

**HOW POVERTY SHAPES WOMEN'S EXPERIENCES OF HEALTH DURING  
PREGNANCY: A GROUNDED THEORY STUDY**

By

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## **ABSTRACT**

The health of pregnant women is a major concern to health care providers. This grounded theory study of 40 women examined the health of pregnant women and the special threat that poverty and violence posed to their capacity for health. Pregnant women experienced their health as an integrated part of their daily lives; that is, they reported that their health was affected by "everybody and everything." Women's main concern during pregnancy was to have a healthy newborn and, to this end, they engaged in the process of creating a healthy pregnancy by engaging in health-enhancing behaviours. In this process, the woman focused primarily on ensuring the birth of a healthy baby. Three conditions were essential to a woman's capacity to create a healthy pregnancy: (1) the acceptance of the pregnancy, (2) adequate financial resources, and (3) supportive relationships (especially having a supportive partner).

Pregnancies invariably carried with them some uncertainty, and this caused the 40 women in this study to experience a state of vulnerability which, in turn, triggered attempts to create healthy pregnancies. This led to a cycle of improving health: the more energy women had to carry out health-enhancing behaviours the better they felt physically and mentally; the more able they were to conduct their daily activities; and, consequently, the better their health. However, living within a context of poverty and/or violence increased pregnant women's vulnerability and decreased their capacity for creating a healthy pregnancy, leading to extreme stress and the experience of threat. Male violence threatened the women's ability to be connected to those who were important sources of emotional, financial, task-oriented, and knowledge-oriented support, and, thus jeopardized their ability to meet their fundamental needs. Furthermore, the lack of sufficient financial resources limited women's abilities to leave their abusive partners. In order to survive, women in these circumstances sometimes reverted to previous, often harmful, ways of coping in an attempt to reduce their high levels of stress. These coping strategies usually took the form of behaviours

that required little energy, such as smoking, not eating properly, and consuming alcohol.

Having financial support and a safe place to go were crucial with regard to enabling women to decide to leave abusive partners. Regaining control of their lives in this way allowed women to refocus their energy on health-enhancing behaviours. The women in this study showed incredible strength as they met the challenges imposed by poverty and abuse. They did not remain victims but took hold of their lives with courage and conviction.

In order to promote the adoption of health-enhancing behaviours by childbearing women, health care providers must recognize poverty and violence as factors that significantly threaten women's capacity for health. Further to this, special efforts must be made to render culturally sensitive care to First Nations women (i.e., recognizing their cultural identity and heritage, their connection to nature, and the importance of the elders of their community). To this end, we must recognize the connections between racism, colonization, poverty, and violence. For until we have eradicated poverty, and the cycle of violence and degradation that is its legacy, we will not have succeeded in doing all we can to ensure the health and well being of our citizens.



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## **CHAPTER ONE: BACKGROUND**

The links between poverty and poor health are well established, and poverty continues to be the most significant persistent predictor of a person's mortality and morbidity (Adams & Wilkins, 1988; Manga, 1993; Wilkinson, 1996). Repeated demonstrations show that people of lower socioeconomic status fare worse than do people of higher socioeconomic status on almost every measure of health. They also have poorer self-rated health and poorer health behaviours (Manga, 1993). This gap between the health experience of the rich and that of the poor has widened in the second part of this century, particularly in the last few decades (Townsend, 1991).

In Canada, as in other Western countries, the rate of poverty is increasing, and women and children are the group most likely to be living in poverty (Glendinning & Millar, 1992; Ross, Shillington, & Lochhead, 1994) — a phenomenon that has been referred to as the “feminization of poverty” (Pearce, 1978). The feminization of poverty presents a great challenge in the current turbulent political climate, when Canadian social programs (such as the Canada Health Act and other social safety nets) have experienced cutbacks. High rates of unemployment suggest that the number of women in poverty will continue to increase and may reach an all-time high by the year 2000 (Glendinning & Millar, 1992; Najman, 1993). No doubt this will have serious implications for the health of children and pregnant women. The health gap between poor pregnant women and the larger society is significant because the health status of women directly affects the health status of future generations (McBarnette, 1988).

The significance of gender as a health determinant has been highlighted in several recent documents (British Columbia Ministry of Health, 1996; National Forum on Health, 1997; British Columbia Ministry of Women's Equality, 1997). Income disparities, double workload, power inequities, and violence are some of the factors that affect women's well-being in our society. However, much remains to be learned

about the effects of poverty on women's health, as the analysis of health inequalities has, until recently, paid little attention to gender (Macran, Clarke, Sloggett, & Bethune, 1994; Marmot, Kogevinas, & Elston, 1987).

The relatively high risk faced by women in regard to poverty reflects the social, political, and cultural context in which they live (Cohen, 1994). The systemic economic dependency of women within families and marriage, in the sexual division of labour, and in social policy creates a gendered vulnerability to poverty (Canadian Advisory Council on the Status of Women, 1991; Thomas, 1994). Women who are poor have less access to, and less control over, resources such as food, shelter, clothing, education, and transportation (Blackburn, 1991). They find themselves either doing menial jobs that carry no benefits or being unable to work because they cannot afford child care (Canadian Advisory Council on the Status of Women, 1991). Frequent threatening and uncontrollable life events and chronically poor living conditions have a tremendous effect on low-income women's health (Belle, 1990). As a response to deprivation and stressful life events, low-income women adopt harmful behaviours (such as smoking) more frequently than do high-income women (Graham, 1994; Payne, 1991; Rajan & Oakley, 1990).

It is well established that women with low incomes experience higher neonatal mortality rates, due largely to low birth weight, than do women with adequate incomes (Canadian Institute of Child Health, 1993; McCormick, Brooks-Gunn, Shorter, Holmes, Wallace, & Heagarty, 1989). Indeed, low birth weight (LBW) accounts for 75% of early neonatal mortality in both Canada and the United States and is a significant contributor to both infant and childhood mortality (Canadian Institute of Child Health, 1993; US Department of Health and Human Services, 1990). Due to alarming rates of LBW worldwide, and the concomitant costs to families and society, its reduction and prevention has become one of the most pressing issues in prenatal care (Levitt, Watters, Chance, Walker, & Avard, 1993).

According to Health Canada (1994a), prenatal care is key to improving infant mortality because it is thought to be crucial to promoting healthy lifestyles and to modifying those health-damaging behaviours most commonly linked to poor obstetrical outcomes (e.g., poor prenatal care, poor nutrition, smoking, and alcohol use) (Tiedje, Kingry, & Stommel, 1992). However, little is known about the effectiveness of current strategies with regard to reducing harmful behaviours (Health Canada, 1994a; Walsh & Redman, 1993). Furthermore, prenatal care is often criticized for being based on the needs of white, middle-class health care providers and white, middle-class pregnant women (Loos & Morton, 1991; Sullivan, 1993). Thus it frequently fails to reflect the interests of lower-class women of colour (Freda, Andersen, Damus, & Merkatz, 1993; Kogan, Kotelchuck, Alexander & Jonhson, 1994; Sokoloski, 1995; Zambrana, 1991).

Current theory does not adequately address how poverty shapes behaviour during pregnancy. According to Wilkinson (1996) the unacceptable health status of the poor has simply been attributed to their poor health behaviours: "When trying to explain the effects of socioeconomic circumstances on health, psychosocial factors are relevant only to the extent to which they are responses to those circumstances" (p. 181). Furthermore, with regard to LBW, outcome measures of women's health status remain ill-defined (Oakley, 1993a). The narrowness of current research and theory has precluded a fuller understanding of women's everyday lives – and thus of factors that influence their view of health and, consequently, their options for health behaviours (Ford-Gilboe, & Campbell, 1996). According to Shiono, Rauh, Park, Lederman, and Zuskar (1997) we need to search new avenues in order to uncover the complete, multifaceted picture of the causes of LBW.

In an attempt to address inadequacies in current prenatal programs, innovative community-based programs (such as Best Start in Ontario) are now flourishing (Canadian Institute of Child Health, 1993; Stewart & Nimrod, 1993). Such



socioenvironmental programs represent the latest trend in health promotion strategies for the reduction of LBW. They represent a “bottom-up” plan in which community leaders first identify needs and goals, then draw on their collective strength to solve problems (Labonté, 1992). However, these new strategies will fail if the voices of women in poverty continue to be excluded. Effective health promotion strategies must incorporate an understanding of how poverty shapes the experience of health, and they must address how the circumstances of a woman’s environment and her everyday life affect her options for health-enhancing behaviours during pregnancy.

The members of the profession of nursing are committed to the promotion and achievement of holistic health (Meleis, 1990) and have historically played a central role in the delivery of care to childbearing families through the promotion of healthy lifestyles and the modification of unhealthy behaviours (Pender, 1987; Carney, 1992; Hargraves & Thomas, 1993).

Consequently, nursing research has provided a wealth of findings regarding psychosocial attributes that re related to individual health behaviours such as hardiness, learned helplessness, self-efficacy (Muhlenkamp & Sayles, 1986), and social support (Bolla, DeJoseph, Norbeck, & Smith, 1996; Aaronson, 1989; Norbeck & Tilden, 1983; Schaffer & Lia-Hoagberg, 1997). However, while these theories focus on individual characteristics, they often ignore the context of women’s everyday lives and its effect on their capacity to take care of themselves (Gazmararian, Adams, & Pamuk, 1996; Palank, 1991).

It is widely accepted that psychosocial determinants of health behaviours are influenced by the social and material conditions that form the context of people’s everyday lives (Mechanic, 1992; Meleis, 1990; Milio, 1976; Pesznecker, 1984; Poland, 1992). Indeed, the Ottawa Charter for Health Promotion (1986) implicitly defines health as a product of social relations: “[Health] is created and lived by people

in the settings of their everyday life, where they learn, work, play, and love" (World Health Organization, Health and Welfare Canada, & Canadian Public Health Association, 1986, p. 427). The factors that influence health are no longer recognized simply as disease or lifestyle behaviours; they also include "peace, shelter, education, food, income, a stable ecosystem, social justice and equity." Socioenvironmental conditions are themselves seen as important health determinants that play a key role in explaining differences in rates of morbidity and mortality between different population groups and nations (Wilkinson, 1996). One of the major conclusions of the National Forum on Health (1997) is that Canada must pay more attention to social and economic determinants of health. The final report of the National Forum noted: "We are particularly concerned about the impact of poverty, unemployment, and cuts in social supports on the health of individuals, groups and communities" (p. 15).

Nurses encounter and care for clients whose health problems stem from socioenvironmental conditions (Moccia & Mason, 1986; RNABC, 1998). In nursing there has been, over the last decade, an increased awareness of the importance of links between health and the environment, and a greater emphasis on examining the relationships between social, political, economic, and cultural conditions that produce health and illness (Butterfield, 1990; Chopoorian, 1986; Kleffel, 1991; Meleis, 1990; Moccia & Mason 1986; Nelson, 1990; RNABC, 1998; Stevens, 1989). According to Chopoorian (1986) the social, political, and economic structures associated with class relations, power relations, political interests, economic policies, and such ideologies as sexism, racism, and classism must be investigated, since all of these influence people's behaviour and, therefore, may potentially interfere with health. Thus it is critical to view health as being socially rather than individually defined; by doing so, we can develop critiques and solutions that address the social structure of health care (Meleis, 1990; Thompson, 1989). Although nursing research does often take environment into account, it does so in an individually oriented (i.e., physiological and psychosocial)

way, thereby limiting our understanding of it as a determinant of health (Hagan, O'Neill, & Dallaire, 1995). To date, nurse researchers have not succeeded in providing a way to understand health as a holistic experience (Allen, 1986; Jones & Meleis, 1993; Reynolds, 1988).

Thus, in order to understand what influences women's health and health behaviours, it is necessary to study the circumstances of their everyday lives; that is, their roles, their material conditions, and the psychosocial characteristics that make up their experience of health. Knowledge about women's perspectives on health and health behaviours in the context of their daily lives is crucial to the development of useful strategies for promoting women's health (Leslie, 1992; McBride & McBride 1994; Meleis, 1990; Nelson, 1994; Oakley, 1993b; Palank, 1991; Poland, 1992; Ruzek, 1993; Woods, Lentz & Mitchell, 1993).

### **The Research Question**

This study focuses on understanding the meaning of health and health behaviours to pregnant women living in poverty. It addresses the research question: "How does the context of poverty and the everyday life associated with it shape pregnant women's experience of health and health behaviour?"

## **CHAPTER TWO: LITERATURE REVIEW**

Existing knowledge regarding pregnant women living in poverty has been structured around understanding and preventing poor reproductive outcomes and has focused primarily on identifying the risk factors related to LBW. Women in poverty appear on national research agendas as a result of the high rates of LBW among their infants. That is, we have focused on the etiology surrounding LBW while ignoring the women most at risk: women in poverty, especially women of colour. Reduction in the frequency of LBW is a high national priority due to its impact on infant mortality and on child health (Canadian Institute of Child Health, 1993). The World Health Organization (WHO) considers the percentage of newborns weighing at least 2500 grams to be an essential global indicator of improving health, and the main strategy for reducing the incidence of LBW has focused on prenatal care (WHO, 1992).

Although several interrelated risk factors have been associated with LBW (Canadian Institute of Child Health, 1993), research has focused predominantly on four of them: (1) the demographic characteristics of non-users of prenatal care (Goldenberg, Patterson, & Freese, 1992); (2) the lifestyles and behaviours of pregnant women (Sanderson, Placek, & Keppel, 1991); (3) the barriers to access to prenatal care (Harvey & Faber, 1993; Lia-Hoagberg, Rode, Skovholt, Oberg, Berg, Mullett, & Choi, 1990); and (4) the characteristics of successful prenatal care programs (Health Canada, 1994a). As there is a wealth of research in this area, I have limited this review to studies that address the impact of poverty on the health and health behaviours of pregnant women. I discuss, in turn, literature that deals with (1) the demographic characteristics of women with poor obstetrical outcomes, (2) barriers to prenatal care, (3) characteristics of effective prenatal care programs, and (4) the lifestyles and behaviours of pregnant women.

## **Effectiveness of Prenatal Care**

### **The Demographic Profile**

Most of the research conducted in this field has consisted of studies portraying the socioeconomic status, ethnicity, and demographics of women who have poor birth outcomes (Boone, 1985; Gennaro, Brown, Stringer, & Brooten, 1994; WHO, 1992). The demographic characteristics of women most at risk for having LBW infants are: low income, younger than 19 or older than 35, non-white, single, and poorly educated (Gennaro, Brown, Stringer, & Brooten, 1994; Levitt, Watters, Chance, Walker & Avard, 1993). Although there are major differences between health care delivery in the United States and in Canada, in both countries the women most at risk for poor obstetrical outcomes are those who are economically, socially, and educationally deprived.

Women who receive little, late, or no prenatal care are also at increased risk for poor pregnancy outcomes (Goldenberg, Patterson & Freese, 1992). Indeed, research in this area has largely been guided by the assumption that prenatal care is the major vehicle for improving pregnancy outcomes (Goldenberg, Patterson, Freese, 1992; Health Canada, 1994a). Further to this, improving access to and use of prenatal services is seen as a cost-effective means of improving infant health (Moore, Origel, Key & Resnik, 1985). Consequently, in the last two decades there has been a substantial amount of research focusing on inadequate use of prenatal care and the barriers encountered by women attempting to gain access to it.

### **Barriers to Prenatal Care**

Barriers to prenatal care are multifaceted, existing both in the system and the self, in that demographic variables, psychological variables and sociological variables interact. Barriers to prenatal care have been categorized into three types: (1) structural/systemic, (2) psychosocial/individual, and (3) socio-demographic (McClanahan, 1992; Melnyk, 1988). Structural/systemic barriers include such things as

transportation problems, financial constraints, absence of child care, inconvenient clinic hours, employment status, family responsibilities, unfamiliarity with community resources, and problematic interaction with health care providers. Psychosocial/individual barriers include such factors as feelings about the pregnancy and attitudes towards health care, social support, and knowledge (Augustyn & Maiman, 1994). Finally, socio-demographic barriers to care include such things as income, education, age, and marital status. These barriers to prenatal care are interrelated and stem largely from poverty (Brown, 1988; McClanahan, 1992; Kliegman, Rottman, & Behrman, 1990; Swartz, 1990).

A study by Health Canada (1994a) sought to identify the barriers to prenatal care. Findings identified three types of barriers: (1) structural and social, (2) values and beliefs, and (3) the low priority given to preventive health care by disadvantaged families. Structural and economic barriers included costs of transportation and child care, a lack of awareness of services, site accessibility, the geographic isolation of First Nations and rural communities, a lack of culturally sensitive programs, social isolation, and a lack of emotional support from family members (especially male partners). Values and beliefs that functioned as barriers to prenatal care consisted of feelings of cultural oppression, powerlessness, and hopelessness; fear of being judged by middle-class health care providers; and, among women with substance abuse problems, fear that their babies would be apprehended if they sought care. The low priority given to preventive health care by disadvantaged families was a result of women having to focus on obtaining food and shelter rather than on seeking prenatal care. This report further concluded that the impact of poverty is often exacerbated by violence, illness, racism, isolation, and a lack of social support, and it suggested revising the definition of high-risk pregnancy so that it takes into account more risk factors than simply risk for LBW.

In a review of the barriers to prenatal care in the United States, Enderlein, Stephenson, Holt, and Hickok (1994) noted that the most commonly reported barriers were financial restraints and inadequate insurance coverage. Many American studies have examined the impact of Medicaid on LBW (Buescher, Roth, Williams, & Goforth, 1991; Handler & Rosenberg, 1992; Hass, Udvarhelyi, Morris, & Epstein, 1993; Schwethelm, Margolis, Miller, & Smith, 1989). A study by Lia-Hoagberg and associates (1990) of a stratified sample of low-income white, black, and Native American women concluded that access to Medicaid does not ensure adequate prenatal care and, further, that the removal of financial barriers is necessary but not sufficient to ensure adequate prenatal care to low-income women. Women in this study reported many other concerns as a result of their poverty (e.g., putting food on the table and paying rent). The authors suggest that future research consider the "total life situation" of low-income pregnant women and that the impact of poverty on their lives not be underestimated. This conclusion is similar to those of others, who argue the importance of focusing on the wider social and economic needs of these women (McCaw-Binns, La Grenade, & Ashley, 1995; Melmeikow & Alemagno, 1993).

Katz, Armstrong, and LoGerfo (1994), in a study concerned with quality of prenatal care and the incidence of LBW, examined the differences between low-income women receiving Medicaid in the State of Washington and low-income women receiving provincial health insurance in the Province of British Columbia. Their findings revealed that, overall, the risk of receiving inadequate prenatal care was much greater in Washington than in British Columbia, mostly due to the American women's late enrolment in Medicaid. In both regions, however, the poor were at similar risk for LBW relative to their more affluent counterparts. These results are consistent with other studies that have found little relationship between the utilization of prenatal care and LBW (Hass, Udvarhelyi, Morris, & Epstein, 1993; Schwethelm, Margolis, Miller, & Smith, 1989). They concluded that the occurrence of LBW is

influenced by complex biological and social factors that may not be greatly affected by prenatal care. According to Shiono et al. (1997), all causes of LBW have yet to be discovered.

### Characteristics of Effective Programs

It is now recognized that adverse social and economic conditions, psychosocial stress in the absence of strong social support, and negative health behaviours (such as smoking and substance abuse) are all important risk factors that have been routinely ignored in studies of the effectiveness of prenatal care (Brown, 1988; Merkatz & Thompson, 1990). One component of prenatal care programs is to offer social support as a means of alleviating some of the stresses associated with poverty (Canadian Institute of Child Health, 1993). Research in the field of social support during pregnancy emphasizes that such support buffers those in stressful circumstances from much that is harmful (Hoffman & Hatch, 1996). This has led to an attempt to determine what types of programs might reduce poor pregnancy outcomes (Fischler & Harvey, 1995; Health Canada, 1994a; York & Brooten, 1992).

A study by Olds, Helderson, Tatelbaum, and Chemberlain (1986) was undertaken to test the impact of a multifaceted prenatal support program for high-risk women (e.g., teenage, single, or of low socioeconomic status). Important elements of support were provided through home visits by community nurses, enhanced social support, and increased availability of community services. Significant positive effects on birthweight and gestational age were found in those who were under 17 years of age and in those study participants who smoked. Teenage women in the treatment group gave birth to infants who were, on average, 395g heavier than were those in the control group. Among smokers, the incidence of preterm birth was 75% lower in the treatment group than in the control group. The women who were visited by nurses made better use of community resources (including prenatal classes and nutrition supplements); reported more interest on the part of fathers; were more likely to be



accompanied in labour by a support person; and talked more with family, friends, and care providers.

Contrary to these findings are those of Rajan and Oakley (1990), who examined the effects of social support on a group of 509 low-income women with a history of LBW. In the intervention group, midwives provided 24-hour on-call service, home visiting, emotional support, counselling, and referrals. Although there were no differences in overall LBW rates, women in the intervention group experienced improved emotional well-being. Rajan and Oakley conclude that social support, while an important part of prenatal care, is not likely to overcome the consequences of economic and social deprivation. However, in a seven-year follow-up study, Oakley, Hickey, and Rajan (1996) found the long-term effects of social support enhanced the health of both the women and their children.

Social support, offered through a one-to-one approach to care and home visiting, is often a feature of enhanced prenatal programs aimed at LBW prevention. Studies in which lay family workers provided special support to disadvantaged women revealed that there was no difference in either intra-uterine growth retardation (IUGR) or prematurity between the treatment group and the general population (Nagy, Leeper, Hullett, Northrup, & Newell, 1988; Spencer, Thomas, & Morris, 1989). It was concluded that, for women at greatest risk, the support of lay workers was insufficient to balance other adverse factors leading to LBW.

Blondel and Bréart (1995) reviewed seven randomized controlled trial studies to determine the impact of home visits on obstetrical outcomes and rates of hospitalization of at-risk pregnant women. They concluded that, overall, home visits improve neither pregnancy outcomes nor the use of health services. However, home visits did lead to women's increased knowledge, increased levels of perceived support, better health habits, and increased satisfaction with care. Blondel and Bréart warned that, although the results were inconclusive, both stress and lack of social support appear to negatively affect pregnancy outcomes. They concluded that "we do not yet

know precisely how all these factors work together to affect pregnancy and what kinds of support play a role in the well-being of women and children and further research is warranted to explore these problems” (p. 270).

In a recent large study (Kitzman, Olds, Henderson, Hanks, Cole, Tatelbaum, McConnochie, Sidora, Luckey, Shaver, Engelhardt, James, & Barnard, 1997), 1,139 women participated in a randomized controlled trial to test the effect of nurse home visits on pregnancy-induced hypertension, preterm delivery, and LBW. These women were primarily African-American and were at less than 29 weeks gestation, had no previous live births, and had at least two sociodemographic risk characteristics (such as being single, having less than a Grade 12 education, and being unemployed). Nurses made an average of seven home visits to those in the treatment arm of the study. The results revealed that these visits appeared to reduce pregnancy-related hypertension, childhood injuries, and subsequent pregnancies; however, no significant differences were noted in rates of LBW or preterm labour. These results confirm that support may not be sufficient to overcome other adverse factors leading to LBW.

In Canada, the Prenatal Health Promotion Project Report (Health Canada, 1994b) evaluated the characteristics of 257 programs in Ontario, Quebec, and British Columbia that dealt with perinatal risk. Most programs emphasized education, healthy lifestyles, and physical well-being. Almost half offered such incentives as food, child care, and access to other services. Group discussion, one-on-one counselling, and classroom presentation were the most commonly used educational strategies, although peer support was also an important component of successful programs. The most common challenges reported were recruiting women to programs and maintaining attendance. This report recommends providing sustainable funding, programs and materials specific to pregnancy and lifestyle issues, culturally appropriate materials in the languages of client groups, access to research information, assistance with recruitment, and an increased focus on preconceptional health. The report notes that

the majority of programs were unable to provide women with travel costs, vitamin and food supplements, child care, maternity clothes, or birth control devices.

Similar results were found in the United States, where the overall success of many programs studied was modest (York & Brooten, 1992). Some major problems with prenatal programs included implementation and maintenance, lack of funding and community support, and lack of formal evaluation mechanisms. With regard to the effectiveness of prenatal care programs in the United States, York and Brooten (1992) offer the following summary: effective programs were those that offered various types of providers (such as midwives and nurse practitioners) who gave women respect and support, that employed various strategies to locate and recruit women, and that provided services with lay workers, including home visitations and educational and social support.

Throughout this literature, there is an underlying assumption that receipt of adequate prenatal care leads to a healthy pregnancy. The relationship between LBW and prenatal care has been the subject of many research studies, most of which show that the presence of the latter leads to a reduction in the former (Goldenberg, Patterson, & Freese, 1992; Thomas, Golding, & Peters, 1991). However, these studies failed to address the content of prenatal care visits, an important factor in the quality of care, and this renders their conclusions suspect (Katz, Armstrong & LoGerfo, 1994; Enkin, 1990; Petitti, Hiatt, Chin & Croughan-Minihane, 1991). The view that improved prenatal care alone is the variable responsible for improvements in maternal and infant mortality and morbidity cannot be supported (Enkin, Keirse, Renfrew, & Neilson, 1995). As it is becoming widely recognized that the major determinants of women's health are nonmedical, it is at least as likely that failure to obtain prenatal care is associated with other adverse health behaviours that may themselves be related to LBW (Dan, 1993; Hall, 1991; Iams, 1989).

There has been little improvement in the incidence of LBW in the last several years, perhaps because past programs failed to recognize the complexity of problems tightly interwoven into the social and economic system (Herman, Berendes, Yu, Cooper, Overpeck, Rhoads, Maxwell, Kinney, Koslowe, & Coates, 1996; Stewart & Nimrod, 1993). Thus, new programs are emphasizing a multidimensional approach. In Canada, the Best Start Prenatal Care Program (Canadian Institute of Child Health, 1993) is based on a socioenvironmental model of health care (Labonté, 1992). One assumption of this model is that LBW will only be reduced through multifaceted programs and creative partnerships between provincial health care and community health promotion activities (Canadian Institute of Child Health, 1993). Thus, a community-wide approach must address the biological, psychological, social, and economic risk factors associated with LBW, and community leaders, policymakers, employers, and voluntary organizations must encourage a focus on the underlying influences on individual health and behaviour. Many strategies may be used to promote health, including social marketing, health education, community development, community organization, policy development, advocacy, community organization, financing, legislation, screening, and early identification and treatment (Stewart & Nimrod, 1993). However, so far it is not clear the community-based approach to prenatal care has heard the voices of pregnant women in poverty and recognized them as experts on their own lives and the care they require.

To conclude, the knowledge gained from ongoing biomedical and epidemiological research to date has been unable to improve reproductive outcomes of women in poverty, since its narrow focus has limited our understanding of how economic, social, and cultural factors affect the health and behaviour of pregnant women (Leslie, 1992).

## **Health Behaviours of Pregnant Women**

This literature is also plagued by systematic methodologic problems. First, the generation of knowledge regarding health behaviour during pregnancy has been hampered by the absence of an adequate theoretical framework (Brown, 1988; Goldenberg, Patterson, & Freese, 1992; Loos & Morton, 1991; Zambrana, 1991). Most research conducted on the health behaviours of pregnant women has consisted of identifying the sociodemographic profile of their consumption patterns with regard to nutrition, tobacco, and alcohol and establishing the harmful effects of these substances on fetal health. Although research on people in poverty has become more apparent in the nursing literature over the last few years, very few studies pertain to health behaviours of pregnant women.

Kemp and Hatmaker (1992) found no differences in anxiety levels among low-income women regardless of their perinatal risk status, although low-risk women had better health practices than did high-risk women – a finding that the authors found difficult to explain. Although the instrument used (the Health Promotion Lifestyle Profile) had been tested extensively, it had not been used previously with pregnant women, thus undermining these results. Further, the forced-choice nature of the instrument items limited subjects' responses.

In an attempt to provide a more adequate understanding of pregnant women's health behaviours, Tiedje, Kingry and Stommel (1992) developed the Beliefs of Pregnancy Questionnaire, based upon the Health Belief Model (HBM), in order to assess pregnant women's health beliefs regarding inadequate care, poor nutrition, smoking, and drinking. The use of a heterogeneous convenience sample of 127 women attending prenatal classes is one of the study's strengths. However, the questionnaire format may have precluded women from commenting on other issues that may have been relevant to them. The HBM has also been criticized for placing too much weight on social and psychological variables and not enough on health

behaviour variables (Galvin, 1992). Evaluative research on Pender's Health Promotion Model, a model similar to the HBM, revealed that it inadequately explains health-promoting behaviours; for this reason, a complete revision of the model has been recommended (Johnson, Ratner, Bottorff, & Hayduk, 1993).

Two large survey studies contribute some insight into health behaviours during pregnancy. Rajan and Oakley (1990) mailed a questionnaire to 467 postpartum women who had participated in a randomized controlled trial of social support in pregnancy. The authors report a correlation between poor diet, alcohol and drug consumption, and smoking on the one hand, and women's economic, social, and emotional circumstances on the other hand. Participants perceived that they did not have it within their power to change their harmful behaviours even if they wished to do so. The researchers concluded that working-class women smoke more than do middle-class women because they have more stressful lives, largely as a result of poor housing and low incomes: "These are structural, not individual problems, and have to be solved through fundamental changes in society, not by imposing an additional burden of guilt on the victims of poor social policy" (Rajan & Oakley, 1990, p. 82).

A study of the health behaviours of pregnant women in rural Alberta involved a total of 173 participants who completed questionnaires (80.5% response rate) (Dow-Clarke, MacCalder, & Hessel, 1994). According to the sociodemographic profile, participants came mostly from educated and high-income households. Most women reported doing something to improve their health during their pregnancy (usually improved eating habits, followed by stopping or reducing alcohol consumption and smoking). Approximately one-third of the women (36.6%) reported smoking during pregnancy. Most (90%) reported being exposed to second-hand smoke. Almost half (48.8%) said that they had consumed alcohol since learning of their pregnancy. Thirty percent were unaware of their immunization status. Although the authors reported

more harmful lifestyles in women with lower incomes, they do not comment on why this should be the case.

Two qualitative studies focused on health beliefs and practices of pregnant women. Patterson, Freese, and Goldenberg (1990) conducted a grounded theory study involving 27 pregnant women in order to explore utilization of health care services. The participants included 14 women who received prenatal care at a county health department clinic, nine women who received private care at either a physician's office or a university affiliated clinic, and four women who did not enroll in prenatal care. Findings suggest that once women accepted their pregnancies, they focused their attention on maintaining their health and that of their fetuses. The level of risk each woman perceived varied according to her estimate of her and/or her fetus's vulnerability during pregnancy. Many women immediately sought a health care provider in order to further ensure a healthy outcome and used strategies such as: searching, consulting, transferring, waiting, and contingency planning. Although these women viewed prenatal care as an important component of promoting a healthy pregnancy, they also valued self-care, which consisted of changes with regard to diet, rest, exercise, consumption of alcoholic beverages, and use of medications. The authors did not elaborate on what conditions might have enhanced the adoption of healthy or unhealthy behaviours during pregnancy.

Higgins, Frank, and Brown (1994) conducted an exploratory study to describe the health practices of 115 women from five different ethnic groups, all of whom were recipients of prenatal care. They concluded that, during the course of their pregnancies, women made changes in their diets, exercise patterns, smoking habits, vitamin intake, and alcohol use. The authors, who did not report the socioeconomic status of the participants, contended that further research was needed in order to identify what motivates health behaviour changes during pregnancy.

Most recent investigations into the health behaviours of pregnant women in poverty have explored smoking habits, as smoking during pregnancy is identified as an important risk factor of LBW (Canadian Institute of Child Health, 1993; Health Canada, 1995a). In a Canadian review of research on smoking and pregnancy, Edwards, Sims-Jones, and Hotz (1994) found that women in poverty smoke more than their middle-class counterparts and they attribute this to their particularly stressful lives. Women who continue to smoke prenatally are more likely to be poor, young, single, to have a limited education, and to be unemployed or to work in a low-status job (Edwards, Sims-Jones, & Hotz, 1994). Stewart and Streiner (1995), in a study to determine the prevalence of smoking in a sample of Canadian pregnant women, confirmed the findings of Edwards and Sims-Jones (1998) and added that women who smoke during pregnancy have more unplanned pregnancies and suffer more physical abuse both during and before pregnancy.

Over the last decade, new educational programs have flourished in an attempt to reduce smoking during pregnancy (Health Canada, 1995b). In a review of smoking cessation programs, Walsh and Redman (1993) concluded that most programs were inadequately developed and were not being delivered by physicians or nurses. Others have also reported the failure of smoking cessation programs (Dodds, 1995; Ershoff, Quinn, & Mullen, 1995; Health Canada, 1995c). According to Logan and Spencer (1996), in a review of the effects of smoking on pregnancy and early childhood outcomes, the authors concluded that while smoking is harmful, the magnitude of its effects may be smaller than previously suggested. They pointed out that behavioural programs aimed at smoking cessation may be ineffective if the social context of women's lives is not considered, as women's capacity to quit smoking may be limited by their social circumstances. Thus, these studies confirm the central and predominant influence of poverty in women's lives.



## **Critique**

Research within the field of prenatal care and health behaviour has primarily documented the needs of white, middle-class, married pregnant women (Loos & Morton, 1991; Morris, 1992; Rodin & Ickovics, 1990). Assumptions about the needs of this group of women are based on perceptions of health care providers, who are largely white and middle class, and these perceptions often differ from those of the women who actually received prenatal services (Freda, Andersen, Damus & Merkatz, 1993; Sullivan, 1993).

When women in poverty have been studied, they have been treated as a homogenous group (Health Canada, 1994a; Zambrana, 1991). Consequently, investigators have traditionally viewed race and socioeconomic status (SES) as confounding variables requiring only statistical control (MacIntyre, 1994; Ruzek, 1993). Few studies systematically report sociodemographic information, and most use inconsistent definitions (Zambrana, 1991). Furthermore, most researchers selected one convenient measure of SES (usually education or income) and failed to consider how other measures could have influenced their findings (Gazmararian, Adams & Pamuk, 1996).

Another major methodological issue with regard to the demographic profile of women who do not attend prenatal care is that variables such as age, parity, education, and income have been analyzed either entirely independently of each other or have been stratified in relation to another demographic variable. Such procedures are inadequate, as it is well known that there are high levels of interdependency among the various demographic variables (Goldenberg, Patterson, & Freese, 1992; Health Canada, 1994a). This has led to an incomplete picture of the implications of poverty on women's health. Few studies have used qualitative methodologies or targeted lower socioeconomic, cross-cultural, and/or rural groups.

Thus, the generation of knowledge regarding health behaviour during pregnancy has been hampered by the absence of an adequate theoretical framework and a number of methodological limitations (Brown, 1988; Goldenberg, Patterson, & Freese, 1992; Loos & Morton, 1991; Zambrana, 1991). According to Zambrana (1991), the most serious limitation in this field of research is the lack of comparability between samples (i.e., ethnicity) and variables (such as the use of different measures for social support). For example, in the United States, variations in the definition of prenatal care (Goldenberg, Patterson & Freese, 1992) and variations in reporting decisions regarding the treatment of missing data probably had implications for assessing the impact of Medicaid expansion on prenatal care (Alexander, Tompkins, Petersen & Weiss, 1991). Indeed, most of the research in the field of prenatal care has been conducted in the United States. This being the case, the substantial differences between the Canadian and American systems of health care delivery, along with differences in ethnicity, educational levels, and socioeconomic positions, must be taken into consideration.

An overview of this body of literature reveals that research to date has relied upon an individualistic perspective to explain the poor health outcomes of low-income pregnant women. Two models have been used for the study of the etiology of health and illness: the individualistic model and the environmental model (Coburn & Eakin, 1993). The individualistic model focuses on individual behaviour as a determinant of health and targets the individual for intervention (Mechanic, 1992). Following this model, the poorer health of those living in poverty is largely attributable to their failure to seek adequate medical care and to their own harmful health behaviours (Nelson, 1994; Payne, 1991; Stewart, 1990). In this vein, Oakley (1993a) claims that because health is constructed as individualized and personal, women who experience health problems are constructed as failing to behave in appropriate ways. As a consequence of this model, differences in behaviour between the poor and the non-poor are posited as a possible explanation for the poorer health of low-income groups. According to

Payne (1991): “[Our] view of inequalities in health [is] reinforced by government emphasis on health education and health promotion, in which the focus is on individual behaviour rather than the structural context of behavior” (pp. 143-144). The ideology of individual freedom and responsibility leads to blaming the poor for their poor health status (Handwerker, 1994; Yeo, 1993) which is, essentially, “blaming the victim” (Ryan, 1976).

In contrast, the environmental model states that most everyday behaviour is conditioned by non-health related motives (McLeroy, Bibeau, Steckler, & Glanz, 1988; Mechanic, 1992; Milio, 1976), and research has demonstrated that dominant factors in health-related behaviour are sociodemographic variables rather than attitudes and beliefs (Haan, Kaplan, & Camacho, 1987; Palank, 1991; Wilkinson, 1996). However, a more appropriate position is not to choose either an individualistic or an environmental approach to health behaviour, but to seek to understand individual behaviour within its structural context (Coburn & Eakin, 1993). The individualistic model and the environmental model are complementary, and both are necessary for a comprehensive understanding of health (MacIntyre, 1994). Nurse theorists have called for integrating the individual and the environmental approaches to health behaviour, thus emphasizing how health is shaped by the larger social environment (Chopoorian, 1986; Kleffel, 1991; Nelson, 1994; Stevens, 1989).

### **Conclusion**

Although research has been conducted in the area of prenatal care and reproductive outcomes among pregnant women living in poverty, the benefits of such efforts have not significantly improved the health of women themselves, nor have they significantly improved neonatal outcomes in the last two decades (Canadian Institute of Child Health, 1993). Over the past few decades, our understanding of the health of childbearing women has been driven by a focus on obstetrical outcomes with little attention being paid directly to the most important risk factor: poverty. It is unlikely

that the knowledge gained from such research will be able to improve birth outcomes, since this narrow focus fails to fully appreciate the influence and interrelationships of the social, economic, and cultural aspects of women's lives: women's own voices remain absent (Hargraves & Thomas, 1993; Health Canada, 1994a; Iams, 1989; Leslie, 1992). Furthermore, women's health has been viewed as important only to the extent that it shapes infant health, and this focus has told us little about the health of women. In other words, children have been given priority over women (Oakley, 1993a; Wise, 1993). The central issue must now be the improvement of women's health, along with (and not merely subordinate to) the reduction of poor obstetrical outcomes.

