reading and writing, writing letters for participants and reading to the children. Stop 103 is also linked with an employment service that does workshops with interested women on job readiness, and they also have a job registry that women can access.

Tips

- **Get information** so that you can help women who might want to finish high school or complete a training course. Get copies of application forms and program information.
- **Learn** about social assistance and other programs that support individuals who are pregnant or parenting and going to school. Ask program participants if they might be interested in a presentation about back to school programs.
- **Find out about** any employment programs and make the information available to interested participants.
- **Start a volunteer program**, defining short-term tasks that could be completed by interested participants. Ensure that the volunteer program is accessible by providing childcare as needed. Find out about the skills of the women in your program. Help volunteers expand their skills. Provide letters of reference or appreciation.
- **Link with** a literacy program to help interested women learn to read and write or teach English (or French) to new members of the community.
- **Ask women** if they want to complete an evaluation form themselves, or if they would like you to go through it with them. Ask if they would like you to go through written materials, information or service directories with them.
- **Provide** staff training in plain language and use it consistently. Use explanatory pictures in your resources.

Ideas for community action

- **Advocate for education and training programs**, especially those that provide childcare and transportation and that provide a living allowance.
- **Advocate for improved work conditions**, such as better pay, safer work, and accommodation for the needs of pregnant workers.

Best advice

“Make sure there is access and equity in everything you provide - whether that’s your personal interaction with women or anything written you distribute. Make it easy for women to get involved. Make it easy for women to stay involved...” Diane Shrott, Healthiest Babies Possible, Toronto

Questions to consider

- Do I respect each woman’s choices about work, school and family life?
- Do I sometimes forget and assume that women can read and write well? Do I know where to refer someone who wants to improve her reading or writing?
- Do I know about programs and subsidies for women who want to finish high school or further their education?
- Do I feel that women should have higher education? I am pushing too hard with women who are not ready or not interested in going back to school?
- Am I familiar with employment standards? Do I know where to refer a woman who has concerns about the way she is treated at work?

THE ISSUE - RURAL AREAS

While there are many advantages to living in rural or isolated areas, rural pregnant women can be extremely isolated. Rural women may not have access to pregnancy services such as midwifery care or prenatal classes. In medically under-serviced areas, some women may not have a family doctor until they become pregnant. It may be difficult for women to discuss difficult issues during prenatal appointments with a health professional that they do not know well. Some women may also have to travel long distances to see their physicians, making it much more difficult to maintain continuity of prenatal visits. Rural women may have less power to control their birth outcomes. There are likely to be fewer services, less access to resources and less options. It is important to ensure that women have realistic expectations about local labour and delivery services. Distance

and weather can create barriers to prenatal services. In many cases there is only one family car and no local public transportation system. If a rural woman is living in a violent situation, isolation is increased and leaving safely may require more planning and support.

Program example

- **Killaloe Best Start Prenatal Nutrition Program** is funded through the Canada Prenatal Nutrition Program. Their county is so large that many agencies and groups have been incorporated into the service delivery plans, in order to provide adequate reach. The program felt it was essential to cover travel expenses to and from the programs. Killaloe also provides food and social support and feels these are critical elements of rural programs. Staff believe in allowing women to develop relationships with each other and that a formal facilitator should take a humble leadership role.

Tips

- **Help women identify** their transportation needs and resources. A woman might have a friend to drive her to the doctor's office but she will need money for gas.
- **Link women** to information about any existing transportation services or travel subsidies.
- **Focus on meeting needs.** The saying, "Diapers get you in the door" reflects the fact that a program's ability to distribute tangible resources such as diapers, or to loan out strollers, cribs, car seats or breast pumps, will bring pregnant women in before the baby is born.
- **Cover travel expenses** through taxi chits, coupons for gas, etc.
- **Recognize valuable rural traditions** such as church suppers, neighbourliness, knowledge of community members, loaning of resources, passing on of hand-me-downs, etc. which may offer support to pregnant women.
- **Consider the location** of a program. When possible offer several local programs, rather than a single central program. Smaller local groups may allow for greater sharing and social contact, as well as being closer to home.
- **Go to the people** you want to work with, rather than expecting them to come to you. Take your services on the road through in-home support or mobile services.
- **Share space** and resources with programs for children.
- **Make time for fun and socialization.** This may be one of the few times that women can get together to talk. There may be a shortage of recreation programs in the area.
- **Include telephone support** in your menu of services to decrease the effects of isolation. Train staff in needs identification and safety assessment for pregnant women.
- **Make sure that** women know you will respect their choices. For example, a woman in your program may choose to bottle-feed. While that may disappoint you, your role is now to make sure she has access to good quality formula and has the information and equipment to prepare it safely.
- **Role model a fun** and positive approach to life. Portray attitudes and values such as friendliness sharing, group participation, acknowledgement of strengths and enjoyment of others company.

