Life Choices and Life Chances:
Pregnant and Early Parenting Women Who Use Substances

by

Camille May Stengel
B.A., University of Calgary, 2007

A Thesis Submitted in Partial Fulfillment of the
Requirements for the Degree of

MASTER OF ARTS

in the Department of Sociology

Supervisory Committee

Life Choices and Life Chances:
Pregnant and Early Parenting Women Who Use Substances

by

Camille May Stengel
B.A., University of Calgary, 2007

Supervisory Committee

Dr. Cecilia M. Benoit (Department of Sociology)
Supervisor

Dr. Helga B. Hallgrimsdottir (Department of Sociology)
Departmental Member

Abstract

Supervisory Committee

Dr. Cecilia M. Benoit (Department of Sociology)
Supervisor

Dr. Helga B. Hallgrimsdottir (Department of Sociology)
Departmental Member

This thesis is a subset of a larger "parent" project under the direction of my supervisor, Dr. Cecilia Benoit. The purpose of the larger project is to seize an unique research opportunity that has emerged with the development and implementation of the HerWay Home (HWH) program, a community-based initiative for pregnant and early parenting women who face substance use and other challenges in the Greater Victoria Area. My research has capitalized on the pre-implementation phase of the HWH program between 2010-2011. Thirteen in-person semi-structured interviews were conducted with women who would likely be clients for the HWH program, based on their pregnancy experiences, substance use concerns and other life challenges. The goal of this research has been to explore these women's pregnancy and postpartum narratives and investigate what, in their view, should be crucial components of the HWH intervention in the short and long-term.

My findings indicate that, consistent with the literature on pregnant and early parenting women facing substance use and other life challenges, a range of complex, intertwined disadvantages exist in their lives that translate into multiple barriers to accessing continuous health and social care during their pregnancy and after the birth of their child. An adapted model of the Health Lifestyle Theory is used to frame the analysis of the data collected from this research. The results from this research support the argument that the life choices of the participants are constrained by structural life chances and social determinants of health that systematically disadvantage and disempower them. The findings also reveal an implicit sense of agency in the women's narratives, as well as key specifics about what they view as the main gaps in care and their desired program services. The findings will be relayed to HWH organizers, and used to inform the development and implementation of the program's services.

Table of Contents

List of Figures

Acknowledgments

I am very grateful to my funders: the Canadian Institute for Health Research (CIHR) for funding this research and my Master's degree with the Frederick Banting and Charles Best Canada Graduate Scholarship; the Sarah Spencer Foundation for awarding me a fellowship in which to hire a transcriber for the interviews; the Michael Smith Foundation for the Foreign Study Supplement, which allowed me to share my research with colleagues at King's College London and others interested in the United Kingdom; and the University of Victoria for the President's Research Scholarship to assist with funding these various opportunities.

A deep thank you to the thirteen inspiring and brave women who took part in my interviews. My goal of this research was to honour your life stories.

My sincere appreciation to the Centre for Addictions Research British Columbia (CARBC) for the research assistantship, the office space, and the supportive work environment. Thank you to Dr. Lenora Marcellus, Betty Poag, Dr. Rachel Phillips and Dr. Helga Hallgrimsdottir for all their input, time, and helpful suggestions during the design and execution of my research.

Thanks as well to Zoe Lu, Ronna West and Carole Rains for being fantastic administrators who assisted with every query and conundrum I had, always with a smile on their faces.

A huge thank you to my supervisor, Dr. Cecilia Benoit, for allowing me to be part of this project, and for all her assistance, resources, encouragement and patience. Your mentorship in and of itself has been such a valuable part of my Master's experience.

I am extremely grateful to my parents, for their genuine interest and support in my educational and personal pursuits, and for being such loving and lovely people.

Last but definitely not least, thank you to my Triangle, Brenda Mathison, Sheri Watkins and Krista Perrey. I would have not survived grad school without you**.**

Chapter One: Introduction

"The criminalization of drugs cannot be separated from the regulation of altered states of conscious imperialism, colonization, and the subordination of women in Western history" (Boyd 2004:28)

Women who use drugs and other substances are the largest group of women impacted by their involvement in the global drug trade, although other areas such as female incarceration for drug trafficking charges are also on the rise (Fleetwood and Torres 2011; Global Coalition on Women and AIDS 2011). Both men and women who use drugs and other substances face barriers to accessing needed and quality health and social services because of policies created under the oppressive ideology of user stigmatization, both in the context of societal norms as well as through punitive measure such as incarceration. However, there is no substantial correlation between increased penalisation of drug and other substance use-related offenses with a decrease in use. Furthermore, criminalisation has arguably increased harms, including health related outcomes and human rights abuses toward people involved in the illicit drug market (Room and Reuter 2012; Stevens 2011; Takahashi 2009; Trace 2010).

Vulnerable populations, such as women, are disproportionately impacted by criminal sanctions regarding illicit drug-related activities in many areas of the world, as well as judgement and stigma with legal substances such as alcohol and tobacco (Pinkham and Malinowska-Sempruch 2007). Canadian researchers Beiser and Stewart (2005) define vulnerable populations as "subpopulations that suffer a burden of illness and distress greater than other residents in Canada" (S4). There exists growing health inequities among women in Canada due to large structural changes including a reduction in support

for stable housing, funding cuts to a variety social welfare and health services and a deficit of programs that address the complex intertwined lives of childbearing women (Beiser and Stewart 2005; Benoit, Shumka and Barlee 2010; Sandall, Benoit, Wrede, Murray, Teijlingen and Westfall 2009). This disparity is exaggerated for women who are part of a vulnerable population such as pregnant and early parenting women who use drugs and other substances, and who are also simultaneously dealing with complex issues including stigma and difficulties accessing basic life needs.

A handful of team-based programs have emerged to address the needs of pregnant and early parenting women in Canada who use drugs and other substances and face complex life challenges. Programs like Breaking the Cycle and New Choices in Ontario, the Maxxine Wright Place Project in the Fraser Valley region of British Columbia, and Sheway in Vancouver, British Columbia have provided a variety of services to the vulnerable population of pregnant and early parenting women who face significant life challenges, including substance use, unstable housing, and other adverse health outcomes (Cailleaux and Dechief 2007; Leslie and DeMarchi 2004; Marshall et al. 2005; Poole 2000; Sword, Niccols and Fan 2004). The newest specialized project is the HerWay Home (HWH) program in the Greater Victoria Area (GVA), British Columbia. The HWH project is a collaborative community-based care program that offers a comprehensive range of support and services for pregnant and early-parenting women with complex lives at a single-access point in the GVA (Benoit, Jasechko, Marcellus and Poag 2010a; Davoren and Poag 2010). Pregnant women who use drugs and other substances, and deal with a range of difficult life issues, are a highly vulnerable population that has potential to benefit from this innovative intervention.

HerWay Home is an acronym for "Housing first, Empowerment, Respect, Women, Acceptance, Your choice, Health, Opportunity, Mother, and Equality" (Benoit, Marcellus and Stengel 2011). The acronym highlights the fundamental principles guiding the development of the HWH. As HWH was in the pre-implementation stage when this research was conducted, the core aspects of the program underlined in the very acronym of the centre itself were important to keep in mind. Over thirty diverse organizations from a variety of sectors have come together with the common vision that the name HWH implies, including nursing and medical practitioners, community-based organizations, government workers, and academic researchers. The goal of the HWH is to be truly collaborative through an integrative approach that will provide a range of health and social services for women who use drugs and other substance during pregnancy and after birth, and struggle with other life challenges during a crucial time in their lives.

A Note About Language in Policy, Practice and Praxis

Interestingly, a number of the sources reviewed for this research used the language of "substance *abusers*" in their analysis of women who use drugs and other substances during pregnancy (Ashley, Giraud and Daniel 2009; Campbell and Alexander 2006; Claus et al. 2007; Lefebvre et al. 2010; Messer, Clark and Martin 1996; Uziel-Miller and Lyons 2000). While seemingly minor, this choice of language suggests that women who use substances are committing an ethical injustice, as they are "abusing" a substance and hence abusing themselves and their children. Other sources, such as Rutman, Callahan, Lundquist, Jackson and Field (2000) and Greaves and Poole (2008), explicitly identify their conscious choice to employ the phrase "substance use" in their documents rather than the more loaded terms of "abuse" or "misuse". Rutman et al. (2000) states that the

latter loaded terms "tend to imply some amount of judgment toward the woman and encourage an avenue of thinking that separates her from the context of her life" (v). Since stigma, judgment and discrimination are major barriers to care for vulnerable populations, there is an urgent need to be conscious of language choice when researching and discussing care options for this vulnerable subgroup (Stubber and Myer 2008). The research population identified for this project encompasses pregnant and early parenting women who use drugs and other substances and are in complex life situations that contain a range of issues including unstable housing, food security, stigmatization and safety.. While the women interviewed had were different in some respects in their life situations, they collectively faced health inequities and systematic marginalization In an attempt to identify this unique population in a non-stigmatizing way, I will henceforth refer to the women I interviewed simply as "the research participants" and/or "the women interviewed". While such designation is not ideal, it is an attempt to capture the population of study without contributing to the stigmatization and marginalization rhetoric surrounding women who live these complicated realities.

Situating the Research Within the Larger Project

The following research is an extension of a mixed-method "parent" study on the innovative HWH. The data for this thesis was collected and analyzed during the first and second year (2010-2011) of a three-year health intervention research grant entitled *Interventions to Promote Health and Health Equity for Pregnant and Early Parenting Women Facing Substance Use and Other Challenges*, which was awarded by the Canadian Institute of Health Research (CIHR). Dr. Cecilia Benoit is the principle applicant on this research project and also my Masters' supervisor. The "parent" research

program aims to shed light on: a) the factors that promote open communication and the full participation of all team members of the HWH so that continuity of maternity care is established and sustained over time and the clients are treated with respect and dignity by providers; and b) the factors that enhance client access to other health and social services that are key in harm reduction and health promotion strategies for this vulnerable population. The study involves a mixed methods design comprised of participant observation of the HWH drop-in centre, semi-structured interviews with the core team of providers connected with the HWH and key local community and provincial governmental stakeholders, and focus group sessions throughout the study.

This research is a subset of the data gathered for the "parent" study through the collection of qualitative interviews. Thirteen in-person semi-structured interviews were conducted with women who could be potential clients for the HWH based on their life circumstances as women in vulnerable situations with complex lives.

The purpose of these interviews were to explore participants' life narratives and investigate what these women believe are the crucial components of a collaborative 'one-stop' resource centre and housing model that specializes in the delivery of health and social care services for the population of study. The central research question for this project is as follows: what are the gaps (and barriers) in maternity and other health and social care services in Canada that should be part of the HWH? In order to investigate this question via the qualitative data of this research, a model of Cockerham's (2005) Health Lifestyle Theory was adapted and utilized to frame the analysis of the data regarding women in vulnerable situations with complex lives. The Health Lifestyle Theory contends that individual "life choices" and structural "life chances" both

constrain and enable an individual's lifestyle habits and health behaviours (Cockerham 2005). Findings for this research project affirm the argument that "life choices" of vulnerable populations are constrained by structural "life chances" that systematically disadvantage and disempower women in vulnerable situations and prove to be an impediment to accessing health and social resources during a crucial time in a woman's lifecourse (Boyd 1999; Campbell 2000; Marcellus 2004).

The intention of this research was to validate the life narratives of the participants and utilize their personal experiences to inform the development of the HWH. A call for this type of research is warranted, relevant, necessary and timely, as there is a need for "more research evidence to support our understandings of, and responses to, women's and girls' substance use" (Greaves and Poole 2008:32). While various populations' experiences of accessing services have been researched before as part of an evaluation of existing programs in Canada (Benoit, Carroll and Chaundry 2003; Cailleaux and Dechief 2007; Leslie and DeMarchi 2004; Marshall et al. 2005; Poole 2000; Sword, Niccols and Fan 2004), this research has the unique perspective of gathering data in the pre-implementation stage of the centre, and the responses from participants' can be used to inform the development of the HWH. The participants' answers provide a "snapshot" of women's barriers to care and the surrounding issues they face in their lives in this vulnerable population.

Feminist methodology, situated in perspectives of intersectionality and community-based research, informed the design and execution of this research. As is common of many feminist-informed research projects involving qualitative interviews, it is important to acknowledge that each of the participants' lives are unique and context specific to a

range of dynamic factors that exist in their lives (Bilge 2010; Ramazanoğlu and Holland 2002; Reinharz 1992). However, many elements in the lives of the women interviewed are anecdotally indicative of greater structural forces enacted in the lives of this vulnerable population, and heavily overshadow their sense of agency. Based on these structural forces, there exists a delicate interplay between life choices and life chances for each of the participants, and the greater vulnerable population, that result in constrained life choices.

Organization of the Chapters

Chapter Two begins discussing relevant literature surrounding this vulnerable population is discussed, and is organized based on themes that emerged during the review. The chapter then briefly outlines individualistic perspectives of health behaviours and highlights the limitations of theories that fail to adequately take social context into account. Cockerham's (2005) Health Lifestyle Theory is then introduced as a useful framework to apply to the analysis of health behaviours situated in a larger social circumstances. The chapter concludes with a brief outline of some Canadian interventions for women in vulnerable situations with complex lives that take action on the social determinants of inequities that impact health through their philosophy, policies and practices.

Chapter Three describes the methodological process that occurred during the research project, including the rationale for the data collection and analysis, as well as the steps to ensure the reliability and validity of the study. This chapter also explores the potential benefits and drawbacks of having the thesis research situated in a larger project, as well as the positive and negative outcomes of the decision to hire a transcriber. The chapter

concludes with a reflexivity section, as well as a mention of the limitations of the research design.

Chapter Four presents the findings from the interviews held with thirteen women in the GVA. As a result of the sensitive nature of the topics discussed, and some of the participants' concerns over their anonymity, each participant is referred to by a number, and any specifics of their lives are removed. Chapter Four is segmented into three main subsections, with each section reporting on a variety of major themes that emerged from the data analysis. The first subsection details the structural context of the women's lives, the second subsection elaborates on the effects and outcomes of the complicated interplay between life choices and chances during pregnancy and after birth, and the third subsection highlights suggestions that the participants had for HWH in order to be a successful intervention for the research population.

Chapter Five discusses the implications of the findings as framed within an adapted model of the Health Lifestyle Theory designed after the data analysis of the vulnerable population of study. Chapter Six summarizes the results from this research project, suggests future directions for my specific research as well as for the larger "parent" project. Chapter Six concludes with policy and practice recommendations for the HWH and other interventions for women in vulnerable situations with complex lives.

.

Chapter Two: Review of the Literature

"History shows us that past and contemporary moral panics about mothers' drug use have failed to examine the social and economic conditions of women's lives. The effects of poverty and social marginalization are continually mistaken for the effects of drugs" (Boyd and Marcellus 2007:115)

Introduction

This chapter outlines some of the main themes that emerged from the review of relevant literature surrounding this specific research population. A short overview of individualistic perspectives of health behaviours, and highlights the limitations of such theories that do not take social context into account. Cockerham's (2005) Health Lifestyle Theory is presented as a complementary sociological framework to analyze data on individuals' health behaviours when situated within larger societal and structural forces and inequities. Chapter Two concludes with a brief discussion of various Canadian interventions women in vulnerable situations with complex lives that take action on the social determinants of inequities through their philosophy, policies and practices.

Structural Context of Women's Lives

The social determinants of inequities include the assortment of structural identifying factors **"**stratification variables such as class, race, and gender, stressful life events and stress-process variables like social support" and impact individuals, as well as the "sense of control over one's life" and feelings of being self effective in the enactment of their agency (Cockerham 2007:17). Utilizing an understanding of social determinants of inequities frames the Health Lifestyle Theory within the lived realities of the population of study experiences. Social determinants of inequities include broader societal level influences on health from a structural impact, and influence and impact individual-level

risk factors like lifestyle habits and health behaviours (Beiser and Stewart 2005; Graham 2004).

Social determinants of inequities impact the differences in heath outcomes which are, to a large degree, the result of inequities in access to quality health care and other key resources (Bartley, Blane and Montgomery 1997; Davidson, Kitzinger and Hunt 2006; Graham 2004; Navarro 2009; Pauly, MacKinnon and Varcoe 2009; Raphael 2006; Williams 2003). Identifying the structural contexts in women's lives "play such a central role in a woman's [life] and her baby's life, health, and survival" (Boyd and Marcellus 2007:66).

Gender

Gender is a central socialized determinant of inequity for women, and the pressures of normative gender roles and structural standards of femininity are exacerbated during pregnancy and motherhood (Boyd 1999; Butler 1990; Campbell 2000; Graham 2006; Martin 2005; Rosenberg 2008). Gender is a social construct that is predominantly established and enacted between groups and social structures (Butler 1990; Rosenberg 2008). Understanding gender as imbedded in social institutions allows for an analysis of the power dynamics entrenched in the inequities that unfairly disadvantage women in vulnerable situations with complex lives. Campbell (2000) explains how "gender failure – the social or psychological incapacity to perform within the constraints of normative femininity" can further vilify a woman when she fails to perform the gendered norm under the guise of heightened femininity (154). The result of such failure in terms of this research is denouncement of the archetypal "bad mother". Such stereotypes often typify this vulnerable populations "unfit mothers, out of control, and a danger to their children"

(Boyd 1999:60). Young (1994) elaborates on societal norms of motherhood: "It's the child's *mother*. The mother is supposed to be the one who sacrifices herself, who will do anything for her child, who will preserve and nurture. That's what mothering *means*" (36).

Using drugs and other substances are health behaviours that contradict such gender norms, and result in women being individually blamed and stigmatized for their lifestyle habits, essentially "failing as a mother" (Boyd 2004:15). Deeply-rooted beliefs of failed gender expectations significantly impact the population of study who are already dealing with difficult and stressful situations (Klee 2002; Rutman, Callahan, Lundquist, Jackson and Field 2000). In order to take this vulnerable population's gendered experience into the forefront of this research, women's life situations are investigated and linked to socio-structural forces within the particular sociocultural contexts (Benoit, Shumka and Barlee 2010).

This vulnerable populations such as women with complex lives often faces stigmatization and discrimination because of their health behaviours, which are perceived to be a "negative choice" by societal rules and norms (Boyd 2004; Campbell 2000; Stubber and Myers 2004). While the physical implications of substance use that have known adverse effects to one's health cannot be ignored, the structural forces at play in the research populations' lives should not be disregarded either. Cockerham (2005) affirms that "the individualistic paradigm of health lifestyles is too narrow and unrealistic because it fails to consider structural influences on health lifestyle choices" (64). tensions between life choices and life chances throughout a woman's lifecourse.

Punitive policies and practices that affect women in vulnerable situations with complex lives work with the belief that the use of drugs and other substances override a woman's agency to make informed decisions about their lives. Boyd (1999) disagrees, contending that substance use "suggests that women actively search over other possibilities shaped by social, political, cultural, and economic variables" and their agency is limited by structural forces (69). In the literature reviewed, the population of study often internalizes self blame and a sense of complete personal responsibility

> For the outcomes of their pregnancies and mothering, regardless of negative social and environmental factors. In the face of an ideology of mothering that ignores the social reality of women, and especially of poor women, women who use drugs are perceived as especially deviant. (Boyd 1999:16)

These internalized beliefs assign total responsibility to the individual for their actions without taking into account context-specific and structural considerations. Such individualized blame manifests with the implementation of punitive policies that hold the individual personally and solely accountable for their health behaviours and outcomes.

Class

An individual's or group's class is the composition of "social positions [which] are inherently unequal because they are part of broader social hierarchies" that exclude vulnerable populations from higher classes (Graham 2004:112). This fundamental position affects the health of women in vulnerable situations with complex lives as it acts as an intermediary for accessing resources, with more additional barriers in place that lower their social position. Frohna, Lantz and Pollack (1999) purport that "using legal or

illegal substances is clearly an individual health behaviour. Yet many individual behaviours are related to socioeconomic position and to other factors not solely determined by individual choice" (554). People are socialized into their lived realities by a number of factors they are born with (including gender), but these factors are given meaning through the socialization process throughout their lifecourse. Poverty is class-based outcome of socialization and structural influence that negatively impact vulnerable populations (Benoit et al. 3009; Leslie and DeMarchi 2004; Pauly 2008b; Perez 2000).