The experiences of women themselves must be understood, as it is they who possess the most precise and in-depth knowledge regarding their health (Code, 1991; Fonow & Cook, 1991). Reexamining the problem of the health of low-income pregnant women according to their perspectives (i.e., taking into account the psychosocial and environmental factors that affect their lives) will allow for the design of more efficient and effective programs and policy. Increasing the effectiveness of care for childbearing women living in poverty will depend on developing adequate explanations of the psychological processes and the social contexts that motivate them to engage in either health-enhancing or health-compromising behaviours. Thus, it is first necessary to fully understand how pregnant women living in poverty view their health.

## **CHAPTER THREE: METHODOLOGY**

In this chapter, I present an overview of grounded theory methodology and a feminist perspective on research. I then describe the way in which this method and perspective informs my research design, including the setting, the sample, data collection, analytic processes, and the scientific rigour of qualitative research. I conclude the chapter by discussing the ethical considerations of this study.

### **Grounded Theory Methodology**

Given the paucity of research on poverty among child bearing women, and the need to develop theory that captures the salient features of women's everyday life experiences, grounded theory methodology is particularly well suited to this study because it allows the problem to be defined by the actors (or participants) within the contexts of their everyday lives. Grounded theory is a qualitative method that uses systematically collected data to build theory in an inductive rather than in a deductive manner (Strauss & Corbin, 1994).

Initially explicated by Glaser and Strauss (1967), grounded theory is a "from-the-ground-up" approach to research that employs analytical techniques on qualitative data (i.e., subject self-reports, field observations, and documents pertinent to the phenomenon of interest) that allow the generation of concepts, the identification, and refinement of conceptual relationships, and (eventually) the development of theory. Because grounded theory methodology can be focused on people as they exist in their social situations, the middle-range theory generated through this method is usually relevant to the context of their everyday lives.

The origins of grounded theory methodology are found in symbolic interactionism (Strauss & Corbin, 1990). Symbolic interactionism is a social psychological perspective with roots in the works of William James, George Herbert Mead, C. H. Cooley, and W. I. Thomas (Stryker & Statham, 1985). However, the term

was first used by Blumer in 1937 (Hammersley, 1989). Within symbolic interactionism, reality is viewed as a social construct, and special emphasis is given to the meanings and experiential aspects of human behaviour (Blenner, 1990). In other words, it refers to interactions among and between people who, over time, are motivated by the symbolic meanings that actions, objects, and events have acquired for them both individually and collectively (Edwards & Saunders, 1990). Symbolic interactionism contends that the experiential aspects of human behaviour are developed through a process of negotiating and renegotiating the reality of the lived world. Symbolic interactionists believe that individuals define their world by processing knowledge in a variety of ways. Three of its key assumptions are:

1. Human beings act toward things on the basis of the meanings that the things have for them.
2. The meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows.
3. Meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he [sic] encounters (Blumer, 1969).

According to this view, people construct their own reality by interacting with, rather than by reacting to, the symbols around them. This results in a socially constituted self as well as in a socially constituted environment. A corollary of this is that individuals can describe the reality of their situations to others and have it understood. In other words, a person's behaviour can be understood when his or her perceptions are understood. A feminist perspective further contributes to an understanding of women's health behaviours in light of the systematic gender inequalities and material realities faced by women.

### **Feminist Perspective**

Nurse scholars are presently combining grounded theory methodology and a feminist perspective (Kearney, Murphy, Irwin, & Rosenbaum, 1994; Keddy, Sims, &

Stern, 1996; Wuest, 1995). Feminist theory lends itself well to grounded theory methodology because it values the experiences of people, their intuitions and analyses, their world, and their sociocultural and political perceptions. It involves sensitivity to the conditions that affect a person's responses and takes into account different sociocultural backgrounds.

Feminist scholarship has emerged from the critical analysis of the traditional androcentric concept of science (Harding, 1991; Keller, 1992; MacPherson, 1983). According to Stacey (1991), "feminist scholars had begun to express widespread disenchantment with the dualisms, abstractions, and detachment of positivism, and were rejecting the separations between subject and object, thought and feeling, knower and known, and political and personal" (p. 111). In seeking to correct the androcentrism of traditional research, feminist social scientists have emphasized the importance of qualitative and descriptive studies, a closer link between the researcher and the researched, participant observation and experiential analysis, action research, acknowledgment of the role of values in research, and a whole host of techniques that are contextual and subjective (Olesen, 1998). Not surprisingly, as a result of dissatisfaction with traditional androcentric models of research, many nurses have adopted a feminist perspective (Allen, 1993; Campbell & Bunting, 1991; Doering, 1992; Hall & Stevens, 1991; Meleis, 1991; Thorne & Varcoe, 1998). Furthermore, feminist theory is congruent with symbolic interactionism, as both respect the person's subjective interpretation of social experience as a source of knowledge (Code, 1991; Glaser, 1992).

Fundamental to feminist science is the acknowledgement that women's experience is a central part of knowledge and that it has been long neglected (Code, 1991). This central tenet is based on two things: (1) the belief that the everyday, personal experience of every woman has worth and should be understood in all its complexity and richness (Smith, 1987; Thompson, 1992), and (2) the belief that

science has a strong androcentric bias and is, therefore, not representative of women (Keller, 1992). Feminists charge that masculine bias in social inquiry has consistently made women's lives invisible and that it has distorted our understanding of women's and men's interactions and the social structures within which they occur (Belenky, Clinchy, Goldenberg, & Tarule, 1986; Benhabib, 1987; Caplan, 1985; Gilligan, 1982; Sherif, 1987). Therefore, it is crucial to determine what is missing from science in terms of priorities, theories, and strategies. Feminism insists that we examine the assumptions central to any given discipline (Chinn, 1985; Clarke, 1992; Jevne & Oberle, 1993; Sherwin, 1992). It asks us to find out which questions get asked and which are ignored and to rethink our assumptions about gender, power, and social institutions (Alcoff & Potter, 1993). Feminist scholars are transforming various disciplines by rethinking basic concepts, theoretical frameworks, and assumptions (Campbell & Bunting, 1991; Cook, 1983; DeMarco, Campbell, & Wuest, 1993). Feminist research moves beyond refining and revising existing concepts; it reconceptualizes the terms of the debate (Marecek, 1992).

In first examining the literature, my initial research interest was low birth weight, for it had been identified as one of the most pressing national and international issues in prenatal care (Health Canada, 1994a). I quickly realized that the most common risk factor for LBW was poverty, and I was surprised to find an immense gap in knowledge regarding the relationship between women's health and poverty. A feminist critique (Ford-Gilboe & Campbell, 1996) assisted me to appraise the prenatal care literature more critically and to conclude that the voices and perspectives of women who are most at risk for poor obstetrical outcomes are mostly absent.

The goals of feminist research are many. Incorporating feminism into nursing research is an integral part of the struggle to liberate women in particular and people in general from environmental oppression (Fonow & Cook, 1991; Reinhartz, 1992). Within a feminist framework, nursing knowledge is elicited and analyzed in such a



way that it can be used to alter oppressive and exploitative conditions (Parker & McFarlane, 1991a). It provides a transforming vision of the future as well as a structural analysis of the present (Stevens, 1989). One important feature of feminist research is the attention it gives to the intersection between the social, economic, political, and ideological spheres of social life and how it influences women. This is similar to symbolic interactionism, which looks at the larger social structures that shape people (Mead, 1934).

For feminists, the divide between theory and practice is unsatisfactory, both personally and professionally (Olesen, 1998). Theory is constantly modified by what proves effective in practice, and practice is constantly shaped by theory. Within a feminist perspective, any separation between theory and practice is artificial. At the heart of feminist research is the notion of praxis. Lather (1986) uses the phrase "research as praxis" to refer to research that attempts not only to understand and critique the power imbalances in society, but also attempts to "change that maldistribution to help create a more equal world" (p. 528). Praxis is essential in order to instigate effective social policy, to improve the quality of women's lives, and to help emancipate those whose lives are locked into unfair or oppressive structures. This view is exemplified by a group of nurse scholars who challenge nurses to incorporate a sociopolitical and economic paradigm into their client-oriented psychosocial paradigm (Butterfield, 1990; Chopoorian, 1986; Kleffel, 1991; Stevens, 1989).

### The Researcher's Role

The idea of objectivity has been extensively criticized by those working within the interpretive branches of the social sciences. People who believe in the validity of objectivity believe that it is possible to separate the researcher (and her/his subjective biases) from the research process and thus to ensure unbiased results. Feminists and interpretive social scientists have rejected the notion that such a separation is possible. Contrary to viewing science as value-free, feminists view it as a social and political

activity (Eichler, 1985). Research is a political process in which the values and the politics of society are reflected in the microcosm of science. Rather than strive for unobtainable objectivity, most feminists want to be clear about how their beliefs shape their practice. Because both questions and answers are very much influenced by the point of view of the investigator, it is essential that the researcher's background be part of the data (Campbell & Bunting, 1991). And so, as much as possible, the researcher must identify her personal values, assumptions, and biases at the outset of the study. Rather than trying to separate ourselves from our data, we should use our personal experience and prejudgments as a way of generating knowledge (Thompson, 1992).

### Reflexivity

Central to this study is the notion of reflexivity. Wuest (1995) advocates the use of reflexivity as a means of enhancing the adequacy of findings when using both a feminist perspective and grounded theory. Anderson (1981) states that reflexivity is the practice of reflecting upon, examining critically, and exploring analytically the nature of the research process. Hall and Stevens (1991) define a reflexive approach to research as that which "fosters integrative thinking, appreciation of the relativity of truth, awareness of theory as ideology, and willingness to make values explicit" (p. 21). The notion of reflexivity is similar to grounded theory's notion of theoretical sensitivity, which refers to "the researcher's knowledge, understanding, and skill, which foster his [sic] generation of categories and properties and increase his [sic] ability to relate them into hypotheses" (Glaser, 1992, p. 27). Strauss and Corbin (1990) have referred to theoretical sensitivity as "the attribute of having insight, the ability to give meaning to data, the capacity to understand, and the capacity to separate the pertinent from that which isn't" (p. 42). Glaser (1992) goes on to assert that "professional experience, personal experience, and in depth knowledge of data in the area under study truly help in the substantive sensitivity necessary to generate categories and properties, provided the researcher has conceptual ability" (p. 28).

In order to emphasize my reflexive stance and to let the reader know who I am, I write using the first person. I am a 34-year-old married heterosexual white Acadian, mother of three, from northern New Brunswick. I studied nursing at the college level and then attended the Université de Montréal to pursue my bachelor's and master's degrees. My interest in this study came from my desire to make a significant contribution to the field of prenatal health. My initial interest led to the examination of LBW infants, as LBW is a major contributor to infant mortality and has been identified as the most pressing issue in prenatal care. Upon examining the literature, I found that there was a dearth of knowledge concerning women and poverty. This led me to ask: "Why, if poverty is the single most important risk factor for LBW and poor obstetrical outcomes, is there so little written about poor pregnant women? Why are their voices absent?"

During the course of my doctoral studies, many life events shaped my thinking, enabling me to relate to many of the life events described by the women in my study. Questions I found useful when reflecting upon and analyzing data were: (1) How is this woman like me? (2) How is she not like me? (3) How are these similarities and differences being played out in our interaction? (4) How is this interaction affecting the course of research? and (5) How is it illuminating and/or obscuring the research problem? (Christman, 1988). During this study, I kept a journal in which I documented this reflexive accounting. First, being a mother of three young children and having two pregnancies during the course of this study provided me with a personal perspective on many of the themes discussed by the women. For example, at the beginning of my second pregnancy I experienced a moderate antepartum hemorrhage. It was a time when we had decided to move (I had completed two years of doctoral course work) largely because my family's safety had, for over six months, been jeopardized by an assailant. The life experiences of having my safety threatened when raising a young child, being pregnant, and trying to study were challenging and stressful. This enabled

me to relate to the sense of vulnerability and threat experienced by many of the women in this study. Likewise, for my second pregnancy I had wanted a midwife because I had found that, with a physician, there was no sharing of power when it came to decision-making. This was an experience common to many of the women in the study. What was different for me was that I had strong emotional and social support and financial stability and, therefore, the ability to change my situation.

In rural New Brunswick, where the study was conducted, the physical proximity of services and size of these small communities increases interactions between social classes, and so I came into contact with a broad spectrum of women. On the other hand, while my work as a community volunteer in the development of cultural and artistic programs for young children brought me into close contact with several parents, especially mothers, it was clear that most women of low socio-economic status did not attend these activities.

What never ceased to amaze me over the five years in which I was conducting this study was the women's desire to provide the best for their children, despite the difficulties in their lives.

### **The Setting**

This study was conducted in two rural communities: Campbellton, a small city in northern New Brunswick, and Listuguj, a Mi'gmaq reserve. Campbellton has about 8,000 residents and is surrounded by a rural area. Approximately 75% of the residents of this surrounding area are Acadian and, therefore, French-speaking.

The Listuguj Mi'gmaq reserve is situated directly opposite Campbellton across the Restigouche River in the Province of Quebec. The on- and off-reserve population of Mi'gmaq is approximately 2,600. Ninety percent of the people living in Listuguj are English-speaking; estimates suggest that less than 30% of the people over 15 speak Mi'gmaq. Due to its close proximity, Listuguj has close ties with Campbellton, where services are offered in both official languages, and Mi'gmaq receive health services

from this city rather than from the CLSC (Centre Local de Service Communautaire) in the adjacent community of Pointe-A-la-Croix, Quebec.

The available socioeconomic data for the city of Campbellton states that the average total female income is \$16,492 and that the rate of female unemployment is 13%. Eleven percent of women have attained a university degree; and 44% have attained less than high school. The total number of single-parent families is 24%; no data is available for the number of single-mother-families (Statistics Canada, 1998).

The socioeconomic data for the community of Listuguj shows that 52% of the people between 15 and 49 have secondary-level education, with 33% having gone on to post-secondary studies and 19% having achieved a post-secondary certificate or diploma (Community Health Plan of Listuguj: Health Program Transfer, 1994). No one between the ages of 50 and 64 had completed high school, so the level of achievement shown by the younger generation is indicative of significant progress. However, the rate remains lower than that in the rest of Canada (where more than 50% have completed post-secondary studies) (Ross, Shillington, & Lochhead, 1994).

For the people of Listuguj, unemployment rates vary significantly from those for Canadians as a whole (Ross, Shillington, & Lochhead, 1994). Fifty-five percent of the population is unemployed, and almost 24% of those over 15 receive unemployment benefits. Forty percent of the people depend on wages for their main source of income, while another 40% depend on social assistance. The total income for individuals over 15 ranges from less than \$2,000 (for 20% of the sample) to a maximum of between \$20,000 and \$39,999 (for 15% of the sample). Almost 40% claimed income between \$2,000 and \$9,999, while 25% declared income between \$10,000 and \$19,999. There was no report of any income that exceeded \$40,000. Clearly, poverty and unemployment are central to this reserve and are comparable to the national poverty rates for Aboriginal people (Ross, Shillington, & Lochhead, 1994).

The prenatal care in both Campbellton and Listuguj is provided by three male physicians (one of whom is an obstetrician) located in Campbellton. At present, no midwifery services are available in New Brunswick, and while there is a pilot study of a midwifery service in a city two hours away from the reserve, to all intents and purposes, midwifery is unavailable. All hospital births occur at the Campbellton Regional Hospital, which has a yearly delivery rate of 500 births.

Prenatal classes are offered by public health nurses either at the public health centre in Campbellton or at the health centre in Listuguj. I attended these prenatal classes in Campbellton at the beginning of my second pregnancy. These classes were based on a high-risk medical model of pregnancy. My intent was to meet other pregnant women; however, no discussion was allowed during the classes. Following the first class, and after being told of all that could go wrong in a pregnancy (even though I'd previously taught prenatal classes in my professional practice), my sense of vulnerability increased; I subsequently stopped attending classes. Of the 40 women participating in this study, 32 (80%) attended prenatal classes. It should be noted that women in New Brunswick and recipients of social assistance benefit from the Early Childhood Initiative, which is offered by public health nurses through the New Brunswick Ministry of Health. One of this initiative's principal goals is the reduction of LBW infants. This service provides women with vitamin supplements as well as with individual nursing and nutrition counselling. In Quebec, a similar program is available at the local CLSC; the pregnant women from the reserve who were recipients of social assistance received, upon request, an extra \$50 per month to assist them with the purchase of groceries.

### **The Sample**

All women attending the prenatal clinic between May 1995 and November 1997 at the Campbellton Regional Hospital received an introductory letter soliciting their participation in this study (see Appendix A). Further to this, all pregnant women

in the community who were in contact with a health care provider (e.g., a public health nurse, social worker, or nutritionist) also received an introductory letter. Initial participants were recruited through this process.

A hallmark of grounded theory methodology is theoretical sampling, a process that requires the researcher to gather data based on the developing theoretical scheme; the process involves examining existing categories and their inter-relationships, evaluating whether there is adequate evidence in each category and, if not, where additional data may be obtained (Strauss & Corbin, 1990). Hence, the logic of ongoing sampling is guided by the process of data analysis. My initial interviews were conducted with women recruited through solicitation letters. Theoretical sampling took over once I had completed some initial analysis. To this end, I employed the snowball technique, asking participants if they knew of others who might be interested in participating.

As it is often difficult to recruit low-income women into research projects, I interviewed all women who contacted me in response to a letter of introduction. As a result, although my initial intent was to interview 20 women, in the end I interviewed 40 so that I could include women from three different ethnic backgrounds: French Canadian, English Canadian, and First Nations. I had initially expected the sample to consist mostly of white women, as, out of 500 deliveries per year in this setting, 90% are white. However, I recruited First Nations women more easily than I had anticipated. All participants lived in the larger Campbellton area or the Listuguj reserve. Multiple interviews were conducted with 12 of the women. I have provided a detailed description of three women in order to allow an in-depth perspective on some of the women of this sample (see Appendix B).

The ethnic backgrounds of the women in the study sample was Mi'gmaq (n = 24) and white (n = 16), of which 12 were English-speaking and four were French-speaking. Ages ranged from 16 to 45, with a mean age of 28. Eight of the women were

19 years or younger, and seven had experienced a previous teen pregnancy. Three-quarters of the women had a male partner; 14 were married and 17 were living in common-law relationships. The other nine women were without a male partner; seven were single and never married, one was divorced, and one was widowed and living with her family.

To respect both their privacy and their sensitivities, I did not ask participants how much income they had but, rather, what constituted their major source of income or employment. Of the 40 participants, 26 were social assistance recipients (six were Mi'gmaq), four were working poor holding hourly positions with benefits, and two received unemployment insurance. All of these women reported that finances were an issue for them, especially in meeting their basic needs and those of their children. The majority reported being poor as children. Just under one-third (30%) were employed. Fourteen of the 40 were homeowners, 18 rented apartments, and eight lived with family. Of the 17 women in the study who were eligible for child support, only one received it. The women's partners' sources of income were as follows: 13 received social assistance, 12 were on unemployment insurance, and six were employed full-time. When asked if they had experienced violence, 18 women responded that their partners were abusive towards them. Of these 18 women, 13 were Mi'gmaq.

The educational levels of the women also varied. Fifteen had not graduated from high school, eight were high school graduates, eight were college graduates, and nine had received university degrees. In total, 42.5% of the women had more than a high school education.

Of the 40 study participants, 33 were interviewed during pregnancy and seven during the postpartum period. Fifty percent of the sample had a planned pregnancy. The mean gestational age of the pregnant women at the time of initial interview was six months: 8 were in their first trimester, 15 were second trimester, and 10 were third trimester. Thirteen women were primiparous and 27 were multiparous. Twenty



percent of the women (all of whom were Mi'gmaq) had previously had one or more abortions; seven women reported having one, and one woman reported having five. Seven women had one previous miscarriage, while one woman had two previous miscarriages. Ten participants were hospitalized as a result of the following conditions: rhesus positive sensitization (1), placenta previa (1), hypertensive (1), incompetent cervix (1), twin pregnancy (1), antepartum hemorrhage (1), preterm labor (2), depression and low weight gain (1), and kidney stone (1). All of these women attributed their hospitalizations to the stress in their lives resulting from abuse.

Participants were asked about health behaviours during pregnancy. Thirty-three women attended prenatal classes, seven did not. Twenty-nine were smokers, eight quit smoking after becoming pregnant, and 21 cut down on the amount they smoked during their pregnancies. Twenty-one women reported drinking on a regular basis (i.e., every week) before conception. The majority of women reported quitting drinking alcohol with the onset of pregnancy, while three reported drinking a very small amount (e.g., one glass of wine a week). Four women used illicit substances, but two quit doing so for their pregnancies. One woman reported using a mixture of cocaine and alcohol that had resulted in a miscarriage at six months during her first pregnancy. Another woman spoke of a suicide attempt through an overdose of prescribed medication before she found out she was pregnant.

#### **Data Collection and Analysis**

Data collection began in May 1995 and concluded in November 1997. Data were collected through participant observation and interviews were conducted over a period of two and a half years. All interviews were audio-taped. A total of 62 interviews were conducted with 40 informants. Twenty-nine women were interviewed once for approximately one hour and a half. Seven women participated in two interviews, and five women participated in three interviews. Four women, who were used to further validate the findings, were interviewed once. Four interviews were

conducted in French and were translated by myself. Being French Canadian and being familiar with the local dialect allowed me to faithfully translate and capture (as much as possible) the meaning inherent within the local linguistic style.

Field notes were kept regarding observations about environmental circumstances, participant characteristics, non-verbal behaviours, affect, communication processes, rapport, power dynamics, and so on during the interviews. Interviews and field notes were transcribed as soon as possible so that all relevant data could be captured (this generally occurred within a period of one week after the interview). Furthermore, I kept memos throughout data analysis in order to document my thought processes and to note major turning points in my thinking. Diagrams were also generated to visually capture the relationships between categories. Memos and diagrams enabled others to follow my decision-making trail as the analysis unfolded, and they allowed me to revisit earlier analysis

Free child-care services were offered to participants while they were being interviewed, and taxi fare was offered to women who did not wish to be interviewed in their homes. Most women arranged their own child care or kept their children with them during the interviews. Women could choose to be interviewed either in a room in the community centre(s) or in their own homes. All but five of the participants chose to be interviewed in their homes. These five included one English woman (who preferred to be interviewed at a friend's home) and four Mi'gmaq women (all of whom were recipients of social assistance and all of whom preferred to be interviewed at the nurses' station). Interview location was a problem on only one occasion when there were not enough toys at the community health centre to entertain the interviewee's two children. The result was a shortened interview.

Over a two-and-a-half-year period, I also gathered data (through participant observation) at such events as prenatal classes and the yearly pow wow on the reserve. Along with interviews, I collected newspaper clippings as well as material from the

health nurse, social workers, and the women's shelter newsletter. I also took photographs of the area and used them as an aid to memory. In addition, I was employed as a health consultant concerned with the assessment and development of maternal child programs, and this further contributed to my understanding of the community. Being from this small rural community and living there for the period during which the study was conducted also gave me the opportunity to interact with women.

The realities of life in a rural community affected women's perceptions of health during pregnancy in that important resources (such as access to adequate health information and health care) were limited. For example, at the onset of this study, First Nations women did not have access to prenatal classes. Also, little written information was available in doctor's offices.

As is typical with grounded theory methodology, data collection and analysis proceeded simultaneously (Strauss & Corbin, 1990). Data were analyzed as they were collected, and initial analysis guided subsequent data collection. First, the transcripts were read line by line so that I could get a sense of the whole before beginning open coding, a process consisting of "fracturing" the data into concepts that could be labelled and sorted while I remained "open" to the process of analysis. Constant comparative analysis was used to examine data points and provisional categories in relation to each other. I then identified properties of the categories and located them along dimensions. In order to reconstruct the data in theoretical terms (a process known as axial coding) (Strauss & Corbin, 1990), I asked the following questions: (1) What are the conditions under which healthy behaviour occurs? (2) What are the consequences of action? and (3) What is the context within which health and health-enhancing behaviours occur?

Data were examined for the influence of both micro- and macrostructural conditions. Once a provisional substantive theory was formulated, it was tested and

validated through interviews with informants, among whom were two social workers (one from the reserve's women's shelter and the other from Campbellton) and two pregnant women (one First Nations and the other white) whom I had previously interviewed. I attempted to arrange a focus group meeting; however, this did not come about, as the women wished to remain anonymous.

Initial interview questions were as follows: (1) What does it mean for you to be healthy during this pregnancy? (2) What things do you associate with well-being and being healthy? As the analysis proceeded, subsequent research questions were developed and used to guide ongoing theoretical sampling. I proceeded with data collection until categories became saturated; that is, until no new data were being added to categories. The analytic scheme was refined until a core construct explained most of the action relating to the phenomena of interest.

### **Pursuing Rigour**

Concern with bias, reliability, and validity stems from the scientific position of logical positivism, which has long criticized qualitative research for its seemingly cavalier attitude towards these concepts (Denzin & Lincoln, 1998). However, qualitative researchers share the conviction that the canons of "good science" should be retained; it is just that they insist that these must be redefined in order to fit the underlying perspectives of qualitative research and the complexity of studying social phenomena (Corbin & Strauss, 1990). Qualitative methodology is inherently different from quantitative methodology in that its purpose is not to establish facts or to test theory but, rather, to gain an understanding of the informant's experience and to generate useful description and theory (Creswell, 1994).

Criteria pertaining to rigour in qualitative research were initially elaborated upon by Lincoln and Guba (1985). Sandelowski (1986, 1993) further elaborated these criteria and suggested that reliability and validity in qualitative research are enforced by examining the data in terms of credibility, fittingness, auditability, and

confirmability. These criteria were employed in this study. Hall and Stevens (1991) have also developed criteria for the pursuit of rigour in feminist research. They identified standards for evaluating the adequacy of feminist research, including rapport, coherence, complexity, consensus, honesty, mutuality, and naming.

### Credibility

A research instrument is said to be valid when there is confidence that it measures what it was intended to measure (Sandelowski, 1986). Guba and Lincoln (1981) suggest that the truth value of a qualitative study should be evaluated by its credibility rather than by its internal validity (as in quantitative research methods). They state that the determination of credibility can be accomplished only by taking data and interpretations to the sources from which they were drawn and asking people whether they believe or find the results plausible. A qualitative study is thus deemed credible if it reveals accurate descriptions of individuals' experiences and if the people having that experience would immediately recognize it from those descriptions as their own (Sandelowski, 1986). The criterion of credibility concerns the faithful interpretations of participants' experiences (Sandelowski, 1986). By validating my interpretations of the data with informants (described in Data Collection and Analysis), and by including the active voices of women in the research account, I have attempted to meet the criterion of credibility. Validation was further ensured by the use of a sub-sample of four women (one First Nations social worker, one white social worker, and two of the pregnant women: one Aboriginal and the other white) to confirm interpretations upon which the study findings were based. Further, credibility is enhanced when the researcher is able to spend time with the informant and can verify information from one interview to the next. The opportunity to conduct several interviews with a number of informants allowed me to do this. In this study, as much as possible, interpretation and analysis were brought back to participants for validation. It has been suggested that the greater the degree of intimacy and credibility the researcher establishes with an informant, the

more accurate will be the information provided (Field & Morse, 1985; Oakley, 1981; Patai, 1991). In this regard, my clinical experience as a community leader and volunteer from this region, as well as being a nurse consultant and mother, enhanced my credibility as an investigator.

### Fittingness

Applicability in qualitative terms is related to external validity in quantitative research. External validity refers to the generalizability of findings and the representativeness of subjects, tests, and testing situations (Sandelowski, 1986). Guba and Lincoln (1981) suggest that the idea of fittingness is more appropriate and should replace the term generalizability when evaluating qualitative research. A piece of qualitative research whose findings fit contexts outside the current research study situation can be described as having fittingness (Guba & Lincoln, 1981). This is further enhanced when the readers view the study findings as meaningful and applicable in terms of their own experience (Sandelowski, 1986). This was supported by the fact that I returned to discuss the study findings with participants who also agreed with these themes and could easily relate them to their own experience as social workers and mothers. I was able to use a sub-sample to verify emerging theory. These women were selected on the basis of their knowledge and experiences of a range of poverty experiences during pregnancy. According to these women, the study has meaning and relevance. Furthermore, the study findings were shown to the members of my dissertation committee (one of whom is an expert in grounded theory and maternal child nursing [May, 1991, 1994, 1995], and the remaining three are experts in grounded theory and feminist theory), to verify their relevance.

### Auditability

Reliability is defined as the degree of consistency or dependability with which an instrument measures the attribute it is designed to measure. In qualitative terms this refers to the consistency, repeatability, replicability, or stability of a study in terms of

the clarity and accuracy of the final research report (Lincoln & Guba, 1985). In contrast to quantitative research, which aims for repeatability of measures and consistent responses, qualitative research emphasizes the uniqueness of human situations and the importance of experiences that are not necessarily accessible to validation through the senses (Sandelowski, 1986). Guba and Lincoln (1981) propose that the concept of auditability be used as the measure of consistency in qualitative research studies. They suggest that a study may be judged as auditable (and thus reliable) if the reader can follow the decision trail of the research process. This criterion refers to the ability of other researchers to follow the decision-making used in a particular study (Sandelowski, 1986). I met this criterion by following well-accepted procedures for data collection and analysis and by using memos to document decision-making. At the beginning of each interview, I used the same approach with all women, and I kept a participant profile of each (see Appendix C). After each interview, I taped my field notes, reporting similarities and differences between the women (as well as overall impressions) and identifying what questions would need to be clarified in future interviews. Ongoing analysis was shared with members of my supervising committee every month to two months to enable them to follow the development of my ideas.

### Confirmability

Sandelowski (1986) argues that "confirmability is achieved when auditability, truth value, and applicability are established" (p. 33). Confirmability relates to the meaningfulness of the findings in light of what else is known or what is reasonable. As will be explained in the final chapters of this report, my findings did resonate with those of other authors. While the interpretive elements in this report are mine, the findings on which they are based represent experiences that have been uncovered using a range of research approaches. While I make every effort here to represent interpretations that are true to the accounts of the women interviewed, ultimately it is the reader who will be the judge of the credibility of this research.

## **Ethical Considerations**

Permission to conduct this study was received from the Behavioural Sciences Screening Committee for Research and Other Studies Involving Human Subjects at the University of British Columbia, from the Restigouche Health Services Corporation, and from the Community Health and Social Services Directorate at the Listuguj First Nations Reserve.

Potential participants received an introductory letter from a nurse at the prenatal clinic at the Campbellton Regional Hospital (or from the public health nurse, social worker, or nutritionist) outlining the purpose of the study and the nature of their participation (see Appendix A). The researcher's and thesis supervisor's names and phone numbers were included in the introductory letter so that the women might contact either if they wished to participate and/or to clarify any concerns they might have. Upon meeting with the women I informed them that they were free to stop an interview at any time, could refuse to answer any question, and could withdraw from the study whenever they wished. I also explained to them that their participation in this study was strictly confidential. Because informed consent is an ongoing process (Munhall, 1988), when the women proceeded to a second or third interview, the issue of consent was again raised, the consent form was reviewed, and they were again informed of their rights.

Difficulties regarding the recruitment of low-income populations have been reported in the literature (Cannon, Higginbotham, & Leung, 1991; Kauffman, 1994; Moore, 1997). To enhance recruitment in this study, several special efforts were made. On three occasions I met with all health care and community workers involved in giving care to pregnant women. I made a presentation to the nurse of the outpatient department where the women attended prenatal medical care, to public health nurses, and to the nurse from the reserve. I made follow-up telephone calls to the head nurse of the prenatal clinic as well as to social workers. Further to this, I gave an honorarium



of \$25 per interview to each woman at the beginning of the session in order to express my gratitude for her time, energy, and contribution to the study. As monetary incentives may involve the exploitation of low-income people, rendering their participation no longer voluntary (Rudy, Estok, Kerr, & Menzel, 1994), the participants were given their honorarium before each interview began.

I obtained informed written consent from each participant on my first visit. The consent forms were printed up in clear, simple language and were offered in French and English. All women in this study were able to read and write either French or English. Information in the consent form included a statement informing prospective participants that no names or identifying information would be used in the study, that participants could withdraw from the study at any time, and that their decision to participate or not participate in the study would not affect the services they received from the community agency (see Appendix D).

Confidentiality was maintained by coding participants' names on typed transcripts of interviews. Participants were asked not to use names during the taped interviews, in order to assist with protecting confidentiality. If names were accidentally revealed, then I deleted them from the transcript. Following transcription and analysis, I erased the tapes. The tapes and transcripts were kept in a locked drawer to which only I had access. In this text all names used are pseudonyms.

### **Summary**

In this chapter I provided an overview of the premises of grounded theory methodology and its relationship to feminist theory, a sociodemographic profile of the women in the sample, a description of the setting, and an outline of my methods of data collection and analysis. I concluded with the ethical considerations that formed part of my research.

The next four chapters present the study findings. In Chapter 4, I present women's meanings of health, showing that energy is essential to a woman's capacity to

take care of herself during pregnancy and to engage in health-enhancing behaviours. In Chapter 5, I discuss the meaning of pregnancy as well as the conditions that constitute a supportive environment and that enable a woman to create a healthy pregnancy. In Chapter 6, I discuss the experience of living with abuse, poverty, and an unplanned pregnancy and how these threaten women's capacity to create a healthy pregnancy. In Chapter 7, I present the strategies and conditions that are essential for women to regain their capacity to create health. In Chapter 8, I present a discussion of the study findings in light of the scientific literature surrounding maternal-child health, the meaning of health and health behaviour. In Chapter 9, I discuss the implications of these findings for nursing practice, education, policy, and research.

## **CHAPTER FOUR:**

### **THE MEANING OF HEALTH IN THE CONTEXT OF PREGNANCY**

Understanding women in the context of their social environment is essential, as women's health during pregnancy is inextricably linked to the fabric of their everyday lives. Moreover, it is this context that shapes their experience of health. An in-depth understanding of the daily reality of women's lives is crucial to developing a theory that will have maximal clinical significance with regard to improving the health of childbearing women (Strauss & Corbin, 1990). This study is an attempt to formulate such a theory; that is, one grounded in the everyday lives of women, told from their perspectives and in their voices.

According to the women in this study, their basic concern was to have a healthy newborn and, to that end, they enacted the process of creating a healthy pregnancy. Having energy is essential to this process, as it enables women to engage in health-enhancing behaviours. Having energy is seen as the body, mind, and spirit all being in balance. This balance stems from the circumstances of women's lives, which affect their capacity to create a healthy pregnancy.

In this chapter I address how pregnant women view their health and the conditions that shape it, what it means to them, and how they attempt to ensure its adequacy. Health is influenced by the interplay between the body and the mind; what affects the body affects the mind and vice versa. Health is a function of a woman's level of energy, as it is this energy that enables a woman to care for herself by engaging in health-enhancing behaviours during pregnancy.

Essentially, women view health as interwoven with their everyday lives and the social conditions in which they find themselves: health is affected by "everybody and everything." Of central importance in shaping the quality of the everyday life of women in this study is the adequacy of their economic status and the quality of their relationships – especially that with their partners. Being in a supportive relationship

and having adequate financial resources to meet fundamental needs (such as nutrition and housing) are necessary to create a healthy pregnancy. When these two fundamental needs are jeopardized, high levels of stress result and, consequently, women experience a lack of control over their lives. In the state of threat, in order to survive, women shift from seeking health-enhancing behaviours to seeking ways to reduce their stress. Often, women revert to old and less healthy coping strategies, such as smoking, not eating properly, and consuming alcohol.

In this chapter I begin by defining health according to the participants in the study and by describing what they do to create a healthy pregnancy. I then describe the circumstances of their everyday lives and how they contribute to creating either a context of stability or a context of threat, as the case may be. I conclude by describing how the circumstances of everyday life shape women's capacity to create a healthy pregnancy.

### **What Constitutes Health**

The main purpose of this research was to gain an understanding of what health means to pregnant women. All the women in the study were asked the following questions: "What does health mean for you?" "Can you talk to me about your health?" For all the women interviewed, health consisted of the integration of the body and the mind. Women's discourses about health, regardless of their education, socioeconomic status, and ethnicity, were rooted both in their experience of the everyday world and in their educational level. The women in the sample who had post-secondary education spoke of the various dimensions of health, and their terminology reflected Western, middle-class, well-educated perspectives. For example, Marie, a school-teacher, mentioned the physical and emotional being tied together, as did Bonnie, a young health care professional: "Like to me, mental [health] is even more important [than physical health]; that's where I feel great. I feel good overall – not just physically but mentally, everything." Those women with no post-secondary education did not

make a distinction between the various dimensions of health and everyday “normal” life:

Myrna: I don't know, I just go day by day and I really can't tell you anything because I guess I live a normal life.

Jennifer: More exercise or stuff like that, you know. Do a lot of things. I don't really think about it, I just let the days go by, you know.

For some women, health has a spiritual dimension. Two women in their late thirties, who had attained a university education, spoke about their spiritual health. Brenda stated: “When I think about health, I think about healthy mind, healthy body, healthy spirit.” Donna stated: “For me, health is to be well mentally, physically, spiritually, to be well with who you are. To have good self-esteem, to know yourself, to feel good about who you are. For me, that's what it means to be healthy.”

#### Physical Health

Women spoke of their physical health in terms of pregnancy-related symptoms, fetal well-being, and disease. Pregnancy-related symptoms are physical complaints brought on as a result of pregnancy. All women spoke of several of these: fatigue, nausea, heartburn, and mild edema. However, these symptoms were put into perspective based on their extent and duration as well as on how impaired they made the women feel. In other words, women assessed the seriousness of pregnancy-related symptoms based on the effect they had on their everyday life and on their capacity to care for themselves. Susan stated that when her pregnancy-related symptoms subsided she started to feel better:

Susan: I've started to feel better. It's about two months now that I've been feeling really good. I'm not sick anymore. At the odd time, I'd get a little nauseated or a little queasy, but not anything to make me feel worried about.

Another woman, Amy, who was unemployed, had an abusive boyfriend, and an unplanned pregnancy, spoke of herself as being unhealthy. However, once her nausea

and vomiting subsided, and she could start to eat and go back to work, she began to feel healthier.