Ideas for community action

- **Advocate for** public transportation access for rural areas, as well as funds to reimburse or subsidize travel costs.
- **Apply for funds** for an increased number of local services, for a mobile unit or for in-home support. Partner with others who already have the resources for these services.

Best advice

“Believe utterly that women do the best they can, then convey this belief to others.” Joanne King, Community Resource Centre, Killaloe

Questions to consider

- Do I consider the context of the lives of women living in rural areas? Do I sometimes have unrealistic expectations of rural women?
- Do I recognize the strengths of rural life, as well as try to address the challenges?
- How can I make it easier for women in rural areas to attend programs?
- Do I recognize that women in rural areas are isolated and may have limited access to information and services?
- Can women call me on the phone if they have a question and are unable to attend the program?

THE ISSUE - ADVOCACY

This resource manual has given you tips, ideas and strategies help you address specific issues for women living in difficult life circumstances. Up to this point, most suggestions have focussed on reducing the impact of poverty, rather than reducing the rate of poverty. However, a global, more comprehensive approach is also important. As poverty is reduced, so are the symptoms of poverty. These broader activities can fall by the wayside as overworked service providers focus on the most pressing, day-to-day needs of pregnant women with low socio- economic status. The purpose of this section is to provide some easy-to-manage strategies when looking at the reducing poverty, not just the impact of poverty.

Advocacy is part of the broader picture. This word has negative connotations for some people. Others believe it is beyond the scope of their work or their capabilities. However, most service

providers engage in some kind of advocacy every day, whether they know it or not. Advocacy means:

- You make a phone call to the food bank on behalf of a pregnant woman.
- You find an interpreter to accompany an immigrant pregnant woman to the Ontario Works office.
- You share the concerns of low-income pregnant women with others to inform them of women's needs.
- You keep up-to-date with new programs and services that reduce the impact of poverty on people in your community.
- You dispel myths about pregnant women living in poverty.
- You stand up for a pregnant woman when you hear others make stereotypical comments.
- You are supportive. You tell a pregnant woman what a great job she is doing.

Of course, advocacy can also be much broader or more overt than these examples. Advocacy includes working with others for social and economic justice. It involves expanding the quality, accessibility and universality of health care, education and social welfare programs, to promote anti-racism, and to protect programs and services that ensure quality of life.

Program examples

- **Think Again** (Best Start Barrie and a community coalition) was an anti-poverty initiative designed to dispel the myths about poverty. It included a media campaign and public forum. The coalition developed pamphlets and bus posters that provided information about the myths about living in poverty. Small tear-off pads that were attached to the posters said, "We want to know what you think" and included a phone number. This allowed the coalition to examine public attitudes and measure the effectiveness of the campaign. The second part of the strategy was a public forum on poverty to dispel the many myths about people living on social assistance.
- **The PRISM Discount Card Program** (AWARE, Kingston) is not directed specifically at pregnant women, but rather towards low-income single mothers; however, it could be adapted to any population. The program was designed to enable single mothers to access to a wider range of goods and services from participating business partners at discounted rates (similar to student or seniors discount cards). The overall goal is to reduce the impact of poverty on single mothers and their children.

Tips

- **Talk** to your co-workers and supervisor. Find out what's possible in your workplace regarding advocacy activities.
- **Think** of covert as well as overt advocacy activities. Some workplaces may not be comfortable with overt advocacy, but are fine with so-called covert activities.
- **Encourage** women to advocate on their own behalf. Help them develop these skills: how to find

out about their rights and responsibilities, how to be assertive without being angry, or how to present their needs and situation to others.

- **Find** an ally on your municipal council or a community leader to act as a public voice for your cause. These people can promote your issue to the broader community in many ways.
- **Educate** yourself about the rules and regulations regarding Ontario Works benefits, the legislation and its application in your municipal region.
- **Share** information about your services with the Ontario Works office. Ask them to reciprocate.
- **Network** with social justice groups. Find out what they do. Let them know what you do to support low-income pregnant women. Get the needs of these women on the agenda of the group.