Frohna, Lantz and Pollack (1999) discuss how since "substance abuse *(sic)* is correlated with poverty, effective interventions must provide for basic economic needs" of vulnerable populations (554). Financial restraints and logistical issues often make expensive services such as childcare care options unrealistic for many women. In Leslie and DeMarchi's (2004) evaluation of Breaking the Cycle in Toronto, they found that half of the women who utilize the program had no income (49.7%), and less than half of the remaining women (43%) were on some sort of social assistance (3). With this figure in mind, "costs for childcare, for personal items needed when away from home, and for transportation" can add up to additional financial stresses that may not allow women to make ends meet in other parts of their lives (Poole and Isaac 2001:23). There is a direct link to larger structural restraints that illustrate how "social deprivation is linked to poor maternal outcomes, thus Canada and the U.S. are *mistaking the effects of poverty with the effects of drugs*" (Boyd 2004:97) (emphasis mine). If the goal of countries such as Canada and the U.S. is to improve the health of women and their children, then issues that tackle the structural obstacle of poverty need to be taken into context when addressing the adverse health behaviours of drug and other substance use during

pregnancy (Boyd and Marcellus 2007). However, the association between poverty and adverse health behaviours are "often seen as being under individual control and, therefore, an individual responsibility" in which "society is increasingly critical of individuals who have such problems" like the population of study, and result in stigmatizing attitudes and behaviours (Hepburn 2007:6).

Stigma

Stigma is a prevalent theme in the literature of the research population (Benoit et al. 2009; Benoit, Shumka and Barlee 2010; Beiser and Stewart 2005; Boyd 1999; Davis and Yonkers 2012; Greaves and Poole 2007; Klee 2002; Navarro 2009; Pauly 2008b; Poole and Isaac 2001; Young 1994). Greaves and Poole (2008) explain how

> Women and girls who use substances are often vilified, both in the media and in everyday conversations. This stigmatization is particularly strong when women who are pregnant or mothering use substances, or when women do not fulfill the gendered expectations of society as a result of their substance use. (33)

Benoit, Shumka and Barlee (2010) add that "while women are not inherently vulnerable to stigma, they do face disadvantages due to structural forces that limit their access to, and control over, material and symbolic resources, and over their bodies and lives" (5). Women in vulnerable situations with complex lives face double stigmatization due to the perceived failure to subscribe to the traditional gender norms of femininity *and* of motherhood. Prominent theorist Goffman (1963) dedicated much of his life's work to studying stigma, which he defined as ''an attribute that links a person to an undesirable

stereotype, leading other people to reduce the bearer from a whole and usual person to a tainted, discounted one" (11).

The ramifications of stigmatization on an individual can be devastating and completely damaging to one's identity, meaning that "people [who] deviate physically, behaviorally, or ethno-culturally from dominant norms and values are subject to disapproval and marginalization" (Benoit, Shumka and Barlee 2010:2). While women who use drugs and other substances in general exhibit risk-engaging behaviour that is deviant from gendered expectations, substance use during pregnancy further distances them from dominant values of Canadian society, and thus they are vilified. Benoit, Shumka and Barlee (2010) explain how

> The effects of this prejudice can result in *enacted stigma*, whereby a person is actively discriminated against, or *perceived or felt stigma,* which refers to a person's assumption or fear that others will discriminate, and results in various modifications of behaviour and thought. (3)

As will be discussed more thoroughly in Chapter Four, the women interviewed for this research expressed many instances of both enacted and felt stigma as a result of the judgement of others on their adverse health behaviours.

Link and Phelan (2001) utilized the groundwork of Goffman's research to argue that stigma is linked to power through five intricately connected components that consist of labelling, stereotyping, separating, stigmatizing, and discrimination (376). First, the stigmatized individual is identified as 'different', and is given a label. The stigmatized individual is then stereotyped, where the label that has been placed on them is connected

to negative attributes. After such stereotypes are associated with the stigmatized individual, the group who has labelled and stigmatized the individual enacts the process of 'othering' by separating the stigmatized 'them' from the perceived normal 'us'. This results in the fourth component, where the stigmatized person experiences a loss of status as a result of their outsider status. Labelling, stereotyping and separating fabricate an argument justifying the subsequent discrimination of the stigmatized individual.

The process of stigmatization is clearly documented in the literature surrounding women in vulnerable situations with complex lives (Benoit, Shumka and Barlee 2010; Boyd 1999; Boyd 2001; Campbell 2004; Poole 2000; Poole and Isaac 2001). As mentioned previously, often the population of study's health behaviours deviate from gender norms of womanhood and especially motherhood, and women in this category are labelled as "different". The stereotyping label of "pregnant drug addicts" holds loaded meaning associated with extremely disapproving attitudes, and is often the language used in popular media to vilify women (Boyd 2001). Using such language creates a clear separation between women in vulnerable situations with complex lives in one category, and the rest of society as the status quo. As a result, this vulnerable population lose any social position and status, and face multiple dimensions of discrimination (Stubber and Myers 2008). Stigmatized women in vulnerable situations with complex lives have little or no agency to fight against or attempt to reverse the stigmatization process on a structural level. It is important that interventions like the HWH actively work to avoid further stigmatizing this already vulnerable group.

Cultural Membership

While one's race and ethnicity are demographic factors, cultural membership in Canada is often connected to one's Aboriginal identity (Mawani 2005). Research on patient admission records reveal that Aboriginal women are the subgroup of pregnant and new mothers most affected by social and structural inequities in the Canadian maternal health care system (Benoit et al. 2003; Benoit et al. 2009; Macrory and Boyd 2007; Marshall et al. 2005). The history of racism towards Aboriginal people in Canada has marginalized and disadvantaged the population for generations. This extreme discrimination has created a number of social and structural barriers for Aboriginal women that have contributed to lower educational levels, fewer job options that often involve engagement in sex work, and living situations at or below the poverty line (Benoit et al. 2003; Benoit et al. 2009; Marshall et al. 2005). While challenges such as these are not exclusive to Aboriginal women, the multiple disadvantages that Aboriginal women face result in an overrepresentation in the population of outpatient clinics and treatment programs.

The Sheway program in Vancouver's Downtown Eastside has found that although Aboriginal people make up a minority of the entire population in Vancouver, Aboriginal women dominate the majority of clients treated at Sheway and have the highest increase of HIV positive people in the Downtown Eastside (Benoit et al. 2003; Marshall et al. 2005). In Sheway's program the average client is a self-identified Aboriginal woman who has likely engaged in sex work and has limited formal education. The typical client in Sheway often faces issues of stigmatization in society due to her lack of education, her form of employment that is not socially acceptable, and her cultural and racial background (ibid). Macrory and Boyd (2007) describe how since Foetal Alcohol

Syndrome Disorder has become integrated into popular public debate since the early 1970s, societal attitudes in both Canada and the US have often correlated Foetal Alcohol Syndrome Disorder as an Aboriginal issue, and this has added to the racist enactment of public policies and laws that have further limited the already constrained options of Aboriginal women in vulnerable situations with complex lives.

Supports and Social Networks

Supports and social networks assist in influencing lifestyle habits and healthy behaviours. Isolation is a major barrier to accessing care facilities and negatively impacts the health of women in vulnerable situations with complex lives (Poole and Isaac 2001; Grzybowski et al. 2009; Leslie and DeMarchi 2004). Leslie and DeMarchi (2004) contend that isolation from supportive services and networks for pregnant women can aggravate conditions of inadequate mother and foetus health (4). Many of the Aboriginal women who live in the Downtown Eastside, especially those with HIV/AIDS, have been relocated from their families and communities, and as a result are socially isolated within the urban city centre and have no cohesive form of social support (Benoit et al. 2003). Immigrant women also face similar isolation through lack of close family interactions and instances of cultural insensitivity during the delivery of their maternity care services (Poole and Ting 1995; Reitmanova and Gustafson 2008). Isolation can be cultural, social and geographical, and the impact of two or more types of isolation only exacerbates issues of inequality for women in vulnerable situations with complex lives.

Benoit et al.'s (2003) interviews with Aboriginal women who utilized Sheway's services found that many women initially accessed Sheway because it provided an opportunity to socialize with other mothers and share their issues of pregnancy and

motherhood. Likewise, a main emergent theme from Lefebvre et al.'s (2010) focus groups was women's desire to have support groups on site at two Canadian women's treatment centres so clients could connect with others in similar life situations. Programs like Breaking the Cycle aim to decrease isolation for women accessing their services by collaborating with other community-based programs that can refer women to Breaking the Cycle (Leslie and DeMarchi 2004). Team-based care programs like Breaking the Cycle, the Maxxine Wright Place Project, New Choices and Sheway are able to maximize their success rates of recruiting and retaining female clients through their collaboration with various social services in their respected communities.

Social networks do not always act as a form of support, and in cases of unsafe associations with others, structural supports services are needed to help the research population exit precarious situations (Benoit, Carroll and Chaudhry 2003; Cailleaux and Dechief 2007; Friedman, Hatters, Heneghan and Rosenthal 2009). Various forms of abuse are often a past and/or present reality in the life chances of women in vulnerable situations with complex lives (Boyd 1999; Cockerham 2005; Davis and Yonkers 2012; Pauly 2008b; Poole 2000). Abuse can take a number of forms, including physical, sexual, mental, and emotional. Various perpetrators of abuse are often past or current intimate partners of the population of study, some who are also the father of the child. In other situations abuse originates from family members such as the woman's own parents. In certain cases the history of abuse begins in childhood and continues throughout their lifecourse throughout significant life events such as pregnancy (Benoit, Carroll and Chaundy 2003; Marcellus 2004; Poole 2000; Sword et al. 2004). Drug and other substance use can become a tool for this vulnerable population to cope with abuse and

resulting emotional, physical, and mental trauma (Boyd 2001; Greaves and Poole 2008; Poole and Isaac 2001). A disproportionate health gap exists for girls and women in Canada, and unfortunately abuse falls under this category as well (Benoit et al. 2009). Greaves and Poole (2008) explain how instances of abuse have a high correlation to drug and other substance use, and girls and women tend to experience abuse at "higher rates than their male counterparts" (31). Women dealing with abuse in their lives and subsequently using substances as a coping mechanism may not be able to fully realize the benefit in accessing social and health services, or may be scared to access such services for fear of stigmatization or repeat offenses from the perpetrator. Subsequent issues of poor mental health and low self-esteem that often accompany victims of abuse further complicate this vulnerable population's motivation to adequately seek out the assistance they need.

Legal Environment

Punitive measures, rather than a model structured around the holistic health and-well being of the woman and her child, are often lacking from various facets of Canadian policy. A Statistics Canada report in 2011 highlighted women who use drugs in their "Criminal Justice System" chapter due to the penalties surrounded illicit drug use, but does not address substance use in their "Women and Health System" chapter (Mahoney 2011). A discussion of health throughout the lifecourse of women must be integrated into policies and practices for this vulnerable population.

The debate surrounding policy and legislative decisions about this vulnerable population often stem from moral and ethical judgments about these women's actions (Boyd 1999; Boyd 2007; Campbell 2000; Campbell and Alexander 2010; Hepburn 2007;

Marcellus 2004). Such judgments tend to fall under two ideological models of care: the autonomy model and the beneficence model. The autonomy model of care is founded on the principle of liberty and the belief that a competent person has the right to make their own decisions (Lambert, Scheiner and Campbell 2010; Marcellus 2004). Medical practitioners caring for women in vulnerable situations with complex lives who adhere to the autonomy model have an obligation to act both in the best interest of the health of the woman and to respect and honour her needs and requests (Lambert, Scheiner and Campbell 2010:168). The beneficence model of care is based on the principle "do no harm", and is rooted in the belief that one's actions should be done with the intention of doing good (Lambert, Scheiner and Campbell 2010; Marcellus 2004). The beneficence model of care often translates into physicians acting in the interests of others, which runs the risk of the physician imposing their values onto the patients and enforcing protective intervention strategies on the patients (Marcellus 2004:734). The beneficence model takes both the interests of the mother and the foetus into consideration, and can result in the interests of the foetus being considered over and above, or at the disregard of the humanity of the woman (Lambert, Scheiner and Campbell 2010:170). For example, under the beneficence model of care, the population of study have had their actions interpreted as a form of child abuse, and used as an argument to enact punitive measures against such women (Lambert, Scheiner and Campbell 2010; Marcellus 2004, Macrory and Boyd 2007).

The autonomy versus beneficence debate is contentious and complicated. These models of care stem from divergent beliefs about the personhood of the foetus and hence, as to whether the foetus has independent or dependent moral status from the mother

(Lambert, Scheiner and Campbell 2010:167). The Canadian Supreme Court ruled in 1989 that a foetus is not deemed a person until after birth, and therefore ensures that pregnant women cannot be prosecuted based on their prenatal conduct, as a foetus does not have any legal rights (Marcellus 2004). In contrast, the U.S. has waged a war against drugs and simultaneously waged a war against women's reproductive rights for the past thirty years (Macrory and Boyd 2007). Legally no state has criminalized the act of pregnant women using harmful substances, but Marcellus (2004) estimates that in more than thirty states there have been upwards of two hundred women accused and found guilty of foetal abuse as of 2007.

Women in vulnerable situations with complex lives are often depicted in society as being a hazard for their children, and the reactionary phenomenon of the "criminalization of pregnancy" is used to describe legal sanctions against pregnant women in general (Boyd 1999:26). The 1997 Supreme Court decision of "Ms. G" is a key judicial outcome that contextualizes the current legal environment for the research population in Canada (Capen 1997; Ginn 1999; Poole and Isaac 2001; Rutman et al. 2000). Ms. G refers to the defendant, a twenty-two year old Aboriginal woman who was five months pregnant when Winnipeg Child and Family Services requested a court order to "confine her 'at a place of safety' until the baby was born" (Capen 1997:1586). This request was made after Ms. G tried to access social support for her addiction to sniffing solvents but was warned there was a "long wait period" for treatment services (Ginn 1999:22). Child and Family Services made the request on the grounds that Ms. G's health behaviours were deemed to have the potential to cause harm to her foetus, and called for Ms. G's mental competence to be assessed (Ginn 1999; Rutman et al. 2000).

While the Manitoba Court of Queen's Bench ruled that Ms. G would have to comply with mandatory treatment and instated a custody order until her child was born, the Manitoba Court of Appeals repealed the decision, which was affirmed in the Supreme Court of Canada. The Supreme Court noted that under Canadian code a foetus is not considered a person, and "unless there is reason to act when the child is born, it ruled, no one may stop a mother from taking a course of action, even if it is potentially harmful to the foetus" (Capen 1997:1587). This case was monumental in Canadian judicial history as it was the first time the Court has ruled on whether it was lawful or not to detain and impose treatment on a pregnant woman against her will (Gill 1999). While the outcome of this case "could be seen as a victory for those opposed to infringement of the rights of women," Rutman et al. (2000) explain how

> The wretched circumstances of a pregnant woman addicted to solvents were not addressed by the decision. Nor did the decision alleviate the desperation of social workers and a provincial court judge who felt compelled to act in this unusual fashion. (ix)

The structural conditions surrounding this vulnerable population were not addressed in the outcome in this court case, and over ten years later, many of these inequalities still manifest as barriers to creating and sustaining healthy lifestyle habits and behaviours.

Living Conditions

The living conditions of women in vulnerable situations with complex lives is not only an important for the health of women during and after their pregnancy, but also for the future health of their children. In the literature reviewed, this vulnerable population

often faced various stages of homelessness or unstable housing conditions, and that negatively impacted many aspects of their lifestyle and health (Benoit et al 2009; Hardey 1998; Leslie and DeMarchi 2004; Pauly 2008b; Perez 2000). The results of Leslie and DeMarchi's (2004) evaluation of Breaking the Cycle found that close to seventy percent of women who utilized Breaking the Cycle were precariously housed or homeless, ranging from women who slept in emergency shelters to women whose rent was so high that they were not able to afford many basic life necessities (3). Pauly (2008b) describes how homelessness often corresponds with an a increase of various other health problems "related to violence, accidents, substance use, lack of housing, poor nutrition, stigma and discrimination" (196). When the essential needs of the population of study are not met, the more difficult it is to engage women in maternity care services, which may be viewed as a secondary need for women who require secure housing and financial stability (Perez 2000). Statistics Canada surveyed women residing in shelters during their 2010-2011 survey, and found that almost a quarter affirmed "drug and alcohol addiction", a third were "unable to find affordable housing", and just over half had "short-term housing problems" (Mahony 2011:16). Cockerham (2007) purports that "living conditions qualify as a fundamental cause of health and disease through social mechanisms like class position that impose health advantages or disadvantages on people" (149). Simply put, any aspect of housing support for this vulnerable population, especially one with long-term assistance towards stable accommodations, can be expected to create an improvement in women's health behaviours (Hardey 1998).

Accessing Health and Social Services

The social determinants of inequities collectively impact the research population's access to health and social services. As a result, the unjustness and discrimination women in vulnerable situations with complex lives experience reduce their chances of utilizing health and social care services (Davis and Yonker 2012; Friedman et al. 2009; Greaves and Poole 2008; Poole and Isaac 2001). Stigma itself profoundly effects women's access to necessary and needed health and social services (Rutman et al. 2000; Stubber and Myer 2008; Sword, Niccols and Fan 2004). Link and Phelan (2001) argue that stigmatization has a large impact on an individual's life chances, and subsequently results in poor health behavioural outcomes. Fears of a stigmatizing labels often lead "individuals to delay or avoid seeking treatment altogether, while those already labelled may decide to distance themselves from the label, forgoing treatment or becoming noncompliant" (Link and Phelan 2006:528). In Poole and Isaac's (2001) research, they found that internalized negative feelings of existing stereotypes about this vulnerable population were a common barrier for women accessing care services. The fear of child removal as a result of stigmatizing opinions of women being seen as "bad mothers" was also a deterrent for Poole and Isaac's (2001) participants seeking out assistance health and social services (19). Fear of child removal as a result of societal stigmatization is a cited explanation for low uptake and retention rates of health and social services with this vulnerable population (Davis and Yonkers 2012).

Although punitive measures tend to be a popular way for the legal system to handle the issues of people who use drugs, especially in the US, research results show that this form of moral legislation is not effective for utilizing and successfully completing programs at substance treatment services and outpatient clinics (Boyd 1999; Campbell

and Alexander 2006; Lambert, Scheiner and Campbell 2010; Macrory and Boyd 2007; Marcellus 2004; Marlatt 1996). Women are often afraid of being incarcerated or having their children taken from them, so they often do not seek out treatment options (Campbell and Alexander 2006, Lambert, Scheiner and Campbell 2010; Marcellus 2004; Young 1994). This does nothing to improve the health behaviours or lifestyle habits of mothers or their children.

Empowerment

Young (1994) defines empowerment as "the development of a sense of collective influence over the social conditions of one's life" (48). She argues this definition expands on the traditional meaning of empowerment that is often applied to individual-based theories of health behaviours, which positions empowerment as progression "of individual autonomy, self-control, and confidence" (Young 1994:38). Empowering women in vulnerable situations with complex lives means taking action on the socially determined inequities via health and social care services that present these women with a range of choices and options in a supportive, safe environment. The goal is that in turn, women are empowered with a sense of self-efficacy to modify health behaviours in a way that will positively impact themselves and their children. Payne (2007) identifies how contextualizing life situations within this complex interplay is necessary on a societal level:

> As a society, we have to stop demonizing women with problematic substance use. We have to learn to look at the whole picture of a woman's life and understand the social determinants of health that play such a central role in a woman's and her baby's life, health, and survival. (66)

Pauly (2008b) encourages health and social care providers serving vulnerable populations to "shift from personal responsibility to enhancing development of decision-making capacity [in a way that] reflects a continuing value on autonomy" (201). Empowerment is key to a successful interventions, and one of the core philosophies of HWH. Empowering clients has the potential to enable this vulnerable population to understand their own lifestyle behaviours and assist in the process of minimizing or even reversing adverse health outcomes.

Understanding Adverse Lifestyle Behaviours

Lifestyle behaviours that are deemed to be unhealthy or pose unfavourable consequences to a person's physical, mental and emotional well-being, include behaviours such as drug and alcohol use, an unhealthy diet, lack of exercise, unsafe sexual practices, and other activities deemed to be risk-taking or to have the potential to result in adverse health outcomes. Such behaviours are often studied at the individual and psychological level, with a range of theories that hypothesize why people act in certain ways. Such theories include the social cognitive theory, transtheoretical model, protection motivation theory and the health beliefs model, among others (Bandura 1986; Prochaska and Velicer 1997; Robberson and Rogers 1988; Rosenstock 1974). The Theory of Planned Behaviour is a popular theory has been used in much research relating to lifestyle and people's behaviours and actions, including the field of physical activity and healthy diet (Ajzen 1991; Blue 2007; Hagger, Chatisarantis and Biddle 2002; Symons-Downs and Hausenblas 2005).