Another component of women's physical well-being is the relationship between their health and the health of the fetus, and a number of women spoke of this. When asked about her health, Michelle, a young pregnant mother, said: "Well, it means a lot [laughs] because if I am not healthy, the baby won't be too healthy either." Elizabeth said: "Whatever you do, your child will feel it too, so that's what I tried to think. If I'm going to do this, my child is going to feel it, so I don't do it." When asked about her health, Lita said: "I feel like I'm so strong and the [fetal] heartbeat, the doctor said it was a very strong heartbeat." Cheryl talked about fetal movement as a sign that reassured her that everything was going well: "If I'm worried, I just ask them (twins) to kick me and they kick and I feel better, you know."

Another component of health the women described was the absence of disease. Karen stated: "I've never been sick a day in my life so I wouldn't know! I'm healthy. I'm the type that doesn't catch the flu that comes around." In this study, women who had no history of medical conditions during pregnancy and who were able to carry out everyday activities without experiencing worrisome symptoms spoke of being healthy. For two women who had a history of arthritis, being able to carry out everyday activities without major pain was a sign of being healthy. For example, Marie, a mother of three, responded to the question, "What does health means for you?" as follows:

Marie: Having a reasonable sense of well-being [both] emotionally and physically. I can stand minor aches and pains, but there is a bit of leeway there. I don't have to feel perfectly fine everyday, but being able to carry on normal things that I would be doing [is important]. Having mobility, intellectual clearness.

Lita told of being able to go to the woods and pick fiddleheads despite the arthritis in her knees: "Last week I was so busy, and I was happy. I was doing what I wanted and, being out in the woods, it felt really good."

In summary, women spoke of their physical health in terms of pregnancy-related symptoms, the relationship between their health and that of the fetus, and the absence of disease and/or worrisome symptoms – an absence that enabled them to carry on with their daily lives.

### Mental Health

Regardless of their level of education, socioeconomic status, and ethnicity, all women in this study described good mental health as a matter of being stable, feeling relaxed, and being happy and content. Women associated poor mental health with being irritable, depressed, and feeling tired and stressed. When speaking of her mental health, Jamie said: “It’s just the way I feel. Like I’m not depressed or anything, I’m just happy.” And Jane: “I think health is keeping a good attitude. To keep a good attitude about life in general. I need to know what is important, who to put first and what to put first in my life. You have to stop worrying so much.”

Women also related their good mental health to their capacity to carry out activities. Marie, a mother of four, connected her health to her ability to be active:

Like the sense that you have the energy, that you are able to do things. In an emotional sense, yes, there is the energy that you don’t have when you are depressed or when you are feeling [physical] or mental fatigue.

### Spiritual Health

In this study, women expressed a range of attitudes towards spiritual health. Just as pregnancy is a time when some women take a look at their lives and question their existence (Colman & Colman, 1991), so it is also a time when they may draw upon their spiritual and/or religious beliefs. Amy described her experience of bearing a new life as a spiritual one:

It was as if the baby was like, how can I explain that. It’s just as if I had a spiritual, I don’t know the expression I’m looking for. It’s as if I came face to face with God when I was pregnant with the baby. It was just that much, so much for me for having my son. It just took my whole life over. It just overwhelmed my whole life when I was pregnant. Like I said, it only started when I was physical, I had seen the physical part of being

pregnant and it just took over my whole body, my whole mind. I don't know, it's as if I was reborn all over again.

When asked about their spiritual health, other women spoke of revisiting religious beliefs and going back to church. For Bonnie, pregnancy was a time to revisit her religious upbringing and beliefs:

It's funny you mention [spirituality] because I was talking to Mom about it just recently, and I said I think I would just kind of like to start going [to church], you know, once or twice a month or something like that. I'll go with her when she takes the grandkids around.

Karen also mentioned the importance of religious beliefs during her pregnancy: "God is the person I use everyday. I pray, I ask him to look after my children, my unborn child and whatever happens, happens."

Other women talked about practising their spirituality through giving to the community.

Donna: I tell myself that by giving I receive even if I don't want to. I would never try to harm anybody. I try to help all that I can, as long as it doesn't hurt myself and my family. I find that gives me the strength to be who I am.

First Nations women's spirituality involved a close connection to nature. This connection acted as an important source of strength (see Chapter 5). Some of them spoke of their spirituality not so much with regard to their pregnancies as with regard to the overall context of their lives. Having lived through assimilation, these women gained strength, pride, and self-understanding as they regained Mi'gmaq spirituality. Some women attempted to learn about traditional Mi'gmaq ways, and others actively practised Mi'gmaq spirituality. The latter group of women had attended university or college and spoke of having the opportunity to reverse the effect of assimilation. Brenda, a community leader, spoke of Mi'gmaq spirituality as the essence of her strength.

Researcher: What gives you strength?



**Brenda:** To maintain your perspective, to maintain your focus, maintain your sense of positive growth and, to me, it has to do with the renaissance of your culture, the renaissance of just getting to know who you are and exercising that strength that we have because it is awesome. I mean it is so great and it's so immense. We're just taking on the challenges, and how we've done that is that we introduced our culture and our language and it's also our spirituality because that's the skin and everything that we are. What happened was, you know, when you look at the dynamics and the phenomena, it's like we were stripped of that for so many years, but now we are going back to rediscover the worth of that and, for me, that's where the answer lies.

For some women, such as Leslie, returning to traditional Mi'gmaq spiritual practices puts them in touch with their cultural identity and gives them a connection with who they are and where they came from.

**Researcher:** So you were talking a lot about the Mi'gmaq way and that gives you a lot of strength.

**Leslie:** Actually, it's nice because there are a lot of things that I've never known. I always knew my language but [not] other things behind it, like when I sing, when my brother is chanting, the writing into that chanting and the sweat lodge and things like that. So now I'm starting to understand more about it, and it feels good when you see people doing things like that.

In summary, for all participants, health had physical and mental dimensions, while for some it also had a spiritual dimension.

### **The Dimensions of Health**

#### **The Integration of Mind, Body, and Spirit**

Women discussed how these dimensions interacted to create a condition of health. For all women, health had to do with the integration of the mind and the body.

Amy confirmed this view:

**Amy:** I didn't have a healthy mental attitude and I think if I would have had more of a healthy attitude about being pregnant that my physical health would have been a lot better. But once my attitude got healthier, I found my physical health got better.

**Jane:** But I think a positive attitude and a smile on your face really helps because if you feel good about yourself, your body will feel good.

Elizabeth, at six months of pregnancy, also discussed the integration of the body and the mind and the balance needed in order to have a healthy pregnancy:

Elizabeth: Having a healthy mind and a healthy body is probably the best state you can be in. If you're not going to keep good care of your body, your body is not going to keep care of you. So if you think positive and keep your body well taken care of, well, then your body will take care of itself and you should have a healthy pregnancy. And that's basically what helps out – taking care of a body.

As has been seen, health for some women also encompasses a spiritual dimension. According to them, being healthy is a matter of having one's physical, mental, and spiritual health in balance. Brenda talked about this balance: "When I think about health, I think about healthy mind, healthy body, healthy spirit. From my point of view, in my life, I try to seek that balance." Trina, a recipient of unemployment insurance, stressed the interconnection between emotional and physical health: "I would define health as being emotionally and physically, mentally stable. To be more content in life, not to let the little things bother you." Most women emphasized the negative impact of stress on this balance and discussed how this affected their health. Melissa spoke of a friend's explanation of the importance of being free from stress:

Melissa: She used to tell me, like a negative attitude and a negative opinion and negative approach is just as harmful to your health, you know, and your state of mind, as anything out there. So learn how to prevent that from entering, you know, your being. So I keep an eye on that and I'm very conscious of it.

Elizabeth: I think some women during pregnancy still continue to do everything they used to do. They still continue to clean and to stress themselves and I think stress is a big part of not being healthy. Don't get yourself stressed during a pregnancy. That's one thing I try not to do for a healthy pregnancy, and it's worked.

In summary, according to all participants, health consisted of a balance between the body and the mind, and some elaborated upon the importance of spirit. Physical health was described in terms of pregnancy-related symptoms and their relationship to

the health of the fetus. Women presented the absence of disease and worrisome symptoms as essential to their capacity to carry out everyday activities and so to create health. Good mental health consisted of being stable, relaxed, and happy, whereas poor mental health consisted of being depressed, tired, and stressed. Good mental health was seen as essential to a healthy pregnancy. For some women, spiritual health was expressed as the value of community giving and/or revisiting religious beliefs. First Nations women identified their close connection to nature and learning their cultural heritage as part of their spiritual health. Generally, being healthy was a matter of maintaining a balance between body, mind, and spirit and being free of high levels of stress.

#### Health As Action

Central to women's definition of health was their belief that health-enhancing behaviours were essential to the creation of a healthy pregnancy. In other words, health had to be actively sought. In this study, women were asked: "What changes have you made since you've found out you're pregnant?" and "What does it mean for you to be healthy?" In response, women spoke of seven main kinds of health-enhancing behaviours: eating habits, exercise/leisure, cigarette and alcohol consumption, sleep/rest, prenatal care, classes. In each of these areas, women typically modified behaviours – cutting out or reducing certain behaviours, substituting some behaviours for others, and making sacrifices – to avoid harm and stress.

These actions were directed towards creating a healthy pregnancy and ensuring a healthy newborn, since the main concern of the women in this study was the well-being of the fetus. Cheryl commented: "It means everything to me! It brings tears to my eyes, you know it means everything to me." It was this concern for the health of the unborn child that motivated women to engage in the process of creating a healthy pregnancy.

## Health As Energy

The women in this study described energy as necessary for the creation of a healthy pregnancy, for it is energy that enables them to carry out health-enhancing behaviours. In this study, the balance women maintained between the physical, mental, and spiritual dimensions of health was a function of this energy. Women who experienced a healthy pregnancy spoke of having high energy, while those who experienced an unhealthy pregnancy spoke of having low energy. Good health was seen to be consistently linked to high energy levels and the capacity to be active. In answer to the question, "How would you define being healthy?" Cheryl responded: "Getting enough rest, eating right, feeling right, feeling and being jolly, having the energy to do things." And Brandy responded: "I feel happy and I have energy." Poor health was consistently linked to low energy levels, which affected the body/mind and decreased the capacity to engage in health-enhancing behaviours. Women spoke of excessive sleep and fatigue, feeling depressed and sad, and not having the necessary energy to take on healthy behaviours. Cathy explained: "When you have lows, you're not good humoured, you don't eat what you are supposed to, you don't take care of yourself and you reject your friends." Denise spoke of low energy when she was not feeling well: "Lazy a lot and tired and I just never wanted to do anything. I couldn't care what I ate. I would eat a lot of take-out; it's not good for you." Similarly, Rhonda noted: "No, I'm not [healthy]. I'm too tired all the time. When I'm tired I feel lazy, I don't want to do things and if I don't do it, like my house is messy, I get moody." She also captured how her health is related to the circumstances of her everyday life: "For me, health, I think it's your life, and if you don't have any highs you are not going to be healthy." Women in difficult circumstances, in particular, described energy as being consumed by stress and uncertainty.

According to these women, health is not a static state and gravitates between high and low levels of energy. As Trina explained, "I had the energy back and

everything was quite normal.” And Amy, who had experienced significant pregnancy-related symptoms, stated that when she felt better she “just was feeling peppier and had a bit more energy.” Karine addressed the contrast between high and low energy levels and how they display themselves:

If I’m sleeping all the time, like if you’re falling asleep, there’s something that’s not going well. If you’re impatient, it’s something that is not going well elsewhere. If I don’t stop, if I’m hyper, I’m healthy.

Thus, having energy is central to women’s capacity to carry out health-enhancing behaviours (i.e., activities that women view as having a beneficial impact on their health). Energy stems from the body and mind (and, for some, the spirit) being in balance, and this balance/stability stems from being free of high levels of stress. A woman’s energy is inextricably tied to the circumstances of her everyday life, and thus it is these circumstances that affect her capacity to create a healthy pregnancy.

### **What Influences Health**

Regardless of their education, socioeconomic status, and/or ethnicity, all the women in this study saw their health as affected by “everybody and everything”. All spoke of this interconnection. Marie, a teacher and mother of four children, commented: “You can’t isolate health from all other things; it is all connected.” Brenda spoke of the interaction between the various spheres of her life and its effect on her health: “To me, it’s all interconnected and it’s extremely important.” Women in difficult circumstances spoke of the importance of quality of life and how it shaped their experience of health. Michelle, a 19-year-old pregnant mother who received social assistance, said: “It depends on how you are living and who you see around every day. That’s what I consider being healthy.” Cathy, a teen mother who had an unplanned pregnancy and was battered during the course of it, stated: “Health is your everyday life, and if you don’t have any highs you are not going to be healthy.”

Women spoke of the various factors that shaped the quality of their everyday lives: their income; their relationships, especially with their partners; their various roles

inside and outside of the home; geographical context; and the delivery of health care. In the following section I present a brief overview of some of these factors and describe how they affected women's everyday lives and, consequently, their health.

### Fundamental Needs

The women suggested that financial resources were at the heart of their capacity to attain health. Not surprisingly, financial resources were particularly problematic for the working poor and those who were recipients of social assistance. Women who were recipients of social assistance stressed that their material life was determined by social assistance programs and that these programs had direct implications for their health. Michelle, a 19-year-old pregnant mother clearly indicated this connection between social assistance and her ability to meet her basic needs.

Yeah, well, it depends on how you live, too, if you feel healthy. If you live in a little place, you don't have air, you don't have furniture or nothing, you really are not going to feel healthy, so, and if you are on welfare and you can hardly get by the month. It's not too healthy if you are worrying all the time.

She went on to emphasize how the harsh conditions of her everyday life created a climate of constant worry and instability.

A woman's financial resources give her the access to resources to meet fundamental needs, and this influences her quality of life by either creating a stable or unstable context, and, consequently, her capacity to create a healthy pregnancy. All women in this study who were recipients of social assistance spoke of not having sufficient money to get through the month and to meet the fundamental needs of nutrition and housing. They worried daily about having to "make ends meet." These women had to rely on various sources of support, which mostly came from family and friends, in order to compensate for their lack of financial resources.

### Relationships with Others

Another central component in shaping women's experience of health was the quality of the relationships in their everyday lives. In responding to the question,

“What does it take to be healthy?” many women spoke of the importance of being loved and supported by their male partners/husbands. Cathy, who was battered during her pregnancy, said: “It takes love, affection. A lot of people who surround you.”

For women in this study, central relationships included those with their partners/husbands, their family, their girlfriends, and their health care provider. The most crucial relationship for many women was that with the father of their child(ren). Bonnie, a young professional who rated herself as healthy, with a good job, and with lots of support from family and friends, noted the central importance of having a good partner:

Like health, you know, you can think of it in terms of fitness but I don't think of it just in terms of fitness. It's kind of just being at peace with yourself and your surroundings, especially with a strong marriage, good partnership there.

Amy, who was in an abusive relationship and had numerous medical complications during the course of her pregnancy, stated:

If you know your family is going to be there to support you, but the person you're with, or your husband, or whatever, if there's a healthy attitude to support you and to help you, [you need] a lot of that, a lot of love and support.

Donna, a married social worker, spoke of having good self-esteem and being surrounded by supportive people as being essential to having good health:

The factors that are important to me [are] that I feel good about who I am, that I accept the good and the bad, that I have good support around me. For me, that's something that [ensures] that I have good health.

Thus, their relationships with partners/husbands, girlfriends, and mothers were instrumental in creating the emotional, task-oriented, knowledge-oriented, and financial support necessary for health, as will be described in detail in Chapter 5.

### Roles Inside and Outside the Home

Women's health during pregnancy was also affected by the various roles they played both inside and outside the home. The geographical area in which the study

was conducted has one of the highest unemployment rates in Canada (Ross, Shillington, & Lochhead, 1994). Being unable to choose whether or not to work is an important source of stress for women, especially for women who are recipients of social assistance. Elizabeth spoke of her disappointment at not being able to get a job:

I didn't think I'd be on social assistance. I always thought I would have my job, but it's hard because the job that I had was only part-time anyway and now that I'm six months pregnant, I can't work in a gym and I had to stop.

Trina: This is the first time I've ever received social assistance. I tried to get a job but there aren't many, especially being pregnant, nobody wants to give you a job.

For women who worked outside of the home, other issues arose regarding the problematic conditions of their employment. Donna, whose husband was a seasonal worker, talked of not having the option to stay at home once she had a child, as they couldn't afford to live on one salary. One working professional with no paid maternity leave spoke of her concerns:

Researcher: Can you elaborate more on your work?

Bonnie: Yeah, that's probably one of my real foggy areas, 'cause I don't know how long I'll be able to work or when I'll feel like going back or what I'm going to be capable of and, being like 50% owner or being partners, I kind of feel, no matter what, I kind of have to go back in two months or so. But financially, I don't think I can do any less. My biggest concern is, like, if I have to leave early. It probably will be fine, but you still kind of think about it because, like, you know, most young couples these days, we have lots of bills to pay.

Not surprisingly, women with children who worked outside of the home encountered major challenges when attempting to balance their responsibilities inside and outside the home. For example, keeping everything in balance was difficult for Denise, a working mother of two children:

Oh, sometimes I do feel stressed. Preparing work in here or bringing my son to daycare or picking him up, going home for supper, cooking and cleaning, and having everything ready, and after cleaning up and getting the kids their baths and bed. It's a lot of, it's enough stress for anybody.



She explained how she relaxed by taking a hot bath, watching television, attending swimming lessons, or just reading a book. Despite her busy schedule, Denise benefited from the assistance of a supportive husband (who shared household tasks), from having the money to afford activities that enabled her to relax, and from having parents who baby-sat her children whenever she needed a break. Having sufficient financial resources to be able to take breaks from mothering gave Denise the capacity to find balance.

What remains essential is being alone. Just get into the car and go or just get out and walk and go somewhere, but with no kids. Where it's just quiet. Swimming – I just learned how to swim recently.

Having support was essential for women with children, as it allowed them to have time to take care of themselves. Karen, who worked at home, described how important it was for her ex-partner to assist in caring for their children:

I have a lot of breaks now so I go out. I don't go out every night, you know, I go out for one hour or if I need time, if I get too tired or anything like that. The father takes the baby all day and all weekend, Saturday and Sunday, and I'm free to do whatever I want. Visit, shop, you know. It's good. I don't feel like I'm tied down, like I'm the only one taking care of the children when I have his help. And he's willing to help any time. He knows when I need it, and he'll just take over.

Unfortunately, of the 17 women eligible for child support in this study, Karen was the only one to receive financial aid and child support from an ex-partner.

### Geographical Context

Four women who had attained university educations found a significant difference between social consciousness in rural as opposed to urban settings. Donna spoke specifically of the impact of the rural environment on her health habits:

I find that since I moved home, I'm not as healthy as I used to be and I think it's simply because I just don't bother to go – local unhealthiness. There is no collective consciousness about health as there was in Toronto. You know there are the health food stores, just a lot of literature on healthy living. So, like moving home, there is just more access to junk food. It's everywhere and there's no public education on healthy eating.

Theresa also commented on the lack of access to healthy food and lifestyles. She told of how the take-out style of fast food restaurants shaped her lifestyle (she took her children to McDonald's on occasion – something she had never done in a larger centre because there were so many healthier options). Two working women also commented upon the difficulty of eating out at healthy restaurants during their pregnancies, as most eating establishments to which they had access were limited to fast foods. Three women commented on the fact that few restaurants prohibited smoking.

Other women spoke of being denied access to information that would have allowed them to make informed decisions about their health. Donna talked about the lack of access to information in a rural centre and mentioned that she was more worried about having her babies there than she would have been about having them in an urban centre:

When in the city, when I would go to doctors, there was literature available in the offices, all kind of support groups, prenatal classes were amazing. There was just everything there. Whereas here, there is nothing. I would notice that when a doctor would examine one of my children or me [it was] just not as comprehensive as it was in the city. And in the city, they scheduled you. You went in at a certain time, they told you exactly what to expect, what was going to be happening, they took you on tours of the hospitals, educated you about everything that was available. And not just educating you about what your decision should be but just giving you the information to help you make decisions. Hum, I found none of that here. None!

Another issue regarding lack of health information in a rural community concerned the use of contraceptives. According to seven women in this study, unplanned pregnancies were often the result of inadequate information regarding contraceptive management. Of these seven, four women reported being misinformed about the interaction between antibiotics and contraceptives. One woman became pregnant with an intra-uterine device that is designed to prevent pregnancy, while

another woman was told by her physician that missing one pill should not result in pregnancy, and one woman was told she was infertile when, in fact, she was not.

All but three of the women interviewed in this study described dissatisfaction with their health care providers as a factor that negatively influenced their health. Five women complained about not having the option to be cared for by a midwife (midwifery is illegal in both New Brunswick and Quebec). Marie spoke of wanting a midwife, whom she believed would respect her and be involved in her total (not just physical) care:

I guess one of the [reasons] I would have been more comfortable with a midwife is that I think they tend to be more closely involved with what is going on instead of just one visit here. The impression that I have gotten is that they are much more looking at you as a person, a whole picture rather than just you come in and then you do two or three little things and okay. And you measure and you do this and that and something else and it's like. That works fine for some things but I don't think it works that well for human beings. I think we are too intricate. The impression that I've gotten about a midwife is that they are more closely connected. A lot of them are mothers who have been through that experience and who have been closely involved with that.

Some women were able to choose their health care providers, albeit not always without resistance. Donna talked about leaving for a larger centre to deliver her fourth child, as her third delivery had been very unpleasant. However, her specialist told her that she was putting herself at risk.

He told me, "You are risking the life of your child if you proceed on this little adventure that you are planning to go on." So I left here feeling, "I'm high risk, I'm going to have another one of those awful deliveries." But I got there and felt totally confident.

Donna delivered her fourth child in a birthing centre with the help of a midwife. She described this as her most pleasurable birth, and it gave her a great sense of personal power.

The predominant factor leading to women's dissatisfaction with their physicians was the amount of time that the latter spent with them. The small amount of time physicians spent with the women did not allow for the delivery of comprehensive care.

Most women felt rushed during office visits. For example, Trina mentioned that, in four years, her doctor had not performed either a pap test or a breast examination, even though she had a history of cervical cancer. The mother of three explained:

I always felt rushed. It always seems like they're ready to go out the door and you're trying to get in. Their hand is on the door. They are trying to say good-bye and you're trying to ask them stuff and they don't take the time to sit there and say, "Is there anything else?" I never missed an appointment but I never had a pap through the whole prenatal care and I always assumed, because I had three kids, I had cervical cancer once, and I just thought that you had a pap smear somewhere in between those pregnancies.

Amy also remarked on not feeling connected with her physician: "No, I didn't feel a connection at all. I found that I felt like I was being pushed through, like I was just another number." According to Bonnie, "I find, a lot of times, my doctor has kind of rushed in and rushed out." Rhonda had a similar perception: "They don't really give you much. Like I find, you just go to your doctor's appointment and they check you and that's it."

As these accounts illustrate, in most cases women believed that their relationships with health care professionals did not contribute to their state of health.

### **Summary**

Thus, from the perspectives of the women in this study, the quality of their lives is inextricably linked to the amount of stress they experience and their capacity to deal with it. Having adequate financial resources gives women the means to meet their fundamental needs without having to worry and thus enables them to deal with stress. The support they receive from partners, family, and friends further assists women in meeting their emotional and financial needs. This creates a context of balance, which, in turn, enables them to have the energy to engage in health-enhancing behaviours and to create a healthy pregnancy.

The findings of this chapter demonstrate that many important determinants of health arise outside of the realm of the affected women. Social policies (such as social

assistance programs, unemployment insurance, maternity leave, and child support) along with employment opportunities determine the material contexts of women's lives and influence their capacity to meet their fundamental needs. These policies also directly mediate affect a women's capacity for health and her ability to care for herself during pregnancy.

## **CHAPTER FIVE:**

### **THE PROCESS OF CREATING A HEALTHY PREGNANCY**

As is apparent from the accounts in the previous chapter, a central concern for the women in this study was to have a healthy newborn and, to this end, they enacted the process of creating a healthy pregnancy. The women in this study viewed health as being woven into the fabric of their everyday lives and the social conditions in which they found themselves. Their capacity to create a healthy pregnancy was related to the circumstances of their everyday lives. For participants in this study, three conditions were necessary to their experiencing a healthy pregnancy: (1) the acceptance of the pregnancy, (2) adequate financial resources, and (3) supportive relationships (especially a supportive partner). Having an accepted pregnancy provided women with the motivation to ensure a healthy newborn. Having adequate financial resources provided women with the ability to meet their fundamental needs as well as to deal with everyday life events, thus allowing them to maximize their health. Having supportive relationships provided women with emotional, financial, task-oriented, and knowledge-oriented support – all of which helped with the creation of a healthy pregnancy.

According to participants, pregnancy induces a state of vulnerability, primarily due to the fear of the unknown. The circumstances surrounding her pregnancy may either increase or decrease a woman's sense of vulnerability. Participant accounts suggested that there are three states of vulnerability during pregnancy: (1) the state of vulnerability inherent within pregnancy, (2) heightened vulnerability induced by a social or medical condition, and (3) threat, the extreme form of vulnerability, which occurred in such contexts as poverty and violence. In order to deal with their state of vulnerability women drew upon the strength of creating a new life as well as upon their environment. The key requirements of a supportive environment were having adequate financial resources and supportive relationships (most importantly, a

supportive partner/husband). Further to this, Mi'gmaq women spoke of the strength they gained from their cultural identity and heritage, their connection to nature, and the elders of their community. These requirements were seen as fundamental to a healthy pregnancy, as they enabled women to validate and normalize their experience and supported their efforts to engage in health-enhancing behaviours.

### **The Experience of a Healthy Pregnancy**

At the heart of the process of creating a healthy pregnancy is having a pregnancy that is both accepted and that occurs within a supportive environment. Once these two conditions are met, women can concentrate on the well-being of the fetus. It is this concern for the health of the fetus that motivates women to engage in the process of creating a healthy pregnancy. This study sample included women with both planned and unplanned pregnancies within a supportive environment and also women with unplanned pregnancies in a non-supportive environment. None of the women in this study experienced a planned pregnancy in a non-supportive environment.

The women experiencing planned pregnancies within a supportive environment had the energy to engage in health-enhancing behaviours and immediately began (enacted) the process of creating a healthy pregnancy. Bonnie was typical of women in those circumstances. A young married professional whose pregnancy was planned and supported by herself, her husband, and their families, Bonnie spoke of how it was important for her to feel stable and supported. She described her husband as being central to this:

I feel pretty fortunate to have a strong marriage and feel ready for all this. Yeah! Like I could have never imagined myself five years ago, 10 years ago, having a child, it just wasn't right. I feel I'm a pretty balanced person and I'm 31. I feel like we're ready for it because I think we've known each other now for four years and a half, and we had a couple of years to do what we wanted, but now we're ready for children.

Bonnie was able to shift her attention and energy to the health of the fetus. She commented on all of the behaviours she carried out during her pregnancy, such as eating better, slowing down at work, resting, and increasing her rest periods as her pregnancy progressed. She also discussed the household preparations she and her husband were undertaking in anticipation of the arrival of her newborn and what it would be like to be a mother.

A supportive environment can go a long way to buffer the otherwise negative effects of an unplanned pregnancy when economic hardship is present. Jennifer, who was a recipient of social assistance as was her partner, was typical of women experiencing an unplanned pregnancy within a supportive environment.

Interviewer: Is there any other area that gives you strength?

Jennifer: My partner and his family. His family comes from a very strong family, also very loving and very caring, so I have a lot of support from them. That's one of the reasons too, like when we found out we were pregnant, it was like I can't see myself just giving it up because it's an inconvenience, and he thought the same way. He said, if we keep this baby we'll have my family's support and your family's support; it's not like we'll have a hard, hard time.

An unplanned pregnancy, with all its financial implications, can cause enormous stress to a woman who is already finding it tough to make ends meet. For Trina, who was already facing economic hardship, an unplanned pregnancy further exacerbated her situation. A university student and mother of two, Trina felt economically stressed at the prospect of an unplanned third pregnancy:

I was scared when I got pregnant with the third one because we had no money, the idea of having kids was tough already. To bring a third one was harder so I didn't tell [my partner] that I was pregnant because I was going to have an abortion because I was scared financially because we could hardly afford two [children] at the time and now to bring a third one.

Trina was living in a large American city and decided to have an abortion, as she and her husband were unable to afford another child. However, after going home to the reserve for a visit, being invited to live there by her husband's family, and realizing that



they would both be able to find employment, she opted to continue the pregnancy. Both Jennifer and Trina greatly benefited from the emotional and financial support of their families and the social cohesion of their communities.

The women who experienced unplanned pregnancies within non-supportive environments had the most difficulty in accepting their pregnancies. These women were distressed by their situation, to which they attributed their poor state of health. Amy, who had an abusive partner and was a recipient of social assistance, described her situation:

I had too much to worry about, where if I would have, mentally planned what I was going to do when I was going to do it, I wouldn't have had so many [health] problems. When you're single, the only thing you worry about is not getting pregnant. You don't want to get pregnant right away until you decide, okay, you're at a point in your life, okay, I'm getting older, it doesn't look as if I'm getting married, now I'm going to decide to make a child.

Women in Amy's circumstances experience a variety of emotions.

Well, me, it was like left, right, and this was wrong, that was wrong [with my health]. But I think a lot of it had to do with my mental healthiness. So I think you have to have the attitude towards whether you want to have this child or what kind of situation you're in at the time. At first, honestly, I didn't want to have the baby. With the situation I was in, I thought about abortion. I didn't plan on getting pregnant and when I did, I had a lot of mixed feelings

Lita, a first-trimester woman with an unplanned pregnancy and an abusive partner, also addressed her fear: "Now that I'm going through this, I've been very scared." Lita and Amy both attributed their poor state of health during their first trimester to their ambivalence regarding their pregnancies. Women who had not yet accepted their pregnancies claimed they would not do anything to harm the fetus but were not actively engaged in the process of creating a healthy pregnancy. Lita: "I didn't plan it and I would never do anything to hurt the baby but I know I'm not ready." Myrna, whose third unplanned pregnancy occurred while she had an intra-uterine device (IUD), spoke in a similar manner.

**Myrna: It wasn't planned; it was an accident and I didn't want to have any other children in the first place, so it didn't make a difference to me if I miscarried or not because – I don't know, it just didn't really bother me and it still doesn't bother me. Like I am not going to go out of my way and do something to harm or make myself miscarry. Whatever happens, happens and it will happen naturally. I don't know if you could say I didn't care, but it wouldn't have bothered me if I miscarried.**

**Women who had unplanned pregnancies, were suffering from economic hardship, and had violent partners and little support spoke of reverting to harmful behaviours such as smoking, not eating properly, and consuming alcohol as a way of dealing with their highly stressful circumstances. Cheryl talked about her first pregnancy as a stressful time that resulted in a miscarriage. She got pregnant upon graduating from high school, and this upset her family members greatly, as they had planned on her attending university. As a result of lack of family support, she moved in with her boyfriend. She talked about how this highly stressful situation adversely affected her capacity to properly care for herself.**

**Cheryl: I still smoke, like regularly, and I didn't take care of myself as well. I didn't give myself time to eat the right foods and I didn't take time to eat the right meals and sometimes I just didn't want to eat because things were bothering me. I can't eat when things are bothering me.**

**Consumed by the stressful conditions of her pregnancy, Cheryl was not able to focus on taking care of herself and enhancing her health.**

**All the women in this study who had unplanned pregnancies decided to continue them. One of the steps towards their coming to accept their pregnancies involved making sense of their situation. Amy described how she came to accept an unplanned pregnancy:**

**Amy: At first, it took me over, it kind of beat me down by then, when I said, "Okay, I changed my attitude; it's not going to get to me anymore. I'm going to control my life; I won't let it control me." Then my whole attitude changed; the whole thing changed. It just went in a complete circle and, okay, I'm ready for it now, no matter what faces me, now, you know, you're scared. When I realized to myself that I can't know what's in the future until it's there, you know, that changed a lot. I had to learn to accept that you don't always have to see what's there to believe**

it. I had to learn to accept that before I could go on, feeling the way I do. Once I saw the physical presence of Tyler [fetus], that changed that attitude where my mind was healthier, mentally and physically. Then I did a lot of soul-searching and stuff like that, which made me come to the conclusion that you can't always know what's ahead. You just have to take it for granted and deal with it when it gets there, and that attitude has changed. I never thought that way before; it was either, got to see it or I don't believe it.

For many women in this study, some physical sign of the baby (such as hearing the heartbeat or seeing an ultrasound) was critical to facilitating their acceptance. Once they accepted their pregnancies, they became actively engaged in the process of creating healthy ones. Coming to terms with, and so being able to accept, an unplanned pregnancy allowed Linda to refocus her energy on ensuring the health of the fetus:

I'm going to have a miserable pregnancy; I don't want to have this child, what am I going to do? I was left, right, and centre then, when I said, "That's it, smarten up, you're going to have a good pregnancy, you're going to have a boy ..." I just focused on that and okay, now that your attitude has changed, and picking yourself up by the seat of your pants, and you better start kicking, and moving on, and you realize, okay, fine now, let's get us healthier, let's keep the baby stronger, let's get this baby out into the world so we can take care of him and love him and all that and enjoy him. So when my attitude changed, a lot of things changed. Even though my situation was still, with his father, wasn't great, I was fighting back. I had the strength and the courage to keep on.

An important source of strength for all women was their ability to bear life and the presence of the fetus. Women with unplanned pregnancies, like women with planned pregnancies, drew strength from their ability to create a new life, and this helped them to accept their condition.

Jane: I felt great [being pregnant]. I'd do it over again. I'd do it one hundred times if I could. Because what I felt when I was pregnant, I felt like superwoman. I knew that life was being born inside of me and I never thought I'd be pregnant. I'd never thought I'd be married or have children. I always doubted myself. When I found out I was pregnant, I didn't doubt myself anymore.

Some women viewed pregnancy as a gift from the Creator, the opportunity to gain a new perspective on life, and/or a gift of hope endowed with strength and meaning.

Barbara commented:

I always believed that the baby was a gift from God. I felt like there was something growing inside of me, I felt the life inside of me and I felt, you know, I don't know, it was just like life was growing inside of me and it was making my life so much more. The baby gave me a lot of energy, a lot of strength, a lot of spiritual strength. It just strengthened everything in me, in my attitude, in my health, in my life, in my spiritual and physical strength.

And Rhonda:

It's a great feeling [being pregnant]. Other than giving birth, that's the best feeling I've ever experienced. It's the movement of my baby inside of me. I mean it makes you think about how can a human being actually be growing in your stomach.

In this study, adolescent women who were abused as children gained renewed meaning and a sense of direction from their pregnancies. Jennifer described her reaction to her pregnancy as follows:

It feels good [being pregnant] because before, I used to feel like a nobody. I'm more happy now, instead of being grouchy and everything. Even my nephew, he notices the changes. You know, jeez, you're more different and it's like this baby is changing my life.

Karine, who was abused by her father while growing up, took a drug overdose while not knowing she was pregnant: "I used to do a lot of drugs, like cocaine. It would knock me out and now I wouldn't even touch a joint. I want to see my little girl." Clearly, her pregnancy gave her a reason to live.

With the acceptance of the pregnancy came the onset of the state of vulnerability, as women realized they were not in absolute control of the outcome of their pregnancies.

### Vulnerability

During pregnancy, women generally experience a sense of vulnerability, as there are always uncertainties regarding the health of the fetus. The women in the

study acknowledged that despite their intentions, they could not be in absolute control of the outcome of their pregnancies.

Jennifer: When I first found out I was pregnant, it was scary, because everything in my life I had controlled up to now, getting my degrees and then working and then taking care of myself, living on my own, being independent. And having this baby has been new and it's been scary in the sense that I can't control it.

Bonnie recognized this, despite the fact that she was doing everything she could to have a healthy newborn:

The only thing I think I'm probably nervous of is something going wrong, you know, beyond anybody's control because you always hear different stories here and there. It doesn't occupy my mind, it just slips in and out about birth defects or something like that, but I know that chances are small.

Lita reflected on her knowledge of her sister's experience:

My sister, her little boy had ADD [attention deficit disorder] and she's having a hard time. And when she was carrying, she was taking care of herself and she never did anything to harm her fetus and this just happened. That really concerns me.

Pregnancy is fraught with other uncertainties, such as concerns about the birthing event itself, including the onset of labour, maintaining a couple relationship, and making the transition to motherhood.

Amy: Oh my God! What am I going to do? I'm not going to have a section and I'm going to have it natural, oh, my God, I'm going to die! It's going to hurt, I'm going to suffer, and all this stuff. Then that was more my focus at that time because, it's, like, we're scared of the unknown, it's, like, "Oh! You can do it!" It's just like jumping out of an airplane even though you've got a parachute, you know you can do it. But until you do it, it's, like, a scary thing. But once you do it, "Oh, well, that wasn't so bad."

Susan spoke of her emotions regarding the anticipation of the birth: "I find that I feel good other than the little things, things like I said that I have an occasional fear crossing into my head now, like the actual birth." Concerns regarding childbirth increase as a pregnancy advances, with women being most preoccupied by the

birthing event during their third trimester. Michelle told of how she changed as her pregnancy advanced:

A lot of things bother me now more than they did before. I guess now, before it didn't bother me at the beginning of the pregnancy, but now it bothers me a lot. I don't know when I'll have this baby.

One woman, who was interviewed during each trimester, brought up her concern regarding the boundaries of her couple relationship. At first, she expressed concern that when the baby was born, her relationship with her husband would lose its intimacy:

Bonnie: I hope I don't feel like the baby's intruding on our lives. I want to make sure that we still have, you know, our intimacy and separate lives from the baby's too. Not that we're going to abandon him. But I think there could be a happy medium there. Because, I think you see that with a lot of people, it's really hard to keep your marriage the same as before.

In a subsequent interview during her third trimester, Bonnie had accepted the idea of making accommodations for her unborn child.