Ideas for community action

- **Organize an action group of low-income pregnant women** to advocate on an issue of importance to all. For example, the action group could:
 - Request of the local transit authority to designate a special seat on each bus for pregnant women.
 - Organize a public myth-busting campaign regarding poverty issues.
 - Campaign for a needed service (such as a prenatal drop-in) in your community.
 - Start a letter writing campaign to local politicians to inform them of poverty issues in the lives of pregnant women.
 - Work on policy change.
- **Start a service provider's coalition** to address the unmet needs of pregnant women living in poverty in your community. For example, the coalition could:
 - Apply for funding for a new program.
 - Organize a public forum to highlight the reality of living in poverty while pregnant.
 - Work with Ontario Works staff to ensure that the needs of pregnant women are met to the fullest extent possible under the legislation.
 - Collaborate on funding for service provision to low-income pregnant women (such as providing childcare).
 - Start a community economic development project (such as a community garden collective that sells its vegetables, herbs, and flowers to local restaurants).

Best advice

“When service providers advocate on behalf of low-income pregnant women, we feel validated - we are publicly acknowledged as important and worthy of community attention and support.” Program Participant

Questions to consider

- Am I doing all I reasonably can to advocate on behalf of pregnant women living in poverty within the scope of my current work?
- In the best of all possible worlds, what can we do to improve the living conditions of pregnant women living in poverty? Which of these things are manageable for our organization/community coalition?
- Am I getting too overwhelmed by the issue and failing to take action because I don't know where to start? What small steps can I take to make change?

THE ISSUE - SPECIFIC POPULATIONS

Some groups of low-income pregnant women are more at-risk than other groups because of social or personal circumstances that might impact negatively on healthy birth outcomes. Among others, specific population groups include immigrant and minority women, adolescents, Aboriginal women, single mothers, and women mandated through the courts or child protection services.

Tips

- **Engage** the woman. This is the key to making sure she keeps coming back to see you.
- **Consult** with others in your community about multidisciplinary issues such as substance use, violence, and so on. Ask service providers with a specialty in these areas to provide in-service training sessions or telephone consultation on a case-by-case basis.
- **Provide** as much as you can in terms of concrete supports such as food, prenatal vitamins, gift certificates, and other incentives.
- **Find** translation services for written resources from multicultural services. Consult with elders. Respect cultural differences.
- **Compile** an inventory of culturally specific information about pregnancy and parenting, food, holidays, spiritual practices, and so on. For example, Healthiest Babies Possible in Toronto has compiled a cultural inventory for the use of their staff. Each staff member collected and recorded information about one country or culture.
- **Ask** the woman about how she would like referrals to be handled (either by giving the information to the women, by making the call for the woman, or by having the referral agency call the woman).
- **Follow-up** with women who miss an appointment or stop coming to your program or service.
- **Discuss** how your program will handle disclosure, confidentiality, informed consent and reporting in a sensitive manner.

Best advice

“I can’t say it enough - the most important thing is respect, respect, respect!”

“Have faith! Pregnant teens usually will have gathered a circle of supports by the time the baby arrives and will have transformed from a laissez-faire teen to a responsible mom.” Wendy Kelen. Special Delivery Club, Kingston

Questions to consider

- Have I done my homework? Do I know as much as possible about resources in my community, including multicultural services, alcohol and drug treatment organizations and services for teens and single mothers?
- Do I always tell women about my responsibility to report to child protection services? Am I clear with her about those circumstances, while fostering a climate of mutual trust and safety? If not, how can I develop that skill?

Here are some case scenarios contributed by service providers who work with specific populations. Overall, their best advice is to encourage small steps to successful change.

Case Scenario #1: Yvonne

Yvonne is a 17 year old black teen. This is her first pregnancy. She says she can't afford to eat well and doesn't like cooking for herself, anyway. She receives \$500/month from welfare and pays \$400/month for the single room apartment where she lives alone. Her kitchen consists of a hot plate and a very old refrigerator. Yvonne has heard about the Food Bank and the Good Food Box but isn't sure how to access them. She wants to "give breastfeeding a try" as it is healthier for the baby and she knows formula is very expensive. But she has heard breastfeeding hurts and makes your breasts sag.

ISSUES TO CONSIDER

- **Her age** – She may be anxious or misinformed because she is an adolescent and this is her first pregnancy.
- **Repeat pregnancy** – She may fail to postpone a second pregnancy and have a rapid repeat pregnancy.
- **Racism** – She may be perceived negatively by the larger society, because she is black, pregnant, unmarried and a teenager.
- **Housing** – Most of her monthly income is spent on rent, which has implications for other areas of her life, in particular food purchases and getting ready for the baby. This financial imbalance also puts her at greater risk of eviction or potential homelessness, since she may eventually find it impossible to allocate this percentage of her income to her housing needs.
- **Support** – She is on her own with this pregnancy and is likely to be isolated from her peer group as a consequence.
- **Food** – She has limited cooking and food storage facilities, cannot afford to purchase adequate food, may not have the information or skills to maximize her limited food budget, and does not know how to access food programs that do exist in her community.