The Theory of Planned Behaviour asserts that people's behaviours are based on three components: one's attitude towards the given behaviour; the subjective norm experienced

through perceived social pressure to engage or abstain in the behaviour; and the behavioural control that the individual assumes they have over the level of difficulty in performing the behaviour (Ajzen 1991; Jones, Sinclair, Rhodes and Courneya 2004). These three components influence behaviour through the intention of the individual to participate in the specific behaviour, which in turn affects the actual behaviour itself (Bellows-Rieken, Rhodes and Hoffert 2008; Symons-Downs & Hausenblas, 2005). Theory of Planned Behaviour posits, and studies have confirmed, that people's attitudes and perceived behavioural control are essential elements for understanding and predicting both positive and negative health behaviours (Ajzen 1991; Bellows-Rieken, Rhodes and Hoffert 2008; Petty et al., 1997). Thus, using the Theory of Planned Behaviour argument, it is theoretically feasible that one can anticipate negative health behaviours, and the modification of such behaviours in people may be possible based on the incentive or persuasion method used to revise a given behaviour.

Social scientists attempt to compliment individualistic theories such as Theory of Planned Behaviour by contextualizing lifestyles and behaviours within larger societal and structural issues. Pauly (2008b) argues that individual-based theories, popular in the biomedical framework of health services, "lack explicit attention to the dominant societal and organizational values" that have an effect on people's behaviours and attitudes (195). Such lifestyles and habits are tied up in broader structural forces that systematically disadvantage different groups of people, especially those with increased vulnerability, and provide fewer opportunities to change such negative behaviour. Sociological analysis of behaviours include Cockerham's (2005) Health Lifestyle Theory. Theories such as the Health Lifestyle Theory focus on broad social and environmental contexts as well as

individual factors in relation to adverse health behaviours in order to have a contextualized understanding of individuals' lifestyle habits within broad macro-level social structures.

Lifecourse and the Heath Lifestyle Theory

The concept of lifecourse can be described as "how circumstances, events and experiences influence a person's health from before they are born and throughout their whole lives is seen as crucial to understanding health inequalities" (Nettleton 2006:185-186). When discussing lifecourse the concept of lifestyle is understood as the research subject's biology combined "within a social context which structures their life chances, so that advantages and disadvantages tend to cluster cross-sectionally and accumulate longitudinally" (Bartley 1997:1194). While lifestyle is heavily affected by structural forces, lifestyle can also have a substantial impact on structure, and "therefore, lifestyle should not be understood as completely determined" (Frie and Janssen 2008:214). Lifestyle affects a person's health and well-being in their day-to-day experiences and throughout their lifecourse, including key moments such as pregnancy and birth. Graham (2006) states that "the primary application of the lifecourse perspective has been to physiological markers of health risk, morbidity, and mortality. But the concept is also important for understanding health related behaviours" like substance use, but also larger conditions like poverty, which reflect larger socioeconomic disparities that impact health lifestyles (228).

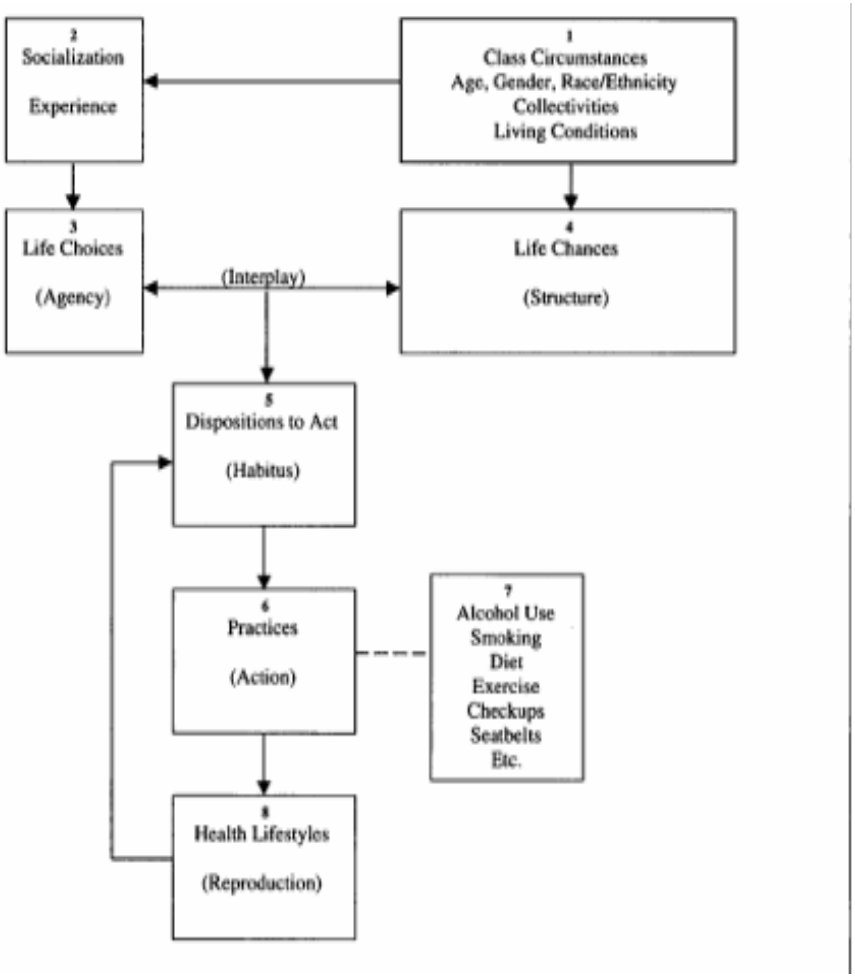
Health lifestyles are collective patterns of people's life behaviours based on the combination of life choices available to them and the life chances they experience over their lifecourse (Cockerham 2005). Cockerham's (2005) Health Lifestyle Theory stems

from the foundational agency-structure debate that is well known in the social sciences. Agency, as originally understood by Emirabyer and Mische (1998), is the process of individuals engaging as purposeful actors in their actions "influenced by their past but also oriented toward the future (as a capacity to imagine alternative possibilities) and the present (as a capacity to consider both past habits and future situations within the contingencies of the moment)" (Cockerham 2005:55). Structure, as described by Giddens (1976), "refers to the generative rules and resources upon with action and interaction can be built" (Williams 2003:133). Agency and structure exist in a tension, as they both enable and constrain the other, but often in an uneven power dynamic (Cockerham 2005; Giddens 1976).

The central thesis to Cockerham's (2005) Health Lifestyle Theory is that "choices and chances operate in tandem to determine a distinctive lifestyle for individuals, groups, and classes. Life chances (structure) either constrain or enable choice (agency); agency is not passive in this process" (61). Cockerham (2005) also credits Weber (1949) with the introduction of the term 'life choices' which "are a process of agency in which individuals critically evaluate and choose their course of action" and are always constrained by available resources and the enforcement of social norms (55). *While agency is not passive, it is always constrained by life chances.* Cockerham (2005) describes life chances as the influence of structure forces on an individual from birth, which continually impacts the course of one's life trajectory (60). Life chances are "to a large extent dependent upon a person's social and material environment", and influence an individual's life choices (Cockerham 2005:57). While some of these life choices and

chances may be obvious to the individual, many decisions in one's health lifestyle are made unconsciously (Cockerham 2005:62).

Figure 1. Health Lifestyle Theory



Lifestyle Habits and Health Behaviours

Lifestyle habits are formed through reaction and interaction with this vulnerable population's constrained life choices and chances throughout their lifecourse. Health behaviours are the outcome of this complex relationship, and can result in adverse health behaviours, which in this population is most identified as drug and other substance use during pregnancy. These adverse health behaviours also include poor diet, lack of exercise, unsafe sexual practices, and other unfavourable health behaviours that are

impacted and influenced by their life choices and life chances. Cockerham (2007) emphasises that "agency and structure operate on a continuum in which agency is stronger in the social conditions on the lower end and structure on the upper end" (186). Ignoring structural life chances and determinants of health removes a key variable in understanding the health behaviours of the research population, and further limits the agency of this vulnerable population.

Successful Interventions

The Healthy Lifestyle Theory assists with conceptually framing the adverse health behaviours are impacted by a myriad of complex life choices and life chances that are structurally disadvantageous to this vulnerable population. As a result, successful interventions for women in vulnerable situations with complex lives need to be open and flexible to the diverse ranges of needs of their clients in order to be effective, and take action on the social determinants of inequities via client empowerment. Women in vulnerable situations with complex lives and deal with substance use issues tend to have a lower self-image and have more self esteem issues than men, which may hinder the belief that they can be successful in completing treatment programs (Ashley et al. 2003). Davis and Yonkers (2012) agree that "measures to increase self-esteem may be integral to achieving positive treatment and reunification outcomes" for the population of study (3).

Having centres that attend to the specific, unique, and complex needs of the research population, and understand the interplay between life choices and life chances for each client, is essential to fostering success in an intervention (Ashley et al. 2003; Campbell and Alexander 2006; Capen 1999; Claus et al. 2007; Lefebvre et al. 2010; Macrory and Boyd 2007; Rutman et al. 2000). Uziel-Miller and Lyons (2000) argue that specialized

substance treatment facilities may be too specialized and not able to adequately deal with the range of issues their female patients face (364). Uziel-Miller and Lyons (2000) found that some centres in the US that provided care for women in vulnerable situations with complex lives either focus too exclusively on prenatal care or substance use treatment without adequately integrating the two situations together, or neglecting clients who deviate from the predominant lifestyle, like mothers who already have children (364). Centres like Sheway, New Choices, Break The Cycle and the Maxxine Wright Place Project strike a balance by creating centres that are tailored towards the specific population while maintaining flexibility to the diverse range of services and options available for their clients in order to maximize the success in the utilization of their programs (Benoit, Carroll and Chaundry 2003; Cailleux and Dechief 2007; Davoren and Poag 2010; Marshall et al 2005; Margaret and DeMarchi 2004; Sword et al. 2004).

Active interventions such as Breaking the Cycle, New Choices, Sheway, the Maxxine Wright Place Project all highlight Canadian initiatives to move towards an autonomous model of care that takes the SDH and other structural forces into account. While such programs are not without a number of challenges, there has been measurable progress and action taken of the social determinants of inequities and attempts to shift societal attitudes towards an awareness of the structural life chances that impact the population of study. As well, women are in the decision-making process during their engagement with these interventions in order to facilitate optimal circumstances for life choices that improve their health behaviours and lifestyle habits. The HWH hopes to join such achievements as a successful intervention.

Summary

This chapter has presented an overview of the complex issues and larger structural forces at play the lives of women in vulnerable situations. Individualistic perspectives of health behaviours fall short of a comprehensive understanding of the complex interplay between life choices and life chances that effect health behaviours. The population of study face a number of socially determinants that impact inequities, including gender and class, the impact of stigma, cultural membership, supports and family networks, the legal environment, living conditions, and the access to health and social services. As illustrated in the review of the relevant literature, accessing necessary health and social services are constrained by other determinants that result in inequities which create barriers to achieving healthy lifestyle habits. The Health Lifestyle Theory assist at outlining a number of key socially determined inequities that influence and impact the research population's lifestyle habits and health behaviours The following chapter outlines the methodology used in this research when interviewing women in the GVA who shared their struggles with their constrained life choices and chances during their pregnancy.

Chapter Three: Research, Design and Methods

"I think that asking women about their experiences and, and having it informed by that is, is great"(Interview Research Participant #6)

Introduction

Chapter Three addresses the methodological considerations of the research, including the rationale for the research sample, methodology, data collection and analysis. As well, this chapter discusses the benefits and potential drawbacks of conducting research for my Master's degree under a larger "parent" project. The pros and cons are also weighted regarding the decision to hire a transcriber to write out the interviews. Chapter Three concludes with a section on self reflexivity, the research process, and the implications of my role as a researcher.

The "Parent" Project: HWH

The HWH program is the newest Canadian intervention to provide comprehensive care for women in vulnerable situations with complex lives (Benoit et al. 2010a; Davoren and Poag 2010). The HWH philosophy is structured largely around the successful principles and practices of other existing organisations such as BTC, New Choices, Sheway and the MWPP, which approach the delivery of services to the research population with a similar team-based methodology. The core philosophies and delivery of these four programs offer a unique and integrated approach for service provision of this vulnerable population. The HWH has closely observed such programs when designing its own model of delivery. All these programs operate on a "one-stop model" in one form or another, as they provide a variety of services for their clients at a single location (Leslie and DeMarchi 2004; Sword, Niccols and Fan 2004). The positive outcomes of these

specialized care programs in Canada, as well as some women-only treatment centres in the US, have a number of effective tactics that create successful, albeit challenging, intervention programs for women in vulnerable situations with complex lives.

Sample

My sample population was both purposeful and non-random, as the thirteen women interviewed had already accessed health and social services for their pregnancy, birth, and/or post partum experiences. The participants also identified a number of factors that made their pregnancy experience difficult and faced vulnerable situations in their complex lives, including substance use, unstable housing, and safety concerns. Horsburgh (2003) explains how this type of selection process seeks to find research participants who have the "ability to provide information (and consequent theory development) about the area under investigation. Situational, rather than demographic, representativeness is what is sought" (311). In order to carry out the intended research, existing connections with the network of organizations already involved in the HWH were summoned. These key informants acted as "gatekeepers" that were essential to accessing the desired research population (Poole and Isaac 2001; Ramazanoğlu and Holland 2002; Reinharz 1992). The gatekeepers for this research were organizations that provide a range of public services that have come together in the common interest in developing HWH. A recruitment poster and an informational one page sheet about the project were designed after consultation and feedback with the research team (please see Appendix A and B). The poster and one-sheet were sent as email attachments and were sent out to these gatekeeper organizations. The email explained the research project and requested the organizations' assistance in facilitating connections with clients they deemed fit the

recruitment criteria and would be interested in participating in the research. All of the key informants responded to the email and agreed to the request, and allowed a display of the recruitment posters in their organizations. Ten of the women interviewed were connected with the research via these key informants. The remaining three women were the result of snowball sampling, as friends who had participated in the research made a referral.

During initial contact (which was either a phone conversation or an email message) a brief explanation of the study was provided, including an outline of the desired participants, the benefits and risks involved, the honourarium, and an assurance of confidentiality and anonymity. The women interviewed were informed that they were allowed to withdraw from the study at any time during and after the interview. A suitable location to hold the interview was discussed during initial contact with each participant. Ten of the thirteen of the women interviewed requested to have the interviews in or around their current living situation. Two interviews were held in a borrowed vehicle, where participants were met in public locations. Two women requested the interviews take place in a private room at the University of Victoria, and one woman requested meeting at a community centre, as it was the most convenient location for her to access. Participants were asked if they had any questions after reading through the consent form. A request to tape record the interview for later transcription purposes was then proposed and all participants agreed. Two audio recorders were used during each interview in order to have a back up in the event that one recorder failed to function properly.

The interviews consisted of structured and open-ended questions; the former organized in order to uncover relevant details about the participants' experiences, while the latter provided participants with the freedom to answer and elaborate however they

chose. The purpose of the semi-structured interviews were two-fold: 1) to validate participants' pregnancy narratives and life experiences, and 2) to review the effectiveness of HWH's services and determine the gaps in ideology or practice as identified by women who have utilized health and social services similar to the ones HWH will offer. Before each interview began, women were informed that the questions asked were meant to be a guide for our conversation, and that ultimately *her* story and *her* experiences were the most important piece of information. This acknowledgement was meant to communicate to participants that *they* were the experts, and that they should not feel restrained by having to answer every question "correctly". Collingridge and Gantt (2008) confirm that "from a qualitative perspective, reliability is uncovering the rich meanings inherent in people's conscious experiences" (390). In order to gather such richness, the life experiences of the women involved in the research were at the forefront of the interviews and regarded as the most significant piece of knowledge guiding this research.

The interview guide (see Appendix C) was divided into three main sections. The first section focused on questions surrounding the participant's life conditions during her pregnancy, including her housing conditions, the status of her relationships with others in her life, and how her drug and other substance use was affected as a result of her pregnancy. The second section of the interview guide focused on the maternity care she received during pregnancy, labour, delivery, birth, and post partum and the interactions she had with their health care providers. The third section of the interview guide shifted the attention to the HWH. Participants were provided with a sheet that spelled out HWH's acronym. After reading out the acronym, participants were questioned about their

opinion of the HWH concept, as well as what they thought should and should not be part of the program.

The participants were offered a thirty-dollar honourarium as a gift for participating in the project, which all thirteen accepted. The honorarium envelope also included a list of the contact information for various counseling and maternal health services. The women participating in the interviews were offered bus tickets to cover the cost of transportation to and from the interview location if the interview was not held in their current housing situation. Participants were also offered the option of having childcare provided during the interview. Only one participant took up the childcare offer, and no participants requested bus tickets.

Method

The interviews ranged on average between forty-five and sixty minutes, with the shortest interview running just under half an hour, and the longest interview coming in at just over an hour and a half. The interviews conducted were framed within feminist methodological research techniques that allowed for data collection and analysis situated within the understanding of "gender relations on the basis of the way in which female inequality has been structured and maintained in society" (Barry and Yuill 2002:19). This involved espousing certain practices and epistemological frameworks such as being "reflexive about the exercise of power in the research process (though power can be conceived positively as well as negatively)" (Ramazanoğlu and Holland 2002:146). Feminist methodology is embedded in other qualitative approaches that seek to reduce power differentials through researcher reflexivity and other techniques. Community-based research seeks to strengthen communities through autonomous participant

involvement and other empowerment-based approaches (Boyd 2008; Benoit et al. 2005; Finley 2008; Pauly 2008a). Community-based research inverts the traditional researcher-participant power paradigm by privileging "the participant's own understanding and processes for meaning-making over those of the researcher" (Finely 2008). Academic-community collaborations face a number of challenges, and seek to minimize power dynamics and promote integration of all members involved in the research process (Benoit et al. 2005; Janssen et al. 2010). This is especially important when working with vulnerable populations.

Intersectionality has also been applied to the framework that guided this research process (Bilge 2010; Falcon 2008; Hankivsky and Christoffersen 2008). Intersectionality is a methodological tool which contextualizes the research within intersecting structural influences that affect individuals in complex ways (Falcon 2008). As illustrated in the previous chapter, this vulnerable population face multiple, traversing factors in their life choices and chances that are structurally imbedded in different forms of discrimination and exclusion. Intersectionality also seeks to highlight the power dynamics and relationships between different social categories (Falcon 2008; Hankivsky and Christoffersen 2008). Intersectionality is an especially appropriate perspective for health research because analysis of different social categories can reveal different health inequities and illustrate their complex interaction and influence over an individual's or group's health (Hankivsky and Christoffersen 2008).

My research is situated in frameworks of community-based research and intersectionality, with special attention paid to gender due to the research population. I identify my research methodology as primarily feminist, informed by these other

qualitative perspectives. Throughout the entire research process I have been conscious about the power dynamic that exists between my role as a researcher and my participants as the subjects being researched. The methodology employed attempted to minimize existing power dynamics and provide space for participants to have agency throughout the research process. In terms of the population of research, "feminists have questioned whether child welfare and protective service agencies are fair, tolerant, and concerned with the well-being, civil liberties, and basic rights of their clients", as well as interviewers like myself, who may also be perceived to have ulterior motives (Campbell 2000:142).

Two ways I consciously sought to minimize the power dynamic between the researcher/researched relationship were through word choice and body language. As mentioned previously language is important in all stages of the research process. After multiple discussions with my supervisor and the HWH research team, I carefully selected the phrase "substance use" over "drug abuse" to use during the interviews. Greaves and Poole (2008) deliberated on a careful decision about language use during their own research on pregnancy and substance use issues in Canada. They agreed on the term "substance use" because

> We were interested in capturing the fact that substance use does appear on a continuum. Not all substance use is harmful and not all problem substance use is actually addiction. We are also really interested in making the differentiation between abuse and substance use and that we use the term "abuse" only when we are talking about violence against women, making "abuse" about people and "problem use" about substances. (31)

Greaves and Poole (2008) and my choice of language reflects a conscious decision not to contribute to the stigmatization of the research population.

Language and word choice was also extremely important during the in-person interviews. The interview guide underwent multiple revisions, and constructive feedback about the guide was shared by other members of the research team. Word choice was especially important when potentially sensitive topics were raised, and resulted in the questions including value-neutral phrasing such as: “how was your substance use affected by your pregnancy?”. The rigor applied to the interview guide resulted in carefully crafted questions that were meant to encourage open and honest responses from the participants and foster a comfortable space in which the encouragement could be nurtured.

During the interviews I was very conscious of my body language and noted how subtle postures and positions could enhance the facilitation of a warm environment for participants to share their life experiences. During the first interview the participant was visibly nervous and uncomfortable about the experience, and, in an attempt to cope with her uneasiness, made herself an alcoholic drink when we first arrived at her living arrangements. Noticing this cue, when she sat down on the ground, I moved from the couch to the ground so I was on the same level as her, both physically and metaphorically. I also assured her at various points throughout the interview that she was in a “safe space” and there was “no judgment” happening during the interview. As well, I made sure to vocalize affirmations at appropriate points throughout her answers in order to validate her responses and encourage her to elaborate. Dowling (2006) states that “[t]he intimate non-hierarchical partnership when conducting interviews in feminist

research is considered more effective than assuming a detached approach" (14). This holds especially relevant in "research involving sensitive issues" such as the topics discussed in the interviews, which included substance use before, during and after pregnancy, among an array of interrelated issues (Dowling 2006:14). While the process of developing rapport with the first woman I interviewed proved to be a bit challenging, she did share some of her experiences and added to the richness of the data collection. My ability to build rapport was enhanced with each subsequent interview that I conducted, and all of the participants appeared to be comfortable enough to move into an exploration phase of the interview where "learning, listening, testing and a sense of bonding and sharing" occurred, although this took place at varying levels (Dicicco-Bloom and Crabtree 2006:317).