Because women cannot control the outcomes of their pregnancies they perceive they are vulnerable, a state that prompts them to engage in health-enhancing behaviours in order to maximize their chances of having a healthy baby. Bonnie, a young health care provider, described what she did to increase her chances of having a healthy baby: "I think, like eating well, you increase your chances of a healthy baby because that is just common sense. But something may still go wrong." Jennifer, also pregnant for the first time, explained her attempts to ensure a healthy baby:

If the baby gets sick inside of me or something, that's something that I can't help. Like I help, trying to be as healthy as I can be, but I feel if [there are] complications or something goes wrong, there is nothing that I can change.

Women spoke of being in a heightened state of vigilance and, consequently, engaging in such health-enhancing behaviours as eating well. Bonnie, a first-time pregnant woman, spoke of this and of how it prompted her to engage in a healthy

lifestyle: "I don't even feel pregnant yet but I've been eating better than I ever had. Just being more conscious of it, like making sure of the milk and the vegetables and other things." The same held true for Susan: "I'm a lot more conscious of what I'm eating, of what I'm putting into my body." Another woman, Leslie, commented on how the significance of bearing a new life encouraged her to become more vigilant about her health and to engage in a healthier lifestyle:

I always felt so sluggish and I don't know, for some reason it just seems like there is another life growing inside of me and I feel like such a different person to do the things, like I say, to diet and exercise a little bit more than before.

In one sense, the state of vulnerability seemed to help safeguard women's health, since the resulting vigilance enabled women to respond to signals from their bodies. These signals, which occurred with the onset of pregnancy and functioned to protect women's health, can be described as "body knowledge." It begins with the onset of pregnancy and continues following birth (albeit to a lesser degree) because women want to ensure their health so that they can continue caring for their children. Lita spoke of listening to what her body was telling her: "That's when I said I'm just going to do what I've always done, and I'll just take certain signs from my body and when the time comes, I'll start taking it easy gradually." Donna also noted how she thought her body informed her regarding the frequency of her meals: " But I noticed that I have to eat. It's not a choice, it's my body who tells me I have to." According to Amy her body seemed to direct her towards healthy choices:

I didn't eat a lot of junk food when I was pregnant, not too much. I found that each time I ate more, I craved more for, like, fruits and raw vegetables and stuff like that, like broccoli and stuff like that.

Women also stated that their bodies told them to pace themselves, to get rest. Cheryl mentioned several bodily reactions that prompted her to change her behaviour in order to safeguard her health:

I just kind of sense when I got to go and sit down. And my stomach tends to tighten up when I do a lot. It tends to feel tight so I sit down and I rub

my stomach and everything loosens up, and they start moving around in there, and I feel happy.

Researcher: It sounds like you have really good judgment.

Cheryl: I do. I listen to my body. When my body says something, I know I've got to do something to fix it. Or when it tells me I'm hungry, we'll have something to eat. If it tells me I'm tired, I'm going to relax.

Certain unusual body signals prompted women to seek medical advice. Mandy described how her awareness of changes in her body prompted her to make a doctor's appointment: "I'm worried about my pregnancy right now. I keep getting these sharp pains and I don't know if that's normal. I have an appointment Thursday. I'm only like nine weeks and I can hardly feel fluttering." Jennifer talked about a similar experience: "I was having this pain on the right side and I thought it was in the tubes so I got really, really scared and I went to the hospital."

#### Heightened Vulnerability

Thus, uncertainties associated with pregnancy placed all women in a state of vulnerability. However, the women in this study exhibited a range of conditions that exacerbated this state, such as: previous miscarriage, having previously had a sick child, being medically at risk, being older than 35, and having already had a negative birth experience. Women who had experienced one or more of these conditions all spoke of their fear of losing the child. They all spoke of engaging in additional health-enhancing behaviours, making more sacrifices, getting medical advice, and avoiding stressful situations.

In this sample of 40 women, eight had experienced a previous miscarriage and 10 knew of a sister or a close friend who had. These women talked of their increased sense of vulnerability and the extra precautions they took to ensure a healthy baby and to decrease their chances of miscarrying. Cheryl, who had had a previous miscarriage, spoke of her fear of losing her twins and the extra care she was taking:

Researcher: Can you tell me what your biggest concern is right now?



**Cheryl: Right now, my biggest concern would be a miscarriage because it terrifies me. I'm trying so hard [this time]!"**

**Cheryl quit smoking, rested, and ate properly – none of which she had done during her first pregnancy.**

**All women with a history of miscarriage associated it with having high levels of stress, and so avoiding stressful situations became important to them. Elizabeth, who had had a previous miscarriage, spoke of trying not to get stressed out, taking it easy, and not lifting weights. "Because I don't want to stress myself too much, the weights are heavy and the only thing I do now is the Stairmaster because it can walk. But other than that, I don't do much of the other exercises." Two other women mentioned taking folic acid and eating healthier foods.**

**Women who knew of a friend or sister who had had a miscarriage spoke of their awareness that this could happen to them, thus confirming their feeling of heightened vulnerability. Jennifer, whose sister had a miscarriage, detailed the extra precautions she took:**

**My sister miscarried. My oldest sister miscarried last year, and it was attributed to a lot of stress. She told me not to pick up heavy things. Where before, I've always been a hard worker and, like, anything, I would pick it up right away. I've never been one to say, well, help me with this. And it was hard for me but the more I watched myself, the more I was scared about what happened to my sister happening to me, so I took real special care in that regard.**

**Susan, a pregnant mother, told of increasing her vigilance in order to safeguard her health:**

**I'm doing the best I can. I have this friend, she was just about one month more than me and she lost her baby and that really was really a cold slap in the face. It made me scared because it could happen to me, too.**

**Donna and Shauna, who both previously experienced a miscarriage, took extra precautions in the preconception period. Donna, a social worker, talked about the importance of health prior to conception and the behaviours she carried out to ensure a healthy body:**

Even before I got pregnant, there was six months that I was watching what I was eating, not to take any alcohol or medications, not to go in smoky places. I tried to eat well at home by taking a lot of fruit, drinking a lot of water and [doing] exercises.

All the women in the sample believed it was important to limit their stress.

Elizabeth, a pregnant woman who had a miscarriage during her first pregnancy, stated:

I think some women during pregnancy they still continue to do everything they used to do. They still continue to clean and to stress themselves and I think stress is a big part of not being healthy. Don't get yourself stressed during a pregnancy so that's one thing I try not to do for a healthy pregnancy and it's worked.

Mandy talked about not allowing anybody to smoke in her house, correlating the experiences of two family members who had been exposed to second-hand smoke and the adverse effect she perceived this had on the health of their fetuses:

My husband's cousin, well, my cousin and his cousin, they were married, and she was seven months pregnant, and the baby's lungs didn't develop, and she had to go to Montreal and have an abortion, and then my brother-in-law's wife, same thing happened to her and she didn't smoke. It was her husband that smoked.

Having previously had a sick child (as did three of the women in this sample) was also a significant factor in prompting women to take extra precautions during pregnancy. Michelle, a pregnant teenage mother whose first son had asthma, spoke of how his condition increased her awareness that something could go wrong with her second child, too:

I try to be as healthy as I can because my first has asthma. We found that out when he was six months, so I am trying to be more relaxed now than I was when I was pregnant for him. And I eat more right, and I try to do all the things I am supposed to do.

When discussing how her daughter had been sick at birth, Elaine commented on the importance of health:

[Health] means a lot to me because of my daughter, Sarah. They were saying that she had a mild heart attack when she was born and it affected her left side – not so much, like she can use it and everything but it's weaker. And I think now, with my second baby, that I don't know what

happened but I just want to know that I do everything right. I don't like making sacrifices, but it's worth it for that. Health means a lot to me.

Elaine spoke of reducing her cigarette consumption to a couple a day and of eating healthier food for her second pregnancy.

Two women mentioned a negative birth experience in their past as a reason for their increased sense of vulnerability. Catherine, a mother of two who was pregnant for the third time, explained:

For my first delivery, I was in a midwifery program. We chose this because, being low-risk, we wanted to have a natural experience and be respected in the decisions surrounding the birth. For our second delivery, we did not have access to such a program and we were left with no option. I had a family doctor who did not want to treat us as partners. Instead he wanted to be in control of the decisions surrounding my body and my delivery. We did not feel respected, nor did he intervene correctly at the time of birth when I had a post-partum hemorrhage. He gave me the wrong drug, atropine, for a post-partum hemorrhage and proceeded to do an excruciating fundal massage.

Another woman spoke of a similar experience. Donna, a mother of four, described her fear following a previously unpleasant experience: "Pregnant in Restigouche, I was definitely afraid of what would happen at delivery." Both Donna and Catherine took extra care with their deliveries, and both went to a larger centre to deliver. Both women, who have attained university degrees, said they could not trust their physician and the quality of the health care provided in their rural community.

Other women who were medically at risk, (Rh positive [1], placenta previa [1], hypertensive [1], incompetent cervix [1], and twin pregnancy [1]) also made sacrifices in order to maximize their chances of delivering a healthy newborn. Karen, who had been previously diagnosed as Rh negative and faced the same risk with this pregnancy, was prompted by her past experience to take extra precautions. She spoke of not wanting to take any chances, including lifting any weights during her pregnancy, despite the fact that she really enjoyed this form of exercise. "Everyday normal,

everyday things, I don't do anything different. But I don't do anything out of the ordinary. I just relax, take it easy, you know."

Two women in this sample spoke of how being over 35 heightened their sense of vulnerability, as they felt their age increased the risk of something going wrong.

Donna, a 35-year-old mother, spoke about not taking any chances:

I didn't want to take no chances. Like I said I did everything for this child, so I wasn't about to save on things like that. And being my age was a major concern to me, too. Younger people maybe can take chances and, you know, take less care, I guess – I don't know. But with me I found it more my age. I wanted to make sure he was really healthy.

As a result, Donna did not substitute another brand label for Materna vitamins, taking exactly what the doctor prescribed rather than a less expensive kind. Katy, a 40-year-old mother of two, made sure she was healthy before she conceived: "Before I got pregnant I got a clean bill of health. When I went to my doctor, my cholesterol was good, my sugar was good, my heart was good, everything was good." Thus a number of social and medical factors created a sense of heightened vulnerability in pregnancy for a number of these women.

Beyond the heightened vulnerability that many of the women experienced, a few women in this study experienced an extreme form of vulnerability due to serious and pervasive threats such as economic hardship and an abusive partner. This state of threat forced women to shift their focus away from creating healthy pregnancies and towards survival strategies. The dynamics of this extreme state of threat and pregnancy will be discussed in detail in Chapter 6.

### **Supportive Relationships**

As has been seen, pregnancy places a woman in a vulnerable state, making her more dependent on a social network and creating intense needs for loving support from others (Colman & Colman, 1991). This sense of vulnerability also prompts women to rely on available sources of support. Having a supportive environment is central to women's health, as it gives them the strength to deal with their vulnerability.

As key ingredients of a supportive environment, women identified their relationships with others (beginning with their male partners and extending to girlfriends, sisters, and mothers) and their family upbringing. Further to this, Mi'gmaq women spoke of the strength they gained from their cultural identity and heritage, their connection to nature, and the elders of their community. This provided women with emotional, financial, task-oriented, and knowledge-oriented support, thus giving them the capacity to direct their energy towards health-enhancing behaviours.

#### Partner/Husband

The most important source of support women identified is the support received from the male partner/husband. Women characterized supportive partners/husbands as reliable and eager to be fathers. Such partners offered women emotional, task-oriented support, thus enabling them to take better care of themselves. Michelle, who, not by choice, experienced her first pregnancy without a partner, compared that situation with her current one:

'Cause for my first pregnancy I just had my mom and my family but that's it, I didn't have the baby's father or anything like that, so down here it's a lot different. I have the baby's father plus my family and a lot more help than I did before.

Women consider their partners to be supportive when they are reliable and offer them both emotional support (e.g., sharing the excitement of the pregnancy, listening and being considerate of her needs) and task-oriented support (making meals, doing housework, taking care of children). Knowing that a partner will be there for her, regardless of the outcome, allows a woman to face the uncertainties encountered during pregnancy. This support helps to buffer feelings of vulnerability. Cheryl commented on the reliability of her partner: "He's here 24 hours per day and if something ever bothers me, he's my backbone." Another Mi'gmaq woman explained the strength and confidence inspired by her boyfriend's encouragement:

Leslie: Timmy, my boyfriend, he gives me a lot of strength.

**Researcher: How does he do that?**

**Leslie: Just believing in me, knowing that I can do things that I always thought I could do, that, I don't know, I try. Usually I'm a very shy person and he always tells me, "Leslie, don't do that, talk to people, they're not going to hurt you." But I know it's just him being there with me. It gives me more strength than what I normally would have, without anybody.**

**Just knowing she will not be left alone allows a woman to face the uncertainties inherent in pregnancies. Karen, a high-risk pregnant mother, described how her partner's support enabled her to deal with the uncertainties of pregnancy: "It was scary and I had his support all the way. He was there every step of the way with me. So it just made it a lot easier for me to face."**

**The level of a male partner's emotional support seemed to be related to his eagerness for fatherhood. The supportive partner's concern extended beyond the woman to the fetus. When he showed signs of attachment to the fetus, that enhanced the woman's feeling of being nurtured and loved. Elizabeth, who lives with her boyfriend, stated: "He's always asking me how I feel and he's always touching me and making sure the baby knows. Every time he touches, the baby kicks. He makes me feel good all around." Bonnie described the pleasure she and her partner took in experiencing the life of the unborn child: "He'll be a really good dad. I just know when he is so excited and ready for an outcome, it really makes both of us feel great. We're counting the days, kind of thing." Amanda, a teen whose unplanned pregnancy made her afraid her boyfriend would leave her, said that she began to feel less fearful when he started showing an interest in the unborn child:**

**When I told him about it, he was happy there. He didn't know what to say but then after that, his parents started talking to him and stuff, like, and they are really happy about it and now he's starting to touch my belly and he talks to it.**

**Due to the increased physical demands of pregnancy, all women experienced fatigue. Consequently, they expressed appreciation when their partners voluntarily helped around the house and assumed certain domestic chores, thereby allowing them**

to rest and to take better care of themselves. The men took care of the women by cooking them a meal, giving them a back rub, or assuming extra household tasks. Jane talked of how she appreciated her husband cleaning when she was tired and cooking a meal after a long day of work so that she could rest: "So when I get home from work, Etienne would cook supper, he'd clean and pick up things for me and I tried to rest, which was great. I needed that."

Cheryl described how helpful her partner was during her pregnancy:

He makes me eat. He cooks and everything. He cleans up a lot. He does a lot of sweeping and everything. You know, things that I can't get to do on my own now.

Sue talked about her boyfriend going out late at night to get her a favourite food:

If I do get hungry at night, it's not often that I get a craving but I do. My boyfriend goes off and running and gets what I want. One night I craved for Dixie Lee (fast-food take out restaurant). It was around 11 o'clock at night. I had to have it so he went! Sometimes, he brings strawberry sundaes.

For employed women with children, task-oriented support from their partners is especially important. Denise talked about the tasks her husband did when she was unable to do them: "He cooks, he cleans, he does laundry and takes care of the kids, he baths them, he does just about everything. Once he starts, get out of his way!" When asked: "Are there things that are done for you that maybe help you?" Elizabeth replied, "He helps out a lot around the house, he cleans a lot." Denise told how her husband took care of the house and children because she is the main breadwinner:

He helps around. Well, he always did. Michael is pretty good, especially with me working, you know. Right now, he's not working but he's here at home and he's the caretaker of the house right now while I'm working.

Many of the women also reported that their partners/husbands did the heavier work. Donna talked about having a good partnership with her husband, who worked on a seasonal basis. When he was not working, he assumed all the household

responsibilities; when he was working, they both tended to such responsibilities, but he did the heavier work.

The most supportive partners were also aware of, and capable of meeting, women's emotional needs. Bonnie spoke of her husband's ability to recognize her needs without being asked:

He's been real great. Really supportive, you know. Like if I'm tired, I'll just go to bed, he'll come and say, "Would you like something to eat?" He could tell [when I worked too hard], you know, just when I would get home and I was really tired, not talking much, he knows it was a long day or a rough day. He knows. He'd just kind of sit back and let me unwind a bit and then would give me a foot rub or something. He's great.

### Supportive Women

In addition to male partners, women also drew support from other women, especially their mothers, sisters, and girlfriends. The contact with other pregnant women helped women normalize the experience of pregnancy and was an important part of prenatal classes. In addition, emotional support from girlfriends enabled women to validate their experiences by sharing them. Female friendship provided a context within which women experienced happiness and the sense of living life with "purposeful energy". Having a pregnant friend, or one who had children, was particularly helpful. Jennifer explained sharing her pregnancy experience with a pregnant girlfriend.

You know, me and Brandy, we do a lot of things together. You know, it's like I've got somebody to be pregnant with me so we do a lot of things and we hang out together and we'll sit down and, like yesterday, me and Brandy, that's all we did is just eat. We eat together and we joke about it. It's exciting for me.

Her friend gave Jennifer a sense of affiliation and belonging – a feeling of connectedness. Jennifer spoke of how she and her girlfriend ate healthy green salads and walked together, supporting each other in engaging in health-enhancing behaviours. Bonnie spoke of friends and a sister with children:



My two sisters each have two kids. In our family, they don't think we should do this and that, but they're just really supportive. It just gives me kind of a little bit of insight which I didn't have, since I'd never spent much time around kids at all until these four or five years being home.

Another important part of feeling supported was having somebody to talk to who was concerned about the woman's well-being. Donna talked about having good friends she could turn to when things bothered her. Michelle spoke of the importance of having someone drop in to talk: "I just want someone around to talk to about how I'm feeling. When they're not there, it's, I guess, it's harder because I have no one to talk to."

An important source of validation came from women sharing their experiences at prenatal classes. One woman said that prenatal classes allowed her to be a part of something and to feel connected with her friends. Cheryl spoke about prenatal classes:

They give you a lot of information and they have other women who've had children before come and they share their experiences so we can get some feeling of what is happening. They are all different people with all different kinds of children and all different ages. They have a lot to share and I get a lot from that. It's interesting! It's the support.

Amy, who experienced verbal abuse during her pregnancy, drew support from the women she met in prenatal classes, calling them a little family who "all went through it together." This gave her a sense of being connected to girlfriends and compensated for her partner's absence.

Amy: And a couple of us, we were in the hospital together when we had our babies. We kept going from room to room, checking on each other and it was fun. It made like a close net with a group of people.

Jane also shared her experience of having meaningful relationships with women from her prenatal classes: "During prenatal class I met a lot of other pregnant women. We all became friends after, because we all had our babies close together."

Another source of support came from having other people around who were excited about the upcoming birth, people who were able to contribute to the creation of a healthy pregnancy. Jane talked about her sister and mother being more excited than she was, and Elizabeth told of the support she received from her mother, her

mother-in-law, and the women where she worked (who had a baby shower for her): "I get a lot of support from them; they are really happy about it." Two women speak of feeling supported by colleagues. Bonnie said: "Everybody at work, too, everybody is quite excited about it. It's a special time!" And Denise remarked: "They talk to her [fetus] and they are very supportive; they can't wait either." Also, one woman felt supported by her colleagues at work when they wouldn't let her do any heavy lifting:

Denise: Well, even just at my work. They wouldn't let me down. I mean there was like the first week, it was like cleanup week, so there was a lot of people keeping an eye on me, on what I was lifting and, you know saying "Get out of there." They kept a good eye on me, oh yeah!

All the women spoke of a variety of tasks done by mothers or family members. Elizabeth spoke of always being able to depend on her family: "Yeah, I can count on them and I can always count on my mom and dad, for sure." Donna's father drove her to her doctor's appointment; Cheryl's mother-in-law went to the soup kitchen for her; and Jane's cousin and the women at the bank had a baby shower for her. Amy spoke about her sister's help during her pregnancy. She talked about how her sister helped her after she left the hospital and was on bedrest for two weeks. Her sister gave her a bell to ring whenever she needed anything, cooked for her, helped her take her bath, and went to get the food she craved.

Amy: She did everything. When I needed to take a bath, she'd come and help me take a bath, she'd wash my back since I couldn't get up and down too much.

Women with young children appreciated having somebody baby-sit in order to give them a break, thus allowing them to rest and replenish their energy. Michelle spoke of this: "The support of the family just helps a lot because if I'm tired and I just don't feel like doing anything, he will take the baby out and I just relax all day." Leslie noted of the assistance she received in caring for her son: "Like my friends, they'll go to the store for me or they'll take care of Nolan [her son] for a couple of hours while I have things to do."

Women also drew support from others when they offered much needed financial or knowledge-oriented support. Financial support was critical to women living on low incomes, and it came mostly from family in the form of borrowing money, assisting with groceries, and purchasing baby items. All those who were “working poor,” as well as women on unemployment insurance and social assistance, mentioned how it was essential to them to receive financial support in order to purchase baby items. Michelle talked about her mother-in-law buying her a crib and other items the baby needed. Jane spoke about her family buying her everything she needed for the baby, including a stroller, crib, and clothing for the first year. Katy, a teen mother, told of the assistance she received from relatives: “I didn’t have to buy everything. I had relatives, they bought me all of the big pieces: stroller, playpen and all. They all chipped in together. So I really had a lot of help.” Women with higher incomes also benefited from this type of support, as it contributed to their feeling of being taken care of.

Women spoke of the important knowledge obtained in the form of stories and advice, from sisters and girlfriends, as they could easily comprehend it and see its real-life implications. When the researcher asked, “Who do you tap into when you have a question about your pregnancy?” Jamie replied, “Mostly Mandy because she’s the one who has more kids.” Donna also mentioned turning to friends for advice: “I have a lot of friends who have children who talk to me about their experiences.”

Women found it very useful to draw from a wide range of other women’s experiences. Cheryl included the nurses at her prenatal classes among her varied sources of information:

They [nurses] give you a lot of information and they have other women, who’ve had children before, come, and they share their experiences, so we can get some feeling of what is happening. They are all different people with all different kinds of children and all different ages, so they have a lot to share and I get a lot from that. It’s interesting; it’s the support.

Lita also talked about how prenatal classes and other women's experiences were relevant to her. She commented on how the knowledge shared by other women was comprehensible, unlike much of the medical terminology used by health care practitioners. In order for women to perceive knowledge to be credible, it must be understandable to them:

Lita: There was a medical part of it, and there were the women that had children before. They were sharing their experiences, which was nice. The medical part of it was interesting, but I couldn't grasp that as much as I could grasp what the women were saying. I'm not the type to take information from a book – that doesn't sink into me; something shared is always better, but it was very helpful because it's a whole new world; maybe not for everybody, but it's a whole new world for me.

In order for knowledge to be accepted as credible, many women felt that it had to come from a trusted source. Jennifer received advice from her older sister, who is a mother of two:

In the beginning, because of the change in my food habits, I stopped eating as much and I didn't feel good about that so my older sister, she told me to start eating like six meals per day, just break it up and just eat like that. If I have a question, I called my older sister.

Lita indicated the difference between knowledge passed on by friends and knowledge passed on by acquaintances:

Well, as soon as I found out I was pregnant, I got some information from everybody. You're going to feel this, you're going to be sick, you're gonna blow up, you're going to retain water, and everything just hit me. I didn't want to be told because sometimes ... mind over matter, you become that and I didn't want to become that, I wanted to take my own pace and see how it unfolded during my pregnancy.

She went on to explain how she relied on the knowledge she received from speaking to the elders and her sister as well as from listening to her body.

Thus, supportive relationships with other women (mothers, sisters, and girlfriends in particular) reduced anxieties, provided encouragement, and became important sources of information and financial assistance for these women as they strove to create healthy pregnancies.

## Family Upbringing

Seven women mentioned a strong family upbringing as an important source of strength. From their families, these women received love, self-esteem, and a sense of self-worth, which they felt created the foundation for meaningful lives and relationships. Brenda explained what she received from her family:

I'm a very fortunate and very privileged individual. I'm very fortunate that I come from a very strong family, as well. I credit everything that I am from the generation of gifts of my father, as well as my mother. I'm part of a good family base and very strong genes so there was a lot of love, a lot of positive, a lot of nurturing, a lot of growing, a lot of stability. And always, I know where to draw the line, always. We always had a line of knowing what it is to respect, what it is to approach a situation, to problem solve.

Leslie spoke of her upbringing as a source of strength. She repeated a conversation she had with her mother: "She said, 'How did you ever become so smart for your age?' I said, 'Well, I was brought up by you and my grandmother so..'" Bonnie attributed some of her strength to her family's values:

Researcher: I just wanted to ask you if you could talk about where you get all of your strength?

Bonnie: I think it just comes from inside. Even as a kid, I just remember we had goals and meeting them. My mom is goal-oriented too, in a different way.

Lita also commented: "My parents have taught me a lot about respect and common courtesy."

## Mi'gmaq Identity and Heritage

Women of Mi'gmaq heritage often described their culture as a source of strength. Educated Mi'gmaq women may be empowered by a heightened awareness of who they are and a knowledge of their strengths. Of the 24 Mi'gmaq women in this study, four had attained college or university degrees. It appeared that the more education the women had received, the stronger their sense of who they were. For example, Jennifer, a college graduate, spoke of how getting to know about her

Mi'gmaq spirituality made her feel proud, thereby contributing to her personal sense of strength: "It makes me feel really good. I'm proud to be who I am, you know. It's how I feel. I feel good. I try to talk to other people about our ways and everything, you know."

Lita mentioned picking fiddleheads for the powwow as a way of manifesting her spirituality; for her, knowing one's own cultural ways is essential to one's sense of self worth. Traditional practices and rituals also contributed to increasing a sense of connection. Denise talked about the sweat lodge: "When you go in a sweat lodge, you come out a different person. It makes you feel real good." Lita talked of the strength she gained from going to gatherings and her feeling of being connected to nature:

It's like when we dance – we're connecting with the earth. And when you hit the drum, you're connecting with Mother Earth." She also spoke of the connection between herself and the spirits: By us paying respect to good spirits, they come around, help us out and watch over us. And they are there for us.

Three Mi'gmaq women spoke of knowledge stemming from the elders and their ancestors. An "elder" is a person over 50 years of age who has lived through many life events, has reflected upon them, and has transformed the knowledge derived from them into wisdom. Denise told of receiving their advice: "I believe the elders. They tell you everything, like, 'Don't do this at this time', or 'When your baby's up all night and sleeps all day, turn around', or whatever... I'll give it a try."

Lita described her experience with an elder: "I was baby-sitting an elder's daughter and I went in and she looked at me and told me she knew I was pregnant before I knew I was pregnant." Such experiences made Lita want to listen to the elder's stories and use them to help her decide upon the extent of her physical activity:

Like, should I be taking it easy because I might be endangering the baby? And then I spoke to another elder and she said they worked hard in their days when they had babies, they worked right up until the last day, scrubbing floors or washing clothes or taking care of the kids, and they always had a healthy baby.

Five Mi'gmaq women spoke of the significance of elders in their community. The elders were respected for their wisdom and were relied upon to provide knowledge and comfort. Denise commented: "Just to listen to [elders], how our sisters lived and what problems they went through, and things that they did, and it's nice to listen to." Jennifer referred to the knowledge of the elders and what she had learned from it:

I guess it would be with the common sense that comes with the traditionalism, a lot of things that I have learned from a lot of elders, from Mohawk elders and Cree and Montagnais, [which] is just being who you are and being happy with who you are. Smudging with sweet grass and sage, I was taught that by a Mohawk elder and it was also giving thanks for giving, for everything that you were given on this Earth. And it went from giving thanks from everything from the ground and up. I feel like brand new again.

Donna, a Mi'gmaq community leader, spoke of what she had gained from the elders:

Again, it goes back to our history. From what I have read, my images of our ancestors are just really strong, physically strong, agile, healthy people that could survive for their children anywhere. You read a lot of stories and the early Europeans praised the Mi'gmaqs because they didn't have all of those vices.

The Mi'gmaq women perceived themselves to be very connected to nature. Their closeness to nature acted as a great source of strength, bringing them a sense of peace and happiness. Again, this was most apparent in those women with a university education. Brenda talked about those spiritual aspects that combined to give meaning to her life, providing her with a sense of connectedness to her past and present as well as with a sense of her closeness to nature:

I find strength in my own spirituality. Because you know, I can be in the church and I can be praying with other people and I look into their eyes and I look at the way they are, that gives me the strength and I get the same, you know. With the sunrise, for example, I get that same feeling because it's a goal within myself. I'm very fortunate because Mom was a vegetable gardener, she was a farmer, so my sister does that. I do the flowers and Dad was into trees and flowers so I do that and I can see, like I look around the neighbourhood and it's all trees that Dad planted, you know. So, like I feed on that and I talk to him and I pray with him

because I'm doing that stuff so ... I have a connection now, you know. I was very fortunate when Mom and Dad passed away. Mom died in 1983 so I inherited my parents' home; we were all born and raised there. We were all raised in that house and so it means so much to me that you know ... that's been the source of my strength, my stability, I'm connected to something and someone and people, so the children feel that as well. I can say, "See that tree over there, I was barely three years old, barely toddling around and I remember Papa, you know, with his shovel trying to get me to help him, you know, and slapping me with his hat, like his straw hat, trying to get the bugs away and stuff.

Many Mi'gmaq women saw a clear relationship between health and nature. Nature was a great source of freedom for these women and acted to alleviate their stress. Lita, a college graduate, alluded to this:

Like, if I have a headache, I always try to ride it out. It's always mind over matter and I say it's not going to last forever. I always try to think about that, or I try to go outside, or go for drives or walk, usually. When we hang around up the woods, it's like a clear air and there is no tension up there; there is no electricity, there is no stress, there is just nature.

Similarly, Cheryl explained the place of nature in her health:

Going for a walk outside and taking in the air. Appreciating it, it does help you relax. It helps you a lot. I love nature and I love going up into the woods for a drive, and stopping and staring at the trees and the animals, and I just love it and it gives you a lot of peace. You know you're at peace with yourself, you're at peace with what's around you, and it helps. It does. It relaxes me. When I'm mad, I'll go for a drive and I'll stop.

Donna spoke of nature in relation to getting to know oneself: "And I guess to me, you really have to know who you are and I think the best way to find out who you are is to take a walk in the woods." Brenda described a similar connection with nature: "So the extent of my spiritual belief is essentially that there is something greater than us and to create a bond, I just go for a walk in the woods."

To summarize, women in this study described the support they derived from supportive partners, families and other women. First Nations women further talked about the benefits received from their cultural identity and heritage, the elders, and their closeness to nature. These sources of support enabled women to cope with their



sense of vulnerability and to validate and normalize their experience of pregnancy. The strength drawn from a supportive environment was critical to women's capacity to engage in the process of creating a healthy pregnancy.

### **The Process of Creating a Healthy Pregnancy**

Creating a healthy pregnancy consists of enacting behaviours geared to maximize one's chances of having a healthy newborn. All the women in the study spoke of engaging in these sorts of behaviours. As noted earlier, they spoke of six main areas of health-related behaviours: eating habits, exercise, alcohol consumption, smoking, sleep/rest restoration, prenatal care and classes. Their strategies for maximizing their health consisted of modifying behaviours (i.e., cutting out/reducing or increasing certain behaviours, substituting one behaviour with another), making sacrifices, and avoiding harm and stress.

Women spoke of creating health as though it were a process involving an upward spiral – a spiral that was continuously reinforced as they undertook more and more health-enhancing behaviours. Amy explained this process: "Everything just kept going around and getting better and better and better all the time." And Lita: "When I feel good, I do things that make me feel good, I feel physically healthy." And Denise: "I've got a lot of energy in me. I do a lot when it comes time to do it. If there's a lot that has to be done, when I get started, you know you can't stop because you've got to keep going."

Because certain behaviours led to the relief of stress, they made women feel good mentally and physically and provided positive feedback, which, in turn, continued to expand this spiral of positive health. In this study, women spoke of going out and meeting friends, exercising, attending prenatal classes, and eating well as being activities that contributed to the promotion of their health. For example, exercise made women feel good both mentally and physically, increased their energy level, relieved their stress, and so promoted better health. Elaine described the importance of

exercise: "When I feel healthy, I really want to [exercise]." Exercising also relieved stress because it enabled women briefly to stop thinking about their worrisome circumstances. As Elaine pointed out: "Going out and exercising makes me feel healthy. It just makes me lively."

Of the 40 women interviewed for this study, 33 spoke of themselves as being healthy overall. They linked being healthy to having energy, having a positive attitude, and having no major pregnancy-related symptoms or diseases that impeded their daily activities. They also spoke of various health-enhancing behaviours they carried out in order to maximize their chances of having a healthy newborn.

Women in this study who described themselves as having a healthy pregnancy typically had supportive partners and/or families, financial security, and a planned or desired pregnancy. If they lived with economic hardship, they nonetheless had reliable sources of financial support and various people to help them in dealing with their situation. If they had unplanned pregnancies, they had supportive partners and friends and adequate financial resources to facilitate their acceptance of their situation. All of the women experienced a normal or heightened state of vulnerability and benefited from a supportive environment, which provided them with enough stability to direct their energy towards engaging in health-enhancing behaviours.

Seven women spoke of themselves as being unhealthy. Poor health was linked to having low energy, a negative attitude, feeling depressed, feeling fatigue, and requiring excessive sleep. These women could not carry out health-enhancing behaviours. Furthermore, all these women experienced significant symptoms, such as excessive nausea and vomiting, bleeding, or preterm labour. Having to deal with high levels of stress, these women reverted to harmful coping strategies.

All of the women in this study who spoke of themselves as being unhealthy during their pregnancies experienced two or more of the following conditions: an abusive partner, poverty, and/or unplanned pregnancies. These women all

experienced the extreme state of vulnerability – threat. They did not benefit from a supportive environment and did not have access to the necessary resources to create a healthy pregnancy.

In this chapter, I have presented the women’s accounts of the conditions required to create a healthy pregnancy. Most of the women were active in their development of health-enhancing behaviours and were able to identify the supports and resources that assisted them with that process. For some women, however, the vulnerability and state of threat were more extreme, and a healthy pregnancy seemed unattainable. In the following chapter, these special threats will be examined in more detail.

## **CHAPTER SIX:**

### **SPECIAL THREATS TO A HEALTHY PREGNANCY**

Whereas most of the women I interviewed were able to achieve a healthy pregnancy, several accounts made it apparent that certain conditions constituted special threats to a woman's capacity to do so. These conditions included economic hardship, domestic violence, and alcoholism. For women in these circumstances, everyday life was a struggle to survive. When unable to meet even basic needs such as being safe, being able to feed oneself, and/or being able to pay rent, the women invariably experienced high levels of stress and uncertainty.

In this chapter I address the impact of poverty, abuse, and alcohol on the women's lives and pregnancies. In addition, I allude to additional social and contextual factors that contributed to placing some women in an extremely vulnerable state. By analyzing the impact of these special threats on their lives, it becomes possible to show how their capacity to create healthy pregnancies was severely jeopardized.

#### **Poverty**

##### **Patterns of Poverty**

Among the 40 women who participated in this study, the majority experienced economic hardship (26 received social assistance, 2 received unemployment insurance, and 4 were among the working poor). Since all pregnancies increase a woman's economic needs (as she requires additional foods, maternity clothing, and items for the impending baby), pregnancy is a time that often precipitates economic difficulties for the working poor. If women take time off work for motherhood, they often must rely on social assistance or unemployment insurance, as their jobs usually offer no maternity benefits. Pregnancy places the greatest strain on women who are already recipients of social assistance, since it further stretches already strained resources.

Most of the women in the study moved in and out of poverty – a pattern that is reflected in the national profile of poverty trends in women (Ross, Shillington, & Lochhead, 1994). Those most at risk are single women with few resources – young women who have no special education or training to give them access to an adequate job and revenue, who receive little family support, and who do not receive child support. Further, since First Nations people have the highest rates of poverty in the nation, First Nations pregnant women are at increased risk of experiencing poverty and, consequently, poor health (Waldram, Herring, & Young, 1995).

As was apparent in the women's accounts, pregnancy directly precipitated a reduction in economic status, as they were forced to depend upon unemployment insurance or social assistance. Trina talked about feeling uncomfortable about having to rely on unemployment insurance:

This is the first time I've ever been on unemployment since I can remember. This is the first time I apply. I think I'm really on it because I'm pregnant and I'm on my last few stages, otherwise, I'd be out there with applications [for] jobs.

Most of these women preferred to work rather than to receive unemployment benefits, as they perceived a stigma attached to social assistance.

Living in the nation's most economically deprived area, where few employment opportunities exist, often meant that the women in the study had to work at part-time jobs, were paid minimum wages, and had few, or no, benefits (Badgley & Wolfe, 1992; Ross, Shillington, & Lochhead, 1994). The major employer in the area was a pulp and paper mill, the closure of which forced several families to leave the community to seek employment opportunities elsewhere. This closure led to the sense of chaos reported elsewhere under similar circumstances (Wallulis, 1998). The presence of economic hardship was felt throughout Restigouche County and was manifested in the closure of several retail stores. The local food bank reported an all-time high in its rate of use. After two and a half years of collecting data from the community, the local newspaper published several editions with sections devoted to

poverty. In a November 1997 edition of the *Tribune*, the local paper, a page was devoted to describing the lives of three people living in poverty – two of them single mothers. In 1992 a local pressure group composed of people living in poverty and called “Poor in Restigouche” was formed to inform the government about the consequences of economic hardship and to create strategies for employment opportunities. Furthermore, during my three years of collecting data and engaging in participant observation, I could feel a sense of desperation throughout the community. More and more families were leaving the area to seek employment opportunities elsewhere. Most social conversation was focused on the reopening of the mill.

Economic hardship was visibly present during many of the interviews conducted in the women’s apartments. Usually their residences were noticeably clean and consisted of one or two small rooms. Little furniture was available, and there were few, if any, decorative items. If it was winter, apartments were usually cold. Most women spoke of wanting to get a bigger place. Cathy, a young mother who was very thin and pale, spoke of how her rent was consuming three-quarters of her welfare cheque. She lived in a two-room apartment, and her furniture consisted of a small plastic kitchen table and two kitchen chairs, one upholstered chair, a foam mattress, and a small television set that rested on a milk box. Another young woman lived in a small two-bedroom apartment. The combined living room and kitchen had a sheet drawn across it. The building had no yard, and people would stand at their doors and smoke. The majority of women in the study did not have access to a yard.

Women whose already meagre incomes were reduced as a result of maternity leave could not live comfortably. Karen spoke about just being able to meet her basic needs: “I’m surviving, I’m not starving.” Another woman, on bedrest as a result of cervical incompetence, was obligated to go on unemployment insurance at a time when her partner was not working. She described this time as difficult, as she was frequently unable to buy groceries and pay the bills.