Small steps to success

- Provide her with bus tickets or taxi chits to help her keep her next appointment with you.
- Provide her with food or grocery store gift certificates.
- Give her information on other food programs.
- Help her find out how to access accurate prenatal and postnatal information about, for example, breastfeeding.

Case Scenario #2: Liu

Liu is a 20 year old Mandarin speaking woman who arrived in Canada one month ago with her husband. She found out about your program from a Chinese promotional flyer posted in a laundromat. Her husband is trying to find work, but in the meantime, they are living off their savings and renting a small one-room apartment. This is Liu's first pregnancy and she has just finished her first trimester. She is having difficulty sleeping, has a poor appetite and feels isolated from her community.

ISSUES TO CONSIDER

- **Securing primary health care** – She is unlikely to have a physician, in particular one who can communicate with her. She may not have a health card, or may not understand the health care system.
- **Culture and language** – In addition to the obvious isolation that can be created as the result of recent immigration, other less apparent issues can also be present. For example, she may have difficulty accessing food that is familiar.
- **First pregnancy** – She is likely to have many new experiences and concerns, all of which might be contributing to her sleeplessness and lack of appetite.
- **Support to the family** – She and her husband are experiencing financial and other family pressures while her husband searches for employment. Support to the family as a whole may help prevent further financial breakdown.

Small steps to success

- Connect her to culturally appropriate services such as immigrant services, food stores and translation services.
- Secure prenatal supports adjusted to her cultural and language needs.
- Investigate local medical clinics or other medical services that may be able to provide services to her, at least during her pregnancy.
- Make referrals to any available employment services for Liu's husband.
- Ask her if she is interested in language classes.

Case Scenario #3: Jane

Jane was mandated by child protection services to attend your program. This is her second pregnancy. Her first child was removed and placed in foster care after the baby was found unsupervised in Jane's apartment while Jane was passed out after a night of heavy drinking. She was living with her mother but moved out a couple of months ago and now lives with her boyfriend, BJ. BJ is on Ontario Works. She would like to take prenatal classes with her boyfriend, but isn't sure if he will come. Jane cut down her cigarette smoking a lot since she found out she was pregnant. (She figures she was not quite 3 months when she found out she was pregnant.) She had been smoking over half a pack and now she is down to 5 or 10 cigarettes a day, depending on the day. A lot of people around her smoke, including her mother and boyfriend. She would like to quit but it relieves her stress and she has heard that it is too stressful on the baby if she quits cold turkey. Jane smoked dope and had an occasional drinking binge but claims to have stopped drinking and using cannabis when she found out she was pregnant, even though her boyfriend drinks heavily. She wonders if it's OK to drink coolers since they are low in alcohol content.

ISSUES TO CONSIDER

- **Tobacco, alcohol, and other drug use** – Her consumption needs to be considered and assessed. Of equal importance is the consumption of those around her.
- **Access to prenatal and parenting supports** – She may need assistance to plan for the arrival of her newborn and encouragement to engage in prenatal activities, whether or not her boyfriend is involved.
- **Threat of reprisal** – She is likely to fear the on-going involvement of child protection services and may only present positive information to you, other service providers, and family or friends.

Small steps to success

- Contract with her regarding your responsibility to disclose to child protection services. Clearly outline the conditions under which you must report to authorities.
- Encourage further reduction in her tobacco use. Provide good, concrete tips to reduce and understand the benefits of reduction. De-emphasize smoking cessation, unless she expresses that she is ready to quit.
- Provide accurate information about alcohol and other drug use; for example, alcohol content of different beverages and standard drink information.
- Provide the number for the Motherisk help line (1-877-327-4636) where she can get confidential, personalized feedback about her use of substances and the potential impact they might have on her infant.
- Brainstorm strategies for coping with others in her support network who use tobacco, alcohol and other drugs.
- Encourage attendance at parenting classes, parent support groups and prenatal classes that accept single moms.