The design and outline of my research was approved by the University of Victoria and Vancouver Island Health Authority ethics committees within a larger "parent" study, submitted for the entire CIHR-funded research project. In keeping with the research ethical protocol of minimizing the potential of harm, participants were provided with a sheet of social and health service descriptions and contact information that focused on mental health and counselling. This sheet was put in the envelope with their honourarium so they could access the information at any point after the interview if they chose. As well, the consent form notified participants that they could contact my supervisor or the ethics committee at any point. Participants were informed that they did not have to answer any questions they were uncomfortable with, and encouraged to provide only as much information as they were alright with sharing. As well, participants were advised that if they started feeling distressed during the interview they could be put in touch with

professional support immediately, and that they could withdraw from the study at any time.

Also in line with feminist methodology, accurately depicting participant responses in their own words was an important step during the interpretation and analysis steps of the research (Acker 2001; Bilge 2010; Dowling 2006; Ramazanoğlu and Holland 2002; Reinhardz 1992). At the end of each interview participants were asked if there was anything they wanted to add that was not covered during the interview, or elaborate further on an issue that was brought up during the interview. This question opened up the potential for the participants to elaborate on an issue or specific point that was important to them in their own words and without questioning prompts that could influence the nature of their answers.

After any comments or issues that were raised in this final question were addressed, and the interview portion was complete, participants were asked if they were interested in participating further in the research process by becoming volunteer members of the Women's Advisory Council. The goal of the Women's Advisory Council is to integrate the population of study into the research process in a very real, tangible way where this vulnerable population can provide feedback and be a continued part of the development of HWH. The progression of the Women's Advisory Council since this research has taken place is discussed more in Chapter Six.

Participants were also asked if they were interested in reviewing their transcripts and providing relevant feedback with regards to accuracy of the text. This form of member checking or "respondent validation" lent to the "sharing interpretations and theorizing with the research participants, who can check, amend and provide feedback as to whether

they are recognisable accounts consistent with their experience" (Roberts et al. 2006:44). Most participants were curiously interested in reviewing their transcriptions. Any identifying items, such as names, dates and locations, were removed from the transcriptions before being sent to the participants, in order to assure their anonymity. After each transcription was sent, participants were encouraged to comment and correct any discrepancies that they saw in the text. The goal was to ensure that the stories, experiences and comments that they shared during the interviews were an authentic representation of their lived understanding, and were not skewed through my own interpretation of their lifecourse.

A few participants were very cautious about how the collected data would be used and who would have access to the interviews. Some participants' hesitancy continued even after the consent form was reviewed, which outlined the importance of their confidentiality and anonymity in the project. After participants were provided with the transcriptions of their interviews, a few women voiced specific feedback that the particularities discussed in their interviews left them concerned about their identity, even though names of people and specific locations and dates were removed from the transcripts. These participants' concerns were addressed and they were assured every effort would be made to ensure their anonymity when the results were written. Dicicco-Bloom and Crabtree (2006) explain how "during interviewing, the participant may share information that could jeopardize his or her position in a system" (319). The information participants shared during the interviews could have potentially jeopardized their relationships with various social and health services such as the provincial Ministry of Child and Family Development (MCFD), their social worker, and/or their health care

provider. Due to the sensitive nature of such interviews, "[t]his information must remain anonymous and protected from those whose interests conflict with those of the interviewee" (Dicicco-Bloom and Crabtree 2006:319).

As a result of cautious feedback from the women interviewed at multiple stages of the research process, individual descriptions profiling each woman's life are not provided in the findings or discussion of the data. Furthermore, each participant is referred to by a number, rather than a pseudonym. This same type of identification has been done in other feminist research projects involving women who use substances as their research focus (Boyd 2001; Bungay, Johnson, Varcoe and Boyd 2009). The rationale behind this decision is that participants were not asked for a pseudonym during the interview, and to decide on names without their consultation is contrary to the principles guiding this research. While I acknowledge that using numbers to identify each participant can be viewed as dehumanizing, picking pseudonyms based on my own assessment of each individual participant would not be ethical. Due to the nature of some of the participants' living arrangements and life circumstances, contact with all thirteen participants was not a viable option.

Data Analysis

The inductive thematic analysis of the data used elements from grounded theory, such as employing various stages of coding, constant comparative techniques, and open coding (Charmaz and Mitchell, 2001; Glaser and Strauss, 1967). Data was organized "into a logical, systematic, and explanatory scheme" in order to develop thematic categories that could be organized into the findings of the research (Collingridge and Grant 2008:393). However, unlike grounded theory, data was not continually gathered through follow-up

interviews with research participants until saturation had been reached (Charmaz and Mitchell, 2001; Collingridge and Grant 2008; Glaser and Strauss, 1967). As a result, the data analysis followed more general research strategies employed in analyzing qualitative interviews.

Analysis began soon after each interview ended; initial thoughts and notes were written down in a research journal as soon as was possible. Some of these thoughts were later shared with the transcriber and contributed to the next level of analysis, where the first stages of emerging themes were discussed between the transcriber and myself. I was further immersed into the data while listening to the interviews and simultaneously reading through the transcriptions. Comments and feedback from participants regarding the accuracy of their transcriptions were considered as they were received and transcriptions were modified accordingly. Transcriptions were then reviewed without the accompanying recording and notes to assist with identifying potential codes as they emerged from the data. The interviews were then re-read while applying the relevant codes and looking for new codes that might emerge during subsequent readings. The transcriptions were read a fourth time, where the codes were applied to overarching themes as they developed. In order to assist with the understanding of the data, key themes were organized on a spreadsheet in order to keep a quantitative tally of the individual themes as they were mentioned in the participants' responses. The spreadsheet was also designed in to easily convey the emerging codes and main themes in a quantifiable manner to the purposes of the research team, and could therefore be accessible for use with the larger "parent" project.

Roberts, Priest and Traynor (2006) emphasize the importance of accuracy in qualitative research, and "reliability and validity are ways of demonstrating and communicating the rigour of the research processes and the trustworthiness of research findings" (41). The rigour involved in the research design and execution was significantly enhanced through the feedback received from the rest of the research team. As mentioned earlier, part of this feedback came in the form of mock interviews, where test interviews with other members of the research team were conducted. This proved beneficial to practice interview skills and receive valuable comments from the range of expertise on the team. In line with feminist methodology and community-based research practices, validity and adequacy were taken in to account throughout the research (Benoit et al. 2005; Ramazanoğlu and Holland 2002; Reinharz 1992; Roberts, Priest and Traynor 2006). Validity was enhanced by sharing transcripts with the participants, and through feedback from my supervisor, as well as periodic input from members of the HWH research team. Adequacy was achieved throughout the research process by frequent reflexivity of research methods, my positionality as the researcher and the influence the research outcomes had within the larger parent project (Pauly 2008b). Overall this entire experience has provided the satisfactory notion of having contributed to a meaningful, tangible project that will be utilized by both the research community and HWH advisory board.

Conducting this research situated me in a relatively unique position in terms of comparison with the other graduate students in the Sociology department, in that this research is part of the larger "parent" project overseen by my supervisor. This position has resulted in a multitude of beneficial outcomes that have significantly enhanced the

quality of the research as well as assisted me in my development as a researcher. While collaborative projects with clear power hierarchies have the potential to create unsatisfactory results, the overall positive experience affirmed the merit of this research endeavour.

My involvement in the larger research project has allowed access to a glimpse of the complexity involved in the creating a collaborative program with a plethora of organizations involved. I was privy to HWH team meetings with a unique and collaborative group of researchers, medical practitioners, coordinators of community organizations and interested members of the public that were all united in the common goal of creating HWH. I was able to observe the tensions between different mandates and agendas that various parties wanted to be pushed through, and the protocol of how to respond diplomatically to tensions.

The experience of working as part of a larger team has also been invaluable. As a result of being hired as a research associate for the project, I was put in a role where I both took directions from and provided advice to people with varying levels of involvement in the project. Jansson, Benoit, Casey, Philips and Burns (2010) outlines the numerous skills that graduate students such as myself gain by engaging in a larger research project. This includes the chance to

> Develop networks with community-based personnel that can facilitate their theses and dissertations, and afford them an opportunity to learn about administering research budgets and the practice if executing methodological and ethical plans in the context of larger, and in our case longitudinal, projects. Students likewise learn valuable

> negotiation skills and practices in research collaborations and participate in multiple forms of data dissemination to various audiences. (140)

I was able to ask for advice and guidance from more experienced researchers, both in my discipline and outside of Sociology. As well, I was able to assist in the training of a community-based research assistant who began her role at CARBC as I was exiting the project, and therefore was provided with the opportunity to pass on the lessons learned and skills gained to the next wave of HWH researchers.

Dilemmas in Qualitative Research

Two potential drawbacks to working within a larger project was the minor restricted freedom over the construction and the design of the research methods, and the delays in progression of the research steps due to the collaborative nature of the project. Every aspect of the research process, from the designing of the interview schedule, to the recruitment posters and emails to key informants, were first run not only by my supervisor, but by the other members of the research team as well. Such communication resulted in multiple feedback sessions, many edited drafts, and extended completion dates. Alternately, if the project was independent research that relied solely on my supervisor's feedback, the time lapse between the stages of the research process would have likely been reduced. While these facets could be interpreted as limitations of conducting research within a larger "parent" project, such aspects were central to enhancing the quality and rigour of the research. The critical responses and thoughtful suggestions provided by the research team has allowed for the careful development of a project that is truly collaborative in nature. Such synergy was extended with the addition of a transcriptionist to my specific research project.

Hiring a Transcriber

As part of the generous funding from the Sarah Spencer Foundation (a private foundation in the GVA that supports local organizations with an interest in women's health issues), a graduate student was hired to transcribe the interviews verbatim. Participants were informed before the beginning of the interview via the consent form that a transcriber would have access to their data, and that the transcriber would sign a strict confidentiality agreement prior to reviewing any of the audio recordings. The original motivation to hire a transcriber was to allow more free time to focus on other areas of the project while my research still moved forward. The unintentional benefits of hiring a transcriber proved to be numerous and advantageous, and overall enhanced the quality of the data analysis. Two main benefits of hiring a transcriber and two drawbacks to this decision are emphasized below.

The first unintentional benefit came in the form of a cathartic release. As a result of the intense nature of the topics raised in the interviews, and the complexity of intersecting oppressive forces that systematically disempowered and disadvantaged participants' lives, I often felt emotionally and mentally drained after conducting an interview. This was exacerbated on occasions when multiple interviews were conducted in a single day. I was able to debrief with the transcriber in a confidential manner, and she was able to provide feedback, as she was also familiar with the raw data. The process of sharing emotional reactions to the data candidly with someone who was equally (if not more) familiar with the material proved to be both personally cathartic and extremely valuable for discussion of the findings.

A second unintentional benefit was the assistance the transcriber had in the rigor process of the qualitative data analysis. The transcriber was able to affirm my insights

and provide new or different understandings on the themes that emerged from the interviews. Such discussions carried on throughout the interview and transcription process, and included a few memorable conversations with the transcriber about the data at various stages of the analysis. These interactions proved to be a form of internal reliability, where the transcriber and myself independently came to the same conclusions about multiple themes and main points. This type of affirmation of validity is important in qualitative research, as "careful craftsmanship and attention to detail makes legitimate results possible and allows for defensible knowledge claims" (Collingridge and Grant 2008:391). The numerous and lengthy discussions with the transcriber about the data proved to be in an unintentional benefit that increased the reliability and credibility of the findings from this research.

While hiring a transcriber proved to be beneficial for the reasons outlined above, there were also drawbacks accompanied with employing someone else to transcribe the interviews rather than taking the task on myself. Dicicco-Bloom and Crabtree (2006) elaborate on some of the challenges involved in hiring a transcriber for one's research:

> Transcribers often have difficulties capturing the spoken word in text form because of sentence structure, use of quotations, omissions and mistaking words or phrases for others. Because people often speak in run-on sentences, transcribers are forced to make judgement calls. The insertion of a period or a comma can change the meaning of an entire sentence. (318)

This sentiment held true for the transcriber. To our benefit, the transcriber and myself often worked in the same office, and she was able to ask clarifying questions in real time as they occurred during her transcription process. When this was not possible, the

transcriber highlighted areas in the transcription where words could not be understood and indicated the time in the recording, so the tape could be reviewed to find the correct words. Even with these measures in place, when the audio recordings and transcription read-through occurred simultaneously, there were various discrepancies in what was spoken and what was written down. These discrepancies were due to the participants' pronunciation and articulation, other noise in the interviews, or a misunderstanding of what was heard. This process proved to be time consuming, and possibly would have been minimized if the interviews were transcribed myself.

Another potential and real drawback of hiring a transcriber was the subsequent level of distance created from the data. As Dicicco-Bloom and Crabtree (2006) point out, transcribers are part of the process of creating inherent meaning and interpretation of the interviews through the decisions of where to place punctuation and when to document pauses that occurred in the recording. The placement of such grammatical necessities adds to or alters the tone of the written text of the interviews. Since the transcription were not done myself, subsequently some of the authority to the meaning-making process was lost. Maybe the punctuation would have been assigned differently if the interviews were transcribed myself? Perhaps the interviews were read and subsequently heard differently during the analysis of the data while using the transcriber's cues to understand the structure of the recorded sentences? Indeed, another level of intimacy with the data may have developed if the entire research process was more of a solo endeavour. These "potential drawbacks" can also be seen as a co-construction of knowledge that assist with the validity and of internal reliability of the data (Reinhardz 1992). As a result, the

decision to hire a transcriber was overall positive, and added to the quality of the research.

Reflexivity

Reflexivity has been an important part of the feminist research process, and has allowed for the critical awareness of my position as a researcher, and all the assumptions and bias that affected this role and potentially impacted the design and delivery of this research. Dowling (2006) explains that reflexivity "involves being aware in the moment of what is influencing the researcher's internal and external responses while simultaneously being aware of the researcher's relationship to the research topic and the participants" (8). Horsburgh (2002) furthers this definition, describing reflexivity as an "active acknowledgement by the researcher that her/his own actions and decisions will inevitably impact upon the meaning and context of the experience under investigation" (307). One goal that reflexivity "can serve as a further measure of validity" for the research by exposing the positionality on the research, as well as the thought process throughout the data collection and analysis (Roberts, Priest and Traynor 2006:44). Dowling (2006) agrees that "reflexivity is a concept central to qualitative research in general, where it is viewed as a means of adding credibility" (17). Validity was added to the research through my attempt to be transparent and reflective of my own opinions and bias and my role and position within the research.

I struggled with the insider/outsider perspective during the interviews and when reviewing the transcriptions. Acker (2001) points out that "questions around insider/outsider standpoints are readily found in sociological writings" and research (155). More often than not, I felt thoroughly like an outsider, especially during

interviews. Throughout the first two interviews the participants made pointed comments about my own lack of children. The first participant ask me candidly whether I had any children and whether I had ever used substances other than alcohol and tobacco. These questions appeared to be a point for her to assess my positionality. The pronounced difference between myself and the first woman interviewed became exacerbated after I left her unstable housing situation post-interview and met up with a fellow graduate student at a private yoga studio. The juxtaposition of the participant's lived reality to my own was starkly emphasized in this illustration of different lifestyle habits. This overwhelming sense of being the 'outsider' – a privileged academic with no children and no substance use or housing issues – prompted serious self-reflection about my capability to adequately conduct the research while not being able to fully empathize with the research population. This concern was discussed with various academic mentors, who assured me that there are challenges to being an 'insider' as well as an 'outsider' in qualitative research, and that one position is not more or less valid. Indeed, in Phillip's (2010) doctoral research she discussed the tensions of feeling like an outsider in the organization where she was conducting her ethnography, but was also wary of crossing the line to become an 'insider' that would result in an ethically precarious situation. Merton (1972) states that these tensions are in part because of the fear and reality that there are some "Insider truths that counter Outsider untruths and Outsider truths that counter Insider untruths" (11).

As the interview process developed the obviousness of my status as an 'outsider' with the participants diminished, in part because of my growing comfort with the questions and responses. The life experiences of the thirteen participants were powerful examples

of the layers of overlapping disadvantage often simultaneously occurring. However, after reviewing the interviews, and especially after discussing the transcriptions with the transcriber, the potential to be an 'insider' was not as far removed as initially thought. While life chances have provided innumerable opportunities for me that have culminated into life choices that benefit my upward social mobility, like pursuing a Master's degree, the participants' interviews illuminated how easily I could have made some of the same life choices as the research participants. Realizing my affinity with participants reinforces how life chances have provided a different path for me, but such life chances straddle the line between the perceived 'them' as subject to be studied and myself as the universal 'us' with a supposed claim to objectivity. This realization provided me with a new level of empathy and understanding for the population being researched. It is not a matter of 'us' as removed academics and 'them' as a specific vulnerable population: 'we' are women who have dealt with different struggles, challenges and stresses in our lives, and based on a number of complex factors, the outcomes of theses stresses resulted in different lifestyle habits and health behaviours. I have had a variety of life choices that have allowed me to enact my sense of agency with overall positive lifestyle habits, while many or most of the women in the research have faced more structural inequities and fewer life chances that have constrained their ability to resist and have even encouraged adverse health behaviours.

Summary

This chapter has discussed the methodological considerations of the research, including the rationale for the research sample, methodology, data collection and analysis. As well, this chapter has highlighted some of the benefits and potential

drawbacks of conducting research under a larger "parent" project, and of hiring a transcriber. Chapter Three also elaborated on the self reflexive nature of the research process and the implications of my role as a researcher, and identified the limitations of this research. The following chapter explores the findings of this study in thematic detail.

Chapter Four: Findings

"I'd never been a parent before, like, it just gets really overwhelming"
(Participant #7)

Introduction

The results represented here are based on the participants' self-reported narrative about their lives, including the use of drugs and other substances while pregnant and after they give birth. While the women interviewed chose to disclose a considerable amount about themselves, inconsistencies and gaps in the logistics and details of their stories were also revealed. Such discrepancies could be based on a number of factors, including the possibility of having a hazy recollection of past events, depending on how long ago the events took place, and other stresses concurrently taking place in participants' lives, including the fear of stigmatization and the degree that substance use played as a role in their mental and physical state during their pregnancy and after the delivery of their children. As mentioned in Chapter Three, considerable effort was made to establish a "safe and comfortable environment for sharing the participant's personal experiences and attitudes as they actually occurred" (Dicicco-Bloom and Crabtree 2006:316). As the researcher I tried to create this type of environment through different methodological techniques. However, barriers to trust may have still existed between the participants and myself due to the sensitive and personal nature of the subject matter, and as a result participants' health behaviours may have not been accurately disclosed during the interviews.

The following themes were measured in order to make quantifiable evidence of the various issues participants' face in their lives. Participants' responses are grouped into

three main areas of focus: the social determinants of inequities surrounding the participants' lives while they were pregnant; the effects and outcomes of the complicated interplay between life choices and chances during pregnancy and after birth; and the participants' suggestions for the HWH intervention based on their own lived experiences.

Participants' background

Eleven of the thirteen participants were post partum with the children that they discussed during the interview. The remaining two participants were pregnant at the time; one was seven weeks along and the other woman was six months along. The average age range of participants was in the early twenties, with the youngest participant being seventeen years old and the oldest participant recently turned forty. The ages of their children ranged from five weeks to nine years old, and of them seven had other children. Six women had other children prior to the pregnancy they discussed in the interviews. There were no questions about my participants' race, ethnicity or citizenship during the interviews. Only one participant mentioned her ethnicity by identifying that she had a Native Status Card. The other participants did not disclose any information about their ethnic, racial or cultural background. As such, *cultural membership* is not identified as a theme in this research. Other determinants that resulted in inequities such as unstable housing and food security issues emerged in the participants' answers as the interviews unfolded.

Stigma was a repeated topic of conversation during the interviews. Nine participants specifically voiced some form of felt stigma. This is not to infer that more participants did not experience felt stigma as a result of their health behaviours, but only nine specifically identified feeling shame, guilt, and other negative emotions associated with

their adverse health behaviours. Participant #11's drug use was connected with her sense of self worth: "when I was pregnant with my daughter and I used because I was already a user, you know, slash loser. I was smoking crack, I was snorting cocaine, I was taking pills." Participant #13 described the agonizing emotional pattern that went along with her drug use while she was pregnant:

> Every time I did it [drugs during pregnancy] I beat myself up and I cried and I felt like shit 'cause there's this baby that's, that's getting it too. But I couldn't, sometime – I was just in the wrong place at the wrong time and I just didn't know how to say no. You know and once you have one you want more. So I'm not justifying it. It was wrong.