For all women in this study, regardless of their previous economic status, pregnancy meant additional expenses and a reduction in economic status. Professional working women experienced stress due to financial strain, as they received a decreased salary when on maternity leave (or they had no maternity leave at all) and faced the increased financial demands brought on by a newborn. However, the difference between the amount of stress experienced by professional women (who have the capacity to create options, have access to other resources, and often have financial reserves) and by impoverished women (who have little money, no reserves, and must constantly struggle to make ends meet) was extreme. Women who were among the working poor or who were on social assistance had few opportunities to change their situations, had no access to subsidized and/or affordable child care, and had no financial stability or savings. Instead of talking about the preparations for the arrival of the newborn, most of their concerns centred on making ends meet.

Clearly, social assistance was insufficient to meet the basic needs of these women and their families. They described going from “week to week” or from “month to month.” This indicates the perspective they adopted in order to cope: “Just let me somehow get through the current week or month.”

Women with the fewest economic resources focused their energy on present circumstances in order to simply survive. Even the most basic needs were sometimes difficult to meet.

As Trina explained:

I had two kids, financially it was tough. We would go to town just to go look around. Never any intentions to buy anything. And you know, when they would ask (children), they would. We would have to say we can't get anything right now, we'll have to wait until later and it became that I said it so much that they already knew, so they would get to town and they would say, “I know, Mom, we can't get it because we can't afford it,” you know. That really, really bugged me. It was the toughest time for me [she broke down in tears]

With regard to meeting the basic needs of food, shelter, and heat, the women on social assistance spoke of going from month to month as a way of life. The inadequate economic resources of the working poor and recipients of social assistance made it difficult, if not impossible, for them to establish any reserves for themselves or their children, further creating a sense of distress and worry regarding both the present and the future.

### Coping with Poverty

As has been seen, social assistance did not allow women and their families to live comfortably. The survival strategies of women living with economic hardship included shifting priorities, sacrificing, and borrowing/pooling resources.

Women dealt with having little by shifting their priorities from their needs to those of their children. They focused on such basic requirements as food, rent, and electricity. Amy explained her shift in priorities following the birth of her son:

Things that I used to think were so important before, they don't even matter anymore. Like material things and stuff like that, that you always thought, "Oh, I'd like this and I'd like that." But that doesn't make a difference for me anymore. As long as I got enough money to feed Tyler, to put clothes on his back, feed me, the rest doesn't make a difference. We don't have too much but I find that if I give him more love, a lot of love and attention, he'll go a long way.

Susan talked about her indifference to material things:

I never really had to worry about that because I'm not a material person myself, so I've never been one of these people [who goes] into a frenzy for clothes or whatever. If I had clothes, you know, I don't care. My son, I'd make sure that he's got good clothes, like not expensive stuff. Sure it would be nice to have it, but it's not a point of worry in my life. I mean, the kid is clean, he's fed, he's clothed, so I was raised to appreciate what I have rather than what I couldn't have, you know.

Karen also expressed her lack of concern about material things: "I don't worry about material things; it's not a number one issue for me. The children are well-fed and well-dressed and I don't worry about anything else." Trina: "Food is our first priority in the house. You buy the fruits, the vegetables, the milk." Elaine told of how getting



something for her daughter was what was most important to her own happiness: "I usually take my cheques and I buy something for Sarah; I always buy something for Sarah. You know, I don't really care about money; I care about happiness and health." Amy also looked after necessities first: "My philosophy was pay my bills, have the food and worry about the rest later. I take a quarter and try to make it into a dollar." Michelle concurred: "Whatever we have to have done, the important things, we do them first." Jane explained that having nothing is not a reason to be depressed: "It's nice to have things but you don't have to feel depressed if you don't have them, and a lot of people do. They feel like nothing if they don't accomplish big things and that's not right." Although she admitted that not having things for herself used to bother her, Denise also indicated that she had shifted her priorities to her children's needs. When asked whether there were ever times that money was an issue for her, she said:

Yeah, Yeah. At first, but after a while you kind of get used to it. And my children, we always make sure they have what they want and that's it. Whether it is an issue or not, they get what they want.

As a consequence of not having much money, women had to make sacrifices at the expense of their own health. Young single mothers who had few resources to draw upon were hit hardest by poverty. As noted by Graham (1994), young women often sacrifice their eating habits in order to allow their children to eat. Donna, a social worker, commented specifically on this situation.

I don't understand how they manage to live. When I make the budget with them, there are some that half, if not three-quarters, goes on rent, the telephone and electricity and very little on food. When a woman tells me that she has \$100 for two children for groceries, and she has two children, I ask myself how she manages to eat well on \$100 but she tells me that's all that is left over. I say to myself, The cupboards must be empty; they must often eat macaroni and drink water. They mustn't eat very much.

Karine also spoke of focusing on her daughter and, consequently, making sacrifices: "You don't need money to be happy. It is enough that my little girl is well; me, I'm okay. As well, if I don't have enough to eat, if she has her milk and diapers, it

doesn't bother me." Mandy added: "I just don't have money left over for ourselves."

And Cathy spoke of not being able to afford a phone:

I must pay the electricity, I must. If I have money, I must pay. I don't have much money left so I can't afford a telephone. There are things I can't have. That's my rent, there, it's not big, I don't have any sofa ... nothing is mine, the only thing that's mine is my two chairs. Well, I have a lot of friends who help me when they come to give me money, then they say that I don't have to pay them right away.

All women on social assistance spoke of borrowing money in order to get through the month. Women's families often loaned them money or gave them meals. Trina told of turning to her family when she needed groceries: "You manage. Like his father's next door, his mother's down the street; we have those people we can turn to."

Karine described relying on her mother when money was tight:

Well, if I'm missing something for the baby, my mother is there. If I don't have money for milk or something else my mother is going to go find it for us. I pay her as soon as I have my cheque, but if I can't, well, it waits. Per month, I can say she gives \$80 to \$100. This month, I think I have to borrow again.

Recalling her sister's generosity at a time when she needed help, Jane told of how her family members supported each other economically:

Then we were always taught you always have someone else to fall back on. Like our family there, there's nothing our family wouldn't do for each other. Like, I remember once I didn't have no money for my car insurance; I was going to take my car off the road. My sister had just sold her Jeep and she goes and she pays all of my car insurance for the year.

Similarly, Amy knew she could ask her family for money when necessary: "So I always made do. If I was stuck, the family was there to give me money. 'Here, you need money, take it! You don't have to pay it back; just take it.'" Denise echoed this: "Well, neither of us was working at that time when we first had our first child. So it was kind of hard and everything, but we had our families there, and they both helped out as much as possible." Cheryl spoke of how she got through difficult economic times: "If

I'm ever stuck, there is always somebody there for me. You know, my mother, his mother, anybody. We've got a lot of support, that's the way it is!"

While many of the women in this study lived with economic hardship, their overall perception of their pregnancies was good if their families contributed by providing economic support. Donna spoke of this:

My experience [of pregnancy] was good. You know, as I said, I had a lot of help. If I hadn't gotten all this help, my diet would've suffered because, you know, paying a place to stay in, money is short. So I mean, if I wouldn't have had the help of my parents, my diet would have suffered in some way, something would have been missing. I was lucky; my mother bought me them.

Some women coped with poverty by moving in with their families and pooling their money. Three women in this study lived with their mothers, and another lived with her grandmother. Being able to stay with extended family facilitated living on limited economic resources. Jane spoke of sharing a house with her family:

[It's] not bad because where I live now the house is paid. Right now, there's two children in one room, my mother and sister are sharing one room, and my husband and I are sharing one room. I'm living with the family. It's okay for a while but when it's too crowded, it's too crowded.

Leslie described how she, her boyfriend, and her grandmother lived together:

Well, I'm living on social assistance and my boyfriend should start working soon. And my grandmother doesn't have to pay rent. We just chip in and go three-ways on the electric, oil, and food. And the rest of the money goes on for if I ever have to buy the baby clothes.

Rent often took the biggest portion of women's resources. Consequently, they were constantly trying to find less expensive housing. When Michelle was first interviewed, she had no telephone. After moving into a less expensive apartment she was able to afford one: "Yeah, because over there [the apartment] was way too expensive – and here it is a lot cheaper than it was over there so I can get by more now."

Two women spoke of using a soup kitchen, which is only available in the city.

Researcher: Does it happen often that you get a hand?

**Michelle: Sometimes. Like in the middle of the month, I find it's the hardest time, but I got to go to the soup kitchen to get some food and do what I have with that.**

**Researcher: How many times do you go there per month?**

**Michelle: It's one time per month. But if, after the 20th, if you need some more, you can ask welfare for a referral and you give it to them and they give you some more.**

**Cathy also talked about going to the soup kitchen: "Because there are people there who are on hard times, then if there are those who abuse it, well, it's their problem. Me, I go maybe, well, one time in two months when I truly have nothing."**

### **Consequences of Poverty**

**The overall effect of economic hardship on pregnant women was the creation of a climate of uncertainty and instability. The additional expenses brought on by a new family member stretched their limited capacity to provide even the necessities, resulting in much anxiety. They were unable to save money or to get ahead, which contributed to their uncertainty about the future. Furthermore, any unforeseen expense precipitated chaos and reinforced the uncertainty of a woman's everyday life. When this happened, the woman's energy was centred on finding ways to put food on the table and to pay the rent. As women experienced more difficult times, they sacrificed their own health in order to provide for the needs of their children. Not surprisingly, the more children a woman had, the greater her economic difficulty. Trina, a mother of three, expressed her concerns about having another child: "I was scared when I got pregnant with the third one because we had no money, the idea of having two kids was tough already. How are we going to make ends meet with a third baby?"**

**Another adverse effect of low income is that it isolates women, as they are often not able to afford a telephone or transportation. Amy, a recipient of social assistance at the time, told of the difficulties they encountered when her partner lost his job:**

**After we were in an apartment, he lost his job and didn't qualify for unemployment, so we moved in up at his parents. Now we lived up**

there, we didn't have no phone, we had one vehicle and his parents worked all the time so they were never home.

Another consequence of poverty is that women have few breaks from their children, as they cannot afford child care. Cathy explained that she could only afford to hire a young girl as a sitter twice a month in the evening, while her son was asleep. She commented on how it was difficult not having any time to herself. Donna, a social worker, stated that these women needed a break from their children because, as a consequence of not being able to afford child care, they were with their children seven days a week, 24 hours a day, and this put their roles as mothers out of balance.

Lack of money reduced the women's options to engage in activities that might have enhanced their health and reduced their stress. Jennifer talked about not having access to exercise because she lived on unemployment insurance: "I wanted to join at the swimming pool but I'm waiting for my unemployment insurance to come in because I have to buy membership there." Additional stress and uncertainty make it hard for all women, but especially for impoverished women, to focus attention on their pregnancy. Impoverished women all spoke of *trying* to do their best, while their more comfortable counterparts spoke of *doing* their best. Middle-class women, unlike their impoverished counterparts, did not speak of the worries associated with paying the rent and were not consumed with the constant worry of making ends meet; rather, they spoke with conviction about the health-enhancing behaviours in which they were engaging in to create a healthy pregnancy.

### **Abuse**

Although I did not initially seek out abuse as an area of investigation, issues related to it began surfacing early in the study. Since violence was apparently a factor to be considered, I began asking: "Is violence an issue for you?" In response, a total of 16 women indicated either that they had been in abusive relationships (within two years,  $n = 7$ ; or within more than two years,  $n = 9$ ). Of these 16 women, 10 said that their partners/husbands were not abusive during pregnancy; four women said that they

were. Of the women who experienced abuse, six had a history of childhood abuse, and another three spoke of their fathers being abusive to their mothers.

With regard to these 18 women, with two exceptions, abuse was carried out by their male partners/husbands. One woman experienced abuse concurrently from her father and her boyfriend, while another woman experienced it from her father. This is consistent with other studies on abuse, which report that it is mostly perpetrated by the partner/husband (Hiese, Pitanguy, & Germain, 1994).

Most accounts of abuse were retrospective, with the exception of three Mi'gmaq women. In these cases, one remained with her husband (placing herself and her children in a shelter whenever the situation became unbearable); one remained with a partner who was episodically verbally abusive; and one had her husband arrested, subsequently reporting that he had stopped abusing her physically, although he still abused her verbally.

As abuse was a sensitive and painful topic, women were given full freedom of disclosure. Most of their accounts of abuse were brief, perhaps because shame or fear made disclosure difficult (Campbell & Landenburger, 1995). Women with more recent abuse tended to describe it in more detail than did those whose experiences were less recent.

#### Forms of Abuse

In this study, women spoke mainly of three types of abuse: verbal, physical, and economic. None of the women mentioned sexual abuse. All of the 18 women experienced verbal abuse, and four stated that their abuse had been exclusively verbal. For two of these women, verbal abuse was accompanied by economic abuse; for the remaining 14 women, verbal abuse was accompanied by physical abuse. All of these types of abuse have in common a male power tactic – to keep an individual woman within the control of an individual man (Campbell & Landenburger, 1995).

All women who were verbally abused by their male partners stated that words had been used to intimidate them, "put them down," or belittle them. That is to say, verbal abuse directly affected their self-esteem, making them feel that they deserved to be abused. Elaine referred to her partner's verbal abuse as her "biggest problem." She spoke of her partner making her feel stupid.

I think it's just my biggest problem. It's that, it's being put down and I don't like it. I don't do it to him. I don't think I deserve that either. You know what, I've been good to him and I've been humiliated by him yelling at me and thinking that I'm stupid and everything.

Another young mother with a five-month-old child said that her boyfriend justified beating her during her pregnancy by saying she deserved it, thus leading her to take the blame for his behaviour: "Well, he said all the time that I deserved it and that's why he did it." Verbal outbursts stemming from male possessiveness lead a woman to be fearful of her partner, thus enabling the latter to further control her behaviour.

Elaine described her experience:

I guess sometimes, he gets a little possessive, not fighting or anything like that. But just that he yells at me like three times already, and I know that it has been three times, I know, and it's loud and all of a sudden, it's like a change.

Jamie spoke of two recent incidents in which her boyfriend hit her:

He hit me once and my mom called the cops on him. I pressed charges on him and he said he was going to change and it wouldn't happen again. He didn't know he was doing it; it was the alcohol. Then I dropped the charges and then it happened again. Then I didn't drop the charges. The second time, I told him, "You're not going to keep on hitting me."

Doreen, a mother of nine, told briefly of the violence she experienced before she had her husband arrested: "Like he was always violent, always fighting and everything."

Karen mentioned being pushed down the basement stairs during a violent outburst.

Cathy reported being battered at five months gestation as well as at three months post-partum; later in her pregnancy she was hospitalized for depression and insufficient weight gain. Although physical abuse is believed to be worse than verbal abuse, two

women commented on the extent of the damage that resulted from the latter. Amy, a mother of a two year-old son, said: "Like, I mean, mental abuse can be just as bad and cruel as physical abuse because it can scar you just as much mentally as it can physically."

The pain that results from living with an abusive partner leaves life-long scars that women are not able to forget. Being fearful, they have difficulty entering new relationships. Rhonda spoke to this fear:

At times, I still think about it but there was just so much mental abuse that it's just something that is very hard to forget. I mean, the whole process of meeting somebody else and trusting them and wondering are they going to hit you, are they going to run around on you, you know. It's hard. I was scared.

Mandy also talked about the effects of being battered by her previous boyfriend and commented on the implications of this for her relationship with her current husband:

But now, when me and my husband get into an argument, I get paranoid and I think he's going to hit me and I just jump on him right away and then I'll end up hitting him and I feel ... like ... I'm sorry, I'm sorry. It's like your ex-boyfriend ruined you. Every time he would yell or something, we yelled back and forth to each other. I'd curl up like that and I was scared he was going to hit me and he's never laid a finger on me.

One woman, who stayed with her partner because he stopped beating her after she had him arrested, talked about the fear that still remains: "But he'll tell me not to be scared because he's not going to hurt me but it's just the fear that I can't approach him or talk to him or nothing because I still fear."

Although no specific questions were asked in relation to economic abuse, three women who were recipients of social assistance brought up issues regarding their male partners' unwillingness to share their money with them. This created a sense of dependency on the male partners, who made the women feel uncomfortable about asking for money. Amy said that her live-in partner would not pay his share of the bills



and spent his money carelessly, further adding to her difficulty in making ends meet.

Elaine, who was expecting her second child, explained this discomfort:

Sometimes I don't even like to ask him – sometimes, you know, for him to get a Pepsi or – I don't know, anything like that. Or to ask for five dollars to go over here. No, what I would like to do for that is that I have some money in the bank so that I don't have to ask him because I kind of feel, and I don't want to feel like ... but that's how it kind of makes me feel that, you know, you're already living under my roof, like why should I give you this and give you that.

For these two women, economic abuse led to accentuated feelings of dependence on the abuser, thus restricting their outings and further contributing to their isolation. Most important, however, economic abuse left a woman with insufficient income to leave an abusive partner or get her own apartment. This, of course, led to increased stress, as she now felt trapped. Amy depended on assistance from her family when she left her abusive partner and moved in with her sister's family.

Thus, additional abuse featured strongly in the lives of a number of women in this study and created barriers to their capacity to create a healthy pregnancy.

#### Context of Abuse

Women who experienced pregnancy with abusive partners felt uncared for at a time when they were most vulnerable. The women in the study characterized their abusive partners as jealous, possessive, manipulative, and uncaring. As noted in the literature, these characteristics are the hallmarks of the violent man (Campbell, Harris & Lee, 1995). Women who are battered are at increased risk for adverse pregnancy outcomes as well as for physical and psychological injury (Bullock & MacFarlane, 1989). It seems that the pregnancy itself often provoked increased jealousy in the male partner (McFarlane, 1989). The abusive man, who desires power and control over the woman, may see the fetus as an intruder or as competition. One woman said that the beginning of her pregnancy marked the onset of her partner's obsessive behaviour and, consequently, her loss of freedom:

Amy: He was a good person at first and everything, but after I got pregnant he just changed, he did a 360-degree change. His personality completely changed. After I got pregnant, he said, "Well, now that you're pregnant we'll be together forever!" What he said still bothers me today. Just like an obsessive person. And he always, I don't know, he got so obsessive in a way that I'd go somewhere and he would question, "Where are you going?" "Why are you going there?" "Why do you need to go there for?" He just changed. I had no more freedom. I'd go see my mother and he would say, "Why would you want to go see her for?" He just changed. I had no more freedom anymore.

Another woman also attributed not having the freedom to see whom she liked to her boyfriend's jealous behaviour:

Jamie: I wasn't able to hang around with certain people and he was like a big baby. I know everybody here and if I would talk to a guy, he would get mad at me right away. I would tell him, "That's my friend, I grew up with him," but I would still get into trouble.

In telling how her partner controlled her and restricted her circle of friends through his abuse, Karine recounted: "If I went out, he would take a fit and I couldn't do anything." Karine further stated that she would avoid talking to certain people in his presence for fear of his reaction, thus she was isolated at a time when she had an increased need for support. This kind of thing threatens a woman's ability to be connected to those who are important sources of emotional, financial, knowledge-oriented, and task-oriented support, thus jeopardizing her ability to create a healthy pregnancy.

Three women spoke of their partners' jealous, uncaring attitude extending to their children. Another woman also told of her partner's non-involvement and heightened jealousy following the birth of their son, which left her as the sole provider:

Amy: Once Tyler was born it never changed [abuse]. He was, I was more or less bringing up Tyler on my own anyway, and I just had him to take care of anyway. You know, he never changed his diapers. He would never get up [to feed him]. I tried to wake him up but he complained and cursed or something. It seemed to get worse once Tyler was born. I don't know if he felt jealous at times more than- It seemed that he was jealous because the baby was taking more attention away from him.

Cathy reported not being able to show or express love to her son when her jealous boyfriend was around. None of the women with abusive partners spoke of them assisting with household tasks or with the care of young children. Unlike women with supportive partners, these women could not draw support from that relationship. Karen spoke of her first partner, who was not involved with the babies and did not attend her deliveries: "The first one there, everything was so different with my first relationship, with that man because, every pregnancy I had, he never got involved. When I had my babies, he wasn't even there at the hospital!"

In contrast, she referred to her second partner as supportive, and she explained the difference it made to her:

Changing diapers, feeding him, teaching him and waking up at night – this fellow, you know, he does all that. He does everything. He's so good. I watch him sometimes and he's so good at what he does, you know. It thrills me!

Another consequence of a male partner's possessive behaviour was that the woman was unable to share with him the joy and excitement of pregnancy and the experience of creating a new life; rather, she had to suppress her excitement out of fear that he would get angry.

Pregnant women with abusive partners did not expect to receive any special consideration from them. Jennifer talked about having to ask her boyfriend to stay around and take care of her when she was nauseated:

And I kept on reminding him. You know, you've got to think about, that I'm having a baby, you know. And it's like, we'd argue a lot about, like because of needs, like I need him, like sometimes when I'm not feeling good, he's not there, you know. And that's what we argued about a lot because I told him, you know, I really need you and everything like that. Especially now, now that I'm pregnant with your child, you know, you should be there for me. And it's like, "Well, I've got to work" or "I've got to do this," "I've got other things to do besides think about [you]."

Amy spoke of her partner as being unreliable and leaving her alone at a time when she was sick and feeling neglected. She explained how this behaviour led to living with uncertainty and stress on a daily basis.

Then, when he'd get mad at me, he would take off in the car and leave, leave me home, alone in an apartment all by myself, pregnant, not feeling well — and he'd take off. So there was a lot of stress like that with him, you know.

A recipient of social assistance at the time of her pregnancy, Amy further described how her partner's manipulative behaviour and her restricted income created a climate of uncertainty and stress once the baby was born:

After we were in an apartment, he lost his job and didn't have enough for unemployment, so we moved in up at his parents. Now we lived up there, they didn't have no phone, we had one vehicle and his parents worked all the time so they were never home. He kept nagging to take off. I'm behind a mountain, behind a big mountain. I got no communication, neighbourhoods are way down the road, I'm in the house with a little baby and he takes off. I'm stuck by myself, in the house, with no phone. The baby could choke to death and I'd be by myself.

#### Consequences of Abuse

During pregnancy, women require stability, support, and love so that they may deal with the uncertainty surrounding the health of the fetus and the approaching labour (Colman & Colman, 1991). Women who live with abusive partners/husbands experience high levels of stress due to the unpredictability of the partner's behaviour, their fear for their own and their children's physical safety, and the fact that any action might trigger an outburst of violence. This situation accentuates uncertainty and compounds stress for pregnant women at a time when they already feel vulnerable.

Speaking of the stress that resulted from living with an abusive partner, Cathy said: "It was stressful. He gave me a lot of stress and still again he's giving me a lot." She was hospitalized for inadequate weight gain and depression during her pregnancy, as she found it very difficult to eat when she was under so much stress. Denise described the uncertainty she felt: "A lot of times, he wouldn't come home for days.

Everybody was encouraging me 'cause I was very depressed. I had a lot of difficulty with my boyfriend."

Living with an abusive partner had both present and future ramifications. Rhonda, abused by her first boyfriend, talked about not being able to forget the beatings she received:

But I was really stressed out. Really stressed out. It was my hardest time. It's a part of my life that I don't even want to think about. I just had my little boy and I'm just thankful that he's not growing up in that environment. It's part of my life that I would like to keep in the past.  
[started crying]

She increased her smoking during her second pregnancy and was hospitalized for a kidney stone; she attributed her poor state of health to living with high levels of stress as a result of being beaten. Jamie, a 19-year-old on social assistance, admitted to drinking a few times during her first trimester, while she was experiencing physical and verbal abuse from her partner: "I did a couple of times. I wanted to drink and it was because my boyfriend got me mad, so I was like fed up. But I changed that. I stayed away from him, too."

Women like Amy, who experienced a great deal of nausea and vomiting and who was eventually hospitalized for an antepartum hemorrhage, attributed their poor health status during pregnancy to the stress and uncertainty of living with an abusive partner. According to Amy: "I was sick a lot but a lot of it had to do with stress I find. Like, Tyler's father had a lot of hard times. He gave me a lot of hard times." Amy also told of mental abuse and the uncertainty of not knowing what to expect following the delivery of her son:

I'd do a lot of things to preoccupy my mind, you know, I'd go out for walks and stuff like that, or I would sit around and work on crafts or something, just something that I didn't have to worry so much about what was coming up in the future with the delivery and how the situation would be with Tyler and his father and I, once Tyler was born.

Thus, according to these women, abuse threatened their pregnancies both directly and indirectly. Women with abusive partners focused most of their energy on finding ways

to avoid confrontations and dealing with high levels of stress. Sometimes these women reverted to ways of dealing with stress that required little energy – such as smoking or not eating properly. For First Nations women this was a special concern, as alcoholism is endemic in their community.

### Alcohol

Regardless of their ethnic backgrounds, those 18 women who had experienced abuse consistently reported that the violence and abuse arose when their male partners were drinking. This relationship between the frequency of violent outbursts and alcohol consumption has been found in many studies (Campbell & Landenburger, 1995; Duffy & Momirov, 1997). The following two excerpts, both from Mi'gmaq women, clearly link alcohol and abuse. Trina: "Well, the only time he would hit me is, the time that I would be scared of him, is when he drank." Lita: "But what happened was that he started drinking and it frightens me because when he does drink, he can become violent and very abusive." Alcohol abuse is particularly problematic for Mi'gmaq women and Aboriginal communities across Canada (Canadian Medical Association, 1996).

The issue of alcoholism within their community was a fact of life for Mi'gmaq women, further augmenting their vulnerability and placing them at risk. Mi'gmaq women spoke of their high levels of alcohol consumption prior to being pregnant as well as of the high level of alcohol consumption passed on from generation to generation. For example, Jamie reported drinking as a way of dealing with her boyfriend's physical and verbal abuse. Melissa, a 26-year-old women pregnant for the second time, said that when she was 17, she had a miscarriage at six months as the result of falling while under the influence of alcohol and illicit drugs. However, the remaining Mi'gmaq women in this study did not report drinking or using substances during their pregnancies. Several reasons may account for this. First, women who abuse alcohol during pregnancy know it is unacceptable and, consequently, may feel

guilty and attempt to avoid judgment (Brundenell, 1996). Also, pregnant women who are abusing alcohol may be dealing with very difficult life conditions (Kearney, Murphy, Irwin, & Rosenbaum, 1995) and, therefore, have neither the time nor the energy to participate in research.

The women in the study spoke of knowing other pregnant women who were abusing alcohol. For example, two women told of others who were drinking considerably during their pregnancies, and one group leader talked of a pregnant woman being escorted out of a drinking facility when she was intoxicated. Another leader spoke of the occurrence of fetal alcohol syndrome in this community and of the extent of learning disabilities in young children due to its effects. Mandy, one of the interviewees, attributed her own memory difficulties to her mother drinking while pregnant with her.

All the Mi'gmaq women in this study were aware of the problems stemming from the abuse of alcohol in their community, recognized how widespread and accepted it was, and how it was passed down from generation to generation. Fifteen Mi'gmaq women reported having a parent who was an alcoholic. First-time pregnant Mi'gmaq women (n = 10) reported a pattern of regular alcohol consumption prior to conception.

Jennifer detailed her drinking pattern:

We would probably start at a friend's house, we would have about two or three drinks there, all depending, if they were hard stuff or beer. Like beer, I would consume about six or seven and then after that I would just stop because it didn't taste good anymore, or I would just like feel a buzz and I didn't want to overdo it. I knew my limits and the same with rum and Coke, that was my other drink ... I could consume more rum than I could beer – say about 10 glasses of rum and Coke in a night.

Jennifer quit drinking with the onset of pregnancy, and this resulted in her being isolated from her circle of friends:

As soon as I found out that I was pregnant, I stopped drinking right away.

Interviewer: Drinking?

Jennifer: Beer, 'cause I used to be like a heavy drinker. Like before and now it's like, a lot of what goes on here is drinking, that's the part of socializing and it's always on Thursday and Saturday nights that people go out, and I wasn't called to go out on these nights anymore.

All women reported drastically reducing their consumption of alcohol when faced with the responsibility of caring for young children. Another young woman, Jamie, also spoke of alcoholism as a way of life:

It's all me and my boyfriend ever did was drink. There is nothing else to do around here [other] than party. Everywhere you go, you see people partying so they would ask us. "Do you want a beer" and we would say, "Sure, why not." There's nothing else to do!

Women spoke of alcohol abuse continuing as children see and accept alcohol consumption as a normal part of life. Denise commented on the widespread acceptability and use of illicit drugs in the Mi'gmaq community: "Yeah, the drugs going around, the 14-year-old kids or 15-year-old kids getting pregnant and then there's the drugs and the alcohol and you know." Jennifer expressed concern for the younger generation: "Especially with kids today because I see them getting into so much trouble as compared to when we were their age – a lot of drugs, a lot of alcoholism."

Denise: It's a big problem in some areas but it shouldn't be [alcoholism]. If it was from one generation to another, of course, it's gonna obviously be that way because that's all they see. That's their path. So I try my best, I mean I was brought up with it. I tried to follow the path but I said no. I can't drink and look after the kids and all that, so I just stopped.

Researcher: Was it [alcohol] a big issue for you before you had kids?

Denise: Alcohol? Oh yeah, like I said, from generation to generation, was my grandmother, my mother and me. So there was a big issue in my family. I mean, like if my parent was still alive today, she would still be drinking. My husband's parents are still alive and he's still drinking.

Trina talked about how her mother's alcohol consumption affected their family:

She [mother] always watched us but she drank too and it played a part in some of our hurt, I think mostly mine. I don't think my brothers and sisters have too much animosity towards my mother for anything because they drink as well!



In this small community, the availability of alcohol was readily apparent. In a geographic area of one square kilometre there were nine grocery stores that sold beer and wine. All displayed beer and wine prominently, along with the telephone number for home delivery service. Off the reserve, and within a one-kilometre range, another 10 stores also sold alcohol.

### Ideologies Concerning Class, Race, and Gender

For the Mi'qmaq women in this study, alcoholism represented one part of a larger social problem within First Nations Communities. Many of them distinguished themselves from other women by virtue of their loss of cultural identity due to historical patterns of colonization. From their perspective, this widespread social phenomenon also affected them individually, reducing their personal strength, self esteem, and sense of identity. Cheryl recalled not really knowing who she was as a child because of confusing messages in the school system:

I went (to school) here and they brought back a lot of the traditional values and the Mi'gmaq ways and it's surprising, it's nice to see because it wasn't there when I was younger. A lot of kids appreciated a lot more. They have a sense of belonging, whereas before, I found we didn't.

During their public school years, when they were bussed to a small community in northern New Brunswick where most of the students were Anglophone and white, many Mi'gmaq people did not learn much about their own history. Brenda, a community leader, directly addressed the issue of racism in relation to her education:

History really screwed us, there is no doubt about that. What we were taught in high school and so on and so forth was always very negative and always served to antagonize, you know. You and I, for example, we could have been the best of friends all through life. Because of what we learned, you know, that caused you to have these perceptions about who I am, so that fits into the racism and prejudice and everything else because it was misinformation and perhaps the lack of knowledge on your part. You know, just generally speaking.

Thus, alcoholism affected many of the women in this study, either directly or indirectly, and in the context of integrating its effects, women alluded to the impact of larger social issues such as ideologies concerning race and social class.

### **The Impact of Threat**

For women living on social assistance, or the working poor, pregnancy obviously created further worries concerning their ability to pay additional expenses, and lack of financial resources contributed to their sense of lack of control over their lives. Impoverished women experienced isolation as a result of not being able to afford a telephone or transportation, and they had to live with the social stigma of “being poor.” In their attempt to provide the basic necessities, they often sacrificed their own nutritional needs for the sake of those of their children. Their energy was consumed by finding ways to decrease their high levels of stress and to meet life’s fundamental needs, leaving them little time to engage in health-enhancing behaviours. Clearly, this situation was exacerbated when they had abusive partners upon whom they were financially dependent. Women in this situation had very little control over their lives. This sense of losing control over their lives was a direct result of women not having sufficient financial resources to create options that would enable them to change their situation as well as of the isolation and stigma that results from being poor and a victim of male violence and domination.

It has been extensively reported that living with an abusive/violent partner/husband is a highly stressful experience for any woman, let alone for a woman who is already experiencing the sense of vulnerability concomitant with pregnancy. An abusive male partner tends to have control over his female partner, and this reduces the woman’s decision-making ability, resulting in social, physical, and financial isolation. Being physically and emotionally battered by her partner, plus being blamed by both him and society for the violence directed against her, results in poor self-esteem and the sense of not being in control of her life.

The women in this study whose lives were affected directly or indirectly by alcohol abuse all discussed it within the context of loss of control. From their perspective, alcohol in the community had a powerful influence on their pregnancy experience, even if they were able to abstain from consuming it themselves. Thus, these special threats all created a situation of extreme stress for the women, directly influencing their experience of pregnancy. All the women in the study who had complications during pregnancy attributed them to stress and the consequent lack of control over their lives. Katy, a teen mom, described the stressful situation created by her abusive father, an unplanned pregnancy, and the fear that her boyfriend would leave her:

I had a lot of problems when I was pregnant. I was on my nerves a lot. Also, there were all kinds of things going on at that time so it probably started the contractions earlier because I had a lot of problems behind that.

Amy attributed her antepartum hemorrhage during her first trimester to having an unplanned pregnancy, an abusive partner, and living on social assistance: "I know next time I don't think I'll have as much morning sickness. I don't think I'll be as stressed out." Cheryl, a Mi'gmaq teen, looked back on her first miscarriage as occurring at a time of intense stress and compared that pregnancy with her current one:

Researcher: Are there things that make it feel that everything is OK?

Cheryl: Knowing that I'm doing my best, which I didn't do the last time. Knowing that I don't have so much stress as I did before, with graduation and moving out of my mother's house and not having the family support. But, like it tears somebody up. It does.

Women who experienced great stress and consequent lack of control as a result of poverty and abuse often reverted to non-energy-consuming behaviours such as smoking, not eating properly, and consuming alcohol. Cheryl, who had a miscarriage, talked about an unplanned pregnancy that derailed her plans to graduate from high school and attend university. Her family's lack of support, having to move in with her

boyfriend, and not having much money caused high levels of stress. She addressed how this affected her health behaviours:

I still smoked, like regularly, and I didn't take care of myself as well. I didn't give myself time to eat the right foods and I didn't take time to eat the right meals, and sometimes I just didn't want to eat because things were bothering me. I can't eat when things are bothering me.

Living with a high level of stress also led Rhonda to smoke more during her second pregnancy, a time when she also had a kidney stone (for which she had to be hospitalized). Another woman, who had been a heavy drinker, said that falling back on drinking during her pregnancy was a result of the stress caused by her physically and verbally abusive partner.

Researcher: Do you still crave the drink?

Jamie: I did, a couple of times. I wanted to drink and it was because my boyfriend got me mad so I was, like, fed up but I changed that. I stayed away from him, too.

One woman also told of a girlfriend whose partner left her when she was seven months pregnant. As a result of dealing with high levels of stress, she started smoking heavily again, lost weight, and was hospitalized.

Thus poverty, abuse, and alcohol represented special threats to pregnancy for some of the women in this study. When present, these factors dramatically reduced their sense of control over their lives and pregnancies, and contributed to coping strategies that were not consistent with what they believed to be health-enhancing behaviours. Women experiencing these factors were unable to create the kind of pregnancy they would have preferred. The dynamics of these special threats and the interactions between them was evident in the accounts of these women.

## **CHAPTER SEVEN:**

### **REGAINING THE CAPACITY FOR A HEALTHY PREGNANCY**

As has been shown, in this study three conditions significantly determined the capacity women had to control the direction of their lives and so to engage in the creation of healthy pregnancies: (1) the acceptance of the pregnancy, (2) adequate financial resources, and (3) supportive relationships (especially having a supportive partner). Having an accepted pregnancy provided women with the motivation to ensure a healthy newborn and, to that end, to take control of their lives. Having adequate financial resources gave women a number of options and strategies for maximizing their health. For women with children, having money allowed them to hire a baby-sitter and to balance caring for others and caring for themselves; for women who had abusive partners/husbands, having an income gave them the capacity to leave. And having the supportive relationships provided women with emotional, financial, task-oriented, and knowledge-oriented support – all of which helped with the creation of a healthy pregnancy.

When a woman was able to control her life and to obtain fundamental needs such as safety, housing, and nutrition, she was also generally able to create a life that was relatively free of high levels of stress and uncertainty, thereby providing a context of stability. This context of stability enabled a woman to focus her energy on engaging in health-enhancing behaviours and creating a healthy pregnancy. Trina spoke of control as crucial, for it allowed her to make decisions regarding the direction of her life. She compared her current situation to her situation as a child, when she had no control over the direction of her life and experienced both poverty and neglect:

I think it was the idea that when I was a kid, things were really, really tough and I had no control over anything because I was a child, you know. I didn't have control over my environment or the actions that my mother would take to move us around in the city all the time. And I said to myself, you know, when I grow up, I'd like to be stable. I will have control. And I won't let people or things influence me to go in the wrong direction.

Cheryl spoke of her lack of control over her first pregnancy, which was unexpected and occurred when she was without either family or financial support. She had a miscarriage: "It's sad. You want to feel sad for yourself and I think the baby's spirit just said, 'It's not time.' The Creator says, 'It's not time for you, you can't.'" With regard to her current situation (a planned pregnancy, a supportive partner and family, and adequate income), Cheryl felt more in control and was able to focus on taking care of herself. She compared her first pregnancy with her current one: "This time, I'm more on my feet."

Marie was single, unemployed, and had an unplanned pregnancy. In addition to this, her boyfriend was verbally abusive towards her. She discussed her lack of control and her inability to choose a loving partner:

Well, a lot of it was because I was single. You know, if you're married and you get pregnant, it's no big deal. You're doing it the old-fashioned way; you're husband and wife, whatever. But being single and, like I had always said, before I'm 35 if I'm not married, I'm going to have my own child. But then I had planned it myself, I had picked out the donor, or the father, or whatever. I would have been in control of who baby's father would have been, when I would have gotten pregnant. This situation, I was not in control of. It took control over me so it had a start on me and I had to kind of fight back to get myself into the control of the situation instead of the situation to be in control of me. So if I would've planned or had mentally, in my head, said, "Okay, I'm deciding within the next year I'm going to have a child," it would have been my decision, something I would have planned and I would have set my mind, mentally, that I was preparing myself for this part of my life.

