

2003




# THE IMPACT OF POVERTY ON PREGNANT WOMEN

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*A Guide  
for Program  
Managers*

**best start  
meilleur départ**

Ontario's maternal, newborn and early  
child development resource centre  
Centre de ressources sur la maternité,  
les nouveau-nés et le développement  
des jeunes enfants de l'Ontario



This document has been prepared with funds provided by Ontario Early Years. Best Start is a key program of the Ontario Prevention Clearinghouse (OPC) and is funded by the Ontario Ministry of Health and Long-Term Care. The information herein reflects the views of the authors and is not officially endorsed by the government of Ontario.

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## Purpose

The purpose of this resource is to assist program managers in supporting their frontline staff who work with pregnant women who live in poverty. This guide briefly highlights key information and guidelines that program managers can use to:

- Determine the needs in the community,
- Develop or revise programs intended for pregnant women who live in poverty,
- Promote awareness of the issues related to poverty and pregnancy,
- Train staff in addressing risk factors,
- Prepare program budgets.

This resource augments the information provided in “Reducing the Impact: working with pregnant women who live in difficult life situations” (Best Start, 2002). “Reducing the Impact” was designed to assist frontline staff to deliver effective strategies for pregnant women of low socio-economic status. It contains a detailed review of the literature, recommendations and program information.

## Introduction

Understanding the issues and effective strategies related to pregnancy and poverty will enhance the delivery of programs geared to pregnant women or those programs that may have pregnant women who live in poverty as a part of the larger participant group.

*“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)

In spite of universal health care, poverty still negatively affects prenatal, infant and maternal health. Women in the lowest socio-economic group are four times more likely to have pregnancy related complications that require hospitalization (Mustard et al, 1995). Infant mortality rates are 1.6 times greater in the lowest income groups (Health Canada, 2000). Some research shows that pregnant women who live in poverty may not be a special needs group, but are the mainstream maternity population (Braverman et al, 1999).

**The poverty rate for all single mothers is 54.2%. The poverty rate for single mothers less than 25 years of age is 85.4%. Young single mothers have the greatest depth of poverty, living thousands of dollars beneath the poverty line (National Council of Welfare, 2000).**

### **Prenatal Care**

- Low income pregnant women who experience other negative life events (poor housing conditions, substance use, lack of social support, child care and transportation) are least likely to seek prenatal care (Marquis & Butler, 2001),
- Most of these women are aware of the benefits of prenatal care but barriers exist that lead to late or no entry to prenatal care (Omar et al, 1998).

### **Stress and Lack of Support**

- The barriers that prevent access to prenatal care also predict high levels of stress and lack of social support (Marquis & Butler, 2001),
- People who are extremely stressed are more likely to be young and single, live in poverty and have low social support and smoke heavily (Van De Sande, 1999),
- They are also more likely to move frequently and are less likely to access available services (Van De Sande, 1999).

### **Abuse and Violence**

- Abuse often starts during pregnancy or if previously existing, the frequency and severity often increases (Marquis & Butler, 2001),
- Pregnant women who live with the threat of abuse and violence are more likely to be depressed, to use substances and are less likely to eat well (Martin et al, 1998),
- Many pregnant women do not report domestic abuse (Marquis & Butler, 2001).

### **Depression**

- There are many interconnected issues related to depression among pregnant women: low social support, substance use and poverty,
- Women with a good social support network report lower levels of depression, before and after delivery (Weber, 1999; Dasilva et al, 1998).

### **Smoking and Substance Use**

- Smoking and substance use are not just poor lifestyle choices. They serve many purposes for women: to cope with stress and depression, to relax and to control appetite/weight,
- Substance use in pregnancy is associated with poverty, with partners who are substance users and with abuse and violence (Centre for Addiction and Mental Health, 1998; Health Canada, 2001),
- If a pregnant woman cannot quit smoking or using substances, reducing the amount she uses will improve birth outcomes (harm reduction),
- Pregnant women who use substances need to feel that services offer safety and security, and that providers will not judge them for their substance use.

### **Nutrition and Food Security**

- Most low income pregnant women are aware of the need to eat well during pregnancy but lack sufficient finances to do so (Van De Sande, 1999),
- Access to good affordable food makes more difference to what women eat than education about nutrition (Wilkinson & Marmot, 1998),
- Many pregnant women who live in poverty report that food expenses come last in the monthly budget.