Using drugs and other substances before, during, and after pregnancy caused participants in the study considerable grief. Part of the distress the participants faced was over the denial of the effect the addictive properties of the substances had on them and the awareness that they were operating outside of social norms, and awareness of their behaviours operating outside of societal norms because they were not able to easily abstain from using upon finding out they were pregnant, or they did not want to abstain. Participant #6, who was taking heroin and methadone the majority of her pregnancy, lamented at the difficulty she had with quitting smoking cigarettes,

> I also just felt like really ashamed too, and that, like OK I should just be able to quit. Like you see like an abuser and you hear all the people who are just like 'I found out I was pregnant and I never smoked again.' You know?

Participants often compared themselves to other people and saw their lack of ability to abstain from using substances as a failure. Participant #8 identified how she felt atypical "because I thought that you know like every normal person should be able to just stop doing things like that," in reference to her substance use during pregnancy. The women I interviewed identified using a range of substances, including heroin, methadone, crack and powder cocaine, crystal methamphetamine (meth), prescription drugs, gamma hydroxybutanoic acid (GHB), marijuana, alcohol, and tobacco. The majority of the participants voiced that they were using more than one of these substances, especially alcohol and tobacco in conjunction with illicit drugs.

Participants were aware that using substances during their pregnancy directly affected their babies, and often had huge amounts of guilt and self-loathing during and after their use. The feelings of anxiety and guilt added to the stress participants' faced in their lives. Felt stigma added to existing pressures participants had in their day-to-day lived reality during their pregnancy, which often perpetuated a cycle of using substances to find relief from life stressors, only to feel bad about their use and ultimately add to their stress.

While participants identified feelings of shame, guilt, and anxiety over their substance use, many of them also clearly articulated struggling with the addictive properties of the substances they used. Participant #4 shared the erratic sequences of guilt she felt when using crystal meth while pregnant:

> Every time I would do some [crystal meth], uh, my baby would start moving around lots more. I'm like oh no, it would make me feel really bad, so I wouldn't, I wouldn't do it for a little bit and then I, I'd do it again, and then, yeah. I felt, I felt really bad doing it, but, it's an addiction so … [trails off].

Although this woman acknowledged the power of addiction, such awareness did not decrease her feelings of shame over her 'life choice'.

Twelve participants recognized feeling some form of enacted stigma and fear of judgement from others. Participant #6 illustrated this fear, stating "I don't think there's really anything that people hate as much as like, a pregnant woman who uses drugs." Participant #6 remembered how she had extreme guilt and shame about her substance use, and was very concerned about the effects of her heroin use on her foetus. She recalled that when she used heroin during her pregnancy:

> It was always just like really scary, you know like if I used and then, you know he'd [her child in utero] be quiet, like not moving. I'd get so worried, just like, my god, am I gonna have to like deliver a dead baby? (Participant #6)

This quote illustrates a grim and real fear for women who use highly addictive substances during pregnancy that are known to cause adverse health effects.

Participant #7 divulged how "I've had situations um, some of the places where I do feel like even though they're great programs and I always feel happy that I went, I felt judged or like, I've been taken the wrong way." This feeling of judgment can deter women from accessing programs that can be beneficial. Participant #7 elaborated on the role stigma had with her decision to honestly share her health behaviours with her health care provider:

> Another thing that's really hard with being pregnant and dealing with any kind of thing, things like that is obviously - the stigma. I think people assume if you're, I

> think just people assume a lot of bad things, unfortunately. So it can be really hard to feel open enough to want to um, tell people that that's what you're going through and access services.

The relevant literature and the above quote affirm that stigma is one of the main barriers to care for women in vulnerable situations with complex lives.

As mentioned in Chapter Three, a limitation of this research is the lack of data on *cultural membership.* Participants did, however, reveal their complicated connections to other individuals and groups while they were pregnant and after they gave birth, which consisted of both their peer, family member and professionals health and social service workers. *Supports and social networks* were important in participants' lives, but such networks also manifested as negative forces that adversely affected participants' life choices. Six women said the father of their child was involved in their children's life. The degree and amicableness of the participants' relationships with the fathers of their children were varied, and often contentious. Participant #10 relayed the rocky history between her and her daughter's father:

> It's been uh, three years anyways since um, the incident. We had a, uh, a case of, they class it as extreme violence. Um, I uh, attempted to stab him. We had a substance abuse problem together. Um, at the breaking point, we finally broke up after seven years and a child and um, we both didn't take it very well. Um I had some mental health issues as well on top of that, with the drug issues. (Participant #10)

Participant #10 also revealed that this incident was the beginning of MCFD involvement in her life. Two participants disclosed how the fathers of their children were currently in jail. Participant #13 discussed the abuse she experienced with the father of her daughter: “I have had numerous guns pointed at numerous spots on my body. Just like when he kidnapped me for when we split up.” She was struggling with the role the father will play in her child’s life once he gets out of jail, but was leaning towards cutting off contact with him completely. Participant #4’s father of her child was in jail when she found out she was pregnant. He had been in and out of jail for theft as well as breaking and entering. Similar to the other participants, she was unsure of what his role would be in her and her daughter’s life once he was released from jail.

The father of Participant #12’s daughter was also currently in jail during the interview. She found it difficult to not have him around to support her and her child, and told me about the interlinking factors behind his incarceration:

> He, [sigh] he’s got a good heart. He does volunteer work at [an organization], his actions were right out of character, I think it had to do with a lot of depression, not being able to take care of us as well as he’d thought he could. Um, he drank a lot, took some pills, went um absolutely berserk and went out and robbed a store. So, um, yeah, he’s gone. I’m left alone again. (Participant #12)

Her relationship with him pre-incarceration, however, was also precarious, and she was debating whether she wanted him in her life again once his jail sentence is over.

The issue of safety surrounding the participants’ life conditions arose out of the theme of abuse. Six participants identified some type of abuse that they dealt with in their life.

This included mental, emotional, sexual and physical violence, and the perpetrators included family members and as well as romantic partners and acquaintances. The range of abuse happened in various points throughout the participants' lifecourse, where two women specifically identified being victims of their own parents' violence. Participant #3 directly connected the start of her drug use to the abuse she faced in her home as a child:

> The only reason I ever started living on the streets or doing drugs is because, well, my dad beat me up and I couldn't go home to see my kids. I ended up homeless because of him […] I didn't like living on the streets, I immediately went and got a tent and I lived out in the parks, which is, I can probably say that's why I started using crystal meth is because the people who live in town and camp in doorways and stay at shelters use crack, and people who live in parks and surroundings are crystal meth users […] crystal meth users are a lot more down the line of people who are, are using it as a, an emotional painkiller. Um, because it numbs your, your emotions. So I found that I fit into that, that category more.

As Participant #3's quote illustrates, the violent abuse she faced in her life was a direct correlation to her unstable living conditions and her drug use.

Participant #2 also faced abuse by a parent. Additionally, she was assaulted by her partner, which resulted in mental and emotional anguish and a miscarriage. During the interview she was in the first term of her pregnancy and was in a relationship with the same partner that had assaulted her. The cycle of abuse for Participant #2 surrounded her, as she revealed:

> I was physically beaten as a child by my mother. My mother was an alcoholic as well, so therefore, I, I brought it on to myself if I ever had children I would never beat my children the way my mom beat me.

While she had made the decision not to repeat abusive actions on her own children, she has become the victim of abuse from her current partner, and has 'chosen' to keep him in her life. Chapter Five will elaborate more on life choices and the constraints of choice within the structural situations of the research participants.

Ten of the thirteen women explicitly identified feeling isolated during their pregnancy**.** Many of the women interviewed shared Participant #6's sentiment during her pregnancy: "I did feel so alone, um, it would've been so nice to like have somebody in a similar situation that I could talk to." Participant #7, who was able to move in to a care home with other young mothers, expressed how "it's better to be around other people that are going through the same thing and not to isolate yourself, so almost like a little community." For some of participants this isolation was a choice, albeit a difficult one, as they purposefully removed themselves from their circle of friends who were engaging in adverse health behaviours. Participant #4 placed herself in the seclusion of her own living situation for months in order to separate herself from people who were involved with unfavourable health behaviours. She explained that:

> I started, like I was using one time, and I started using a lot and I was like ugh, I can't do this, and I'm like, kinda forgetting that I was pregnant so, I was like, and then when it would like click, and I was like oh man, and finally I just stopped talking to everybody, and people would call me and I would just hang up the

> phone, and then sometimes I would unplug my phone, and for two months I just stayed in my place. I got up to go get groceries. No actually, not, not even groceries, from my mom grocery shopped for me. And she'd bring stuff to me. The only time I went was for a, a walk, so I could get some fresh air and to go to appointments. I didn't barricade myself in that place, and not talk to anybody. (Participant #4)

While she still occasionally ran into her friends when she was in the GVA downtown core, she did not associate with them as a condition of her motivation to abstain from crystal meth use. Participant #3 felt she had **"**lost all of my friends who, well, I obviously don't really wanna be around them anymore. They've, they're living a totally different lifestyle than me". She elaborated that she was able to connect with existing services for young mothers and socialize with women in similar situations as herself.

The legal environment that surrounded participants during their pregnancy and after the birth of their children was contentious. Eight women were involved in the legal system for issues connected to their adverse health behaviours and lifestyle habits. Participant #2 had recently finished a court case regarding a restraining order against her romantic partner due to him physically assaulting her. He had recently moved back in to a shared living arrangement with her and she mentioned how they were both trying to "move forward". Participant #2 explained that "I've never been physically beaten up by a guy before. So, and I am deeply in love with this man, for him to do that when he was drunk, it's really messed with my head". Participant #12 shared how legal issues in her home province forced her to move west, and explained how

> I knew if I stayed I'd probably be in jail and I would be pregnant with her and probably have her in there so I, I fled. […] we [her and her daughter's father] came here and I didn't know where I was, I'd never left home before, I'm from a small town […] it's a back-wood town, never been on a city bus, never been on a Greyhound, to come here. [It was a] big life experience.

This quote highlights how Participant #12's trouble with the law resulted in her leaving her community and main source of social and peer supports. As a result, she had been dealing with issues of isolation since she moved to Victoria, especially after the father of her daughter was incarcerated.

Eleven women revealed that MCFD was involved in their lives, which the participants referred to as "the Ministry", "social services" or simply their "social worker". Participants expressed how important it was to know that their case file with MCFD was closed. Two women stated that they were still waiting for the final paperwork to confirm the end of their case. Participant #5, who was on methadone during her pregnancy, shared her exasperation about having MCFD involvement:

> Another thing that was really, really, really hard for me is I had done everything I possibly could to have no involvement of Ministry of Children and Families. I had done everything right, uh, because I wanted to. I didn't wanna have any chance of losing my daughter. I mean I went to meetings, acupuncture, pool, like two or three times a week I was at um, you know prenatal groups, um I was in contact with my doctor, had the, the random drug tests, um, I was in contact with the hospital social worker, and I met with her a few times, prenatally and she, which

> is a lot better they say to be proactive that way, than have them meet you at the hospital and all they have on a piece of paper is 'oh she has a drug history and she's on methadone' and that's their first time they've ever met you and they don't know what's going on with you, right? So I met her um, beforehand, which I was recommended to do and I was reassured by her that I would, there was no need for me to have any involvement with Ministry of Children and Families based on the fact that I was doing awesome, and then, right up to the last minute she was on holiday when I went in to have my baby and the woman that was replacing her, as the hospital social worker at the hospital right up to the last minute, to the day before my surgery told me everything was fine, I wouldn't have to deal with any social workers that way at all. Because, I mean, that's scary for some, someone in my situation.

Participant #5 expressed frustration that her meticulous actions to avoid MCFD involvement were fruitless, as an anonymous person reported her to MCFD the day after her child was born. The report claimed she was drinking alcohol during pregnancy, an accusation which she adamantly denied. She was successful in maintaining custody of her child once random drug testing results during her pregnancy and after the birth of her child were all negative.

Nine participants identified that when they were pregnant they were concerned that their child would be removed from their care after birth. This fear was often a direct barrier to accessing any type of health or social services. Participant #6 expressed how "it was really, really, really stressful cause I didn't feel like I could talk to anybody about it" because of the obligation health professionals have to report potential harmful situations

that may place children at risk. Participant #10 described a tense situation between her and an MCFD worker:

> They [the Ministry] basically told me that if there was any drugs found in her system, she was drug tested right at birth, at birth um, if, then if there was any drugs in her system aside from the ones that they gave him and went to her um, that she would be taken from me immediately and there was nothing in her system, obviously; she's here with me.

The fear of child removal was so great for some of the participants that even if they had maternity care, they did not disclose their entire history of adverse health behaviours to their provider. Participant #13 explained that she

> Was honest with her [midwife] to a point about my [substance] usage [of crack cocaine], but as far as she knows I stated clean as soon as I found out 'cause I didn't tell hardly anybody because I was afraid of the Ministry of Children services coming down on me.

Participant #5 echoed this sentiment, stating "I think there's always the risk hanging over people's head if they're too honest, if they're gonna deal with social workers." This ever-present risk acted as a deterrent for many women to disclose the extent of their adverse health behaviours. Participant #8 appeared to not let this risk prevent her from sharing her history with her obstetrician. She felt that she "was pretty honest with her [obstetrician] about everything. I mean I thought that's my duty as a pregnant women to do for my child so that she could give me the best care" (Participant #8). This woman's response is

rare in this vulnerable population, as almost all of the women interviewed with were fearful that "not being perfect in their [social services] eyes meant that I couldn't have my daughter" (Participant #9).

The *living conditions* of the participants during their pregnancies and directly after the birth of their children were crucial factors that affected their health behaviour, especially their housing situation. Ten women identified unstable housing as part of their lived reality during their pregnancies. Participant #11 was living in a housing complex where many residences were using addictive substances. She divulged how at her living situation

> Every door, you could knock on and you, somebody was doing something you know, or somebody would knock at your door and they'd have something and they'd come in and, you know even though I was pregnant, they still would do that, right? So and I didn't have enough willpower to say no. (Participant #11)

Of this, six women identified being completely homeless at one point during their pregnancy, with four women specifically living outside. Participant #4 shared some of the challenges of living outside while being pregnant. She revealed how

> I was on the streets [homeless] until I was seven months pregnant […] it is really hard 'cause you can't get the proper nutrition and you can't get the proper sleep and you can't move around. I found out, I found that I couldn't move around much 'cause of, I was sleeping on the ground so I was always, my body was aching (Participant #4).

Participant #1 was also living outside while she was pregnant, and was living in a temporary unstable home with an acquaintance during the time of the interview. She told me how "I almost like living on the street better […] Cause it was, it's uh, it's every day I know what's going on and I know what's gonna happen at the end of the day and I know where I'm sleeping." She added that "I'd rather have the consistency of sleeping on the sidewalk than not having consistency at all" (Participant #1).

Participant #3 emphasized the need for stable living conditions and inadvertently exposing the lack of structural supports available and accessible for this vulnerable population in the GVA. She stated that

> Jail was really good for me. Um, it took away any, any want that I did have to do drugs like it, I mean it made it so that it was not an option at all. Um, then there was the fact that there was somewhere to sleep every night, and there was three meals a day, and uh, people to talk to and medical professionals right there is, I could see a doctor if I needed to. (Participant #3)

Unstable housing was not only a lived reality for many of the women interviewed, but was also a specific barrier preventing custody of their children. Participant #12's unstable housing situation affected her ability to gain custody of her daughter. This woman was caught in a frustrating cycle where "I couldn't get a place without having [my daughter], I couldn't have [my daughter] without getting a place. It was a big runaround for four months and it was still a runaround" (Participant #12). Unstable housing further complicated the living conditions and legal environment that the majority of participants' experienced on a daily basis while pregnant and post partum.

Food security was mentioned as precarious for some of the participants. Five women mentioned lack of adequate nutrition as an issue in their lives as mothers. Participant #3, who was pregnant when the interview was conducted, expressed frustration when her midwife would

> ask about stuff like my diet, what my diet is everyday, and I mean, I eat at a shelter every day. That's my diet. I eat what I get in my food hampers […] Um, so it doesn't really matter what my diet is. It's not my choice.

The discussion of nutrition was complemented with some participants sharing their involvement in different neighbourhood community kitchens, which had a range of positive benefits. Participant #10 talked about a weekly program she was involved in specifically for new mothers, where she was able to enjoy the social aspect of cooking, as well as give something back to other women in similar situations. She described the community kitchen as "awesome. We also cook for uh, I think it's every other week we cook for [the prenatal program she used to be involved in] as well" (participant #10). She emphasized that she would like to see more programs with similar initiatives in the GVA. Participant #12 also accessed a community kitchen. In the passage below, she outlines the various benefits to taking part in the program:

> I go to [a community program for mothers] every week. I do a cooking class there. Well its' um, it's all of us mothers that do [a prenatal program], our babies are all older now they're outta that, so we do a community kitchen and we cook for [a prenatal program], um, every other week we cook something for them, but we cook every week and we take the food home, and either something that we can

> eat then or freeze or we're gonna do, start getting into canning and that. And, like I, I remember when I was little doing that with my nanny, you know what I mean? So, that's kind of exciting to be able to do that. And we're a good group, we, we've, we're all pretty much the same, just laid back, we're not uppity, uh, have the world at our fingers type people. This is what it is, you know? I make the most out of it. [Her daughter] and I have a great time. (participant #12)

In addition to the obvious benefit of receiving homemade food, this woman's participation conjured up nostalgic memories from her own youth of canning with her grandmother, and was able to share the important meaning-making activity with her daughter. The community kitchen also provided a safe, judgment-free space to have social time with other mothers. As will be discussed near the end of this chapter, the various benefits of community kitchens were acknowledged by a number of the participants and was suggested as a HWH service.

Five of the women interviewed identified their *mental health* as an issue that added to the stress during their pregnancy and after the birth of their child. Participant #12, who was in a custody battle with MCFD over her child when the interview was conducted, admitted she was dealing with a range of emotional hardships, stating "emotionally I'm a wreck. I'm always a wreck. I'm up, down, sideways". Participant #9 disclosed that she started using crack cocaine "because I started just trying to get away from reality", and used her drug of choice to try and cope with her mental health issues. Participant #12 also used substances as a way to manage her life stress, stating "back home, people around me, um, I was surrounded by drugs. […] I used it more as a coping mechanism not to deal with my mom's death" (participant #12). As confirmed in the literature, substance

use is often a tool to try to deal with traumatic events that take place in the lives of the women in this vulnerable population.

Other participants alluded to issues of mental health that went unaddressed during their pregnancy. Participant #8 acknowledged that

> I had post partum depression for two years so I would've liked some counselling, but I just didn't know how to ask I guess. I just didn't wanna, I didn't wanna bother people with my problems I guess […] I was scared that because I had had the Ministry involved already for um, the drugs and drinking while I was pregnant that someone would be like 'oh, well she's unstable to take care of her child' or something like that, so I just didn't ask, cause I just was scared.

Fear of being deemed an unfit mother and having her child removed from her care prevented this woman from receiving the post partum mental health care that she needed.

The participants networks and social supports, as well as their living conditions, legal environment, fear of stigmatization, and their demographic factors all cumulatively impacted their *access to health and social services*. As mentioned previously, stigmatizing attitudes of health and social care workers, whether perceived or enacted, negatively impacted participants' willingness to access the services initially and repeatedly. The majority of participants did not access any type of maternity care until they were five or six months pregnant, either because they were not aware of their pregnancy beforehand or were fearful of judgment by health care professionals.

Six women mentioned a lack of support from health and social services during their pregnancy. Participant #3 revealed that "my midwife I'm not appreciating so much right

now, cause she's doubting my homebirth," While this participant's midwife had reason to be cautious of her decision for a homebirth due to her history of adverse health behaviours and lifestyle habits including substance use, lack of stable housing, and absence of a postnatal support system, Participant #3 felt that her midwife was not listening to her desires to have a "natural" birth, and that her choice for her labour and delivery was not being taken seriously. Participant #9 felt that "I just didn't have the supports as far as an addiction and being a young mom" in terms of her interactions with social and health services during her pregnancy. She lived with the very real fear that "if I had slipped, I don't think that there would've been any help for me as a new mom" (Participant #9). Some of the other participants echoed this woman's sentiment of feeling powerless in the system if they relapsed or continued to engage in adverse health behaviours.