Case Scenario #4: Dora

Dora is an 18 year old woman of Aboriginal descent. She did not plan to get pregnant, however, her mother and her sisters all had children early. When she found out she was pregnant she dropped out of school and her boyfriend, Joe, stopped seeing her. She smokes a pack a day and says she is not interested in quitting. Her mother smoked through all her pregnancies and the children were all healthy. Anyway, she has heard that you gain less weight and have smaller babies if you smoke. Dora does not want to have an 11 pound baby, like some of her friends. Dora is currently staying with a friend, but soon will need to find a place of her own. She is five months pregnant and came to your program because she heard that you give out gift certificates for groceries.

ISSUES TO CONSIDER

- **Beliefs about early parenting** – Some Aboriginal communities see early parenting as a normal and healthy occurrence.
- **Cultural approaches to parenting** – There are many different cultural beliefs about what to do during pregnancy and how to raise children.
- **Cultural** – Find out about the values and expectations of her cultural community - she may not feel comfortable looking you in the eye, may prefer to sit beside, rather than across from you, may feel very uncomfortable if you touch her hair.
- **Discrimination** – Aboriginal communities are still wrestling with the debilitating effects of discrimination and the residential school system.
- **Support to the family** – Extended family support and community support are very valuable to individuals during pregnancy, especially young, single mothers.
- **Diabetes** – Rates of diabetes are much higher in Aboriginal communities and can be linked to large unhealthy babies.
- **Tobacco** – Tobacco is a sacred herb for Aboriginal communities. Smoking rates are very high, and smoking may be a social norm.

Small steps to success

- Welcome her into your program.
- Connect her to culturally appropriate services such as a local friendship centre.
- Ensure that your program tools are multicultural (food models, infant and breastfeeding models, pictures on the walls etc).
- Find out more about Aboriginal beliefs and values about pregnancy and parenting.
- Help her find out about housing options.
- Tell her how to apply for social assistance, and what the expectations will be.
- Ask about diabetes in her family and encourage her to discuss diabetes with a health care provider.
- Let her know that there are safe and healthy ways to prevent high birth weights.
- Let her know that, if she is ready to cut down on smoking, you have information that can help her.
- Ask her about her immediate and extended family and possibilities of support.



things to keep in mind

THE TOP TEN TIPS FROM WOMEN

1. Information on health risks is not enough. In order to make healthier choices we need practical information, advice and resources, support and encouragement.
2. Recognize that our lives are very stressful, but don't lose sight of the fact that we want the best for our children. It is just really difficult to put advice into practice.
3. Talking with other women is so helpful. While service providers have health information and services that are important, women living with the same challenges can help with practical ideas on how to get through each day and how to make ends meet.
4. Take the time to ask what would help. Don't make assumptions and remember it is not easy to talk about how difficult our lives are.
5. Understand why it is hard for us to be healthier, for example smoking helps us cope with day to day worries and fears. Help us make changes, but don't make us feel guilty or shameful.
6. A warm welcoming environment is so important, no matter what the program or service. We need to feel we fit in and belong and that people want us to be there.
7. Find out more about the challenges we face. Ask or read about different cultural beliefs about childbearing, what it is like to live on a very limited income and the challenges we face.
8. Search out the real practical supports that would make the most difference for us. Provide information on food banks, geared to income housing, crisis shelters, stores with second hand maternity clothes, places where we could borrow a car seat.
9. Make it easier for us to use the services. Think about what you can do around transportation, childcare and other things that may make it difficult for us to be involved. Understand that we may bring small children. Provide clean, safe toys and children's books. Think about providing services closer to home.
10. **Look at the big picture. Think about my needs. It is not just about the baby I carry. Think about things that can change in the community, not just about the things you can help me change.**

THE TOP TEN TIPS FROM SERVICE PROVIDERS

1. Always have written resources available because women soak up information, especially when they're pregnant. Service providers tend to underestimate the usefulness of written information. It's private and anonymous. And a woman, especially if she's new to your program, can spend the morning reading and not have to look someone in the eye until she's comfortable enough to do so.
2. Always think about how the woman feels. Analyze your programming from the perspective of the woman. Ask yourself continually, "Would I feel comfortable walking into this situation?"
3. Allow women (especially new ones) to bring a friend to programs. I know this is hard to do with numbers rising all the time. But it's so important. She needs the comfort of someone familiar nearby. Invite some friendly moms to attend your program so that the space is fuller and not so intimidating.
4. Ask program participants what they need and then implement it! If you're doing a focus group or needs assessment, pay them for their time. Cover their childcare and transportation costs. Give them food during the meetings.
5. Acknowledge women both when they arrive and when they leave - it honours them.
6. Review your library and eliminate any book, video, or magazine that is out of date. Don't chain books and other resources to your desk. Let women borrow them and get some use from them. Make photo copies of the sections of most importance to her.
7. Do your homework. Find out about all the services available in your community and make use of them.
8. Ensure that all staff are non-judgmental, friendly, accepting of all family types, and informed about all programs so that anyone who calls or drops by can be given accurate information immediately.
9. Respect the woman's differences in all aspects, including child rearing, relationship choices, and food preparation.
10. **You can't write a prescription to fix it all. Try not to get caught up in being solution-focussed all the time. Many times, the best thing to do is listen and let the woman tell her story.**