**Impact of poverty on pregnant women - what every manager needs to know**

*There are many factors that contribute to poor birth outcomes such as food security, stress, violence and abuse, lack of support and substance use. When combined with poverty it increases the risks of both the mother and the infant.*

## Recommendations

*These recommendations include information gathered from a variety of sources: current research, interviews with pregnant women living in poverty and their service providers.*

### Lay the Ground Work

#### 1. Dispel myths

Misconceptions, values and beliefs about low socio-economic status may interfere with obtaining the support needed to develop effective programs and services. Managers may have to clarify fact from myth as they support the needs of pregnant women of low socio-economic status, whether it is with decision makers, potential funders, politicians or even their own staff.

Some common myths include:

*Low-income women don't know how to budget.* The problem is not the mismanagement of money. Most low-income women receive less money than is needed to provide the basic necessities of life.

*You don't need money to bond with your child.* 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. Research shows that the children of parents living in poverty are less healthy than those of higher income families.

*Teens get pregnant so that they will have enough money for their own apartment.* Most pregnant teens do not intend to get pregnant. Many are trying to leave a difficult situation at home or may be fleeing an abusive partner.

*We managed without, so they can too.* It is much more difficult to manage than it used to be. Extended family supports are less common. It takes two incomes for families to make ends meet.

*Women on welfare are too lazy to work.* Most women on welfare are unable to work or can't find work.

Program Managers are encouraged to:

- Explore myths regarding pregnant women who live in poverty with staff.
- Consult staff for their frontline expertise.
- Create opportunities for staff to support each other and share ideas.
- Provide your staff with local statistics and successful approaches to working with women of low socio-economic status.
- Visit other successful programs.
- Include frontline staff in program planning and evaluation.
- Ensure that staff has access to current listing of resources in their community.

#### 2. Build networks

Network with not only those with similar services, but reach out to broader based programs such as literacy programs, schools and libraries. Consider nontraditional partners such as small businesses or large retail chains. Many private businesses are acknowledging that they have a social responsibility to become involved in health and social issues in their community.

- Host a networking day/community event with a good speaker. This may get people excited about an issue.
- Potential speakers could come from a variety of sources: a local food bank, Ontario Works, a grassroots agency, an anti-poverty coalition or a family resource centre.

- When approaching a potential partner, send a letter of introduction and follow it up by a telephone call.
- If a potential partner expresses interest, make a personal visit.
- Make sure you have a list of reasons why you need this person's contribution.

### 3. Prepare, train and support staff

Dealing with complex issues such as poverty, violence and substance use can be overwhelming. Acknowledge this with your staff and follow up regularly.

- Provide inservice education not only on the issues related to pregnant women living in poverty but ways in which staff can deal with their own stress.
- *“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.”*

### 4. Gather local statistics

Local statistics will be required when applying for funding for programs and services geared to pregnant women who live in poverty. It may be difficult to find local statistics. Many surveys do not collect this information and there is some controversy in the definition of poverty.

- For information regarding your local area you may contact the following: health units, hospitals, Community Action Programs for Children (CAP-C), Canadian Prenatal Nutrition Programs (CPNP), Better Beginnings/Brighter Futures Programs, municipal social services department, social planning council, district health council, community health centres, urban planning departments, community information centres, Ontario Early Years Centres and researchers at a nearby university or college.

### 5. Determine local needs

Do not make assumptions about the needs of pregnant women who live in poverty. Determine the priority needs of the women in your community.

- Involve pregnant women in the strategic planning, program design and evaluation.
- If you are doing a needs assessment/focus group pay the participants for their time. If money is not available provide them with an appropriate gift. Cover child care and transportation costs up front. Do not wait to reimburse them after the session. Give them food during the focus group.

**Babies First (CPNP, Peterborough, 705-748-9144)** consulted women and paid them for their time before the program began. The development of the program and budget followed to meet those needs. This program provides participants with transportation, childcare, a morning snack and lunch, a \$15 per week gift certificate for food, access to a pound of frozen ground beef, a bag of frozen vegetables and orange juice from an on site freezer.

## Shape the Program

### 6. Access prenatal care

Pregnant women who live in poverty face many barriers to accessing prenatal care: structural barriers such as lack of transportation, no telephone, health care provider shortages, cultural and linguistic barriers, and high levels of stress.