Seven participants expressed a lack of choice and agency they perceived to have throughout their pregnancy and birth. Participant #3, who was pregnant when the interview was held, described the lack of choice she had during her first pregnancy, where substance use was also involved:

> With my first I was nineteen and I was, had no idea what I was doing and I would've done it a lot different. It was very, very medical, very, very by the books and I had a birth plan written out that was a natural birth plan and it was kind of scoffed at by all of the professionals once I got to the hospital. So, but didn't really have a choice.

Limited options and choice came from many different areas of the participants' lived experiences. Participant #8 experienced severely restrained agency during her contemplation over the decision to get an abortion. During the entire decision-making process the father of her child dictated whether or not he wanted her to get an abortion, resulting in his decision to keep the child. As mentioned above, the relationships with the fathers of their children were often in flux for the participants, and in this case, contributed to the lack of choice she had over her pregnancy.

Seven participants mentioned transportation and mobility issues as a barrier for accessing maternity care and other resources during their pregnancy. Participant #3 explained how transportation, as well as finances, prevented her from obtaining specific prenatal supplements, telling me how "it's the iron that I need because I've taken it before and it's from the compounding pharmacy. I have no way to get out there and I don't have the money to spend on it if I did." Her main mode of transportation was either through public transportation of by walking. Participant #3 shared two negative experiences that occurred while on public transit which involved prejudice towards herself and another woman, and impacted her willingness to use the bus. Participant #1 also had a story of discrimination while accessing public transit. She told me how "I was trying to get a food hamper and I didn't have a bus ticket and the bus driver wouldn't let me on that day, and I was like, fucking eight months pregnant. [I was] So choked […]" (Participant #1). As a result of this experience, an extremely pregnant woman did not eat dinner that day. Participant #1 and Participant #5 identified that coordinating transportation and scheduling for multiple services in a variety of places is especially

difficult for someone who is using drugs and other substances and may be in an altered state of consciousness.

Participants also identified positive experiences while utilizing health and social services they were able to access while pregnant. Participant #6, who shared many stories of feeling stigmatized by health and social care workers, had a positive experience with her doctor. She explained that

> The youth clinic referred me to her. Um, and she was really good. She was really, really good. Um, I was fairly honest with her about what I used, um, and she was really, really respectful about it and just like thanked me for telling her and said that if I'm honest with her she'll be honest with me and um, she was really, really good. (Participant #6)

Participant #11 had her child removed from her care after birth, but had partial custody of her daughter when the interview was held. She described a positive prenatal experience in her obstetrician's office:

> He [the doctor] said he, actually touched my shoulder when my daughter was sitting on my lap and the foster mom was sitting right beside me, and he touched my shoulder and he says 'your daughter is one hundred percent healthy' and he says 'you're doing a great job. You keep up the good work. She is completely fine. (Participant #11)

Instances of honesty and positive reinforcement resulted in participants' optimistic attitudes about their health care providers.

Just under half of the participants had a midwife as their maternity care provider, which is significantly higher than the national average. Overall participants had positive experiences with their midwives and described a range of favourable qualities associated with the care they received. Participant #13 felt positively about the experiences with her midwife because

> It was less clinical and more personable. I liked it […] she was caring and she listened to you and she had great advice and she made that extra effort to either come to your house or – it just was felt so, family-like. You know it wasn't clinical.

Participant #1 has had midwifery care for all four of her pregnancies, and was happy with the care she received. She divulged how "you can trust them [midwives] more [they're] in your life for a longer time [and they] don't drop [you] when the baby's done" (Participant #1). A commitment to quality care on the midwife's part was a reoccurring topic with the women interviewed that had this type of maternity care. When Participant #4 was asked what she liked about her midwife, she responded that "she's really nice. And you could call her at any hours of the day, any hours. They have a pager, you call a pager and you leave a message. They call you back [snap] like that," indicating the promptness and attentiveness of her midwife. In this instance, Participant #4's midwife made an extra effort to provide quality and personalized care to her participant, and it did not go unnoticed.

Some of the women interviewed specifically identified individual agencies in the GVA that assisted with their range of needs during their pregnancy and after the birth of

their child. Participant #12 expressed how: “the Single Parent Resource [Centre] were an immense help. Big time. Emotionally, physically, everything.” Participant #7 credits her positive life growth with the assistance of the Bridges for Women Society, a centre in the GVA that specializes in support for women who have been affected by abuse and trauma. She elaborated on how Bridges would

> Help women to build their self-confidence back, help them to build their boundaries, help them, um, just believe in themselves and so they really get better, and it’s an amazing program. I loved it so much and it helped me a lot, it’s one of the biggest reasons that I turned everything around. (Participant #7)

This participant and others who accessed services like Bridges suggested that HWH ensure that they are connected to the range of supports that are already in place in the GVA. This suggestion is elaborated on near the end of this chapter.

Effects of Complicated Life Choices and Chances

Two participants planned to have a child, while eleven participants (not the same eleven post partum) said that their pregnancy was unplanned and was a surprised. Participant #4 disclosed that

> I didn’t believe it. I was shocked. I, I’ve like never got pregnant before, I was like this can’t be, and like, her dad never had any kids ever, so, it was weird. I didn’t, I didn’t wanna believe it.

This disbelief and shock was shared by a few of the other participants. Part of Participant #4’s initial denial of her pregnancy was a result of her living circumstances that were less

than ideal preconditions to bring a child into the world. Participant #13 painted a bleak reality of her living situation when she found out about her pregnancy:

> Actually I was living outside. I was outside for about two and a half, three years. Um, back home and then there. And the father ended up going to jail in September. And about two weeks after he went in, I kept getting sick and kept getting sick and I thought it was the dope I was doing. I thought it was the morphine 'cause I was smashing morphine more than anything. And um, it kept happening, kept happening and then I thought well, maybe I'm pregnant, but I was afraid to test because then I'd have to quit and I wasn't ready to quit.

Indeed, "not wanting to quit" was a sentiment shared by a few of the participants. Participant #6, who was using heroin and methadone, divulged how she felt like she had to quit, but it was not something she wanted to do or fully accepted for a while:

> I, totally quit when I was about seven months pregnant and um, it was really hard, um, cause I just kept thinking like oh just one more day like, I'll quit tomorrow, I'll quit tomorrow, and like in my seventeen-year-old mind, you know?

This quote emphasizes that this woman, as well as a few of the other women interviewed, were not even legal adults themselves when they became pregnant, and where forced to make some difficult decisions in their life within severely restricted life choices.

Many participants were quite young when they found out they were pregnant, in their late teen years or early twenties. Some of the participants identified that their substance use was a way of coping with the stress in their lives, and was a way to temporarily

suspend their reality. All thirteen respondents identified that stress was a big issue during their pregnancy, labour, delivery and birth. The stress participants felt in their life stemmed from a variety of complex, often intertwining issues that affected their life choices and chances. Participant #10 directly connected the stress of her unplanned pregnancy to her substance use habit, and used drugs as a coping mechanism upon the shock of finding out she was pregnant: "I was pregnant and I knew when I was five weeks pregnant, and I was like freaked out and so I probably did crack a lot then." Part of the fear and shock of accepting their pregnancy was negotiating their health behaviours during this new stage of their life. Participant #5, who was on methadone for the majority of her pregnancy, stated "I never wanted to have a baby while I was on methadone. I, one of the things that was really hard for me was coming to terms with the fact that my baby might be born with withdrawal symptoms just from being on the methadone." Struggling with the guilt of engaging in adverse health behaviours during pregnancy was an ongoing battle for many participants, and added to an already stressful situation.

Eleven participants identified their pregnancy and/or the birth of their child as a motivation to decrease or quit their problematic substance use. Participant #9 admitted "if I wasn't pregnant I wouldn't have stopped drinking and doing drugs." Participant #5 echoed her sentiments: "if I hadn't gotten pregnant, I have no doubt I would still be using today." Some of the participants explained how as soon as they found out about their pregnancy, they were able to completely abstain from using most of their problematic substances. Many of these women still smoked cigarettes during their pregnancy, and went back to using their substance of choice (usually alcohol or crack cocaine) after their child was born. Other participants did not have such an easy journey. Participant #6

stated that quitting her heroin and methadone use "wasn't like, magic, like 'oh I'm pregnant now I can quit drugs' it was like, I kept using like on and off until I was about seven months pregnant."

Many of the participants referred to their child specifically as a "blessing" that assisted with them decreasing or desisting in their drug use and "changed their life around." Participant #4 revealed how "I didn't expect to be pregnant. It straightened up my life through. It was a blessing." Participant #6 had her issues with substance use during pregnancy almost a decade ago, and has had time to reflect about her life then versus now. She shared a story about when she told her child

> You know what if you hadn't come into my life like I would be making bad choices and, and I wouldn't be doing this. Like you're, you're the best gift that, that's ever happened to me. (Participant #6)

The range of themes that have emerged through participants' narratives call attention to the complex situations that they faced while pregnant.

Eight women mentioned that they were randomly drug tested throughout their pregnancy, labour, delivery and birth, which was rarely a choice but always a requirement. Some participants claimed they were happy to comply so they could prove their abstinence from drugs and other substances. Participant #5 shared how her maternity doctor:

> Pretty much right away instated um, weekly random drug tests, which I was fine with because that way I knew that if anything came up anybody called in on me,

> if there's any type of problems I could down on paper with the nurse standing over me watching me urinate that I hadn't been doing drugs.

Participant #9 explained how "I had to do random drug testing uh, which was pretty much, it was voluntary for me, cause I wanted to keep her [daughter]". Most participants acknowledged that in order to maintain custody of their children after their birth, undergoing random drug testing during pregnancy was necessary to prove to MCFD that they were deemed 'fit' to be a mother.

Other women shared the hassle and anxiety involved in being drug tested during pregnancy. Participant #10's process was disjointed:

> At first it was, um, I had to call into a number uh, every single day, um, for about three, I think it was three, in three-month increments. Um, and they would tell me yes or no that, that day right when then and there you'd come in at this time. And automatic fail if you don't show up. Um, and then it got kinda spaced out where um, she would get the order for one and send me, send me for, for one, and they would randomly call me up and say 'kay, you're coming in' pretty much, and I'd go for one. I just, passed 'em all. Thank god!

Part of the euphoria over her tests outcomes were that the results meant she was able to keep her child.

Six women mentioned the importance of bonding with their child, and lamented the lack of bonding that occurred as a result of their adverse health behaviours. Participant #6's son was placed in a separate room in the hospital to allegedly help him withdraw from heroin, and although she questioned the legitimacy of this method, did not feel she

had enough agency in her situation to voice her discontent. As a result from being separated from her child initially after birth, she found it difficult to bond with him once her son was returned to her care. She elaborated on how

> Even once we got home it was still really hard just because I, I felt like I had a really hard time bonding with him, um, and then, I didn't really feel like I was totally, you know, in love with being his mom until he was probably like two and a half. It took a really long time. (Participant #6)

She did not lose custody of her child, and, now that her child is older, she described having an amicable relationship with him. Participant #8, who was in the process of trying to regain custody of her son when the interview took place, and expressed feelings of guilt that "he's just not my kid and I feel really bad for that, because I think he deserves a lot more than what I gave him while I was drinking, which is really upsetting to me." Participant #7 also had feelings of remorse due to the effect her adverse health behaviours had on her relationship with her child, and was unable to recall the specifics of breastfeeding her daughter:

> The thing is that I have my memory of her being that little is really foggy because I wasn't really present mentally, which is a really, really big regret of mine because that time is so short and it's like so important to me anyways […] I don't, she'll never know, she was younger but, I always will and I'll never be able to get that time back. So, it makes me sad.

Five participants' had their children removed from their care shortly after they gave birth. All five participants had visitation rights with their children, and four of the women were in the process of trying to regain custody when they were interviewed. Participant #12 told a grim story about her anguish of not being able to breastfeed, and subsequently not bonding with her daughter, after her child was removed from her care. Participant #12 was in an unstable housing situation, saved her pumped breast milk in her hotel fridge on the hope of regaining custody over her child and being able to breastfeed. She elaborated:

> I had the health nurse come because I was, bloating up and it was really bad and I, and then my, my milk wasn't coming in for a while so they suggested smelling her clothes, so the clothes that I had her in, in the hospital. So here I am in a motel, smelling a baby's clothes. Look at that picture, it was tough man, real tough […] That was a big heartbreak for me. And uh, I think she missed out on it, and the whole time I was pregnant with her, everybody, about how important it is breast milk and blah blah blah, all through the pregnancy and uh, had me really excited about doing it. And I missed out. Missed out on it; something I'll never get back. (Participant #12)

This woman's experience demonstrates the incongruence between health and social services, which resulted in a lack of quality care for the client and exacerbated the stress in her life. Participant #12 was aware as a result of public health campaigns that breastfeeding is the most healthy option for a new baby, but experienced distress as she was unable to fulfill this need. As well, her unstable housing situation, which she mentioned was in an area prone to "drug dealers and addicts," was her current living

situation while she was concurrently dealing with depression over the removal of her child. Participant #12's convoluted circumstances are situations that interventions like HWH attempt to take action on in order to improve the health outcomes of both clients and their children.

Suggestions for HWH Intervention

Participants asserted their agency when they were asked about their opinion on factors that could contribute to HWH becoming a successful intervention for the population of study. Participants challenged the stigma present in their lives through reflexive contemplation about services that aim to assist women with similar life situations as themselves. At just over half of the women interviewed, seven participants voiced how they wanted specific drug and alcohol counselling groups for pregnant and early parenting women. Participant #9 stated that "I think that was the most impact on me is not having that support group when uh, especially being pregnant and being scared of that." Some participants specifically identified not attending drug and alcohol group counselling meetings because they were not able to find childcare. Participant #5 felt that it was "aggravating me because, you know, I talk to my doctor, I talk to my counsellor and they're like 'oh you should get to more groups' and it's like yea, are you gonna watch my baby?" Participants did not want to bring their child to group support counselling sessions and face the potential for further stigmatization for this vulnerable population. Participant #5 explained that

> There really needs to be a place for women to go where they can bring their children and go to a drug and alcohol support group. I can't go to any groups with

> my baby, and if you're a single mom that is really tough. That means you don't get to groups.

Participant #7 lamented "I would just want like to be around more people that were in my situation," which she and other participants did not feel were represented at standard drug and alcohol group counselling meetings. Participants experienced tension in the gap of care with their health care practitioner encouraging them to access supports, but not being able to find supports for this vulnerable population, and therefore limiting or foregoing utilization of services all together. Participants' pregnancy narratives highlight the need for HWH in Victoria and the surrounding area so women in vulnerable situations with complex lives can find peer support from other women in similar situations and professional supports from compassionate service providers who are empathetic to the complexity of the research population's lifecourse.

Providing a space to share experiences with someone who was dealing with a similar situation as them was a key theme in the gaps of care participants experienced during pregnancy and after birth, and subsequently proved to be a barrier to accessing health and social services as a whole. As well, peer support groups, which included childcare, were mentioned as a suggestion for HWH. Participant #6 was enthusiastic about the idea of support groups specifically for this vulnerable population, as when she was pregnant "I really wanted to just, like, talk to other women who were going through what I was going through." Participant #9 also identified this gap in current care, stating

> There's nowhere, you know, we can just casually talk about it but I'd like to have something um, where moms feel they're understood especially as moms and

> having a kid screaming at them and you're just thinking I need something to escape with.

This quote acknowledges how the stress of new motherhood coupled with the isolation of not being able to access services with other people in a similar situation can drive this vulnerable population to relapse or continue to engage in adverse health behaviours. The responses from the women interviewed clearly underlined the need for support groups specifically for women in vulnerable situations with complex lives at HWH.

Participants also expressed a need for empathetic HWH workers who were informed of the day-to-day challenges their clients' face. Participant #8 stated that "I think you need someone that's speaking from experience […] that's the number one, biggest thing. Someone that you can relate to." The women interviewed shared stories of frustration when they were put in contact with different social service workers who did not seem to acknowledge the complex and overlapping factors that this vulnerable population faced in their lives. Participant #5 also felt that the support groups should be led by staff who can understand the factors that impact women in vulnerable situations with complex lives. She suggested that HWH have an "organized peer group for support. […] I guess just coming from the uh, the standpoint of somebody that's dealing, that's dealt with addictions, that's, you know, still struggling and whatever, um, I can talk, I just feel safer" (Participant #5). Other participants shared this woman's opinion that having informed, compassionate health and social care professionals would assist in fostering open communication between the client and the service provider.

Many of the participants recommended that the HWH have a liaison between MCFD and HWH clients, so that the fear of child removal will not be present inside the centre.

Based on Participant #6's experiences and lack of choice during her labour, delivery and birth, she felt that HWH should have

> That education piece and just having somebody who, who is really aware of, of how the system works and of what alternatives can be fought for […] I know that for myself I just didn't feel like I even had a right to advocate for anything. Like I was just like, like a really shitty person who was already a burden and like doing bad things and to even like you know, question, I was already making like all thee horrible choices and so obviously I didn't, you know, like how can I say that I have a good idea?

Her quote also demonstrates how felt and enacted stigma prevented her from receiving the type of care she desired, and is important for HWH service providers to keep in mind when delivering their services to such a vulnerable, stigmatized population. Participant #1 echoed this recommendation, suggesting

> I think you gotta set up a, I don't know, confidentiality form that you guys don't tell the Ministry, anything you guys say, like if I came in there and 'this is happening, oh my god I'm gonna have a break down…go use' type thing, that you guys go, just go tell the Ministry you guys just - obviously if I'm hurting myself or somebody else, you know, say something, but, if I had a relapse and I come back and be honest and then not you in general, but then you guys work around that to see how you're gonna prevent it next time, not kick somebody out if they fuck up once. 'Cause if they're honest with you and say 'hey I fucked up' and then you kick 'em out, yeah, that's one of my problems, I get kicked out.

Participant #1's suggestion emphasizes the need to have low threshold entrance requirements for incoming HWH service users in order to foster a level of trust with HWH providers to share honestly and openly about their struggles with adverse health behaviours and lifestyle habits.

As acknowledged in the previous section, fear of child removal was identified as a major barrier to accessing care, and participants' often viewed MCFD as a negative force. Participant #8 expressed how clients at HWH should "be able to ask for support without consequences and being looked down upon, and the Ministry [of Child and Family Development] does that a lot." Most participants voiced feeling judgment and experiencing enacted stigma from MCFD. Participants stressed the importance of having HWH be a place of non-judgment. Participant #5 suggested that a mission statement outlining HWH's mandate would help to cultivate

> Maybe having something like [a mission statement] that in plain view like in the waiting room that says "we're non-judgmental" like what you're going through, like one of the things they have down at [another organization] on the wall is um, "we know that even", generally speaking like that, off the top of my head, I can't remember it …. it's like "we know that even though you're dealing with drug and alcohol issues you still want the best health care you can access and, we know, we're judgmental, non-judgmental and we're here to like help you and [we are] gonna be here to support you, and, and help you access, you know whatever you need to access today". That kind of thing. (Participant #5)

In order have a level of transparent support at HWH, the initial stages of the program will only be for female clients. The idea of having a women-only centre was received with mixed support with the women interviewed. Participant #4 expressed how she specifically avoided access a social services program because it was women-only and "I like to do everything with my boyfriend." She felt that HWH should allow men to access the centre, and should have parenting classes exclusively for the fathers. Other participants approved of the women-only space in order to ensure the safety of HWH's clients. When Participant #5 was asked about her opinion on a woman-only space for HWH, she responded:

> Yeah, um, I think mainly geared towards just the women and the children would probably be better just because of the fact that there is such a prevalence of abuse issues with women dealing, unfortunately, with women dealing with uh, these types of issues and their spouses.

All participants agreed that fostering an environment for women where they felt safe to access HWH's services was of the utmost importance. Participant #11 stated that the cultivation of feeling safe at HWH, regardless of the service being accessed, was an important piece for the centre being accessed by the target client population. She emphasized how if

> That's what you need when you're feeling the way you're feeling, or I'm feeling, like, you're vulnerable and I mean, you know, and if you had a place where you could sit and feel comfortable, even just to have a cup of tea or just to get away

> from where you're at, at the time [….] it's gonna benefit people, right? (Participant #11)

This quote underscores that, above all, HWH should strive to be a safe haven from stigma, judgment, and other negative attributes that affect substance using pregnant and early parenting women in their day-to-day lives and prevent them from accessing the care and resources they need.

As mentioned in the previous section, unstable housing was not only a lived reality for many of the women interviewed, but was also a specific barrier preventing custody of their children. Most of the participants emphasized that housing is a crucial component for HWH to run as an effective intervention. Participant #1 stated that 'if you have nowhere safe for the baby to live you can't work properly to get the baby back," highlighting the importance of housing in any key intervention that aims to successfully take action on socially determined inequities. Participant #10 agreed that "it kind of jeopardizes if you don't have your housing, you lose custody of your children." She had been on the waiting list for housing since well in to her pregnancy, and was thrilled to find out she was given housing after the birth of her child, which she described as exciting as "winning the lottery. It was one of the happiest days of my life" (Participant #10).