Unlike Marie, Donna, a 35-year-old who opted to have a child without the involvement of the father, was in control of her decision, had access to adequate revenue, and had the support of her family. Consequently she was able to decide the circumstances of the pregnancy, save money, and direct all of her energy towards the creation of a healthy pregnancy. Just as a healthy pregnancy is determined by the amount of control women have over their everyday lives, so the amount of control they have is determined by the extent of their freedom and balance.

The extent of a woman's freedom determines her capacity for control over her life and, consequently, the amount of stress she will experience. In this study, women identified the freedom to have an adequate income, to be safe, to be informed regarding contraceptive use, and to choose their own health care providers as most significant with regard to their capacity to control the quality of their everyday lives. Mi'gmaq women also mentioned the freedom to have a non-stigmatized cultural identity.

From their perspectives, the more freedom women had, the more personal strength and control they had. Donna addressed this sense of freedom:

That's what a healthy person should be, to have enough to survive, that you can survive in any circumstances because you are physically and emotionally stable. And you have freedom of movement and nothing should stop you from being where you want to be.

As a result of having freedom, a woman is able to attain a sense of balance, a sense of stability. It is this balance that creates the energy that she needs in order to engage in health-enhancing behaviours and so to create healthy pregnancies.

In this study, all of the women who rated themselves as unhealthy attempted to change their life situations in order to regain the capacity for a healthy pregnancy. The strategies they used demonstrated their priorities as well as their understanding of factors over which they might exercise some control. In this context, they described focusing on their children, identifying places to go, having emotional support, and drawing upon the insight and strength gained from having resolved past conflicts.

### **Concern for the Children**

Central to prompting women to regain control was their fear of harming the fetus and their concern for the well-being of their children. Five women identified not wanting to expose their children to abuse as a reason for leaving their abusive partners. After realizing that her abusive partner had not changed following the birth of their son, and because of her concern that his abuse would eventually affect him, Maria left

her abuser at five months post-partum. She told of being at a social function where he was tormenting her and of what happened when she asked him to take her home:

So he said, "I'll see you tomorrow," and I said, "No, don't come back, I put up enough with all we've been through." And he said, "Yeah, but I never, ever hit you." I said, "No, you never hit me, but you might as well have smacked me in the face instead of— it would have been a relief from the mental abuse." I said, "I can't take it anymore and I don't want Tyler to be brought up this way and don't come back."

Lita also mentioned the welfare of her child in connection with her decision to leave an abusive partner: "I have to decide. I'm not going to stay because now that I have someone to take care of ... I can't be bringing a child into a world of uncertainty and danger." Lita left her partner during her first trimester, as she did not want a life of violence for her son. Essential to Lita's decision to leave was the fact that she had a seasonal job that provided her with an adequate income, and she also had the support of her family, especially her sister, who lived nearby.

Women who were abused as children often based their decision to leave their partners on their own childhood memories. Rhonda remembered her experience of being abused as a child and decided not to expose her child to the same thing:

I was an abused child. It's just something I don't want my child to go through. There was violence at first, my little boy's father used to beat me. I said I couldn't take it anymore. I didn't want my children to grow up that way.

Having lived in less than optimal circumstances as children, three women spoke of wanting something better for their progeny. Past experience caused Trina to take steps to ensure that her children would be protected:

'Cause, I figured that I couldn't live in a house with violence because I lived with it with my mother, and then I couldn't let the cycle continue and I had to stop it, and I figured the only way I could stop it was to get educated, get a job and live on my own to provide for my own children.

Women found the courage to deal with difficult situations when they focused their attention on the well-being of the fetus. Amy, at the time of her unplanned pregnancy, was living with an abusive partner, and they were both recipients of social



assistance. She described how she decided to work on improving her attitude for the sake of her fetus. The strength received from creating a new life gave many of the women in the study the ability to deal with difficult times. Katy, talking about her pregnancy and the stressful times she went through with her abusive alcoholic father during it, said that thinking about the baby helped her a lot: "Another thing that helped me was that I would think about my baby a lot. If I'm pregnant, I don't want to lose it; I have to think about him, so I would think of my problems less." Another woman who had just left her abusive boyfriend responded to the question, "What gives you strength?" as follows:

Jennifer: The baby, that's what I think about. You know, when I'm feeling down, I just, you know, I just talk to the baby. Or I feel my stomach and you know, I know that he's there. That's what brings my day up, or when I'm feeling mad, or sad, or something, I just think about it, or I just look at the ultrasound pictures, and I know that I'm okay. That's what gives me strength.

Women in these difficult circumstances also drew strength from their other children. Doreen responded to the question about what gives her strength with: "Seeing my children makes me feel healthy." Jane talked about her daughter waking up and saying to her, "Mommy, I love you. She's cuddly and she's warm. She calls me 'maman' all the time. It's so cute. When I hear that in the morning, it makes my day". Staying strong for their children was a powerful motivator for many of the women, as Rhonda said, "I have to be strong for my children." Similarly, Denise described the way in which responsibilities to her children energized her:

I don't know what gives me all that strength or energy sometimes. It just comes about because I know it's got to get done and I got to make myself get around to doing it. My kids, too, do a lot; they can be helpful sometimes. Just seeing them, being happy, that's what does it, I guess.

Thus for many women, concern for the future and their other children motivated them to find strategies to deal with the challenges they faced.

## **Resources and Shelter**

For all the women in the study, having somewhere to go and adequate financial resources were crucial to their ability to determine the quality of their lives. Amy talked about her sister's offer to let her stay with her as crucial to her decision to leave her abusive partner. As soon as this happened, Amy left him. Three women in this study had had previous access to a women's shelter, and this had given them the strength to aim for something better for themselves and their children. When asked, "What gave you the strength to leave?" Mandy answered, "The Haven House [women's shelter]." Women spoke of the knowledge that they could always go to this shelter as an important source of comfort.

Having money enables a woman to leave her abusive partner. Elaine said that she would leave her abuser if she had the money. "And maybe, if I had the money, I would get really fed up some day and that's not too far away from here. I'm going to get my own apartment." Trina explained how she learned to stop the abuse she was experiencing by regaining control over her life:

I figured the only way I could stop it was to get educated, get a job and live on my own to provide for my own children, because I had just had my last daughter at that time when the abuse started happening.

Lita left her abusive partner during her first trimester, as she had a stable income and was able to get an apartment of her own. It is clear from the accounts of these women that access to resources and shelter were critically important factors in their capacity to create a healthy pregnancy.

## **Emotional Support**

Emotional support was also crucial to women who were having difficulty finding the strength to go on. Jennifer's friend helped her cope in difficult times:

My friend, Amanda. I can call her anytime in the night, or whatever, and, you know, just start crying. I tell her all my problems and she'll be, like, you know, "I'll be up, I'll come up and I'll keep you company."

Katy also told of how she received support from others when her father was abusive towards her: "They would talk to me a lot; they didn't want me to keep everything inside. They would make me go out, every second day, they would talk to me about it, so it would come out. I had too much inside of me." Jamie talked about her aunt helping her out when she was in an abusive relationship, giving her the strength to leave: "Like my aunt, she works at the nurse's station and she helped me out, like she boosted my ego up a little bit more, and talked to me, and took her time, and talked to me."

Women also spoke of their religious beliefs as a source of strength in difficult times. Trina talked about going to church as a form of psychotherapy:

It would make me feel better inside, and I would ask for guidance, for strength, to make the right decision, and it would help me make it through the week. When I went to church, I would have all the stuff bottled inside, and when I came out, I was content. I felt like it was like psychiatry in a way. You know, it was my way of dealing with stress and I looked forward to going on Sundays.

Donna talked about the priest coming to visit her and her nine children once a month and how they enjoyed it. Some women found that praying constituted an important source of strength for them. Amy spoke about how she would have conversations with God:

I just kind of, I don't know, just my inner self kind of had a discussion with God about why I'm having this child and why at this time in my life. I don't know, it's kind of strange to say but you kind of get your own answers to your questions, and I would always pray.

Cathy spoke of seeing a television commercial that stated that women do not deserve to be battered; this confirmed her worth and caused her to think differently about her situation. Another woman stated that her aunt, who is a social worker, gave her the strength to leave, as did her mother, who found the violence against her daughter unacceptable.

The range of emotionally supportive messages and relationships described by these women clearly indicates the importance of emotional support.

## Resolving Past Conflicts

Women who were raised in abusive situations drew strength from having lived through them. Trina spoke of how her difficult upbringing had prepared her for life by giving her strength, insight, and wisdom:

I sort of said all those bad things that happened, sort of made me the person that I am today, and it's really not such a bad person. It's really a good strong person that can deal with a lot of what life throws at me. I can deal with it better because I felt like I dealt with bad things first and that was when I was really small.

Trina talked of the strength and perspective she acquired as a result of being raised by a poor alcoholic mother in a big American city:

It was harder then. It's easier now. That's why it's easier to cope with the little things here because they don't seem like major things like before. I felt like my childhood prepared me for my adulthood so that my adulthood now, I don't know what to say, that it wouldn't be easy but it won't be so rough either, you know. Yeah, but it's not as hard as when I was a kid. I found it tough when my mom drank. My brothers were taken away. We were taken away for a short period of time. When we went back my mother still drank. We were all born there [big city]. But it's tougher, too, to live in the city because I lived there with my kids. My first two were born there and we lived there, and it's tougher living in the city, but you learn a lot of life skills. You have gangs and prostitutes and things like that, so to me these are little minor things that are going to be okay [going month to month] to get by. It's something that I can deal with and move on, not dwell and sit there, and cry, and become anxious and worried about. It's not a big deal for me.

Having grown up with abuse, Michelle spoke of the insight this had given her about not staying in a situation if it got bad: "I know what it's like for somebody to have that kind of violence around and it won't happen to me. I told my mom, she even knows, that if something happens like that, I wouldn't stay in anything like that." In contrast, two women spoke of being raised in a loving family, of having good self-esteem, and of knowing they did not deserve their abuse. Elaine gave credit to her parents: "My mother and my father, they made me feel good. You know, they used to buy me things and stuff like that. And [they were] loving." For Jennifer, the implications of having a lot of love while growing up reached far into her adulthood:

Well, I interviewed my mom a lot and my older sister, even my grandmother. Because women in my family have always been very strong, so I'm lucky in that regard. We were brought up, not that we were very, very, very well off when we grew up, but we had a lot of love in our family.

Three women stayed with abusive partners during their pregnancies. All of them stated that they wanted a father in order to maintain the family unit for their children. They believed it was important to adhere to a vision of the ideal nuclear family. Mandy recalled wanting to stay with her first partner, despite the fact that he used to beat her, so that her son could be with his father, "Like, I wanted to stay for little Billy and it still didn't work out."

Amy explained the importance of the family unit and how it related to her decision to attempt to make an abusive relationship work:

Like, when I first found out I was pregnant, I left him because the things were stressing me and he was giving me a hard time, and stuff like that. Then about one month down the road, I thought, well, if I'm ever going to know if it's going to work out between Tyler, his father and I, I thought, well, I'll try. Then if it doesn't work out, well, when Tyler is older I can tell him. My priority was to keep the family unit together as much as I could, so I tried it, I mean I still cared for his father at the time.

While two women who left abusive relationships stated that their partners did not pay attention to their children, one woman decided to stay in such a relationship because her partner was good to her children:

Trina: But I usually go home [after using the shelter] because the kids like home, the kids love their father. Their father is a really good father, you know. He's just not a really great husband or a great spouse but he's getting better. But when he's drinking, I remove myself from the house, I sleep somewhere else for the night because the fear takes me away from the house.

Another reason women stayed in abusive relationships was that they hoped that once the baby was born things would change and the situation would improve. Amy described her hope that the abuse would stop: "I figured things would get a lot better once the baby was born. You know, like he'd finally be here." However, the situation

only worsened once her son was born, and Amy left her partner when her child was five months old: "He wasn't any help and I just ended up having two babies instead of one." Like Amy, Cathy kept on giving her boyfriend chances, as she wanted her son to have a father. However, at five months post-partum, when he beat her again, she left and filed a complaint against him.

For the women in this study, the process that resulted in a decision to leave an abusive partner involved three factors. First, women had to recognize that they did not deserve the abuse. Second, they had to acknowledge the potential harm to their fetus and/or children. And third, they had to come to the realization that the violence would continue despite promises that it would stop. The availability of economic resources and housing was crucial to enabling women to decide to leave.

The decision either to have her partner arrested or to leave him was often brought about by a physical encounter. Women often spoke of reaching a turning point: a point at which they simply could not take it anymore. Some women traced their turning point to specific situations. One woman first had her partner arrested after he beat her while she was six months pregnant. The second time, when her son was five months old, she had a peace bond placed on him. She was determined to stay in the relationship for the sake of her son until the situation reached a climax: "I tried and I tried, and everything I tried made it even worse. And finally, it came to one big point, and then I cut the violence out of my life." Karen also talked of the point at which she left her partner: "Because he was starting. Fights were getting more serious. And pushing me down the stairs in the basement – that was the last straw. I said, 'I'm out of here.' Elaine explained: "I was tired of the drinking, the arguing and his drinking. I couldn't take it anymore – his abuse. So I left, I decided I had enough."

Once women decided not to stay in violent situations, they took different steps with regard to leaving. Four of the women left their partners without pressing charges, two others had them arrested and stayed, while another two had them arrested and

left. Two women spoke of ending their physical abuse by pressing charges. Trina spoke of taking control by getting an education so that she could provide for herself economically. However, both she and Doreen talked about having their partners arrested as a turning point in ending physical abuse.

And finally, I just couldn't take it anymore [the violence]. Like I put down a report to the cops, and after that he kept serving time, but now, it's been five years and we argue and everything but no physical violence.

Both of these women continued to live with their husbands and both spoke of a significant decrease in the overall pattern of abuse.

Two women pressed charges and stayed, but when the abuse continued, they finally left. Both of these women were in new relationships at the time of the study.

Jamie explained:

He hit me once, and my mom called the cops on him. I pressed charges on him and he said he was going to change and it wouldn't happen again. He didn't know he was doing it; it was the alcohol. Then I dropped the charges and then it happened again. Then I didn't drop the charges the second time. I told him, "You're not going to keep on hitting me."

Cathy also chose to take legal action against her partner when she left him, as he kept pursuing and threatening her. She left after a second beating:

Well, when I was pregnant, I was around six months pregnant, my boyfriend and I had a fight and he beat me, then I had him sent to prison. Then, when I left him, I was returning to him since he had changed, but he abused me mentally, then, it was again (beatings), it's like before.

Four women preferred not to press charges against their partners but ended the abuse by leaving. Confronting abusive situations and attempting to change them was how these women attempted to create healthy pregnancies.

### **Regaining the Capacity for Health During Pregnancy**

The women interviewed in this study showed incredible strength as they met the challenges imposed by poverty, abusive partners/husbands, and alcoholism. They

did not remain victims but took hold of their lives with courage and conviction, making things better for themselves and their children.

Women such as Lita and Amy, who both experienced unexpected pregnancies and had abusive male partners, spoke of feeling better as they regained control over their lives upon leaving their partners. When women reestablished control over the circumstances of their lives, they regained the energy to focus on health-enhancing behaviours. Such behaviours contributed to good mental health, which, in turn, gave them more energy to engage in caring for their general health, thereby creating a spiral tending towards positive health. Both Trina and Amy spoke of this. Trina: "I had the energy back and everything was quite normal." And Amy: "I just was feeling peppier and I had a bit more energy."

Jamie also spoke of how her life changed after she left her abusive partner and started taking care of herself by walking and eating right. When asked, "How do you feel now that you are on your own and without him?" she replied: "I feel better! Like, instead of drinking all the time, wasting my money and wasting my time, my life."

Another consequence of leaving an abusive partner was more personal freedom. Cathy, who was battered during her pregnancy, spoke of this:

Cathy: I feel better, even though I have less money. It's like I can do what I want when I want to. I don't have anybody over me telling me what I can do or can't do, I can do what I want with my money. I feel like the pressure is off.

Karen also spoke of the consequences of leaving her abusive partner. She currently lives with a new partner who helps her with the kids and who is a seasonal worker. She commented on the quality of her new life and the support she received from her new partner:

He's a great parent: changing diapers, feeding him, teaching him and waking up at night, and this fellow, you know he does it all. He does everything. He's so good. I watch him sometimes and he's so good at what he does, you know. It thrills me! So everything worked out, he accepted my new life and his, I guess! But it's just different. It's better!



Marie stated that, although she had less money living without her boyfriend, she did not mind because she had freedom: "I have a lot more freedom. That's why I like it even though I don't have as much money. I like it because I can do what I want to and there's nobody to stop me." This freedom enables women to make decisions regarding daily activities and thus contributes to their quality of life. Karen noted the difference between her old and her new partner, who is not abusive, and described the freedom and control she now has in her home:

I don't worry about laundry because nobody pushes me to do anything here. Nobody will complain if there is no supper. Nobody will say anything. Now I run the house the way I want it. Nobody complains. When I feel like sleeping, I sleep. If I feel like cleaning up, I clean. If I don't feel like cleaning, I don't clean.

Having the capacity to make decisions regarding her everyday life gave Karen a sense of control.

Women who left difficult relationships spoke of the strength they gained from knowing that they were able to survive them. Women with difficult life histories tended to meet present challenges with resolution. Consider Elaine:

I've been through worse and I got out of it. I was with somebody else before and I loved that person a lot but I had to get out of the relationship. I had to, and I did, and I forgot about that person and it's giving me strength now to think about when I was back there.

Mandy said that living on a tight budget was minor compared to living with her first partner, who beat her. She stated that, "after going to hell and back," she was able to confront anything during this pregnancy.

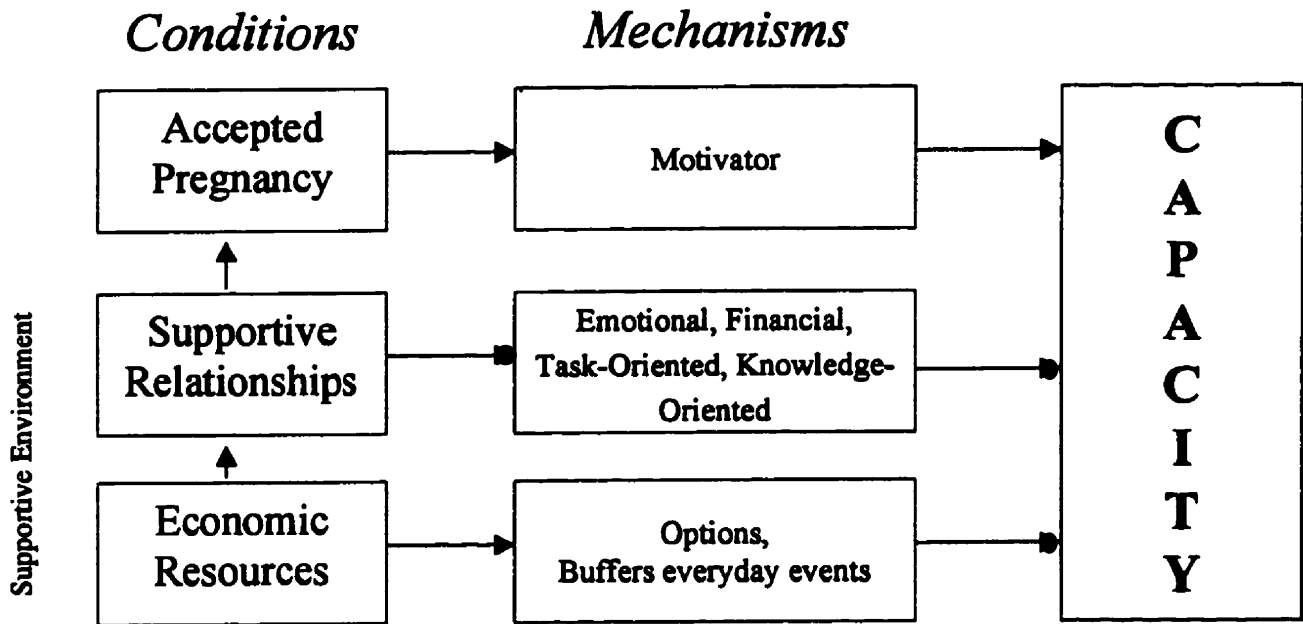
Thus all of the women in this study who had experienced special threats to their pregnancies were conscious of the challenges that confronted them, and they made sincere efforts to alleviate threat, regain control, and engage in health-enhancing behaviours. The complexity and challenge inherent in their lives did not deter them from trying to develop strategies for having healthy pregnancies.

## Summary

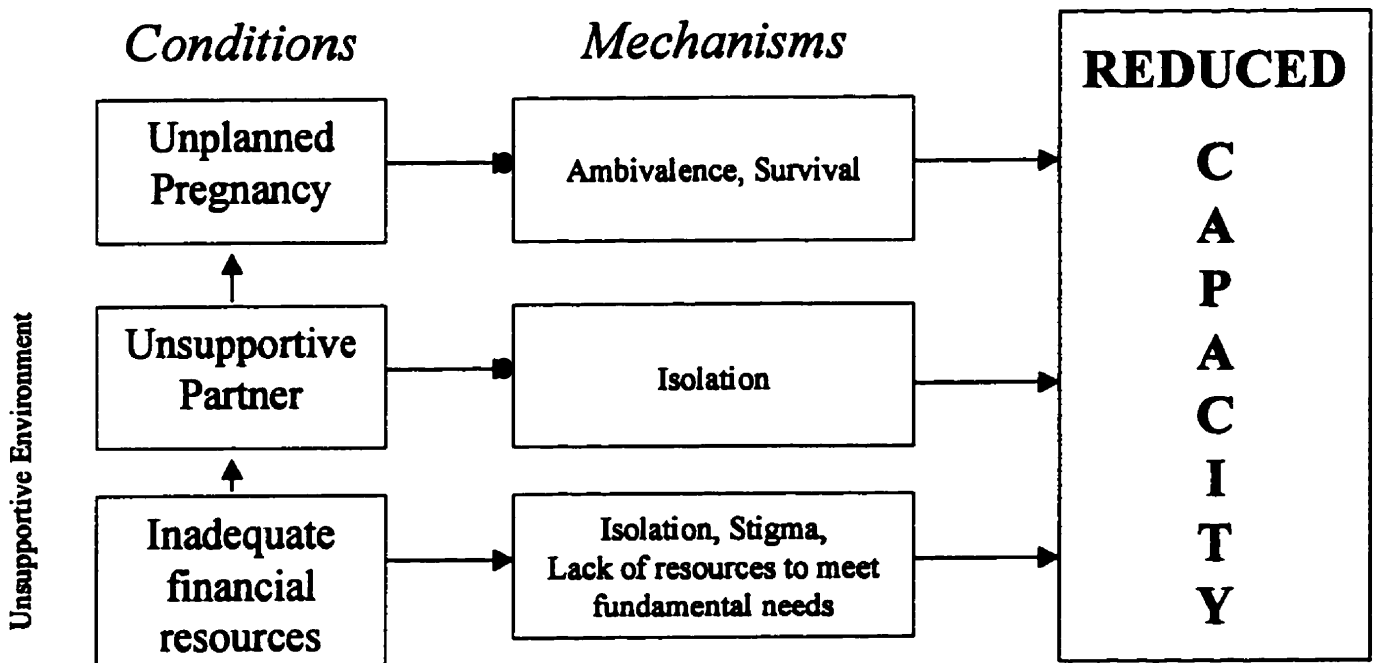
In order for women to create healthy pregnancies, they require the energy to engage in health-enhancing behaviours. In this study, three conditions are fundamental to this capacity: (1) having an accepted pregnancy, (2) having adequate financial resources, and (3) having supportive relationships. These conditions give women freedom and balance (stability) and, with that, the capacity and energy to engage in health-enhancing behaviours (see Figure 1). When women's financial, physical, and/or emotional security is jeopardized they experience a loss of control over their lives and, hence, the state of threat. This, in turn, reduces their capacity to deal with stressful events. In these circumstances women often fall back on those coping styles, often harmful, that are most accessible to them, such as smoking, not eating properly, and consuming alcohol (see Figure 2). It was found that women remained with abusive partners because they wanted to have fathers for their children; because they wanted to maintain the family unit; and because they hoped that, once the children were born, things would change.

However, when the violence/abuse continued, women either left their partners or pressed legal charges, clearly insisting on something better for themselves and their children. Despite the adversity they faced, all the women in the study attempted to regain control over their lives. Concern for the well-being of the fetus as well as other children gave women the strength and motivation to fight back. They also drew strength from having previously resolved difficult life experiences. Conditions that were instrumental to the process of their regaining control were: financial resources, a safe place to go, and emotional support. The women in this study showed incredible strength as they met the challenges imposed by poverty and abuse. They did not remain victims but took hold of their lives with courage and conviction.

# Figure 1: Creating a Healthy Pregnancy



# Figure 2: Threats to a Healthy Pregnancy



## **CHAPTER EIGHT: DISCUSSION**

This study was designed to gain an understanding of the impact of poverty on the everyday lives of pregnant women. In Chapter 4, I show that having adequate financial resources and being in a supportive relationship are central to a woman's capacity to create a healthy pregnancy. In Chapter 5, I discuss the experience of pregnancy as well as the various sources of support upon which a woman draws in order to deal with her feelings of vulnerability. In Chapter 6, I describe the special role of poverty and violence in creating the state of threat. In a state of threat, a woman's focus shifts from health-enhancing behaviours to survival strategies. Often, in these situations, a woman reverts to unhealthy coping behaviours simply because they require little energy. In Chapter 7, I describe the notion of capacity for health as well as the conditions that are essential in order for women to be able to create healthy pregnancies.

Through providing a detailed account of the social context of women's lives, my use of grounded theory contributes an understanding of women's experience of health in the context of threats to pregnancy and explains how the circumstances of their everyday lives shape their experience of health. Using grounded theory and a feminist lens allows me to show the impact of different circumstances on women's capacity for creating healthy pregnancies. This study reveals that, even in very difficult circumstances (such as poverty and abuse), women attempt to maintain or regain their health in order to care for their fetuses and children. This study also helps us to understand women's strengths, courage, and creativity in the face of complex and stressful social and economic conditions. Seldom have we focused on the strengths and creativity of low-income women who successfully manage their lives and interact with their environment as they learn how to meet their needs (Ford-Gilboe & Campbell, 1996; Rose, 1990).

I believe that the major contribution of this study is its emphasis on the importance of the social context of women's everyday lives – a context that shapes their health during pregnancy. The findings of this study show that, with regard to pregnant women, the interaction between their environment and their health is far richer and more complex than was previously understood. I have attempted to view health from both the microscopic and the macroscopic perspective. What has been absent in the philosophical discourse surrounding women's health is the integration of these two perspectives, since health was conceptualized either as psychological or as sociological. Understanding health holistically will help health professionals to appreciate how women conceive of their health and how their conceptions are influenced by their everyday lives. From this perspective, we do not take either an individualistic approach or a social-structural approach to health behaviour; rather we seek to understand individual behaviour within its social context.

In this chapter, I compare the major findings of my study with those in the literature. I address maternal-child nursing, women's health, and the health behaviour literature. But first, I acknowledge the special situation pertaining to First Nations women.

### **First Nations Special Considerations**

As was apparent in this study, First Nations women may face heightened vulnerability and threat as a result of the triple effect of racism, classism, and sexism. Living in an environment where substance abuse is accepted as a way of life contributes to instability, unpredictability, and continued abuse (MacMillan, MacMillan, Offord & Dingle, 1996). Historical injustice, colonization, and economic dependence has led to social malfunction in First Nations societies. The main problem is that lack of productive employment has undermined traditional roles and status relationships, especially for males, most of whom are no longer the food providers for their family or kin group. Thus, they are denied the opportunity to validate their self-

worth by contributing to the survival and well-being of their family and community. Unemployment has devastated morale and undermined the culture. This, in turn, has bred extraordinary levels of social pathology (Boldt, 1993, p. 223). All of these factors create a context that threatens the health of the community and, especially, the health of those who are most vulnerable – the pregnant women and unborn children (Canadian Nurses Association, 1994; Health Canada, 1994a; Long & Curry, 1998). As has been found elsewhere, consuming alcohol is a familiar way of coping in this community, and it is a way that is often passed down from generation to generation (Canadian Medical Association, 1996; Herbert & McCannell, 1997). The high incidence of substance and alcohol abuse within this population (a large number of newborns are affected by fetal alcohol syndrome and fetal alcohol effects) is a well documented and unfortunate fact (Amaro, Fried, Cabral, & Zuckerman, 1990; Health Canada, 1996; Ross, 1997).

In this study only women (n = 4) who had attained post secondary education had a sense of cultural identity that they were able to use as an important source of strength. The worth of elders, their connection to nature, and their community celebrations were important aspects of their cultural identity. This is similar to the findings reported by Turton (1997) in an ethnographic study of Ojibwe people. They found that ways of knowing about health included stories from oral tradition, knowledge from elders, commonsense knowledge, spiritual knowledge, and self-knowledge. Unfortunately, most First Nations women in this study did not identify cultural identity as a source of strength. Colonization and the resultant social disintegration of First Nations communities (Canadian Nurses Association, 1994) was evident in this study, as it is in others. For example, Long and Curry (1998) conducted a qualitative study of the traditional beliefs and practices related to pregnancy among Native American women. Their findings revealed the breakdown in the transmission of cultural wisdom among Native American women as a result of federal assimilation

policies and the death of elders (see also Dempsey & Geese, 1995). The unacceptable situation of First Nations people is something that all health care professionals must strive to alleviate.

### **The Experience of Pregnancy**

In this section, I will first consider how the accounts of participants reflect the general claims made by major theorists in the maternal-child nursing literature with regard to the process of creating a healthy pregnancy, the experience of vulnerability, and women's sources of knowledge during pregnancy.

#### **Creating a Healthy Pregnancy**

For the women in my study, having a healthy newborn was their main concern during pregnancy. These 40 women engaged in the process of creating a healthy pregnancy in order to maximize their chances of having a healthy newborn. This finding is similar to that of Rubin (1976), one of the foremost theoreticians of the psychosocial aspects of pregnancy and mothering. Rubin developed a framework within which she identified four main maternal tasks: (1) seeking a safe passage for herself and her child, (2) ensuring the acceptance of the child, (3) binding-in to her unknown child, and (4) learning to give of herself. Rubin organized these tasks according to trimester, but she acknowledged that they may overlap. These tasks involve an active process and occur progressively during each of the trimesters of pregnancy, continuing for three to six months after birth (Templeton, Estes, & Douglas, 1988). The two tasks in Rubin's theory that most resonate with my study findings are: seeking a safe passage and ensuring the acceptance of the child. Rubin (1970) viewed the latter as the key to a successful pregnancy, as once it occurs, the woman moves on to seeking safe passage. These two tasks are echoed by the accounts given by women in this study. Once they have accepted their pregnancies they move on to actively engage in the process of creating healthy pregnancies. This is similar to what was found by Rubin (1984) and, later, by Patterson, Freese, and Goldenberg (1990). In my

study, the extent of a woman's ability to engage in the process of creating a healthy pregnancy is related to three essential conditions: acceptance of the pregnancy, support from a male partner, and adequate financial resources. Women for whom three of these conditions were present engaged more easily in health-enhancing behaviours than did women who had financial strains and/or a violent partner and had not yet accepted their pregnancies. Women who had desired pregnancies but had financial worries found it more difficult to focus on health-enhancing behaviours, as they experienced many other chronic worries (such as putting food on the table and paying the rent), which consumed much of their energy.

Rubin's writings are silent on issues such as the quality of a woman's relationship with her partner/husband or the impact of a violent partner on her ability to accept her pregnancy. In my study, women who had unplanned pregnancies and abusive partners had the most difficulty coming to terms with accepting their pregnancies and, thus, delayed or never began the process of creating healthy pregnancies. In addition, the accounts of women in my study illuminate the importance of financial resources with regard to facilitating the acceptance of an unplanned pregnancy.

Women described the process of creating a healthy pregnancy as having to do with being actively engaged in behaviours geared towards maximizing their chances of having a healthy newborn. Women engaged in various health-enhancing behaviours: eating healthy food, exercising, decreasing alcohol and nicotine consumption, sleeping/resting, attending prenatal classes, and avoiding stress. Among the various strategies they reported engaging in were: cutting out/reducing questionable behaviours, increasing certain behaviours, substituting one behaviour with another, making sacrifices, and avoiding harm and stress. The idea of making sacrifices (such as giving up smoking) is similar to Rubin's notion of learning to give of oneself.



The behaviours of the women in my study are also similar to those reported by Higgins, Frank, and Brown (1994) in an exploratory study in which they found that women made changes in their diets, exercise patterns, smoking habits, vitamin intake, and alcohol use. These authors contend that future research needs to address what motivates women to make changes. My study sheds light on the conditions that motivate women to engage in health-enhancing behaviours: having an accepted pregnancy, adequate financial resources, and a supportive partner. In my study, the more women were surrounded by various forms of support the more they were able to modify unhealthy behaviours. For example, women in my study all attempted to quit smoking, but while some were successful others were only able to cut down. The women who quit had non-smoking supportive partners, financial stability, employment outside the home, and supportive friends. The women who cut down but did not stop smoking had partners who smoked, were mostly unemployed, were poor, and were First Nations.

#### The State of Vulnerability

In my study, all women experienced the sense of vulnerability inherent within the experience of pregnancy. This is also found in other work in the field of maternal child-health. Several scholars have noted pregnancy as a time of crisis and psychological unrest (Benedeck, 1956; Bibring, Dwyer, Huntington, & Valenstein, 1961; Cohen, 1979; Leifer, 1977; Sherwin, 1987; Tilden, 1980; Valentine, 1982). In looking at the development of maternal behaviour, early analysts such as Benedeck (1956), Deutsch (1945), and Bibring (1959) based their work on intrapsychic perspectives. Most of their knowledge in this area was derived from clinical observation, and they emphasized the importance of the woman's relationship with her mother. These theorists viewed pregnancy as an acute period involving profound psychological and physiological changes (as profound as those experienced during puberty and menopause). More recently, Colman and Colman (1991) refer to

pregnancy as a time of personal crisis: “familiar patterns have to be changed, thus invoking vulnerability and fear of the unknown” (p. 91). These theorists substantiate my finding that, during pregnancy, women experience a sense of vulnerability because they are not in full control of the outcome of their pregnancies. The findings further shed light on the sources of strength women draw upon in dealing with the state of vulnerability (such as having access to supportive people, having a strong upbringing, having resolved past conflicts, and having strong cultural traditions). In addition, women draw strength from their ability to create a new life. My findings also bring new meaning to the notion of vulnerability. The women’s revelations indicate that the state of vulnerability acts to increase their awareness by increasing their vigilance, which further motivates them to engage in health-enhancing behaviours. In other words, the state of vulnerability functions to safeguard women’s health.

Some women in my study experienced a state of heightened vulnerability that was induced by medical or social conditions. These women attempted to deal with this situation by engaging in specific protective behaviours. This finding is similar to that of Patterson, Freese & Goldenberg (1990), who note that “the level of affect surrounding seeking safe passage varied according to the woman’s estimate of her and/or her baby’s vulnerability during pregnancy.” Corbin’s (1987) theory of “protective governing” among pregnant women with chronic disease is also echoed by pregnant women who experience heightened vulnerability. Other scholars have employed similar notions to refer to this state of heightened vulnerability. Mercer (1990) coins the term “increased vulnerability” to describe at-risk parents. “When things don’t go as expected and disappointment or illness occurs, the additional strains, grief, and encompassing problems place the parents in a state of increased vulnerability” (p. vii). Field and Marck (1994) employ the term “uncertain motherhood” to describe women’s experience of heightened stress due to three types of uncertainty: (1) reproductive, (2) waiting, and (3) diagnostic. They claim that uncertainty can be altered through credible

authority, social support, and education. The work in this field has been mostly limited to describing heightened vulnerability and threat resulting from medical conditions and chronic diseases, and has generally not considered the implications of poverty or violence with regard to shaping the experience of heightened vulnerability or threat during pregnancy.

My findings extend the notion of heightened vulnerability to encompass the state of threat – an extreme form of vulnerability. Mercer (1990) has also explored vulnerable families and their adaptation to threat and loss. She discusses parents whom she calls at-risk: chemical abusers, non-married heterosexual mothers, lesbian mothers, and homeless and HIV-infected mothers. She suggests that adapting to a crisis involves psychological and environmental readjustment which leads to an increased ability to cope. She defines threat as “any event or series of events that places a desired or valued person or outcome in jeopardy, thus creating dis-equilibrium for the individual” (p. 39). This is echoed to some extent in my findings, which show that women experience threat as a result of lack of stability/balance due to poverty and violence.

My findings emphasize the central importance of a woman’s financial resources in shaping the experience of health and health behaviours. A woman’s ability to cope in a healthy way is seriously limited by inadequate financial resources and the strain of abusive relationships. Such circumstances as inadequate financial resources (often due to inadequate social policies that have allowed women to fall into poverty in the first place) further decrease a woman’s ability to leave an abusive partner.

#### Women’s Sources of Knowledge During Pregnancy

An important source of knowledge in this study stemmed from women’s bodies. In other words, women paid attention to signals from their bodies (body knowledge) when attempting to engage in health-enhancing behaviours. According to Rubin (1984), seeking safe passage during pregnancy is principally accomplished by the acquisition of such knowledge as that derived from medical advice, books, and other

women. In reviewing the literature, I found only two studies that spoke of body knowledge during pregnancy. Jordan (1977) found that women's knowledge of their own bodies enabled them to be competent judges of their own health during pregnancy. Similar findings are reported in a more recent study by Browner and Press (1996), who conducted ethnographic interviews with 158 women enrolled in prenatal care in order to learn how they incorporated biomedical advice into their self-care practices. Although the income of the people in their study was significantly higher than was that of the people in my study, and although their sample was ethnically varied (i.e. Mexican-American), there are similarities in the findings. Body knowledge is defined as subjective knowledge derived from a woman's perception of her body and its natural processes throughout the course of a pregnancy (Browner & Press, 1996). As in my study, women in Browner and Press's study made decisions regarding medical recommendations according to the body changes they were experiencing, their own prior history and knowledge, and their everyday life situations; women attained knowledge mainly through their previous pregnancy experiences as well as through other women who were pregnant or who had children. For example, in my study, First Nations women based their decisions about cutting down on, as opposed to quitting, smoking on whether or not they smoked during other pregnancies and still had large babies.