- Provide incentives. Offer transportation, milk, prenatal vitamins, meals/snacks and grocery gift certificates.
- Address a wide range of issues: substance use, domestic abuse, food security and financial concerns.
- Utilize harm reduction approaches when necessary.

- Provide in-home supports: home visits, telephone support and services offered through computer technology.
- Consider offering prenatal classes for adolescents in school settings. This may allow participants to obtain school credits for prenatal class attendance and provides support for new mothers to continue their education.

**Higgins Method (Montreal Diet Dispensary, Montreal, 514-937-5375)** describes its approach as global. In addition to providing food to participants, it also provides support, advice and referrals. Staff receives an initial four weeks of training and continued inservice training in psychology, counselling, substance use and abuse during pregnancy.

**Breaking the Cycle (pregnancy and substance use program, Toronto, 416-364-7373)** utilizes the harm reduction approach. It does not condone substance use but seeks to decrease its incidence and the harm that it causes. Breaking the Cycle evaluations have shown healthier birth outcomes, better maternal health ratings and fewer breakdowns in parenting relationships.

## **7. Culturally sensitive programming**

Ensure your program resources are culturally inclusive.

- Food models, infant and breastfeeding models and pictures on the wall need to reflect the cultural diversity of participants.
- Reinforce culture sensitivity. Become aware of different cultural practices, but avoid generalizing. Encourage openness and responsiveness. Don't make assumptions about someone's culture.
- Allocate funding for interpretation services. Utilizing a family member may interfere with confidentiality, especially if family violence is an issue.

**Toronto Public Health (Healthy Babies Healthy Children Program, 416-338-7600)** budgets for interpretation services for its professional staff.

**Stop 103 (Toronto, 416-652-7867)** is a prenatal program that works in partnership with a local literacy program. They assist interested women in learning English, writing letters, preparing resumes and reading to the children. Stop 103 is also linked with an employment service's job registry, and conducts workshops on job readiness.

## **8. Access other support services**

Ensure service coordination.

- Ideally support services should be offered on site: food banks, clothing exchanges, toy lending library, individual counselling, telephone and computer access.
- If other support services are not available on site, ensure your referral services lists are up to date and encourage frontline staff to assist clients with referrals as necessary.

**PRISM Discount Card Program (AWARE, Kingston, 613-545-0117)** was designed to assist single mothers to access goods and services from participating business partners at discounted rates, similar to student or senior discount cards.

**Parkdale Primary Prevention Project (CPNP, Toronto, 416-530-6850)** obtains donations of flannel material and yarn. This is offered to participants interested in making maternity and baby supplies.



## 9. Restrictions

- Do not exclude women from prenatal programs based on the stage of pregnancy. For example, some programs only admit participants in their first two trimesters of pregnancy. Women at any stage of pregnancy need to be included.
- Ensure there are services available to the women postnatally. You may want to provide postnatal services at your prenatal program or ensure there is a follow up program available to women once they have given birth.
- Do not exclude women from using just one service your program may provide. For example, some programs require a woman to attend prenatal classes to qualify for food bank usage. Some women may only feel comfortable in accessing one service. These women may require more time to build trust in the service providers before they feel ready to access all the services they require.

## 10. End of the month programs

Food security needs of pregnant women who live in poverty are greater from the middle to the end of the month. This coincides with the timing of distribution of social assistance cheques.

- Provide increased food access in the latter half of the month.
- Approach local businesses for donations of food and/or baby supplies.
- Incorporate celebrations in your program. Establish ways to celebrate the birth of a baby or a milestone or a success such as a participant quitting smoking. This celebration may be the only one this family will receive.

**Healthy Mothers Healthy Babies (Sandwich Community Health Centre, Windsor, 519-258-6002)** provides a welcome package to all participants. It is a tote bag filled with information about the program's prenatal services, nutrition, parenting and breastfeeding. It includes a baby bath thermometer, safety information, recipes, free samples, coupons to attend prenatal programs, prenatal exercise classes, home visits, cooking classes, milk and egg vouchers, coupons for video rentals, skin and make up demos, prenatal vitamins and a smoke alarm from the local fire department.