AFTER THE BABY IS BORN

After the baby is born the woman will need a new range of services. This resource addresses socio-economic status and pregnancy. An entirely new range of resources and supports will be needed to help reduce the impact of low socio-economic status on families with infants and children. When designing or assessing prenatal programs, service providers need to consider what will happen after the woman has “graduated” from their program. Services that provide warm, welcoming atmospheres and link women to social support are of great value. Many programs limit services to women who are pregnant and women who have infants up to the age of 6 months. Women may want to continue attending, causing a space problem and challenges in serving a wide range of women and families. Consider ways to help families move on to services that are better suited to meet their needs. Provide lists of programs and services for families. Arrange for tours of family resource centres or other programs for families with young children. Anticipate concerns and help women bridge to the resources that will help them care for their children.

evaluation



There are a number of ways to evaluate initiatives related to socio-economic status. Evaluation can show the progress, value and success of your program. It is advantageous to show to the community, funders, management and political representatives that your program is really making a difference. They may be asking why a large portion of the budget goes to food and transportation, and may question their role in improving maternal newborn health. In many cases, a few weeks of intensive care in NICU for one infant has the same cost as an entire pregnancy support program. While numbers are valuable, there are many other things that we need to ask and track in order to provide a comprehensive program evaluation.

Evaluation tools need to suit the initiative, for example the evaluation of a media campaign would be very different from that of a prenatal support program. It is not within the scope of this resource to provide details on how to evaluate all program types or how to interpret the results. There are a few key points that apply to the evaluation of socio-economic status and pregnancy initiatives. These evaluation concerns and challenges are elaborated below:

Denial or under-reporting of substance use – If you are evaluating sensitive issues such as tobacco, alcohol or drug use, participants may under-report because they are concerned about staff reactions and about possible apprehension of present or future children. Ensure evaluations are as confidential as possible and recognize that the information has some limitations.

Asking about abuse or violence – If your evaluation asks about abuse or violence, ensure that the partner is not present and consider factors related to the woman's safety. Be prepared with lists of shelters, housing options, legal assistance, financial assistance, distress or help lines and police contacts, in case a woman discloses a violent situation, and wants help.

Group size – It is very rare to have a group large enough to determine accurate comparisons in areas such as low birth weight or breast feeding rates. Information from several years or from several different programs may need to be combined in order to get sufficient data.

Comparison group – It is difficult to find a comparison group in order to determine if you are making a difference. Women of low socio-economic status are a varied group. There are great differences between programs and communities. The health characteristics of the women may be significantly different from those of the general population. You may need to concentrate on other areas of evaluation, rather than trying to show the value of your program by comparing participants to another group of people.

Process evaluation – It is helpful to track information about the process of change in your program or initiative, what went well, what didn't, and what you learned along the way. This information can help you in planning future initiatives, and can be shared with those who want to do similar work.

Participant feedback – It is critical to get feedback on a regular basis from the people involved in your program. Their input can help you determine what is helpful, needs to be changed or expanded upon.

Some things can't be measured – While many participants in pregnancy drop in programs say that the social support and welcoming atmosphere are the most important aspects of the program, it is difficult to measure their levels and their exact influence on health. Keep in mind, that while we can't always measure and track these types of factors, that does not mean that they are not important.

What you provide isn't always used – If you are providing advice, a woman may not be able to put the information into practice. If you are providing food, the woman may feed it to her children, even if she is aware of the importance of healthy foods during pregnancy. While it is important to track requests for information, referrals and resources distributed, be aware of the limitations of relating this directly to improved health.

Stigma – Consider how a woman would feel completing the evaluation. While evaluation results are critical to the success of your program, you still want the woman to feel welcomed in a non-judgmental setting.

Literacy – Some participants may have low levels of literacy. Some women may need assistance to understand and complete evaluation forms. Think about ways you can ask about this and provide assistance in a way that does not stigmatize.

Language – Program participants may not be comfortable in the language used in the evaluation. If necessary, have evaluation questions translated.