In my study, another important source of knowledge that women used to inform their health-enhancing behaviours was the women they knew. This source of knowledge was considered credible because it involved a relationship of mutual concern and similar experiences. In my study most women did not establish a successful therapeutic relationship due mainly to the fact that physicians would not spend enough time with them. Furthermore, the majority of women in my study often felt that they were not respected by their physicians and so did not find them a source of support or knowledge.

With regard to the quality of the health care provider, in a study conducted by Taylor and Dower (1997) involving diverse groups of women who were asked about health care delivery, 250 women spoke of being upset by their health care provider's attitude of superiority. They believed that this attitude kept them uninformed and uneducated. They also noted a general lack of respect, manners, compassion, and caring. Still other researchers have pointed out that health care providers reduce women's capacity for health (Oakley, 1993b; Thorne, 1993). In contrast, women who had midwives regarded them as important sources of strength (Stewart & Soderstrom, 1991). This is also reflected in my study, in that women who had midwives spoke of their special trusting relationship with them and considered them an important source of support and knowledge. This shows the central importance of having a therapeutic relationship based on partnership and mutual respect.

In describing the experience of pregnancy, my findings are consistent with and extend beyond already published work in the maternal-child literature. They go beyond this work by expanding our understanding of how poverty and violence create special threats to women's health through decreasing their capacity to engage in health-enhancing behaviours. My findings also indicate how the state of vulnerability functions to motivate healthy behaviour, which can serve to safeguard women's health. Furthermore, I show how women's body knowledge functions as an important source of information that may be utilized to enact health-enhancing behaviours.

I now go on to discuss my findings in relation to the literature on the meaning of health. I first present a historical overview of philosophical understandings of health and then situate my findings within it.

### **Conceptualizations of Health**

According to Dolfman (1973) the word "health" first appeared in writing around AD 1000. From the time of the ancient Greeks until the 17th century, health was viewed holistically. Then, during the Cartesian revolution, the more restrictive view of

health as a disease-free state, along with the body-mind split, began to emerge (Engel, 1977). In more recent decades, the relatively new, technologically oriented biomedical perspective has dominated Western medical practice (Lyddon, 1987). This perspective stems from Newton's mechanistic model, which views the body as a machine. The implication is that if this machine breaks down, then a medical intervention is required in order to fix it (Capra, 1982).

The World Health Organization (WHO) attempted to return to a holistic view of health by defining health as "a state of complete physical, mental, and social well-being, and not merely the absence of disease" (WHO, 1947, p. 83). In the 1970s the medical approach began to expand and eventually emerged as the individual lifestyle approach (also called behavioural approach). Particularly influential was A new perspective on the health of Canadians (Lalonde, 1974), which incorporated death and disease into the health field concept of health. The health field concept of health is comprised of four elements: human biology, environment, personal lifestyle, and health care organization. The importance of people's lifestyles (behaviours) (e.g., smoking, nutrition, and exercise) was acknowledged as it became increasingly clear that individual health behaviours affect health status (McElmurry & Tashiro, 1997). This view shifted attention to non-medical determinants of health (Badgley, 1994). Within nursing, health-promotion, medicine, and the social sciences, this led to an increased focus on how individual behaviours affect health (Grace, 1991; Laffrey, Loveland-Cherry, & Winkler, 1986).

The individual lifestyle approach to health is enhanced by the view that people's health is influenced by the social and material conditions that form the context of everyday living (Mechanic, 1992; Meleis, 1990; Poland, 1992). This appeal for notions of health to encompass health determinants is supported by Achieving health for all: A framework for health promotion (Epp, 1986). This framework concedes that the factors influencing health are not simply those related to disease or

lifestyle, but also include “peace, shelter, education, food, income, a stable ecosystem, social justice and equity” (p. 1). It is widely recognized that socio-environmental conditions are important health determinants and that they explain differences in morbidity and mortality rates among different population groups and nations (Wilkinson, 1996). This latest definition of health is a response to the failure of medical and behavioural approaches to reduce mortality and morbidity rates in low-income populations and to the high cost associated with care (Labonté, 1994; Stewart & Nimrod, 1993). The philosophical framework for health is important, as it dictates the care and programs that health care providers are able to render to populations.

In nursing, the concept of health is central. Indeed, it is identified as one of nursing’s metaparadigms (Fawcett, 1984; Meleis, 1991). Nursing has traditionally favoured a broad notion of health – one that encompasses physical, emotional, social, political, and environmental components. Nurse theorists have written extensively about health. The notions of health in nursing have also followed mainstream philosophical ideologies and discourses surrounding health. Schultz and Meleis (1988) refer to the knowledge developed by nurse theorists as conceptual knowledge; that is, as the product of reflecting on nursing phenomena.

For the past decade, nursing theories have been criticized for narrowly defining the environment as being restricted to the immediate milieu of the person and as being individually oriented (Butterfield, 1990; Chopoorian, 1986; Hagan, O’Neil, & Dallaire, 1995; Kleffel, 1991). Over the last decade, nursing has come to an increased awareness of the importance of examining the relationships between the social, political, economic, and cultural conditions that produce health and illness. Several nurse scholars have called for research that takes into account the larger environmental context of women’s lives and its impact on women’s health (Chopoorian, 1986; Daykin, 1993; Kleffel, 1991; Stevens, 1989; Woods, Lentz & Mitchell, 1993).

Input from the women in this study force us to consider the social context of women's lives and how it shapes their experience of health and, subsequently, their capacity to engage in health-enhancing behaviours. I have attempted to view health from both a microscopic and a macroscopic perspective. A holistic understanding of health helps us to appreciate how women conceive of their health (body, mind, and spirit) and how they are influenced by their everyday lives. We do not need to select either an individualistic approach or a social-structural approach to health behaviour; rather, we need to understand individual behaviour within its social-structural context. Bearing this in mind, in the next section I will discuss my findings in relation to the literature on the meaning of health.

### **The Experience of Health**

I will now provide an overview of research conducted in the area of health. First, I compare my findings concerning the experience of health with what is found in the nursing literature. I then examine the impact of stress on health and health behaviours as well as the notion of control and how it relates to health. I conclude by critiquing the literature on health and individual lifestyle theories and by discussing the theoretical relevance of my study. I emphasize the importance of looking at the social context of women's lives when attempting to understand their experience of health.

In a meta-analysis of 112 qualitative studies stemming from grounded theory, phenomenology, and ethnographic perspectives, Jensen and Allen (1994) derive substantive interpretations of commonalties concerning wellness and illness. The samples included participants whose ages range from seven to 81 as well as representatives of both genders from diverse ethnic groups (including Canadian, Black-American, Spanish-American, Mexican-American, Finnish, Swedish, and Aboriginal). Participants in the samples include healthy individuals as well as people with chronic illnesses, but there are no pregnant women. Jensen and Allen's conclusions, however, resonate with my findings insofar as such themes as abiding vitality, transitional



harmony, rhythmical connectedness, unfolding fulfillment, active optimism, and reflective transformation are concerned.

First, the idea of abiding vitality refers to a feeling of being energized and vigorous as opposed to feeling drained and without energy. Vitality is disrupted when harmony is lost, and this resonates with my findings that positive health is expressed through having energy and feeling happy. In contrast, poor health is expressed through having no energy and feeling tired and depressed. The notion of harmony involves a sense of balance and stability. When their stability was disrupted, the women spoke of experiencing low energy. Furthermore, the women in my study described their ability to engage in self-care as requiring energy, and they claimed that this energy stemmed from the balance in their everyday lives.

The second theme, transitional harmony, refers to that fact that when one experiences health, one also experiences a sense of harmony and balance. With balance comes a sense of peace and the feeling that one is in tune with oneself, others, and the environment. This experience may be disrupted by disease, which, in turn, creates an imbalance and a sense of loss of control. To restore this balance, one must "heal one's way back." Similarities between these findings and the accounts of the women in my study are evident. Women in my study refer to the necessity of having balance/stability in order to focus their energy on health-enhancing behaviours. This balance requires that the body-mind-spirit be free from high levels of stress. A woman's loss of control may be the result of this balance being disrupted by high levels of stress, by insufficient financial resources, and/or by a violent male partner. Jensen and Allen (1994) claim that health-disease shapes everyday life. They describe how social supports and interpersonal relationships influence the way the individual reacts to health-disease. They point out that one's "education, social roles, and economic status may determine the extent to which health-disease disrupts or enhances family, work, and social activity" (p. 362). They observe that income and education buffers the effect

on family work and social activity, and they further indicate that conditions in women's lives that create stress and disrupt harmony have a definite impact on chronic illness. In other words, it is acknowledged that the social context of women's lives shapes their experience of disease and health.

The third theme, unfolding fulfillment, is described as harmony and a feeling of purpose and satisfaction that contributes to the involvement in meaningful activities. This finding resonates with the idea of having a desired and supported pregnancy – one in which women are motivated to engage in health-enhancing behaviours. To have energy and experience balance/harmony, a woman must create meaning out of her experiences. During pregnancy, a woman can do this by being connected to the fetus, herself, others, and her environment. Jensen and Allen (1994) classify these as the intrapersonal, interpersonal, and extrapersonal dimensions of connectedness. Being connected to others is essential and assists women to normalize their experience of vulnerability. Furthermore, the extrapersonal dimension of the environment may take on a different meaning for groups such as the Mi'gmaq, who have a close relationship with nature. In my study, the sense of connectedness is disrupted for women who are isolated due to the social stigma of being a "welfare mom" and/or having been battered. Further investigation into low-income women's experience of connectedness is needed.

The fourth theme is described as active optimism. Being healthy involves having a sense of control and being motivated. When women experience a desired and supported pregnancy, they have the motivation and energy to engage in health-enhancing behaviours. To do this effectively, they require such resources as financial resources, safety, and support. These resources give women the capacity to create health and, subsequently, a healthy pregnancy. When the natural flow of life is disrupted, so that balance may be altered and control may be lost, a sense of uncertainty may ensue. Restoration of balance requires regaining and sustaining a

degree of control. In my study, women said that their sense of control was related to their capacity for control. In order to have control, women need an adequate financial resources and the support of people who are close to them. When these resources are available, options are created and the women feel they have control. Jensen and Allen's (1994) meta-analysis found that people with disease feel controlled, passive, vulnerable, fearful, helpless, and overwhelmed by life. This is similar to my findings, which show that threat, brought on by the interplay of violence and poverty, decreases a woman's capacity to be in control of her life.

The fifth and last theme, reflective transformation, involves the idea that life has meaning and scope and that balance prevails. One creates new meanings in the process of being and of stretching to meet the challenge of disease. People are capable of healing and accepting themselves and others. This idea resonates with my findings, which show that women who have experienced poverty and/or abuse can change their situation.

Together, Jensen and Allen's (1994) meta-analysis and the current study substantiate Blaxter's (1990) contention that people's experience of health usually relates to such phenomena as: feeling vital, having energy, having good social relationships, experiencing a sense of control over their lives and their living conditions, being able to do things they enjoy, having a sense of purpose, and experiencing a connectedness to "community." This being the case, it follows that the negative impact of stress on health and health behaviours cannot be over-stated.

#### The Impact of Stress on Health and Health Behaviours

What is not raised either by Jensen and Allen (1994) or by Blaxter (1990) is women's conceptualizations of health. In my study, women described the meaning of health as the interplay of the body, mind and spirit. Positive health, or "being healthy," involves these dimensions being in balance. This balance can be disrupted by stress, which may reduce a woman's capacity to be in control of her life. In addition, stress

permeates the mind, body, and spirit, leading to such health problems as pre-term labour, increased nausea and vomiting, and ante-partum hemorrhage. The importance of social circumstances as determinants of women's health is widely recognized (BC Ministry of Health, 1996; BC Ministry of Women's Equality, 1997; National Forum on Health, 1997; Stewart, Abbey, Meana, & Boydell, 1998; Walters, 1993). It is well established that women who experience increased stress during pregnancy have a higher incidence of poor obstetrical outcomes (Goldenberg & Gotlieb, 1991; Istvan, 1986; Levin & DeFrank, 1988; McDonald, 1968; Nuckolls, Cassell, Kaplan, 1972). Thus it seems reasonable to posit that women's sense of the impact of various social determinants on their pregnancy outcomes is, indeed, grounded in "objective" reality.

Curry, Burton, and Fields (1998) state that stress affects pregnancy outcomes indirectly through changes in activity, sleeping, food intake, and the use of substances. In turn, high levels of stress during pregnancy are correlated with little social support, frequent depression, low self-esteem, inadequate weight gain, and increased substance use (Collins, Dunkel-Schetter, Lobel, 1993; Hickey, Cliver, Goldenberg, McNeal, Hoffman, 1996; Oakley, Rajan & Grant, 1990; Pritchard & Mfphm, 1993). Furthermore, it is increasingly recognized that the use of substances by pregnant women is related to such stressful situations as domestic violence (Campbell, Poland, Waller, & Ager, 1992; Kearney, Murphy, & Rosenbaum, 1994; Parker, McFarlane, & Soeken, 1994; Pursley-Crotteau & Stern, 1996).

In my study, women's choices with regard to health-enhancing behaviours were restrained by lack of adequate financial resources and by male domination and/or violence. The women tell us that when in a state of threat, they experience a sense of losing control over their lives. This results from their reduced capacity due to lack of money and/or having a violent male partner. Without the economic resources to ensure basic survival needs, women have a limited ability to change their situation. In order to survive in extremely stressful situations, women often revert to old coping

strategies, as healthier options may not be readily available. Women who fall back on unhealthy behaviours (such as smoking) do so not because of a character flaw but because they need a way of coping. Attributes such as personal efficacy and learned helplessness have received a great deal of attention in health sciences and psychology literature (Abramson & Seligman, & Teasdale, 1978; Wilkinson, 1996). Wilkinson (1996), however, advances the idea that psychosocial factors are only relevant to the extent that they are responses to socio-economic circumstances. This idea is contrary to the popular notion that learned helplessness is a fixed personality characteristic as found elsewhere (Campbell, Miller, Cardwell, Belknap, 1994).

My findings are echoed in Lachman's (1996) literature review on stress and self-care, which concludes that individuals turn to maladaptive behaviours (such as smoking, alcohol, or drug consumption) according to the following combination of factors: (1) the individual perceives a loss of control over her/his situation, (2) the individual's resources for adapting to her/his situation are diminished, (3) and the number and/or duration of stressors is increasing. In the previous sections, I discussed the first two conditions. The third condition, chronic stress, is well known to be experienced by low-income people and tends to upset their everyday lives (Blackburn, 1991; Payne, 1991; Whelan, 1993). The women in my study, especially those who were recipients of social assistance, all spoke of a month-to-month kind of existence – an existence that created chronic stress.

There is a vast amount of literature and research on stress and coping (Jones & Meleis, 1993); however, in general it does not fully address the complexities of vulnerable pregnancy. Nonetheless, it does generally substantiate my findings in that it addresses stress as a clearly negative factor in the determination of health. In my study I found that, in order to deal adequately with stress, a woman must be able to make choices; that is, she must have reasonable control over her life.

### What Determines Choices of Behaviours: An Analysis of Control

My study's notion of women's capacity to create health is similar to Shields's (1995) notion of empowerment. In a qualitative exploratory study of 15 women between the ages of 21 and 71, Shields examines the process of empowerment and describes it as being able to make choices and being in control of one's life. According to Shields, having choices relates to one's sense of control over one's life as well as to having a sense of connectedness, which, in turn, she describes as a wholeness and balance that enables women to experience freedom. In my study, a woman's freedom is metaphorically expressed by her level of energy. According to Rodwell's (1996) review of the literature on empowerment, choice is embedded in the idea of empowerment; however, we often fail to recognize that choice is not equally available to all people.

For women, a number of factors contribute to a perception of low control. According to Chodorow (1978) a women's perception of low control results, in part, from childhood socialization and gender role training. Rosenfield (1989) adds that these perceptions largely come from and are reinforced by adult social conditions, which decrease the control available to women. Without equitable access to financial resources, women are vulnerable and are subject to many forms of oppression (e.g., discrimination in education, employment, housing, and transportation). Oppressive circumstances resulting from ideologies such as classism, racism, and sexism reduce a woman's freedom and choice, and this, in turn, decreases her capacity to be in control of her life. According to Bolton (1997), poverty adversely affects women's liberty, freedom, and pursuit of well being.

Overload and fatigue are well recognized as threats to women's health. In my study, women who worked both inside and outside the house and who had a number of children experienced increased stress as a result of overload. Overload also occurred in the case of unemployed women who could not afford child care and so

could not have time for themselves. Nelson (1997) identifies the lack of time and energy due to constraints related to financial needs and the demands of multiple-role activities as a significant barrier to the desired health practices of low-income women. Similar findings were published from a Canadian study (Stewart, Abbey, Meana, & Boydell, 1998) involving 153 mostly white (83%) women, with a mean age of 52 and a range in ages of 21 to 80. Women stated that persistent fatigue was most common, and they attributed it to combinations of work both inside and outside the home, no time for themselves, a lack of exercise, financial worries, and relationship problems. Although this sample was composed of non-pregnant middle-class women, it can be assumed that pregnant women would face these and other challenges.

It is also widely recognized that women's health is affected by whether or not they are employed as well as by the economic climate in which they live (Doyal, 1995). Unemployment is often associated with stress-related mental and physical problems and is often linked to poor health (Demarais, 1991; Wilkinson, 1996). Mental and/or physical illnesses associated with unemployment are not only experienced by the unemployed woman, but also by her spouse. What is essential is having the capacity to decide one's circumstances regarding one's work and to be able to control how the work environment affects one's health (Matthews, Hertzman, Ostry & Power, 1998; Wilkinson, 1996). It follows that a woman's ability to influence her circumstances of employment may greatly influence her stress level.

Wilkinson (1996), an international scholar in the field of wealth and health, believes that poor health is the result of economic deprivation and the disintegration of social cohesion. The quality of social life is one of the most powerful determinants of health and is closely related to income. Wilkinson's work resonates with the women's accounts in my study, which show that in order to have the capacity for health, women need material resources and a sense of connectedness (cohesion) to their community. Having a supportive network of relationships, especially partner/husband

and friends, and living in a good community are important to a woman's health. Family and friends can provide basic needs and can help to look after women, especially during a pregnancy. Emotional and economic support can also be provided in times of distress. Families and friends provide love on an ongoing basis and are there to support individual lifestyle choices and changes. In my study, violence towards women disrupted their connectedness to their friends, families, and communities, resulting in their isolation and decreased levels of emotional and financial support. Unfortunately, Wilkinson does not take gender into account, thus overlooking patriarchy as an important determinant of health (Doyal, 1995; National Forum on Health, 1997; Payne, 1991).

When, for any or all of the above reasons, women feel that they are not in control of their lives, they often attempt to cope by beginning to engage in unhealthy behaviours. At this point it may be useful to examine in detail a specific example of one such behaviour – smoking. I choose to look at smoking because it is both common and extremely damaging.

#### Smoking: A Specific Example of an Unhealthy Coping Behaviour

In the state of threat, women in this study often fell back on old and unhealthy ways of dealing with stress. Most women in my sample reverted to smoking due to the stress associated with poverty and violence. Scholars in various fields have found that the prevalence of smoking among women is an expression of how they cope with stress.

In a Canadian review of research on smoking and pregnancy, Edwards, Sims-Jones, and Hotz (1994) found that women in poverty smoke more than their middle-class counterparts, and they attribute this to their particularly stressful lives. Women who continue to smoke prenatally are more likely to be poor, young, single, to have limited education, and be unemployed or to work in a low-status job. Stewart and Streiner (1995), in a study to determine the prevalence of smoking in a sample of



Canadian pregnant women, confirmed the findings of Edwards and Sims-Jones (1998) and added that women who smoke during pregnancy have more unplanned pregnancies and have suffered more physical abuse both during or before pregnancy.

Other work done in this field (not with pregnant women) further resonates with this study's findings. Graham (1987a), in a sample of single mothers, finds that cigarettes offer a means of coping by enabling the structuring of daily routines, providing a break, and creating a physical and emotional distance between mothers and their children. Graham (1994) states that smoking helped single mothers to care for their children, even though they were aware that the behaviour was detrimental to their health. These women described smoking as a reward for sacrificing their own desires in order to provide for their children (Graham, 1987b). Smoking provided these women with a way to keep going, even when they had little remaining strength (Graham, 1994, p. 103). Other authors report similar results. Rajan and Oakley (1990) found that working-class women smoke more than do middle-class women because they live in poor housing, manage low incomes, and have more stressful lives. The women in my study, like those in the above studies, demonstrated awareness concerning the current medical evidence relating smoking to health outcomes.

The findings of the above British scholars are echoed in a Canadian study that identifies socio-psychological factors associated with smoking cessation among 126 disadvantaged women. The women were primarily poor, unemployed, geographically isolated single parents (Stewart, Gillis, Brosky, Johnston, Kirkland, Leigh, Persaud, Rootman, Jackson & Pawliw-Fry, 1996). Individual and focus group interviews were conducted with these women in rural Atlantic Canada, and the settings and characteristics of the samples were similar to those found in my study. The unprecedented multidisciplinary approach (nursing, medicine, health administration, epidemiology, psychology, and health promotion) to smoking cessation was a strength of this study. The identified factors associated with smoking included coping with

stress, loneliness, powerlessness, low self-efficacy, social pressure, and addiction. The authors concluded that women smoked to cope with the chaos and crises of their everyday lives and that they connected smoking to a lack of control over their environment.

From the above studies it is clear that women use smoking as a way of coping with their devalued roles as women and mothers, their lack of economic power, and their chronic stress. This view is supported by Wilkinson (1996), who states that “the unhealthy habits of the poor tells us about people’s morale, stress, and the extent to which they feel in control of their lives” (p. 189). He maintains that people in poverty smoke more than do people with an adequate income because they have more psychosocial stress.

### **Critique of Lifestyle Theories**

I have shown that, in relation to the experience of health, there are important similarities and differences between this work and the published health literature. I have shown that, in order for women to adopt health-enhancing behaviours, they need to have financial resources and emotional support. It is clear that stress adversely affects a woman’s ability to be in harmony with herself and her environment as well as her ability to be in control. And, when she loses control, a woman often turns to unhealthy behaviours as a way of attempting to cope with her situation. Traditionally women’s unhealthy behaviours have been viewed as character flaws (such as learned helplessness) rather than as a product of her socio-structural environment. Let us now turn to an examination of lifestyle theories and their inadequacy with regard to explaining women’s health.

Individual lifestyle issues are recognized as important factors influencing women’s health. In Canada, one of the primary goals of prenatal care is to target harmful health behaviour in high-risk groups (Health Canada, 1994a). One method used to reduce LBW is to focus on such modifiable risk behaviours as smoking,

nutrition, alcohol, and substance abuse (Health Canada, 1994b). Traditionally, the individual lifestyle approach to health promotion focuses on personal behaviour as a determinant of health and targets the individual for intervention (Labonté, 1992). According to Mechanic (1992), the study of health behaviour seeks to understand what induces people to take preventive action and to avoid risks to health. The individual lifestyle approach emphasizes the need for people to make healthy choices and, according to Yeo (1993), the ethic that informs the individual approach prizes individual freedom and responsibility. Current health promotion models, such as the Health Belief Model (Pender, 1987), emphasize individual responsibility for health and stresses and the importance of personal attributes such as knowledge, perceptions, and motivation with regard to determining health-related behaviour (Kleffel, 1991; Nelson, 1990; McLeroy, Bibeau, Steckler & Glanz, 1988; Stevens, 1989).

An individual lifestyle approach to health focuses attention on behavioural differences between the poor and the non-poor as potential explanations for the poorer health of the former (Nelson, 1990). According to Payne (1991), the most frequently used explanation for the higher levels of mortality and morbidity among low-income groups is that of behaviour. People in low-income groups suffer poorer health and have shorter lives than other people because of health threatening behaviours. Payne (1991) further states: "It is a view of the inequalities in health, reinforced by government emphasis on health education and health promotion, which focuses on individual behaviour rather than the structural context of behaviour" (pp. 143-44).

The individual lifestyle approach explains behaviours in terms of negative personality traits. When the poor (the "biologically and socially flawed") are studied, they are contrasted with the non-poor and are discussed in light of what they do not have and how they differ from the norm (Moccia & Mason, 1986). Often, mainstream discourse locates the causes of poverty within the poor people themselves and blames them for their inadequacies, lack of initiative, unhealthy behaviours, and/or acceptance

of dependency (i.e., learned helplessness). Poverty thus becomes not a circumstance but a personal attribute (Cerullo & Erlien, 1986). One harmful effect of poverty is the associated stigma that accompanies the poor, who are presented as a pathological subculture (Hall, 1997; Waxman, 1993).

Several critiques of the individual lifestyle approach to risk factors have flourished within the social sciences literature over the last decade. In a review of the determinants of health behaviour, Palank (1991) concludes that the individual lifestyle approach separates people from their social, physical, and economic environments and ignores how the life situations of the poor influence their health behaviour. Current strategies to reduce smoking among young women may not be successful unless they are grounded in an understanding of the material and cultural constraints and pressures that result from gender inequalities (Daykin, 1993; McLeroy, Bibeau, Steckler & Glanz, 1988). Health behaviours thus appear to be clearly related to the social environment in which they are embedded (Logan & Spencer, 1996; Pill, Peters & Robling, 1993). Contrary to viewing health as an individual problem, social-structural frameworks shift the attention to the social causes of behaviour and identify specific interventions (Hancock, 1993; McLeroy, Bibeau, Steckler & Glanz, 1988).

Historically, when health is constructed as an individualized, personal product, women in poverty are identified as failing to behave in appropriate ways. The use of terms such as "lifestyle" and "health behaviour" focuses attention on changing individuals rather than on changing the social and physical environment that maintains and reinforces their unhealthy behaviours (McLeroy, Bibeau, Steckler & Glanz, 1988). Such an ideological framework naturally conceals the extent to which infant mortality is due to social and economic factors.

Wilkinson (1996) believes that, when there is a smaller gap between the rich and the poor, people experience better health and more social cohesiveness. Among developed countries, those with the best health are not the richest but the most

egalitarian. Countries such as Sweden, which is socially cohesive, has a strong community life (communitarism) and low mortality rates. The same parallel can be drawn with regard to infant mortality. In countries such as Sweden and Finland, which have the lowest rates of infant mortality in the world, the income gap between the rich and the poor is relatively low, and a political ideology of communitarism is fostered. Consequently, these countries have more policies that are women-centered (Acker, 1994; Wennemo, 1993). For example, the poverty rate for single mothers is 64% in Canada as compared to 4% in Sweden (Baines, Evans, & Neysmith, 1991). The reverse is also true. The United States, with its large gap between the rich and the poor, has one of the highest rates of infant mortality among developed countries. The mainstream ideology in American society is based in libertarianism (Wilson, 1996). The triple effect of classism, racism, and sexism is thought to be a primary explanation for the higher rates of LBW among low-income, African-American women (Wise, 1993).

Despite this compelling social critique, viewing the individual as the focus of health interventions is not inherently inappropriate. Indeed, there is considerable reason to assist pregnant women in the attempt to quit smoking both for their health and for the health of their fetuses. Nevertheless, without a critical understanding of the ontological and epistemological foundations of this phenomenon, we would have no way of addressing the larger social context of smoking during pregnancy. Health behaviours such as smoking should be viewed as structural, rather than as individual, problems and should be solved through making fundamental changes in society. Social problems are not resolved by imposing an additional burden of guilt on the victims of poor social policies (Rajan & Oakley, 1990).

### Summary

My study has been built on what has been discovered and reported by others, and it has added richness and depth to general claims about the effect of socio-

structural context on individual behaviour. It does this by making explicit what it is like for women who are attempting to achieve a healthy pregnancy within the context of threat. In this chapter I discussed the findings of my study in light of the literature surrounding maternal child nursing, the meaning of health, and the notion of control. I also discussed smoking as the way in which some women cope with their loss of control due to stress, which is often the product of poverty and/or violence. I conclude by critiquing the individual lifestyle approach to health behaviours. Having done this, I will now go on to Chapter 9, in which I will examine the implications of my study for nursing practice, education, policy, and research.

**CHAPTER NINE**  
**HOW POVERTY SHAPES HEALTH DURING PREGNANCY:**  
**IMPLICATIONS AND CONCLUSIONS**

The objective of this study was to contribute to an explanation and understanding of the effect of poverty and violence on the meaning of pregnant women's health and health behaviours in the context of their everyday lives. I used grounded theory methodology and have been inspired by a feminist perspective. Forty women of diverse ethnicity, age, and socio-economic status were involved in the study. These women described the act of being engaged in health-enhancing behaviours as necessary to the process of creating a healthy pregnancy. To create a healthy pregnancy, women require energy, the availability of which is determined by the conditions in which they live. A woman's capacity to engage in health-enhancing behaviours is dependent upon having an accepted pregnancy, having adequate financial resources, and being involved in supportive relationships.

The results of my research add breadth and depth to the limited body of knowledge regarding the implications of poverty and violence for the health of pregnant women. The practice of looking at health from women's perspectives brings new understandings and knowledge because it captures the importance of context with regard to women's capacity for health. It also offers a way of understanding how women create health during pregnancy and the conditions that promote the adoption of health-enhancing behaviours.

This study also contributes to the extant knowledge on women's health by incorporating the importance of material resources and how they may affect a woman's health by limiting her capacity to be in control of her everyday life. Without equitable access to financial resources, women are vulnerable and subject to many forms of oppression (e.g., discrimination in education, employment, housing, and transportation).

This study expands on the existing childbearing literature – which predominantly focuses on individual traits, values, and beliefs – and demonstrates that women cannot be fully understood apart from their socio-economic context, as the latter necessarily shapes their experience of health and their health behaviours during pregnancy. From the findings of this study, a number of significant implications can be drawn for nursing practice, education, health and social policy development, and research.

### **Implications for Nursing Practice**

At the basis of rendering effective prenatal care is the importance of understanding the experience of health during pregnancy and the conditions that either promote or decrease a woman's capacity to engage in health-enhancing behaviours. Understanding how a woman's everyday life shapes her experience of health is central to assessing health and health behaviours during pregnancy. In this discussion, I first examine the importance of a woman-centred approach as well as what reconstructing expertise concerning women's health might entail. I then go on to look at the implications for understanding and assessing the meaning of pregnancy within a context of poverty and violence. I examine the role of political activism and, finally, address the implications of my findings for First Nations women. The practice initiatives identified here draw on the themes that emerge from my study.

### **Women-Centred Approach**

Nurses and health care providers who render services to pregnant women are in a unique position to work in collaboration with women who find themselves in undesirable conditions during pregnancy. At the basis of rendering prenatal care is a woman-centred approach to understanding behaviour (Cohen, Mitchell, Olesen, Olshansky, & Taylor, 1994). This entails looking at women's behaviour within the overall context of their lives and from their perspectives. Health care for women must be holistic and must take advantage of the latest research on women's physical and



mental health. Such a feminist approach acknowledges women's needs and how they are affected by the social structure within which women find themselves (Ruzek, 1993).

Developing a practice around principles embedded in this woman-centred approach requires the development of collaborative methods of working with pregnant women – methods that emphasize their capabilities rather than their deficiencies. Understanding strength from the perspective of women in poverty can change the way nurses view their patients. Understanding the possibility that a pregnant woman experiencing poverty sees herself as strong, rather than assuming that she sees herself as weak, will influence the ways in which nurses relate to her. Women also learn and draw strength from the resolution of past conflicts. Nurses can serve as part of a woman's support network by showing unconditional acceptance and pointing out her unique strengths. Assisting women to identify their strengths may assist them to realize their emancipatory potential (Ford-Gilboe & Campbell, 1996; Lather, 1986). Nurses should help women to focus on developing their abilities rather than on the seeming hopelessness of their problems.

Spending enough time with women to establish a trusting and meaningful relationship with them is the cornerstone of rendering effective prenatal care. An atmosphere in which individuals feel comfortable, secure, and valued enough to express themselves freely facilitates equality and participation.

Having supportive relationships (e.g., partners and social networks) is essential to validating women's experience of vulnerability, as they are necessary components of a healthy pregnancy. They provide a woman with emotional, financial, task-oriented, and knowledge-oriented support. Certain ways of fostering support for women includes putting them in contact with various support networks, providing prenatal care in a group context, providing family centres, providing parent and

toddler groups, and providing various kinds of women's groups. All of these can bring women together and function as a part of prenatal care.

### Reconstructing Expertise

Traditionally, health care professionals have assumed expertise with regard to pregnancy without acknowledging women's innate body knowledge (Browner & Press, 1996). Furthermore, the use of the traditional at-risk models and the medicalization of women's health serves to further increase women's sense of vulnerability (Duden, 1993; Oakley, 1993b; Turner, 1995). My findings suggest that pregnant women use body knowledge to direct their own health-enhancing behaviours. Thus, women's expertise with regard to their own bodies needs to be valued. Adopting the view that women have innate body knowledge would foster a relationship between women and health care professionals that is based on mutual respect. It would also contribute to helping women develop their sense of confidence.

Another important source of knowledge comes from the experiences of other childbearing women. The women in this study valued information from other pregnant women because they could relate to it in a concrete way. Therefore, it is important that, during prenatal classes, women be given the opportunity to exchange stories while they seek to validate their experiences. Being able to connect with other women is an important part of a woman's reassuring herself of her ability to bear and deliver a new baby. It is essential that women who have experienced conditions similar to those of the women enrolled in the classes give these prenatal programs. One advantage of prenatal care and programs offered by lay women is that the language adopted is user-friendly. Peer counselling may be important to low-income women (Lapierre, Perreault, & Goulet, 1995). Prenatal classes must be organized and conducted in partnership with women themselves; ideally, the nurse would be a facilitator rather than a leader or teacher.

### Understanding and Assessing the Meaning of Pregnancy

At the heart of promoting health-enhancing behaviours is a wanted and accepted pregnancy, for this serves to motivate women to engage in health-enhancing behaviours. As an accepted pregnancy is the main motivator for engaging in the process of creating a healthy pregnancy, it is imperative to assess how a woman thinks/feels about her pregnancy. During prenatal visits attention must be paid to whether or not a woman wants her pregnancy as well as to her level of social and financial support. Nurses need to be fully aware of a range of available services, and they need to help women become aware to their options and to be supportive of whatever decision they make regarding whether or not to terminate their pregnancies. Also, nurses may be of help to women by helping them work through their ambivalence and offering them a woman-centred approach to care.

Women in poverty have more unplanned pregnancies than do their middle-class counterparts (Balakrishnan, Lapierre-Adamazyk, & Krotki, 1993). In this study, unplanned pregnancy was attributed to lack of knowledge regarding the interaction of antibiotics and oral contraceptives and being told that missing one oral contraceptive pill would not result in pregnancy. Such instrumental initiatives as labelling oral contraceptive packages with information regarding the potential for pregnancy may assist in reducing misinformation.

### Understanding and Assessing Poverty

First, any strategy that aims to improve pregnant women's health and their capacity to meet their own needs must be centrally concerned with poverty. Women's poverty must be a central item on the agenda of all health care providers. It is time to shift our focus to incorporate a broader social view of health and to take both individual and collective responsibility for the health and well-being of women. It is time to take seriously the concept of "social determinants of health," which signals a progressive, contemporary approach to health – one concerned with going beyond

women's habits and their genetic endowment to look at how their daily lives affect their capacity to make healthy choices.

Individual health workers and agencies need to increase their awareness of poverty. Health care providers need to evaluate the extent to which practice is influenced by attitudes towards poverty – attitudes that often distort the focus of their work. This may be difficult and may require the encouragement and support of colleagues. We need to ask whether our strategies and methods reflect an awareness of both the structural nature of poverty and its impact on women's health. We must ask such questions as: "What conditions or resources must women have in order to behave in a recommended fashion?" (Parrott, 1996) "What individual, environmental, and community-based supports are required to enhance women's capacities for creating healthy pregnancies?"

Our practice needs to recognize that financial, health, and social problems are inseparable and that they stem from the same set of social and economic factors. Often institutions tend to respond to women's poverty in a fragmented manner. The value of inter-agency work is that it avoids fragmentation and moves our practice away from trying to find individual solutions to tackling problems that are rooted in social and economic conditions.

For example, understanding poverty as a power issue, as suggested by Mason (1981), would mean that nurses and health care providers would have to understand that illnesses are correlated with poverty because of structural as well as personal issues. This approach calls into question the liberal ideology of individual freedom, which often results in "blaming the victim," and forces us to examine how individual behaviour is affected by the larger social environment. Behaviour is undoubtedly important to health, but the crucial question is how it relates to other aspects of women's lives. Women often feel frustrated by behaviouristic approaches to health care, as they do not take into consideration the entire context of their lives. In order to

provide adequate health care to pregnant women, one must take into consideration the conditions within which their everyday lives are lived.

As women in this study have confirmed, financial resources are among the most important determinants of a pregnant woman's health. Therefore, women must be asked such questions as: Is money an issue for you? What is your main source of income and/or employment? Is making ends meet a problem?

It is important to recognize that many women with low incomes may have limited time and energy because of their lack of resources. Therefore, health services must facilitate access to care. To make women of childbearing age welcome it is essential that all services rendered to all pregnant women be child friendly (e.g., offer child care and play areas). Transportation should be an essential component of all prenatal care services. It is also important to be able to provide alternatives to office visits.

#### Understanding and Assessing Violence

Violence dramatically threatens women's health and the health of their fetuses (Bullock & McFarlane, 1989; Dye, Tolliver, Lee, & Kenney, 1995; Parker, McFarlane, Soeken, 1994; Ratner, 1998). According to McFarlane (1993), one in six pregnant women is abused during pregnancy. As suggested by others (McFarlane, Parker, Soeken, Silva & Reel, 1998), educating women regarding safety helps to reduce violent episodes. The emergency room or the prenatal clinic may provide an entry point for such teaching. It is important to follow up on missed health care appointments, as these may be the result of abuse, substance use, and/or low-self-esteem (Dietz, Gazmararian, Goodwin, Bruce, Johnson, & Rochat, 1997; Gielen, O'Campo, Faden, Kass, & Xue, 1994; Greenberg, McFarlane, & Watson, 1997; Ratner, 1995; Taggart & Mattson, 1996).