## Critical Considerations

### 11. Food Security

Information about good nutrition is secondary to food security. Do not assume that all pregnant women who live in poverty need education on how to budget, menu plan and follow Canada's Food Guide. They need the money to purchase or alternate ways to obtain healthy, fresh, nutritious food.

- Spend your program funding where it is needed – on food, meals and grocery gift certificates.
- Utilize innovative means to ensure food security: start a bulk buying club, make monthly visits to farmers' markets, open a lending library of cooking equipment, provide spices and condiments.

### 12. Advocacy

Advocacy does not need to be linked to political activity. Small steps can make a difference.

- Encourage staff to make phone calls on behalf of clients and/or accompany clients to referred services.
- Share concerns of pregnant women who live in poverty with funders, politicians and other decision-makers.
- Develop an awareness campaign dispelling myths about pregnant women who live in poverty.

## Program Evaluation

*It is important to show the community, funders, upper management and political representatives that your program is really making a difference.*

## Conclusion

**Think Again (Community Coalition, Barrie)** was an anti poverty initiative designed to dispel myths about poverty. It consisted of a media campaign and a public forum.

### 13. Rural issues

Rural pregnant women may be extremely isolated. Lack of transportation, distance and weather conditions can cause barriers as well as, fewer services and options.

- Provide transportation to and from prenatal programs, community services and prenatal appointments.
- This is a challenge that many rural services face. There are a number of programs that are attempting to address this issue by approaching taxi companies for discount services or religious organizations that provide transportation to seniors or those with disabilities that may be able to broaden their clientele to include pregnant women who live in poverty.

You may be asked why a large portion of the budget goes to food and transportation, and may question their role in improving maternal and newborn health. A few weeks in NICU for one infant has the same cost as an entire pregnancy support program. While most programming uses quantitative evaluation, there is merit in qualitative evaluation. This may include individual interviews, written feedback and group discussions. This will provide a more comprehensive program evaluation. For more detailed information on program evaluation refer to “The Guiding Principles for Program Evaluation”, <http://www.uottawa.ca/academic/med/epid/principale.htm> or The Health Communication Unit ([www.thcu.ca](http://www.thcu.ca)) at (416). 978.0522.

- Know where your program fits into the big picture of programs and services for pregnant women. Invite other services to partner with you in providing program evaluation. They may have evaluation methods, which you can adapt to your program.
- Assess your impact upon the reduction of risk behaviours such as substance use during pregnancy.
- It is important to track the process of change in your program – what went well, what didn’t and what you learned along the way.
- Keep a log or journal for participants to write their comments in. Let the women’s voices be heard. Subjective information can go a long way in influencing funders, politicians and other decision-makers.
- Ensure that your evaluation forms are sample tested for their readability. If necessary, have the forms translated into other languages.
- Don’t over evaluate.

The experiences of pregnant women who live in poverty, their service providers and managers, combined with the research, demonstrate the impact of low socio-economic status on maternal and newborn health. The impact of poverty can be lessened with innovative interventions. Managers and service providers alike have the capacity to create meaningful change.

Breaking the Links Between Poverty and Violence Against Women, Health Canada

Centre for Social Justice, [www.socialjustice.org](http://www.socialjustice.org)

Child Poverty Profile 1998, National Council of Welfare, [www.ncwcnbes.net](http://www.ncwcnbes.net)

Finding Your Way: A Guide to Ontario Works for Single Mothers, video and handbook, [aware@kos.net](mailto:aware@kos.net)

Guidelines for Partnering and Collaborative Arrangements with the Private Sector and Other Partners, Health Canada, May 2001, <http://www.hc-sc.gc.ca/socialmarketing>

Pregnets, Network for the Prevention of Gestational and Neonatal Exposure to Tobacco Smoke, [www.pregnets.org](http://www.pregnets.org)

Reducing the Impact: Working with Pregnant Women who Live in Difficult Life Situations, Best Start 2002, [http://www.beststart.org/pract\\_prod/anti\\_poverty/REDUCE.pdf](http://www.beststart.org/pract_prod/anti_poverty/REDUCE.pdf)

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## Key Resources

## References

## Acknowledgements

Best Start would like to thank the many pregnant women, frontline service providers and program managers who contributed their time and insight into developing this guide for program managers. In particular thanks to Jennifer Reid who drafted the original text of this resource as well as Charlotte Rosenbaum and Beth Fraser for their valuable input.

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