Over evaluation – Consider the impacts of regular extensive evaluation on program participants. When appropriate, frame the evaluation as an informal conversation, rather than yet another form.

Qualitative versus quantitative – While quantitative results (i.e. numbers of referrals, numbers of participants, numbers of resources distributed or health outcomes) are very valuable, do not underestimate the importance of qualitative results (how people feel, what they like or what they think about things)



resources and services

GENERAL RESOURCES & SERVICES

- **Best Start Resource Centre** has a range of resources on maternal and newborn health and provides presentations, consultations, workshops, and assistance by phone, email and fax. Phone 1-800-397-9567 or (416) 408-2249 or visit the website at www.beststart.org.
- **CAPC/CPNP** (Community Action Program for Children / Canada Prenatal Nutrition Program) have created a database/library of resource materials that projects from across Canada have created or find useful. The web site address for their library is www.hc-sc.gc.ca/Library/.
- **The First Nations and Inuit Health Branch** of Health Canada has a wealth of information about healthy pregnancies. Look on the web site at www.hc-sc.gc.ca/fnihb/chp/cpnp.
- **Pregnancy Outreach Program Handbook, British Columbia.** At the time of writing, this manual was undergoing revision. The 1997/98 version is available from BC Ministry for Children and Families, Victoria, BC www.mcf.gov.bc.ca/pubs/public_health.htm.
- **Public Health, including the Healthy Babies, Healthy Children program** has a range of services including prenatal classes and in-home supports. Contact the public health office in your community.

PRENATAL PROGRAMS

- **Home Visiting Tool Box** is a resource tool kit that provides a starting point for existing CAPC/CPNP (Community Action Program for Children / Canada Prenatal Nutrition Program) home visiting programs and for new home visiting programs. It is available from Algoma Cooperative Children's Services. Call 1-705-945-5050.
- **Special Delivery Club Kit** prepares pregnant teens and single women for pregnancy, labour and delivery, and infant care. It is available from the North Kingston Community Health Centre. Call 1-613-542-2813.

NUTRITION

- **Building A Healthy Baby** is a simple, graphic depiction of Canada's Food Guide that show how each segment in the Guide corresponds to a developing system in the baby. It is available from the Saskatchewan regional office of Health Canada. Call 1-306-780-8313.
- **Building Healthy Babies - A Prenatal Nutrition Book for Community Health Workers in First Nations Communities** is a reference book about prenatal nutrition that can be used to help plan a prenatal program or sections can be used as part of existing prenatal programs. It is available from www.hc-sc.gc.ca/fnihb/chp/clearinghouse/clearinghouse_printed.htm#Nutrition.
- **Healthy Babies Eat Home Cooked Food** is an outline of a workshop on baby food making. It is available from the Food Share, Metro Toronto program. Call 1-416-392-6653.
- **So You Want A Healthy Baby** is video about Aboriginal prenatal nutrition. It is available from www.hc-sc.gc.ca/fnihb/chp/clearinghouse/clearinghouse.
- **Who Wants To Be a Healthy Mom?** is a prenatal nutrition game based on the TV program of similar name. They also have a menu planner game to accompany a menu planner guide that can be affixed to the refrigerator. The resources are available from York Region Health Services. Call 1-800-735-6625 or 1-905-895-4512 and ask for Health Connect.

TOBACCO, ALCOHOL & DRUGS

- **Enhancing FAS-related Intervention at the Prenatal and Early Childhood Stages in Canada** is a best practices guide that examines FAS-related intervention activities in CAPC/CPNP (Community Action Program for Children / Canada Prenatal Nutrition Program) programs across Canada. Jointly produced by Breaking the Cycle and the Canadian Centre on Substance Abuse, it is available from the CCSA. Call 1-613-235-4048, [email pubs@ccsa.ca](mailto:pubs@ccsa.ca).
- **Info Packs: Smoking Cessation in Pregnancy** identifies tools, skills and resources you need to develop a plan of action for smoking cessation during pregnancy. It is available from the Program Training and Consultation Centre at www.ptcc.on.ca/rds.
- **Motherisk** has a help line on substance use during pregnancy, in addition to many other resources. The toll free number is 1-877-327-4636 or visit the web site at www.motherisk.org.
- **Motivational Approaches Within the Stages of Change for Pregnant Women Who Use Substances: A Training Guide for Service Providers** is a training manual that provides strategies to use with pregnant women who use alcohol. Jointly produced by Breaking the Cycle and AWARE, it is available from AWARE. Call 1-613-545-0117 or [email aware@kos.net](mailto:aware@kos.net).