Routine screening for exposure to violence is essential for all pregnant women (Helton, McFarlane, & Anderson, 1987a; Parker & McFarlane, 1991b; Stewart &

Cecutti, 1993). Prenatal care should include a routine screening about domestic violence (Helton, McFarlane, & Anderson, 1987b). In assessing a battered woman, the nurse must also examine her own feelings about violence. She must be committed to the idea that violence is a public health concern, not a private one, and that it falls within the scope of nursing interventions. Questions addressing abuse can be addressed when the health care worker is asking a woman about her prenatal assessment of stress, her support networks, or her relationship with her partner. The questions may be: "How does your partner feel about the pregnancy? Is he supportive? Do you argue frequently? Does he ever hit you or hurt you? Are you afraid of him?" Women should be appropriately counselled, informed of resources such as shelters, and offered emotional support. Those institutions whose philosophy and intent is to assist battered women are the most consistently helpful resources. Shelters and affiliated agencies provide safe housing, food, clothing, transportation, legal advocacy, support counselling, and education for women. A safe, supportive environment and assistance in dealing with social agencies and abuse issues allow women to break the cycle of violence.

When working with women who are abused, nurses can help them imagine alternatives to their situation by introducing them to another reality – by showing them that there are viable alternatives. This leads me to a discussion of political activism.

#### Political Activism

Nurses diagnose and treat people who are victims of an unequal social structure and the economic and political policies that govern it (Chopoorian, 1986). As a predominately female profession, nursing has many of the same issues and concerns as do women and their families. As advocates for women and children, the profession plays a vital role in the advancement of women and of women's health care policies. As nurses and consumer advocates for women, we must take advantage of our large

numbers, our credibility, and our political position to promote an awareness of the consequences of poverty.

The need for nurses to become politically active is not new. Many nurses recognize that advocating for improved educational, occupational, health, and housing opportunities for women in poverty may be the most important thing they can do. Political activism is critical at a time when diminished resources mean fewer resources for women in poverty. For the most part, however, nurses do not see themselves as agents of political change. They must prepare for this role at the undergraduate, master's, and doctoral levels, and throughout this process they need to be supported by professional nursing organizations.

Another important issue is that women must have the freedom to choose the type of health care provider that best meets their needs. Having health care providers who share similar views regarding holistic health (such as nurses/midwives) would benefit women and contribute to establishing trusting relationships. The establishment of midwifery services for all provinces (they already exist in Ontario and British Columbia) would allow women more freedom in their choice of health care provider, and nurses should advocate this. Certified nurse-midwives and other nurses have shown that they can positively affect pregnancy outcomes (Piechnik & Corbett, 1985; Slager-Earnest, Hoffman, & Beckmann, 1987; Smoke & Grace, 1988; Wagner, 1998).

Nurses can provide many primary-care services just as well as their medical counterparts, and they can do so at less cost. In doing this they would also increase the number of primary care providers available for prenatal care. Nurses are not only competent to perform physical assessments, but also to offer psychosocial support, counselling, and education (Cohen et al., 1994). With these skills, nurses are able to provide high-quality care effectively to at-risk populations.

### First Nations Considerations

First Nations peoples have the highest rates of poverty in Canada (Frideres, 1998). They are more vulnerable than both non-Aboriginal women and Aboriginal men when it comes to levels of income and employment opportunities (Fleras & Elliott, 1992; Frideres, 1998; Statistics Canada, 1995). The problems stemming from poverty as a result of colonization and racism have led to high rates of alcoholism, violence, and illicit drug use within First Nations communities across Canada (Drost, Crowley & Schwindt, 1995). According to Henry, Tator, Mattis, and Rees (1995) "aboriginal women are the most victimized group in Canadian society" (p. 63). From birth, Aboriginal women have had to confront gender, race, and class discrimination. This places First Nations pregnant women at increased risk of experiencing poverty as well as violence and alcoholism and, consequently, of not having the capacity to create a healthy pregnancy.

First it is imperative to make First Nations women central to nursing practice and the process of empowerment, as reported elsewhere (Brunt, Lindsey, & Hopkinson, 1997; Labonté, 1994). To reestablish their cultural identity, many First Nations women feel the need to know their own history. Educational tools such as the talking circle and the Medicine Wheel may promote Aboriginal ways of knowing. First Nations women in this study often spoke of their spirituality and of the importance of being close to nature. During the prenatal period, therefore, it is essential that providers of health care services to First Nations women incorporate the teachings of the elders into their services.

To reduce the challenges First Nations women may face during their pregnancies, it is important to implement policies directed towards reducing the accessibility of alcohol and cigarettes on the reserve. Prohibiting their sale to minors and prohibiting home delivery services are examples of strategies that could assist in reducing the magnitude of the substance-abuse problem. More treatment centres are



needed for those with substance-abuse problems. As it is early childhood education that promotes cultural identity, services for young families would also make an important contribution.

Another important issue that is seldom raised in the health care literature is the increased incidence of high birth weights within Aboriginal communities (Pettitt, Nelson, Saad, Bennett, & Knowler, 1993; Steinhart, Sugarman, & Connell, 1997). This is especially important, as First Nations have a high incidence of cigarette smoking (Health Canada, 1994c). Traditional information regarding the use of tobacco and its adverse effect on birth weight does not take into consideration the high birth weight in some First Nations communities. Clearly, there needs to be further research into the effect of cigarette smoking on women with gestational diabetes and on the high incidence of macrosomic infants among First Nations women. Also, it would be important to further understanding women's decision-making processes regarding smoking and previous high birth weight infants.

### **Implications for Nursing Education**

In this section I first address the ideological implications of including poverty in nursing curricula. I then examine how the mass media deal with issue of poverty.

#### **Ideology**

The promotion of women's health requires an understanding of the links between women's living conditions/social circumstances and their health status and health-enhancing behaviours. It is essential to take into account the social, economic, and racial determinants of health and disease.

It is important to determine whether or not women are substance abusers, regardless of assumptions about ethnicity or social class (Gruslin, Selby, Davies, Leyland & Franche, 1998). According to Selleck and Redding (1998), nursing curricula often do not adequately address this issue, and nurses tend to have negative attitudes

towards pregnant women who abuse substances. It is essential that the implications of violence and substance abuse form part of nursing curricula.

As part of their professional growth, it is essential that nursing students come to understand their own biases and that they consider the effect these biases have on their practice. With the implementation of an anti-oppressive pedagogy, several things can be done to unveil current mainstream stereotypes (Roman, 1993). A first step towards deconstructing stereotypes is to discuss with students their views of poor women. Readings that reflect more balanced perspectives of women in poverty and First Nations women expose students to the idea that these women have strength (Bartol & Richardson, 1998; Joseph, 1992). The literature used for teaching purposes should be critically examined for gender, class, and ethnocentric bias (DeMarco, Campell, & Wuest, 1993). For example, it is important to examine the names and labels used to define women in poverty (Miller & Dzurec, 1993). Our use of language determines how we view social organization, social meanings, power, and individual consciousness (Weedon, 1987). Language shapes our view of reality and reflects our underlining priorities.

It is essential that all nurses working with childbearing women examine the historical underpinnings of "motherhood" and "familism" (i.e., the nuclear family). The ideology of familism operates as a principle of social organization at both the domestic and public levels (Dalley, 1988; Hooyman & Gonyea, 1995). One must understand how the traditional image of the "poor mother" has developed and why the ideology of motherhood (which is tied to the notion of the nuclear family) has a different connotation for working-class women than it does for middle-class women (Polakow, 1993). North Americans tend to look negatively upon any family form that is not white, middle class, and heterosexual, and the nuclear family continues to be the stereotypical "ideal" family form. Dalley (1988) points out that the nuclear family is the form against which all other forms of human relationship are measured and judged;

non-nuclear family forms are deemed to be deviant. Baber and Allen (1992) suggest deconstructing the notion of the family by challenging concepts and constructions of reality that are accepted as natural and unchangeable, and by calling into question existing social arrangements.

### Mass Media

Our popular conceptions of poor pregnant women shape our political realities. In our society, women in poverty are often portrayed as inadequate mothers (Gordon, 1991; Swift, 1991). This ideology is transmitted into our unconscious by various media, and it perpetuates the image of the poor woman who cannot provide adequate care to her children. Meanwhile, the daily insults of poverty and abuse experienced by poor women receive little attention from the media (Bolton, 1997). Furthermore, media images do not reflect the strengths of women who experience poverty.

As nurses, we need to work to ensure views of poor women that go against negative stereotypes and that portray women's strengths and insights. Furthermore, it is essential that the mass media insist upon zero tolerance for poverty and violence against women. After all, zero tolerance campaigns have proven useful with regard to drinking and driving as well as smoking.

The best opportunity for nurses to develop a critical analysis of such social forces as the mass media will be in the context of their basic nursing education. Creative learning activities that direct students towards analyzing and integrating such messages, and envisioning processes by which ideological change could occur, should be included in all nursing educational curricula.

### **Implications for Policy**

My study findings also have important implications for policy. In this section, I first address the implications for health and social policy and then go on to look at the implications for economic policy.

## Health and Social Policy

To improve women's health prospects, it is unnecessary to create vast and costly new health programs. Internationally, one of the most important factors in determining the health status of poor women and, in turn, the outcomes of their pregnancies and the rate of infant mortality, is social policy (Enkin, Keirse, Renfrew, & Neilson, 1995; Wennemo, 1993). For example, Sweden, whose social policies promote equality for women and a high standard of living, has one of the lowest rates of infant mortality and morbidity in the world (Ohlsson & Fohlin, 1983; Sidel, 1992).

Critical to the debate around LBW is an artificial division between medical and socio-environmental models of health. Those who view the health of pregnant women from the perspective of the medical model may find it difficult to recognize the influence of social factors, and vice versa. Policy interventions that bridge the two models by making social changes and evaluating their effect on clinical outcomes enhance the possibility of a positive future for the health of pregnant women. Past policies and programs may have failed because they did not recognize that what had been perceived as "individual" problems cannot be separated from the social and economic systems within which they occur. It is essential that policy-makers reorient health care strategies to meet women's needs and to serve more women. One way of doing this is to directly involve women in the policy process.

The National Forum on Health (1997) found that existing health services do not always meet the needs of women, and it recommended greater support for women's involvement in decision-making as well as revisions to gate-keeping roles with regard to health and health policy. Because women's health often directly reflects their social status, no health strategy can be successful in the long term unless women become equal partners in creating social policy.

## Economic Policy

In Canada, economic policy leaves many women vulnerable to financial stress (Baines, Evans & Neysmith, 1991). Women's accounts and the work of other investigators suggest that an important strategy to reducing LBW may be to advocate for laws that protect women from financial stress (Health Canada, 1994a). In Canada, the welfare system itself has been criticized as a major cause of women's poverty, as it does not allow recipients to earn any significant amount over and above assistance benefits, and its eligibility requirements stipulate that recipients cannot have any savings or assets (Canadian Advisory Council on the Status of Women, 1991). This system is based on an absolute measure of poverty (i.e., meeting basic physiological needs) and does not consider the additional expenses brought on by pregnancy. The women hit hardest by the welfare system are single Aboriginal women – usually young women who have no special education or training, who receive little family support, and who do not receive child support from fathers.

Many women in poverty are recipients of welfare, and others often have low-paying jobs that lack benefits. Employment training and education opportunities are needed to break the cycle of poverty and abuse and to build self-esteem and self-sufficiency. Women need decent housing in safe locations and high-quality, affordable childcare if they are to become healthy mothers. Job training and employment assistance will be of limited effectiveness unless women also have adequate housing, transportation, and childcare. In addition, mandatory child support from the father would be a key to preventing women from falling into poverty (Gouvernement du Quebec, 1997; Kitchen, Mitchell, Clutterbuck & Novick, 1991).

### **Implications for Research**

In the last section of this chapter, I examine the implications of this research for further nursing investigation. First, I look at the implications for critical interpretive and

collaborative approaches to women's health, and then I offer suggestions for future research.

### Critical Interpretive Approaches

Moccia and Mason (1986) state that nurses should be committed to challenging social policies that continue to "influence the reproduction and perpetuation of poverty and the negative attitudes and prejudice toward the poor" (p. 21). They believe that research will play an important role in this regard. Further research from a feminist perspective will help to break down the myths and stereotypes about women who live in poverty and their experiences during pregnancy. If the issue of women and health behaviours is to be framed within a new ethic, then women and researchers need to work together to challenge images and practices that distort women's lives. Research conducted by nurses with women who live in poverty could serve to change consciousness, ensure the provision of appropriate health-related services, and change entrenched practices. Incorporating feminism into nursing research is an integral part of the struggle to liberate women in particular and people in general from environmental oppression (Fonow & Cook, 1991; Reinhartz, 1992). Within a feminist framework, nursing knowledge is elicited and analyzed in such a way that it can be used to alter oppressive and exploitative conditions (Parker & McFarlane, 1991a). Critical inquiry is used to help people see themselves and social situations in a new way and, thus, to insist upon being emancipated from oppressive social systems and relationships.

Nurse researchers and caregivers must join in creating theories that rest on different assumptions than do those deriving from the current relatively privileged worldview. This can be accomplished by giving credence to critical and interpretive methodological approaches that allow researchers to go beyond merely "describing" what women experience and place women's experiences within their social, economic, and political context (Thorne, Kirkham, & MacDonald-Emes, 1997). When

designing studies, issues such as economic status and ethnicity have to be seriously considered so as to avoid developing theories of pregnancy that rely solely on middle-class, ethnic majority worldviews. It is evident that social influences on health must become a major focus for health research. Important social influences on health, including poverty, violence, and racism to name but a few, have been frequently ignored.

Nurses need to examine their approach to research and to question prevailing views on individual responsibility. The philosophical underpinnings of the individual-centred approach to health care implies that health and illness are a matter of individual responsibility and behaviour (Caraher, 1994). In other words, the roots of illness and health are viewed as being within the control of the individual and are not related to her/his social context. The liberal interpretation of individual responsibility and freedom results in poor pregnant women being blamed for their health behaviour "choices" and for taking self-imposed risks. It is time to shift our focus to incorporate a broader social view of health and of individual and collective responsibility for the health and well-being of women. It is time to take seriously the concept of "social determinants of health," which signals a progressive, contemporary approach to health, one concerned with acquiring knowledge beyond women's habits and their genetic endowment.

### Collaborative Strategies

To address such a complex area as poverty, it may be essential to work within multidisciplinary research teams. A multidisciplinary team that is sensitive to issues of gender, race, class, and sexual orientation should coordinate this research (Dan, 1994; Heldring, 1998; Reutter, Neufeld, & Harrison, 1995). Special considerations for conducting research with First Nations may include such requirements as researcher sensitivity to, respect for, acceptance of, and partnership with research subjects (Cook

& De Mange, 1995; Tookenay, 1996). They should also include using First Nations women as researchers.

According to Macintyre (1994), the processes producing social variations in health can be viewed as a continuum. There are the macro-political and economic characteristics of a society; the cultural economic and social features of regions and communities as well as social circumstances, family dynamics, work, and domestic conditions; individual psychological traits and processes such as self-esteem and personal coping mechanisms; and the cellular and molecular level of human experience. The overall level of health in a population and the social distribution of health are both products of interactions between all elements of this continuum, from the most social to the most biological. The job of unravelling and addressing the causal processes that produce social variations in health will be best served by a range of disciplines working together. A collaborative approach to health research would be ideal, with policy-makers and women intimately involved in working with researchers to frame the questions to be answered. Policy-makers may have limited expertise regarding the practical impact of their policies on public health. Reciprocally, health care providers may have limited expertise regarding the formation of public policies in other sectors. Are there strategies that can contribute to a closer integration of health, social, economic, and environmental agendas?

Research methods that elicit women's experiences within their overall social context are essential to developing adequate policies and programs for women in poverty. Also, such methodologies as participatory action research would further strengthen the voices of women (Maguire, 1987). The goal of participatory research is not merely to describe and to interpret social reality, but to change it. Its intent is to transform reality and so to emancipate the oppressed. It holds up self-determination, emancipation, and personal transformation as its most treasured goals.



### Testing the Theory

This study proposes an alternative theory of pregnant women's health. I contend that women's capacity to engage in health-enhancing behaviours is dependent upon having an accepted pregnancy, adequate financial resources, and supportive relationships. As with all new theories, additional investigation will be needed to refine and test this theory. We need to conduct more research into the role of environmental factors in fostering women's capacity to create a healthy pregnancy. Further studies could elaborate on how creating a healthy pregnancy is influenced by such policies as maternity leave. This data could be used to lobby for policies that are sensitive to the demands of pregnancy. Knowing the working conditions associated with poverty and how these influence a woman's health, and learning more about the health-enhancing behaviours and strategies of women with children who work inside/outside the home, will help us conduct further studies of various types of health care providers and their influence on women's capacity for health. It is necessary to provide more sources of support at the institutional level in an attempt to render quality and cost-effective care.

Unlike most studies, mine deals with considerable ethnic and socioeconomic diversity. It is truly remarkable how little of the research to date does this. And without a commitment to gathering information in this area, the likelihood for improvement is limited. Future research should address women of various ethnic backgrounds living in various circumstances (e.g., lone-female headed families, lesbian women, teen women, multiparous women, rural/urban women, etc.) and compare their capacities for health. It would be beneficial to further investigate hard-to-reach women and those women who do not accept their pregnancies. As accepting one's pregnancy is a key motivator with regard to women engaging in health-enhancing behaviours, to further understand the process of accepting an unplanned pregnancy could be of great benefit to women.

There is a limited amount of research on the notion of body knowledge. More research in this area is required, as it is crucial to understand how women use their body knowledge in making health-related decisions.

We also need to further investigate how the notions of balance and energy relate to a woman's capacity to engage in health-enhancing behaviours. We need to test the notion of capacity as it applies to middle-aged, teenaged, and homeless women and compare what we learn with what we know about how it relates to pregnant women's health. And we have to further understand how different sources of stress affect a woman's level of energy and ability to engage in health-enhancing behaviours. And what specific resources and skills are required to enable women to cope with the health effects of poverty?

Finally, it is evident that social influences on health must become a major focus of health research. These include violence, sexual assault, harassment, discrimination, racism, and sexism, to name but a few. Such issues have been completely excluded from the major health surveys conducted to date. The result of this exclusion is a distorted, limited, and inaccurate portrayal of pregnant women's health.

### **Conclusion**

The health of pregnant women who are at risk of poor obstetrical outcomes is a significant concern in Canada and throughout the world. For pregnant women, the implications of poverty are significant, and their health status directly affects that of future generations. It is well established that low-income women continue to experience higher neonatal mortality rates than do middle- and high-income women, due largely to LBW.

The findings of this study indicate that women's main concern during pregnancy is having a healthy newborn. To this end, women engage in the process of creating a healthy pregnancy by actively engaging in various health-enhancing behaviours to care for themselves and their fetuses. Having energy is essential to this

process, and it stems from having the body, mind, and spirit in balance. This, in turn, stems from the circumstances of women's lives. The balance women have stems from their capacity to be in control of their lives. A woman's capacity to create health during pregnancy depends upon the circumstances within which she finds herself. In this study, circumstances that most influence her capacity to create a healthy pregnancy are: (1) an accepted pregnancy, (2) adequate financial resources, and, (3) supportive relationships (especially with her partner/husband).

During pregnancy a woman experiences a state of vulnerability due to fear of the unknown, and the circumstances surrounding her will either increase or decrease her sense of vulnerability. The women in this study experienced three levels of vulnerability: (1) the vulnerability inherent within pregnancy itself, (2) the heightened vulnerability induced by a medical condition, and (3) the extreme vulnerability induced by threat, which occurs in such contexts as poverty, violence, and/or unplanned pregnancy. These three states of vulnerability all affected women's capacity to create healthy pregnancies – the first and second positively; the third negatively. The state of vulnerability inherent within pregnancy may safeguard women's health because it increases their vigilance and their access to body knowledge. Women who experience a heightened state of vulnerability as a result of having a medical or social condition may further increase their state of vigilance and so potentially further improve their health, enacting more protective behaviours. Contrary to the first two states of vulnerability, women who experienced the state of threat, (i.e., the sense of losing control of their lives), often fell back on old and unhealthy behaviours, such as smoking, not eating properly, and consuming alcohol, in order to cope with their high levels of stress.

My study emphasizes the central importance of considering the social context of women's lives and its influence on their capacity to create healthy pregnancies. It clearly shows the relationship between poverty and violence and suggests an

association between these special threats and a range of preventable outcomes. It can be said that the worth of a society is evident in the respect it affords its women and children. Any attempts to address women's health must address the issue of poverty. If we are truly committed to ensuring the health of future generations, then women's poverty needs to be a central item on the agenda of health care providers and policy-makers. All strategies that aim to improve pregnant women's health and, indeed, the health of the entire population, should have poverty as their central concern. For until we have eradicated poverty, and the cycle of violence and degradation that is its legacy, we will not have succeeded in doing all we can to ensure the health and well-being of our citizens.

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**APPENDIX A**

**INTRODUCTORY LETTER**

**INTERVIEW PARTICIPANTS NEEDED FOR  
STUDY ON THE MEANING OF HEALTH DURING PREGNANCY**

As part of a study on the meaning of health during pregnancy, Joanne Roussy, (Ph. D. student, UBC School of Nursing) is searching for volunteers who would be willing to be interviewed. Pregnant women and newly delivered women who are willing to be interviewed are invited to participate in the study. The purpose of the interview is to find out more about what it means to be healthy during pregnancy.

Each interview will be tape recorded and should last for approximately 45 minutes to 1, 1/2 hours. Interviews will be scheduled at a time and place that is convenient for you. Neither your name nor any other identifying information will be recorded and the information will not be shared with anyone except my advisors at UBC. You may withdraw from the study at any time, or request to have the tape recorder turned off for parts of the interview, or have portions of your interview erased if you wish. In no way will your refusal to participate in this study affect your medical care.

If you think you would like to participate in this study, and would like more information, please call Joanne Roussy at the number listed below. This will in no way obligate you to participate in the study. If you would like to speak to my faculty advisor, please call Dr. Katharyn May (604) XXX-XXXX (charge call to XXX-XXXX).

An honorarium of \$25 will be given to you for your time for the interview, which will take about an hour. A second interview may be requested in order to clarify and check issues you raise.

Thank you,

Joanne Roussy, RN Ph. D. student  
1 Athol St.  
Campbellton, NB  
E3N 1Y2  
XXX-XXXX

Katharyn May, DNSc, RN, FAAN  
Faculty advisor  
(604) XXX-XXXX





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**APPEL POUR DES PARTICIPANTES  
UNE ÉTUDE SUR L'EXPÉRIENCE DE LA SANTÉ  
PENDANT LA GROSSESSE**

Dans le cadre l'expérience de la santé pendant la grossesse, Joanne Roussy (étudiante au doctorat, University of British Columbia, école de Nursing) est à la recherche de volontaires. Les femmes enceintes ou celles qui viennent d'accoucher qui veulent se prêter à ces entrevues sont invités à participer à cette étude. Le but des entrevues est de mieux cerner ce que signifie être en santé pendant la grossesse.

Chaque entrevues sera enregistrée et sera d'une durée de 45 minutes à 1 heure et demie. Les entrevues auront lieu dans un endroit et à une heure qui vous conviendront. Votre nom ou tout autre renseignement qui pourrait vous identifier ne seront pas enregistrés. Ces renseignements ne seront dévoilés qu'à mon directeur de thèse à UBC. Vous pouvez vous retirer de l'étude à tout moment ou demander d'arrêter l'enregistrement pour certaines parties de l'entrevue, voir même en faire effacer certaines parties si vous le souhaitez. Votre refus de participer à cette étude n'affectera en rien vos soins de santé.

Des honoraires de 25\$ vous seriont versés pour une appréciation de votre temps. Une seconde entrevue pourrait vous être demandée afin de clarifier ou de vérifier les données que vous avez soulevées.

Si vous pensez que ce projet pourrait vous intéresser et que vous désirez plus de renseignements, vous pourrez me rejoindre au numéro ci-dessous. Ce premier contact ne vous engage à rien. Si vous voulez parler à ma directrice de thèse d'études, veuillez appeler Dr. Katharyn May (604) XXX-XXXX (facturer l'appel au 506 XXX-XXXX).  
Merci, Joanne Roussy XXX-XXXX

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Mrs. R. XXXX  
Vice-president, Patient care  
Restigouche Health Services Corporation  
Campbellton Regional Hospital  
189 Lily Lake, C. P. 880  
Campbellton, NB  
E3N 3H3

RE: Ethics approval

Dear Mrs. XXXX,

Following our telephone conversation last December, regarding my doctoral research, I am writing to you in order to seek ethical approval to interview pregnant women, or women who have recently delivered, at the Campbellton Regional Hospital. I am a doctoral student in Nursing at The University of British Columbia conducting a qualitative grounded theory study on the meaning of health during pregnancy. Your collaboration would consist of having health care providers distribute a letter of introduction (see enclosed letter) to pregnant or newly delivered women. I would offer information sessions to the health care providers involved in the care of this clientele, as to explain the purpose of the study as well to answer any questions they may have. I have also enclosed The University of British Columbia Behavioural Sciences Screening Committee for Research and Other Studies Involving Human Subjects form, to inform you of the specifics of this research.

If you have any further questions, please do not hesitate to contact me and/or my chair, Dr. Katharyn May.

Thank you very much for your collaboration in this process.

Sincerely,

Joanne Roussy, RN, Ph. D. student  
1 Athol St.  
Campbellton, NB  
E3N 1Y2  
XXX-XXXX

Dr. Katharyn May, DNSc, RN, FAAN  
Professor & Director  
T206-2211 Wesbrook Mall  
Vancouver, BC  
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(604) XXX-XXXX

## **APPENDIX B**

### **Women's Profile**

#### **April**

April says that she is the black sheep of her family. She is the first of three girls. Her mother, Debbie, says that April was always with the wrong crowd and was placed under foster care twice as a young teenager. April is in high school and has repeated grade 12. She dates a young Mi'gmaq boy who is known to be violent. April's mother does not accept him in her house. April has already been involved in two motor vehicle accidents while in the company of this boy. Her mother and father separated while she was in Grade 12, and she has not heard from her father since. After April's father left she began to have parties when her mother worked at night, thus disrupting the sleep of her two younger sisters. As a result of this, Debbie asked April to leave. April moved in with her aunt. Debbie said that she should have left her husband sooner, as he repeatedly told April that she would end up pregnant and living on the reserve with the Indians. She also said that he called her stupid all the time.

April's mother was pregnant at 19 and got married. She was married for 19 years. Debbie's father left her when she was very young. Debbie is from a large family and her mother was an alcoholic. She was raised in very impoverished conditions and shared a small bedroom with nine brothers and sisters. Debbie stayed at home to raise all of her children. She trained as a nurse when she was 31 and her youngest daughter was four.

April drinks and parties a lot. When she found out she was pregnant she continued to drink a bit, but she stopped following an ultrasound. April has considered an abortion, but then she went to the ER for bleeding and had an ultrasound. She said she was unable to go through with an abortion after seeing the fetus.

April is hoping that her boyfriend will change as a result of her pregnancy. He has had several other girlfriends while dating her. Debbie cannot understand why April stays with him despite the abuse.

Throughout her pregnancy April attended high school and received her diploma. Her mother came to accept her pregnancy, and April received much financial and emotional support from her aunt. Her mother and two aunts attended the birth of her daughter.

April found an apartment not far from her mother's house. She is on social assistance, and her boyfriend continues to drink and party. However, April says that since she decided to keep the baby she stopped smoking and drinking. She says that she would like to attend college and become a travel agent. She started to worry about her drinking when she started to enjoy drinking alone.

### **Jane and Amy**

These are two sisters from a family of five, and their father died when they were young girls. They both currently live with their mother in a very small home, which their mother owns. Amy, the youngest sister, was told by her doctor that she was infertile. She had been married but left her husband. She said that she could not live with him after he went to war, for he had become a stranger. Amy was dating Jo and had just left him, as they always fought after she found out she was pregnant. She was living in a small apartment and had just lost her job. Jo was also unemployed. She went back to him and lived with his parents because she wanted a father for her son. During the course of her pregnancy she was very nauseated and had to take sick leave. She also had an antepartum hemorrhage.

Amy's sister Junaita offered to let her come and live with her, whereupon Amy left Jo and moved in.

Jane was a sales manager at Sears, and her husband was a janitor at the time of her first pregnancy. She found out she was pregnant at the same time as her husband lost his job. Jane wanted a second child but waited for her mother's approval, as there was just not enough room in their small house. Amy slept with her mother in a single bed the size of a closet. The two children slept in a very small room, while Jane and her husband shared their room with their new son. They could just barely fit the crib in the room.

Jane was terribly worried due to the economic hardship with which she lived. All conversations revolved around the issue of not having enough money to do this or that. Her lack of money affected every aspect of her life, especially her sense of freedom. She also talked about the possibility of her sister moving out and getting her own place so that they could have more room. She finds not having enough room very stressful. Jane says that she tried to do her best to be healthy during her pregnancies, despite all of the other issues she was faced with.

Marie, their mother, smoked for the duration of her pregnancy, at times making Jane feel sick. Jane does not feel that she can ask her mother to stop, as she is living under her roof. Jane stopped smoking as soon as she found out she was pregnant. She got exercise by walking and tried to eat healthier foods. She says her husband helps her a lot, as he makes her meals, rubs her feet, listens to her, and is always there for her. She had a healthy pregnancy and delivered a healthy baby girl.

For her second pregnancy Amy had to go to a new doctor, as her old one had moved away. She says that it just wasn't the same: he didn't take much to during visits and never once examined her or asked her how she was feeling. On a visit during her fifth month he told her that he could not read the result of her alpha protein test and that she'd have to go to Halifax for an amniocentesis. At this point she changed doctors, as she did not want to go for a test that would jeopardize the health of her fetus.

Jane states that she was so worried that she experienced contractions and was unable to sleep for one week. Jane did not work full-time for the duration of her pregnancy. She took care of her daughter and worked on a casual basis as a bank teller. She continuously spoke about not knowing how she would make ends meet once her son was born. She had help from her cousin, who had a shower for her and bought her all of her diapers. Jane stated working full-time at six months post-partum. Her husband quit his job, as he was experiencing verbal and physical abuse at work. It created a lot of home stress, and when he hit his daughter as a result of this, he decided to quit. He found another temporary job.

### **Lita**

Lita is a 26 year-old Mi'gmaq woman. She attended college, speaks French, and is employed as a seasonal worker at a cultural centre. I first met Lita when she was three months pregnant and experiencing severe nausea. She broke down in tears when I asked her how she was feeling. She talked about having an abusive boyfriend and said that she was considering leaving as she did not want to expose her child to his abuse. She had not planned to get pregnant. Her pregnancy was a result of her not being informed about the effects of combining an oral contraceptive with antibiotics. She expressed a lot of anger about this. She was experiencing nausea and vomiting, and she expressed a lot of ambivalence about her pregnancy.

Over the course of the interviews Lita came to accept her pregnancy and to care for herself. She left her boyfriend at the end of the first trimester. An important part of Lita's acceptance of her pregnancy involved hearing the fetal heartbeat. This established a real connection for her. She made sacrifices, such as not going to smoky places (e.g., bingo halls) and cut down on her coffee consumption and cola intake. She stopped going out to night clubs so as to avoid crowds and the danger of being poked in the abdomen.

Lita stated that she would like to live on the reserve (she was renting an apartment off-reserve during the course of her pregnancy). However, she would spend

her days at her mother's or sister's house on the reserve and would only use her apartment as a place to sleep. Just before her delivery, a new apartment became available. Lita moved in and, a couple of months later, her sister and her son moved in with her. She enjoys having her sister around.

Lita taught me much about First Nations beliefs, especially those concerning nature. Being outdoors and being free were closely connected to her spiritual being. She loved picking fiddleheads. She spoke of her childhood and of how her father used to fish the Restigouche River. She also spoke of what it's like to grow up in a small community where everybody knows you. Lita spoke of the importance of the pow wow to her community – of how it allowed her people to relearn their spiritual practices and to recover their sense of pride. She also had an amazing sense of humour.

Lita keeps a picture of her son's father on his dresser, and she keeps in touch with his sister and parents.

Lita phoned me when she had her son. I went to visit her and found a confident mother and a beautiful boy asleep in his crib. His bedroom was beautifully decorated, and there was a dream catcher on the wall. Lita became a friend and invited me to her son's first birthday.

**APPENDIX C**  
**PARTICIPANT PROFILE**

**Pseudo name:**

**date of interview:**

**age:**

**Para: Gravida: Abortion:**

**previously BF:**

**Gestational age:            planned pregnancy:            contraception:**

**Medical condition:**

**previous C-section:**

**civil status:    married:    common law:    divorced:    widow:**

**nationality:**

**smoker:            alcohol:            substance use:**

**violence:**

**income:**

**employment:                            years of education:**





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**APPENDIX D:  
CONSENT FORM**

**A GROUNDED THEORY STUDY ON THE MEANING  
OF HEALTH DURING PREGNANCY**

The purpose of this study is to better understand the experience of health during pregnancy. The study is being carried out by a University of British Columbia student researcher, Joanne Roussy (RN, MSc), in partial fulfillment of a Ph. D. in Nursing.

If you agree to participate, your involvement would consist of discussing your experiences with the student researcher in an interview. The interview would be tape recorded so that it can be transcribed and analyzed. All information is strictly confidential; code numbers will be assigned to the interviews and the identity of the participants will not be disclosed in any way on the tape recordings, the transcript, or the final report. Secondary analysis by the student investigator at some future date is not being discounted. Short passages from various interviews will be read by members of the student's dissertation committee; similarly, short passages may appear in the final report and in some publications based on the study. If you wish, you may receive a copy of the results of the study.

At the beginning of the interview, you will be given an honorarium of \$25 for your time, which will take about an hour. Further, a second interview may be requested. The length of the interview will be about 45 minutes to 1, 1/2 hours. You would be free to terminate the interview at any time, to have the tape recorder turned off during some segments, and/or to have portions of the tape erased in your presence if you are uncomfortable with what has been recorded. The researcher may ask you to participate in subsequent interviews. None of the information you share will be made available to any health care providers. You also understand that you are not obligated to participate and may withdraw from the study or refuse to answer questions at any time.

There are no known risks that are anticipated as a result of your participation in this study. You may derive some benefit through the opportunity of being able to express your feelings about aspects of your experiences during pregnancy.

I, \_\_\_\_\_ hereby declare that I have read and understood the information. I consent to participate in the study. I understand that

neither my name/nor other identifying information will be used in the final report or published papers resulting from this study. I understand that if I have any questions or concerns about my participation in the study, I can contact Joanne Roussy XXX-XXXX or Dr. Katharyn May, Study supervisor, at (604) XXX-XXXX (charging this call to 506 XXX-XXXX). I acknowledge receipt of a copy of this consent form.

Student researcher:  
Joanne Roussy, RN. BSc., MSc.  
UBC School of Nursing  
Home phone : xxx-xxxx

Faculty advisor:  
Katharyn May  
UBC School of Nursing  
Phone: (604) xxx-xxxx

Signature of Participant: \_\_\_\_\_

Date: \_\_\_\_\_



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**FORMULAIRE DE CONSENTEMENT  
ETUDE SUR L'EXPERIENCE DE LA SANTÉ PENDANT LA GROSSESSE**

Le but de cette étude est de mieux comprendre l'expérience de la santé durant la grossesse. L'étude est menée par Joanne Roussy dans le cadre de ses études pour obtenir un doctorat en Nursing.

Si vous décidez de participer, vous devez discuter de votre expérience avec l'étudiante qui fait la recherche. L'entrevue sera enregistrée afin d'en permettre la transcription et l'analyse. Toutes les informations communiquées seront strictement confidentielles; un code sera assigné à chaque entrevue et l'identité des candidates interviewées ne sera pas dévoilée sur les enregistrements, les transcriptions ou dans le rapport final. Une analyse subséquente pourrait être effectuée à partir de ces données. De courts extraits tirés de différentes entrevues seront lus par des membres du comité étudiant de dissertation. Des courts extraits pourraient également se retrouver dans le rapport final ainsi que dans des publications basées sur l'étude. Vous pouvez, si vous en faites la demande, recevoir une copie du résultat de l'étude.

Au début de l'entrevue, vous recevrez un montant de 25\$ en guise d'appréciation. Une seconde entrevue pourrait vous être demandée afin de clarifier ou de vérifier les données que vous avez communiquées. Les entrevues auront lieu dans un endroit et à une heure qui vous conviendront. Ni votre nom ni aucun renseignement qui pourrait vous identifier ne sera enregistré. Ces renseignements ne seront dévoilés qu'à mon directeur de thèse à UBC. Vous pouvez vous retirer de l'étude à tout moment ou demander d'arrêter l'enregistrement pour certaines parties de l'entrevue, voir même en faire effacer certaines parties si vous le souhaitez ou si vous ne vous sentez pas à l'aise avec ce qui a été enregistré. Votre refus de participer à cette étude n'affectera pas les soins de santé que vous recevez.

Les renseignements que vous partagez ne seront pas donnés aux personnes qui travaillent dans les soins de la santé. Vous comprenez que vous n'êtes pas obligée d'y participer et que vous pouvez faire cesser l'entrevue ou refuser de répondre à des questions à tout moment.

Votre participation n'encourt aucun risque pour vous. Cette expérience pourra probablement vous être bénéfique en vous permettant d'exprimer vos sentiments concernant certains aspects de votre expérience durant la grossesse.

Je \_\_\_\_\_ déclare avoir lu et compris l'information. Je consens à participer à l'étude. Je comprends que ni mon nom ni aucun autre

renseignement pouvant m'identifier ne sera utilisé dans le rapport final ou lors des publications résultant de l'étude. Je comprends que si j'ai des questions concernant ma participation dans l'étude, je peux contacter Joanne Roussy au xxx-xxxx ou Dr. Katharyn May, directrice de thèse au (604) xxx-xxxx, facturer au 506 xxx-xxxx. J'ai reçu une copie du formulaire de consentement.

Joanne Roussy, inf. M. Sc.  
1, rue Athol  
Campbellton (N.-B.)  
E3N 1Y2  
Ph: xxx-xxxx

Katharyn May, DNSc, RN, FAAN  
Faculty advisor  
(604) xxx-xxxx