Poor nutrition and lack of food security was a reality in many of the participants' lives during their pregnancy and after their birth, and was identified as an issue for HWH. Some of the women interviewed mentioned the benefits of accessing community kitchens services, and suggested that HWH have similar programs available. Participant #8 suggested that HWH

> Have house dinners where everyone can get together and cook and eat and , you know what I mean? […] it's good just to talk about stuff and whatever and, and talk and, and share stories […] I think it's a validation thing for me to be worthy to eat I think it's something just deep down […] I need to be able to eat with someone.

This woman's caption illustrates that community kitchen programs are about more than "just good food". In addition to having access to a range of nutritious sustenance, community kitchens provide a space for women to socialize and feel accepted within a group of women who are dealing with similar struggles in their lifecourse.

Participants had a list of practical and professional service recommendations for HWH. Participant #4 mentioned how she would have like to have access to "prenatal yoga [classes]. I wanted to do that so bad but it's like a hundred ten bucks a month, ugh, it's like, I don't have the money for that!" Many participants suggested having a range of health and fitness classes and facilities available for this vulnerable population's physical and mental well-being. Participant #8, as well as other women who were interviewed, suggested "parenting courses. Cause I, I went into it [motherhood] with knowing nothing" (Participant #4). Participants also recommended that HWH provide courses aimed at improving communication in relationships, learning about the cycle of violence, and conflict management and resolution.

In terms of logistics of the physical location of HWH, downtown Victoria was strongly discouraged. Multiple women mentioned that downtown Victoria was an area they avoided in an effort not to engage in adverse health behaviours. Participant #11 emphasized that

> Location is big important. It's like if you could go by a rec[reation] centre or something where it's more positive people, do you know what I mean? As opposed to downtown where it's kind of, that's where people sort of seem to get in more trouble.

Participant #11 expanded on this point by describing a treatment centre she tried to access downtown during her pregnancy, and the undesirable aspects of the centre's location:

> It's a really good place. They have great things to offer, and lots of classes […] but it's, you have to go three times a week, and you're there for two hours each class, and so you get a break in between so you have to go outside, well, I do, because I smoke cigarettes, so I go outside and smoke a cigarette. Well people from downtown know that that's an addictions place, you know like dealers and things like that or just whatever, people and they, like I said they prey on those kinda people and they like physically come up to you and ask you, 'hey, you lookin'? You need anything, or?' You know, and it's just like you, your mouth startin' to water, and you're sick to your stomach and, and I just put out my cigarette and go back in, right? And then again I would see people that I would know from other times or whatever and it would be like, that would scare me too. So, I'm not saying going downtown in general is scary, it's just, it's a real trigger.

This quote clarifies the conundrum that while the services currently in GVA have a range of supports in place that are beneficial to the client population accessing them, the location can prove to be detrimental for women in vulnerable situations with complex

lives who are trying to remove themselves from environments that may trigger a relapse into adverse health behaviours and lifestyle habits.

Summary

This chapter has illustrated the complicated nature of systemic barriers that participants face as of result of a variety of complex interrelated lifestyle habits and health behaviours. Participants' background, experiences with stigmatization, the surrounding legal environment, participants' supports and social networks and living conditions all impacted their access to health and social services while they were pregnant. Such intricate determinants affected and influenced the life choices and life chances of participants through the major lifecourse event of pregnancy. Participants' life narratives were utilized to gather suggestions for intervention programs such as HWH. The range of recommendations for HWH suggested by participants highlight the complex lives and multiple, overlapping disadvantages that need to be kept in mind while developing interventions that take the Health Lifestyle Theory tension of life choices and life chances into account.

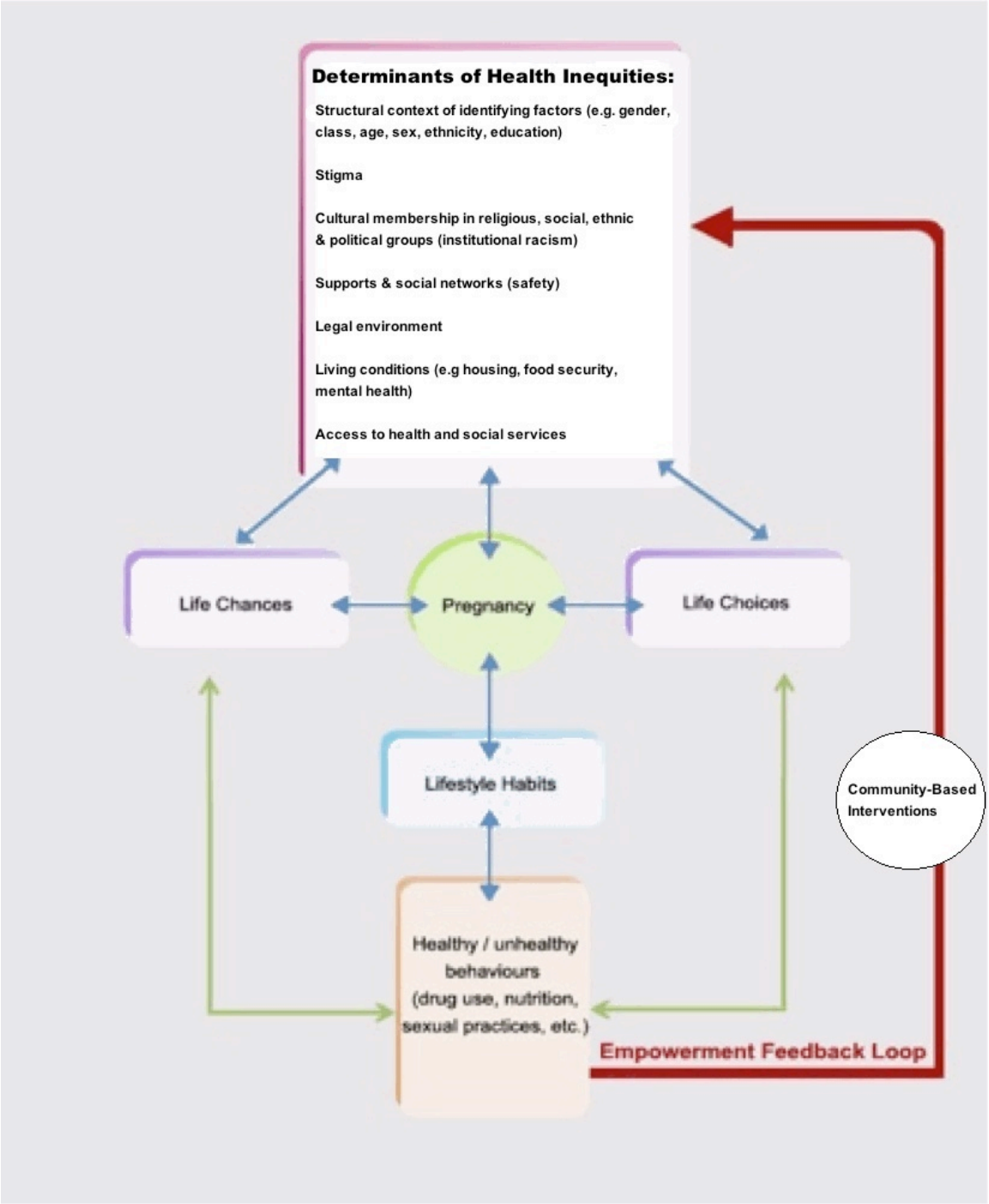
Chapter Five: Discussion

"it does take a long time and it does take patience from other people, for people, for addicts to be parents again" (Participant #9)

Introduction

The research process developed a purposeful qualitative study of the pregnancy and birth narratives of thirteen VGA-based women in vulnerable situations with complex lives. The central aim identified at the onset of this research was to determine the barriers and gaps in maternity care and other health and social care services in Canada that should be part of the HWH intervention. This goal was implemented by exploring participants' life narratives and investigating what the participants believe are the crucial components of interventions that specialize in the care of this vulnerable population. The results indicate that the life choices of women are constrained by structural life chances that systematically disadvantage and disempower women in vulnerable situations with complex lives. While Cockerham's Health Lifestyle Theory was a beneficial theoretical framework when discussing the literature surrounding the research population, after the data were analyzed it became apparent that an adapted model of the Health Lifestyle Theory should be employed to accurately reflect complex situations of the women interviewed. The following discussion employs this adapted model for this vulnerable population in order to discuss the implications of the research findings. The limitations around this research study is also addressed in this chapter.

Figure 2. Adapted Health Lifestyle Theory[1]



[1] The reference for this adapted model was taken from: Benoit, Cecilia. 2012. Treatment and Prevention of Substance Use Among Pregnant and Early Parenting Women. Proceedings from the *National Anti-Drug Strategy (NADS) Speaking Series*. Department of Justice. Ottawa, Ontario.

Contextualized Life Choices and Chances

Researchers have proposed that there has been a "feminization of poverty", which is accentuated when women who live in poverty-ridden circumstances are also part of vulnerable populations with additional risk factors (Boyd 2004; Campbell 2000; Perez 2000). The institution of *gender* is embedded in various social structures that influence women's actions in their day-to-day lived experiences, and is exacerbated when women are pregnant. Women in vulnerable situations with complex lives are not only immersed within the societal rules of Western femininity, the intrinsically *female* act of a pregnant body further pressures conformity to gender norms. Failing to perform one's prescribed gender role through adverse health behaviours is not only be a "bad woman", but also a "bad mother" (Boyd 1999). Such ill feelings on a societal level towards this vulnerable population is emphasized by the personal responsibility and self blame neoliberal rhetoric common in societal attitudes towards this vulnerable population that view life choices as entirely a result of individual actions.

Class circumstances have "the most powerful influence on lifestyle forms", and are deeply entrenched in issues of poverty (Cockerham 2005:56). Accessing resources is more difficult for the population of study, who often occupy a lower socioeconomic status, due to issues such as transportation to stigmatizing attitudes of service providers. Boyd (2004) cites how "the criminalization of drugs lent credibility to punitive practices by social services, medical professionals, and non-state agencies that sought to regulate women suspected of using drugs, especially during pregnancy" (92). Punitive legal sanctions surrounding this vulnerable population reinforce class hierarchies, and are imposed through the power differentials between socially deviant research population and people engaged in various structural institutions that can act as a constraining influence

over women's agency. The class circumstances of the participants' interviewed for this research were essential in the level of success of achieving a healthy lifestyle and adopting positive health behaviours. Cockerham (2005) demonstrates this homogeneity through agency and structure, stating that "living a healthy lifestyle was not simply a matter of individual choice, but to a large extent depended upon a person's social and material environment for its success" (Cockerham 2005:56-57).

The life choices of the participants were constrained by various structural forces that systematically disadvantaged and disempowered this vulnerable population, resulting in restricted agency that diminished participants' self worth through *stigmatization*. Both felt and enacted stigma often proved to be instrumental in the amount of perceived agency and self-efficacy participants had over their lifestyle habits and health behaviours. Stigmatization was further developed by the individualized blame common in societal popular rhetoric surrounding women in vulnerable situations with complex lives. Agency in the neoliberal context has resulted in blame that is individualized and stigmatizing, "rather than exploring the many constraints that women, and especially mothers, experience" through structural forces that impact and influence inequitable conditions (Boyd 1999:72). It is the women in this vulnerable population who are held solely responsible for

> Failing to cease their illicit (and licit) drug use. Subsequently, women blame themselves. Rather than examining the social context of women's lives, health professionals question whether a mother exhibits sufficient responsibility toward her developing foetus, and whether she has followed medical advice. (ibid).

The social context of this vulnerable population's life chances, and how such life chances influence their ability to select from various life choices, is a crucial overarching point that must be kept in the forefront of any discussions which seek to assist in modifying the research population's health behaviours in order to improve the lifestyle habits of both women and their children.

As identified previously, *cultural membership* did not emerge as a main determinant of inequities in the data. This finding is inconsistent with the main demographics of many successful interventions in Canada (Benoit, Carroll and Chaudhry 2003; Boyd 2007; Boyd and Marcellus 2007; Cailleaux and Dechief 2007).This is a gap in the data, and this research. However, such absence could be interpreted as an effect of the presence of institutional racism, coupled with a history of systematic trauma-induced happenings, has resulted in a divorcing of many Aboriginal people from the ethnic cultural background and heritage. Residential schools, which lasted up until the 1990s, and other detrimental acts by the Canadian government have splintered cultural membership (Browne and Thomas 2011; Dua, Razack and Warner 2005; McDonald and Wingfield 2008; Rice 2011). While this interpretation could be an assumption based on my analytic understanding of my context-specific research, the literature across not only the country, but across and throughout western nations, affirms the real and systemic racial oppression of marginalized groups throughout societies (Hier and Walby 2006). Although issues of race and cultural membership were not explicitly mentioned in the interviews for this research, the silence of this subject speaks to the societal attitudes and beliefs that are engrained in a history of racism in Canada.

The *supports and social networks* participants identified as influential on their lifestyle habits illustrated the impact of associating with and belonging to different networks. Precarious and often contentious involvement of the children's fathers was a source of stress for participants, and for some the relationship included acts of abuse. Participants who experienced intimate partner violence or other forms of abuse identified their attempts to remove themselves from such unsafe situations. Isolation was one of the outcomes that resulted from participants withdrawing from individuals and social networks that triggered adverse health behaviours.

Participants named a range of existing health and social services in the GVA that provided supported guidance and tools for women in vulnerable situations with complex lives trying to modify their lifestyle habits to incorporate positive supports and social networks into their day-to-day lived experiences. The extra efforts made service providers did not go unnoticed by participants. The research population's experiences with empathetic and supportive service providers who treated them with dignity and respect made a memorable impact, and encouraged the development of a trusting relationship between the vulnerable population and service providers, and social and health services as a larger structural force.

The *legal environment* surrounding the population of study is often cloaked in a constant fear of child removal that in some cases become a reality. Institutional measure such as random drug testings were implemented into participants' day-to-day lived experiences while pregnant, which reinforced the stigmatization of their health behaviours. The ever-present threat of punitive action resulted in participants viewing MCFD as a service that hindered rather than assisted with women's agency and self-

efficacy, and fostered conditions that placed MCFD and participants at odds with one another. Other socially determined inequities directly impacted the legal environment participants' experienced while pregnant, especially in cases of child custody when participants had unstable housing conditions.

Participants' *living conditions* during pregnancy dramatically affected their lifestyle habits and health behaviours. The majority of women who participated in this research dealt with unstable living situations, including homelessness, incarceration and unsafe living environments due to the threat of violence. This caused considerable mental and emotional stress on a number of participants and further impacted their health and well-being. Unstable housing was also a contributing factor in some participants being denied custody after their child was removed from their care. As well, participants identified the importance of proper nutrition for women in vulnerable situations with complex lives, and many women expressed frustration at the constrained choice when they depended on the limited options available from food hampers at different social services.

Access to health and social services were directly impacted by the other social determinants of inequities. Stigmatization, unstable housing, and a legal environment that threatened punitive action all acted as the largest factors for participants delaying or foregoing health and social services care while pregnant. The socially determined inequities often intersected in participants' lives simultaneously and resulted in multiple determinants that negatively influenced attempts to access needed services. Stigma entrenched in the fear of legal action drove women away from receiving the care they needed. While many factors acted as barrier to care, participants also identified existing support services in the GVA area that took action on the research participants' inequities

and assisted in modifying their lifestyle habits to reflect more beneficial health behaviours. While a decrease or cessation from adverse health behaviours was one of the outcomes of engaging with existing support services, participants also identified increased feelings of self worth and varying levels of contextual understanding of the structural factors that impacted their life chances and choices.

The *empowerment feedback loop* illustrates the action taken on the social determinants of inequities while emphasizing the self-worth of the research population as key agents in the production of their health behaviours (Davis and Yonkers 2012). The empowerment feedback loop must be enacted in order to successfully take action on the socially determined inequities that limit the agency of women in vulnerable situations with complex lives. The empowerment feedback loop was activated with the data collection via qualitative interviews, in that the interviews provided a platform for women to share their stories and have their experiences validated as a legitimate form of knowledge. This knowledge further empowers the participants in this research through the application of their suggestions to the HWH's philosophy of service delivery espoused in the autonomous model of care. The design and execution of this research placed participants in the position of the expert, and their pregnancy narratives and HWH program suggestions will be used to help inform the creation of HWH. Williams (2003) emphasizes that "lay causal narrative[s] contextualises the impact of social structure on health in a very powerful way", and in this case, will help inform the future direction of a development one-stop shop centre for women in vulnerable situations with complex lives (147). Empowerment of this vulnerable population in the GVA can also take place in interventions by utilizing the autonomous model of care and continuing to include

women effected by the intervention in the design and execution of the HWH program and related research. Utilizing the autonomous model can be enacted through providing a range of choices that include favourable lifestyle habits which deter choices that have adverse effects and instead encourage the adoption of healthy behaviours (Kuhlmann 2009; Marcellus 2004; Young 1994). The bottom line of policy and practice discussions about the research population "should be to strengthen women's autonomy in the decisions that beat on their own lives" and to be able to advocate for their own best interests in a supported network (Campbell 2000:192).

The implications of this research emphasize the contemporary necessity of the creation of interventions like HWH. Existing centres with similar structures, such as New Choices, Sheway, Breaking the Cycle and Maxxine Wright Place Project have all conducted evaluations of their programs to assess the effectiveness of their services and the success of their client update. The research, done at the pre-implementation stage of HWH, found similar life situations and barriers to care in my participants' pregnancy narratives as in the client populations of the already existing centres. Williams (2003) explains that when "thinking about developments in the analysis of social structure and health there is a widespread acceptance of the need for a deeper and more fine-grained understanding of the relationship between the individual and his or her social context" (149). Taking a qualitative interview approach to this research imbedded in feminist, community-based research and intersectional methodologies has allowed for the development of an understanding of the participants' social contexts' during pregnancy *in their own words.* This act in itself is a step towards empowering this vulnerable

population in regaining agency over their lives and promoting a sense of self-efficacy with their lifestyle habits and behaviours.

Limitations

There are a few limitations in this research that are important to mention. The first limitation was the narrow scope of my sample. While utilizing key informants already involved with HWH assisted with a speedy recruitment response, it also resulted in a lack of diversity from participants who had received similar care from these gatekeeper organizations, and possibly even from the same care providers. The second limitation was the lack of specific demographic questions in the interview schedule. In the initial drafting stages the interview schedule consisted of both a demographic questionnaire and a series of semi-structured interview questions. After feedback from my supervisor and the research team, the questionnaire was removed, as consensus among the team was that the demographics were not the main focus of the research. The research team also voiced concern that both a questionnaire and an interview may result in participant fatigue. As a result, particular questions pertaining to the participants' socioeconomic status, age, level of completed education, ethnicity or race, cultural background, employment status, or other demographic factors were not explicitly collected. Most of the participants mentioned their age at some point during the interview, and described situations surrounding their low socioeconomic status.

Summary

This chapter has discussed the implications of the research findings, framed within the adapted model of the Health Lifestyle Theory for women in vulnerable situations with complex lives. Participants faced a range of structural disadvantages that limited their

agency to make life choices that promote favourable health behaviours. In order to successfully take action on the socially determined inequities that often act as structural barriers for this vulnerable population, interventions must employ an empowerment feedback loop into their service delivery design that provides a space for the research population's agency and self-efficacy to guide the development of lifestyle habits that support positive health behaviours for both the women and their children. The final chapter contemplates future directions of the larger "parent" project investigating HWH, as well the potential for subsequent areas of analytic exploration from my specific research. Chapter Six also provides policy suggestions for HWH and other interventions for women in vulnerable situations with complex lives and concludes with some final overall remarks on the research subject matter as a whole.

Chapter Six: Conclusions

"bringing a child into the world; it's a big responsibility, and therefore you need all the right support and all, all the right things from that the community has to offer" (Participant #2)

Introduction

The responses from the thirteen women interviewed for this research can be used to assist with taking action on inequities and facilitating insight into suggestions for future improvements for interventions like HWH. The findings indicate that women in vulnerable situations with complex lives live complex lives that are constrained by a variety of life choices and life chances that interact and influence each other. As a result, there are multiple barriers in place that can make accessing health and social services extremely difficult, systematically disadvantage and disempower vulnerable groups, and often manifest as adverse lifestyle habits and health behaviours. The responses from participants indicate that HWH is a much needed addition to current health and social services in the GVA for women in vulnerable situations with complex lives. This research modestly attempted to reduce the crucial gap that is often existent in traditional "top-down" designs of a research project which struggles to integrate the opinions of the population being studied from the "bottom-up" (Jansson et al. 2010). By utilizing an adopted model of the Health Lifestyle Theory and emphasizing the role of empowerment for women in vulnerable situations with complex lives, this research has attempted to fill this gap in knowledge for the larger HWH research project and design implementation.