TEEN PREGNANCY

- **Living Lessons - Teen Pregnancy/Teen Parenthood Game** is a socially interactive game, based on research, encouraging wise choices and responsibility. Contact Brighter Futures, Port Colborne 1-905-714-0227.
- **Pro-action, Postponement, and Preparation/Support: A Framework for Action to Reduce the Rate of Teen Pregnancy in Canada** is available through the Canadian Institute of Child Health at 1-613-230-8838 or at www.hc-sc.gc.ca/hppb/childhood-youth/cbp/npfproject/index.htm.
- **Rock and Talk Facilitators Guide** is a 12 session group program for teen moms, addressing a range of nutrition, parenting, and self care issues. It is based on the Special Delivery Club but has increased the smoking component and is translated into French. It is available from the Victorian Order of Nurses in New Brunswick. Call 1-506-672-9647.

VIOLENCE AND ABUSE

- **A Handbook for Health and Social Service Professionals Responding to Abuse During Pregnancy** is a resource manual that examines issues of family violence during pregnancy and strategies for its prevention. It is available from the National Clearinghouse for Family Violence, www.hcsc.gc.ca/hppb/familyviolence/html/pregnancy/english/index.htm.
- **Centre for Social Justice** is an organization concerned with social justice issues. They have many available publications and resources. Contact them at www.socialjustice.org.
- **Colouring Outside the Lines: Practice and Theory in Community Programs** is a report from CAPC/CPNP (Community Action Program for Children / Canada Prenatal Nutrition Program) Think Tanks that outlines the community development process. It is available from www.hc-sc.gc.ca/hppb/childhood-youth/cbp/nfp/project/index.htm.
- **Finding Your Way** is a video (with companion handbook) by and for single mothers on Ontario Works that answers many common concerns raised by women on social assistance. It is available from AWARE. To order, call 1-613-545-0117 or email aware@kos.net.
- **Ontario Coalition for Social Justice** is a provincial organization concerned with social justice. Contact them at www.ocsj.ca.
- **Postpartum Depression and Anxiety: A Self Help Guide for Mothers** is an easy-to-read booklet produced by the Pacific Postpartum Support Society. It is available by contacting the Society in Vancouver, B.C. Call 1-604-255-7999.
- **The PRISM Discount Card Program Handbook** provides an overview of the program as it operates in Kingston and guidelines for establishing a similar program in your community. It is available from AWARE. Call 1-613-545-0117 or email aware@kos.net.

A FINAL WORD

“Don’t be discouraged. The issues can feel overwhelming. But focus on the small steps. They can make a big difference.” Monica Petzoldt, MotherCare, Barrie

glossary of terms

Accessibility – relates to the presence or absence of a range of barriers to services including transportation, hours of service, etc

Advocacy – the act of taking action on behalf of others

Depth of poverty - the difference between the persons income and the poverty line

Determinants of health – the entire range of factors that influence health including income and social status, social support networks, education, employment and working conditions, social environments, physical environment, personal health practices and coping skills, healthy child development, culture, health services, gender, biological and genetic endowment

Empowerment – actions that serve to increase the capacity and capability of others

Fear of reprisal – fear that there may be negative consequences such as apprehension of her children or of her baby once it is born

Fetal alcohol effects - a diagnosis of this syndrome implies prenatal exposure to alcohol resulting in brain damage and or growth problems and or birth defects that may including distinct facial characteristics

Fetal alcohol syndrome – a diagnosis of this syndrome implies prenatal exposure to alcohol resulting in brain damage, growth problems and birth defects including distinct facial characteristics

Food security – initiatives that increase access to food, not just knowledge of healthy food choices

Judgmental attitudes – attitudes that judge the values, beliefs and actions of others implying blame and guilt

Plain language – simple straight forward language using short words and sentences and focussing on the information that is most important

Prenatal Care – regular education, medical assessment and intervention during pregnancy

Retention – the length of time a woman stays in a program, for example, drug or alcohol treatment

Structural barriers – barriers to services such as lack of transportation and child care

Socio-economic status – defined by an individual’s income, level of education and occupation and can include issues related to housing, cultural background, material possessions and the perception of having a meaningful role in social life

Stages of change – when individuals change a behaviour, they usually go through a series of well defined stages, including pre-contemplation (not thinking about change), contemplation (thinking about change), action (in the process of change) and maintenance (trying sustain the new behaviour)

Ways and means – tools, supports or material needs necessary to put advice into practice

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