Currently there are favourable political outcomes that exist for Canadian integrative care interventions for this vulnerable population. However, there are a plethora of social, economic and structural inequities that contribute to a number of complex barriers for

women who need to utilize services at such interventions. HWH is a promising initiative that follows in the footsteps of other successful collaborative care centres to provide safe, judgment-free health and social services for this vulnerable population in the GVA. The participants' responses highlight the necessity of programs and practices that HWH will provide, and further strengthen the justification for the forward progression of this collaborative care intervention in a timely matter.

Future Directions for the Larger "Parent" Project

As mentioned in Chapter One, a Women's Advisory Council made up of primarily research participants was created after the completion of my data collection. Two "coffee shop" focus groups with the Women's Advisory Council had taken place during the time this thesis was written. Four women participated in the first focus group, and six women joined the discussion for the second meeting. Dicicco-Bloom and Crabtree (2006) argue that "integrating reciprocity into the creation of knowledge" between researcher and participant is a valuable trait of qualitative research (317). The Women's Advisory Committee has provided the women interviewed with a space to become more involved in the larger research project for HWH and further validate their life experiences and opinions on health and social services in the GVA as a legitimate form of knowledge. The Women's Advisory Council has acted as a facilitation for empowerment by assisting participants with the development in their "ability to be reflective and critical about the situated social basis of individual action" and the structural forces that impact their lives (Young 1994:50).

The research grant, under the direction of my supervisor, continues well after the completion of my segment of the research project. After my research was conducted, the

research team began the first wave of interviews with service providers, systems' level participants, and other researchers who have been involved in HWH process. Wave two will commence after HWH is up and running, while wave three will take place after HWH has been in operation for one year. The research team has also been successful in receiving a catalyst grant from CIHR entitled *Treatment and Prevention of Illicit Substance Use Among Pregnant and Early Parenting Women.* This catalyst grant will allow the team to follow members of the client population at the initial uptake of their access with HWH, and re-visit the clients at various later dates to assess their progress in the program.

Future Directions for the Specific Research

Connected to the larger research project, it is important that the Women's Advisory Council moves forward and continues to meet as a group. The hope is that the Women's Advisory Council will inform the policy and practice of HWH as it unfolds. In order to maximize the dissemination of my specific findings, information and research briefs will be created and distributed to the individuals and organizations involved with HWH in order to inform the delivery of their services. These briefs will also be distributed to the participants who were involved in the research, in order to provide a concise version of the research absent of academic jargon. As well, these briefs can be used to inform the general public of the barriers in place for this vulnerable population and the development of HWH.

A major subtheme that emerged from the research was the importance of space and place for the participants, including both their housing situation, as well as the location and environment of the health and social services they accessed. This subtheme has

potential to be investigated as a dominant focal point of future analysis of this specific research, or of other research on women in vulnerable situations with complex lives. Harm reduction strategies are another area that could be explored further with this research. Future analysis could consider the harm reduction strategies the population of study utilize in their daily lives, either formally through health and social services, or informally through other networks or through self-management techniques. For my doctoral research I plan to expand on the knowledge and skills I have gained throughout this research process and continue to move in the direction of health and human rights-based policy projects for this vulnerable population in Europe.

Policy Implications

The recommendations from this research pertain to the development and delivery of services at HWH based on the participants' answers. These responses are in line with existing evaluations of similar centres like Sheway, Breaking the Cycle, New Choices, and the Maxxine Wright Place Project. Since the research was conducted at the pre-implementation phase of HWH, there is great potential to use the participants' recommendations to avoid the pitfalls that some of the other existing interventions have encountered. While difficulties in coordinating a centre like HWH are complex, and this research will not magically remedy these complications, there is potential to learn from the participants' responses as HWH progresses forward.

One recommendation that can be carried out in the creation of HWH is to put careful consideration into the physical location of the centre. In Poole's (2000) evaluation report of Sheway,

> The barrier identified most often by Sheway staff and allied professionals was the location of Sheway in the dangerous Downtown Eastside area – which may be a deterrent for pregnant and parenting women living in other areas of the city, who are trying to avoid exposure to drug use. (16)

As seen in Chapter Four, this sentiment is echoed by the participants' concern of having the HWH in downtown Victoria. In order to maximize the success of the HWH, the centre needs to be located in a place within the GVA that is both accessible via public transportation but located a safe distance from downtown. As well, having a support system in place that provide this vulnerable population with housing supports is essential for the future expansion of HWH.

The development of a communal kitchen could prove to be a valuable addition to HWH's autonomy-focused service delivery model. Based on the participants' responses who currently participate in a community kitchen program, the benefits are multifaceted and reach beyond nutritional needs, as the program provides a social space of non-judgment for women to relate to other mothers in a similar situation without fear of stigmatization. Other pragmatic recommendations include drug and alcohol support groups specifically for women in vulnerable situations with complex lives, a range of classes that address parenting and communication skills, clothing and toy exchanges, and fitness programs for mothers.

Other participant suggestions for HWH, while equally, if not more important, may be difficult to implement. Providing a safe space from MCFD child protection workers is a difficult endeavour because of the legal responsibilities involved if harm towards a child is suspected. As voiced by the participants and confirmed in the literature, the fear of

being reported keeps this vulnerable population from accessing proper maternity care, and prevents them from honestly disclosing their adverse health behaviours with their health care provider. Poole and Isaac's (2001) investigation of the barrier to care for substance using mothers found that "women fear that the child protection system will respond in an arbitrary fashion and automatically apprehend their children on the basis of use alone, if they admit to needing help with drug use, especially for illicit substances" (15). Such well-documented information on this barrier places HWH staff in a difficult situation. The suggestion of a liaison between HWH clients and MCFD workers may be a possible solution to ease this tension.

The underlying research participant-based recommendation for HWH is to foster a stigma-free, non-judgmental centre where women who are pregnant and new mothers can access a range of social and health services that help them manage their complex lives. Such interventions need to have the *empowerment of people* as their primary objective (Navarro 2009) (emphasis added). For HWH, this objective can be implemented through the continual involvement of this vulnerable population in the design, delivery, and evaluation of HWH's services.

Concluding Remarks

The successes of interventions for the research population relies on a variety of factors. Flexibility, openness, non-judgmental attitudes, communication and collaboration are all elements of Breaking the Cycle, New Choices, Sheway and the Maxxine Wright Place Project that have helped to create successful care centres with favourable outcomes for their clients. HWH embraces these same philosophies and ideals, and plans to learn from the triumphs of these fellow Canadian programs. These interventions will not end

inequalities for this vulnerable population in Canada, nor will they produce pregnant and newly parenting women who completely abstain from all adverse health behaviours. Programs such as HWH are not miracle interventions that will fix the complicated intersection of social and moral issues surrounding the provision of health care service delivery to women in vulnerable situations with complex lives. What centres like HWH will do, and what Breaking the Cycle, Sheway, New Choices and the Maxxine Wright Place Project have done and continue to do is assist this vulnerable population by providing a safe and attentive environment that will individualize care programs to the specific needs and desires of each client. While structural life chances can constrain women's agency, centres such as HWH and the others mentioned aid to empower and promote clients' agency through a supported network of life choices for this vulnerable population. Programs such as these are tangible examples of how the inequities in the Canadian health and social care systems can be reduced through the collaboration of services and resources that embrace an underlying compassionate and autonomous care philosophies aimed at reducing inequalities and taking action on socially determined inequities through empowerment and self-efficacy.

References

Acker, Sandra. 2001. "In/outside: Positioning the Researcher in Feminist Qualitative Research." *Resources for Feminist Research* 28(3/4): 153-172. Retrieved August 31, 2011, from CBCA Reference and Current Events. (Document ID: 477649071).

Ajzen, Icek. 1991. "The Theory of Planned Behaviour." *Organizational Behaviour and Human Decision Processes* 50: 179-211.

Ashley, Olivia Silber, Mary Ellen Marsden and Thomas M. Brady. 2003. "Effectiveness of Substance Abuse Treatment Programming for Women: A Review." *The American Journal of Drug and Alcohol Abuse* 29(1): 19-53.

Baker, Elizabeth, Marilyn Metzler and Sandro Galea. 2005. "Addressing Social Determinants of Health Inequities: Learning from Doing." *American Journal of Public Health* 95(4): 553-555.

Bandura, Albert. 1986. *Social Foundations of Thought and Action: A Social Cognitive Theory*. Englewood Cliffs, NJ: Prentice-Hall.

Barry, Anne-Marie and Chris Yuill. 2002. *Understanding the Sociology of Health: An Introduction.* Second Edition. London: Sage Publications Ltd.

Bartley, Mel, David Blane and Scott Montgomery. 1997. "Socioeconomic Determinants of Heath: Health and the Life Course: Why Safety Nets Matter." *British Medical Journal* 314(7088): 1194-1196.

Bellows-Riecken, Kai, Ryan Rhodes and Krista Hoffert. 2008. "Motives for Lifestyle and Exercise Activities: A Comparison Using the Theory of Planned Behaviour." *European Journal of Sport Science* 8(5): 305-313.

Beiser, Morton and Miriam Stewart. 2005. "Reducing Health Disparities: A Priority for Canada." *Canadian Journal of Public Health* 96*:* S4-S7.

Benoit, Cecilia. 2012. Treatment and Prevention of Substance Use Among Pregnant and Early Parenting Women. Proceedings from the *National Anti-Drug Strategy (NADS) Speaking Series*. Department of Justice. Ottawa, Ontario.

——— Dena Carroll and Munaza Chaudhry. 2003. "In Search of a Healing Place: Aboriginal Women in Vancouver's Downtown Eastside." *Social Science & Medicine* 56: 821-833.

——— Lenora Marcellus and Camille Stengel. 2011. HerWay Home

Program: Promoting Health and Healthy Equity for Pregnant and Early Parenting Women Facing Substance Use and Other Challenges. Proceedings from the CPHA Annual Conference: *Public Health in Canada: Innovative Partnerships for Action.* Montreal, Quebec.

——— Mikael Jansson, Alison Millar and Rachel Phillips. 2005a. "Community-Academic Research on Hard-to-Reach Populations: Benefits and Challenges." *Qualitative Health Research* 15(2): 263-282.

——— Jennifer Jasechko, Lenora Marcellus and Elizabeth Poag. 2010a. "HerWay Home: Integrated Support for Women and Children with Complex Lives." Information Brief 1: March 15, 2010. The Woman's Health Research Network. Retrieved April 1, 2010 (www.whrn.ca/documents/HerWayHome.pdf*)*.

——— Leah Shumka and Diane Barlee. 2010. "Stigma and the Health of Vulnerable Women." Research Brief 2. March 15, 2010. The Women's Health Research Network. Retrieved April 1, 2010 (*www.whrn.ca/documents/Stigma.pdf)*.

——— Leah Shumka, Kate Vallance, Helga Hallgrimsdottir, Rachel Phillips, Karin Kobayashi, Olena Hankivisky, Colleen Reid and Elana Brief. 2009. "Explaining the Health Gap Experienced by Girls and Women in Canada: A Social Determinants of Health Perspective." *Sociological Research Online* 14(5)9. Retrieved June 20, 2010. (http://www.socresonline.org.uk/14/5/9.html).

——— Rachel Westfall, Andrienne B. Treloar, Rachel Philips and S.Mikael Jansson. 2007. "Social Factors Linked with Postpartum Depression." *Journal of Mental Health* 16(6): 719-30.

Blue, Carolyn. 2007. "Does the Theory of Planned Behaviour Identify Diabetes-Related Cognitions for Intention to be Physically Active and Eat a Healthy Diet?" *Public Health Nursing 24*(2): 141-150.

Bourgeault, Ivy Lynn and Gillian Mulvale. 2006. "Collaborative Health Care Teams in Canada and the US: Confronting the Structural Embeddedness of Medical Dominance." *Health Sociology Review* 15(5): 481-495.

Boyd, Susan. 1999. *Mothers and Illicit Drugs: Transcending the Myths*. University of Toronto Press: Toronto.

——— 2001. "Feminist Research on Mothers and Illegal Drugs." *Resources for Feminist Research* 28(3/4): 113-130.

——— 2004. *From Witches to Crack Moms: Women, Drug Law and Policy.* Carolina: Carolina Academic Press.

——— 2007. “Introduction: The Journey to Compassionate Care.” Pp. 10-20 in *With Child: Substance Use During Pregnancy: A Woman-Centred Approach,* edited by Susan C. Boyd and Lenora Marcellus. Nova Scotia: Fernwood Publishing.

——— 2008. “Community-Based Research in the Downtown Eastside of Vancouver.” *Resources for Feminist Research* 33(1/2): 19-43.

——— and Lenora Marcellus. 2007. “Chapter Nine: Harm Reduction in Action: Future Directions.” Pp. 111-119 in *With Child: Substance Use During Pregnancy: A Woman-Centred Approach,* edited by Susan C. Boyd and Lenora Marcellus. Nova Scotia: Fernwood Publishing.

Bilge, Sirma. 2010. “Recent Feminist Outlooks on Intersectionality.” *Diogenes* 57:58-72.

Browne, Annette and Jo-Anne Fiske. 2001. “First Nations Women’s Encounters with Mainstream Health Care Services and Systems.” *Western Journal of Nursing Ethics* 23(2):126-147.

Bryers, Helen MacKenzie and Edwin van Teijlingen. 2010. “Risk, Theory, Social and Medical Models: A Critical Analysis of the Concept of Risk in Maternity Care.” *Midwifery* 26: 488-496.

Butler, Judith. 1990. *Gender Trouble: Feminism and the Subversion of Identity*. New York: Routledge.

Bungay, Vicky, Joy L. Johnson, Coleen Varcoe and Susan Boyd. 2010. “Women’s Health and Use of Crack Cocaine in Context: Structural and ‘Everyday’ Violence.” *International Journal of Drug Policy* 21: 321-329.

Cailleaux, Melissa and Lynda Dechief. 2007. “‘I’ve Found My Voice’: Wraparound as a Promising Strength-Based Team Process for High-Risk Pregnant and Early Parenting Women. *UCFV Research Review* 1(2):16-38. Retrieved April 7, 2010. (http://journals.ufv.ca/rr/index.html).

Campbell, Cynthia I. and Jeffery A. Alexander. 2006. “Availability of Services for Women in Outpatient Substance Abuse Treatment: 1995-2000.” *Journal of Behavioral Health Services & Research* 33(1): 1-19.

Campbell, Nancy. 2000. *Using Women: Gender, Drug Policy, and Social Justice.* Routledge: London.

Capen, Karen. 1997. “Mother’s Rights Can’t Be Infringed to Protect Foetus, Supreme Court’s Landmark Ruling States.” *Canadian Medical Association Journal* 157: 1586-1587.

Charmaz, Kathy and Richard G. Mitchell. 2001. “Grounded Theory.” Pp. 128-153 in

Handbook of Ethnography, edited by P. Atkinson, A. Coffey and S. Delamont. London: Sage.

Claus, Ronald E., Robert G. Orwin, Wendy Kissin, Antoinette Krupski, Kevin Campbell, and Ken Stark. 2007. "Does Gender-Specific Substance Abuse Treatment for Women Promote Continuity of Care?" *Journal of Substance Abuse Treatment* 32: 27-39.

Cockerham, William C. 2005. "Health Lifestyle Theory and the Convergence of Agency and Structure." *Journal of Health and Social Behaviour* 46: 51-67.

Cockerham, William C. 2007. *Social Causes of Health and Disease.* Cambridge: Polity Press.

Collingridge, Dave S. and Edwin E. Gantt. 2008. "The Quality of Qualitative Research." *American Journal of Medical Quality* 23: 389-395.

Davis, Katherine and Kimberly Yonkers. 2012. "Making Lemonade Out of Lemons: A Case Report and Literature Review of External Pressure as an Intervention with Pregnant and Parenting Substance-Using Women." *Journal of Clinical Psychiatry* 73(1): 51-56.

Davoren, Jill and Betty Poag. 2010. *HerWay Home Program: Comprehensive Programming for Women and Children in Victoria* [PowerPoint slides]. Retrieved from (http://www.bcwomens.ca/NR/rdonlyres/C1AA97BC-FAAB-40E9-972D F377EE729080/45395/HerWayHomeBBpresentation.ppt).

DiCicco-Bloom, Barbara and Benjamin F. Crabtree. 2006. "The Qualitative Research Interview." *Medical Education* 40: 314-321.

Dowling, Maura. 2006. "Approaches to Reflexivity in Qualitative Research." *Nursing Researcher* 13(3): 7-21.

Dua, Enakshi, Narda Razack and Jody Nyasha Warner. 2005. "Race, Racism, and Empire: Reflections on Canada." *Social Justice* 32(4):1-10.

Falcon, Sylvanna M. 2008. "Intersectionality." *Encyclopaedia of Gender and Society.* Thousand Oaks, CA: SAGE. P. 468-70. *SAGE Reference Online*.

Finley, Susan. 2008. "Community-Based Reseach." *The Sage Encyclopaedia of Qualitative Research Methods*. Thousand Oaks, CA: SAGE. Pp. 98-101. *SAGE Reference Online*.

Fleetwood, Jennifer and Torres, Andreina. 2011. "Mothers and Children of the Drug War: A View from a Women's Prison in Quito, Ecuador." Pp. 127-141 in *Children of the Drug War: Perspectives on the Impact of Drug Policies on Young*

People, edited by D. Barrett. New York: International Debate Education Association, iDebate Press.

Frie, Kristin Grosse and Christian Janssen. 2008. "Social Inequality, Lifestyles and Health: A Non-Linear Canonical Correlation Analysis Based on the Approach of Pierre Bourdieu." *International Journal of Public Health* 54(4): 213-221.

Friedman, Susan Hatters, Amy Heneghan and Miriam Rosenthal. 2009. "Characteristics of Women Who Do Not Seek Prenatal Care and Implications for Prevention." *Journal of Obstetric Gynecologic and Neonatal Nursing* 38: 174-181.

Frohna, John. G., Paula M. Lantz, and Harold Pollack. 1999. "Maternal Substance Abuse and Infant Health: Policy Options Across the Life Course." *The Millbank Quarterly* 77(4): 531-566.

Ginn, Diana. 1999. "The Supreme Court of Canada: Rules on Coercive State Intervention in Pregnancy." *Canadian Woman Studies* 19(1/2): 122-132.

Glaser, Barney and Anslem Strauss. 1967. *The Discovery of Grounded Theory: Strategies for Qualitative Research.* Chicago: Aldine.

Global Coalition on Women and AIDS. 2011. *Women Who use Drugs, Harm Reduction and HIV*. Geneva: Global Coalition on Women and AIDS.

Global Commission on Drug Policy. 2011. *War on Drugs: Report of the Global Commission on Drug Policy.* Retrieved from (http://www.globalcommissionondrugs.org/Report).

Goffman, Irving. 1963. *Stigma: Notes on the Management of Spoiled Identities.* Englewood Cliffs, NJ: Prentice-Hall.

Graham, Hilary. 2004. "Social Determinants and Their Unequal Distribution: Clarifying Policy Understandings." *The Milbank Quarterly 82*(1): 101-124.

Greaves, Lorraine and Nancy Poole. 2008. "Highs & Lows: Canadian Perspectives on Women and Substance Use." *Canadian Women's Health Network* 29-33.

Hagger, M., Chatzisarantis, N., and Biddle, S. 2002. "A Meta-Analytic Review of the Theories of Reasoned Action and Planned Behaviour in Physical Activity: Predictive Validity and the Contribution of Additional Variables." *Journal of Sport & Exercise Psychology* 24: 3-32.

Hardey, Michael. 1998. *The Social Context of Health*. Buckingham, UK: Open University Press.

Hepburn, Mary. 2007. "Preface: Drug Use and Parenting." Pp. 6-9 in *With Child:*

Substance Use During Pregnancy: A Woman-Centred Approach, edited by Susan C. Boyd and Lenora Marcellus. Nova Scotia: Fernwood Publishing.

Hier, Sean and Kevin Walby. 2006. "Competing Analytical Paradigms in the Sociological Study of Racism in Canada." *Canadian Ethnic Studies* 38(1): 83-104.

Horsburgh, Dorthy. 2002. "Evaluation of Qualitative Research." *Journal of Clinical Nursing* 12: 307-312.

Humphries, Drew. 1999. *Crack Mothers: Pregnancy, Drugs and the Media.* Ohio State University Press, Columbia.

Jansson, S. Mikael, Cecilia Benoit, Lauren Casey, Rachel Phillips and David Burns. 2010. "In for the Long Haul: Knowledge Translation Between Academic and Nonprofit Organizations." *Qualitative Health Research* 20(1): 131-143.

Jones, Lee, Robert Sinclair, Ryan Rhodes and Kerry Courneya. 2004. "Promoting Exercise Behaviour: An Integration of Persuasion Theories and the Theory of Planned Behaviour." *British Journal of Health Psychology* 9*:* 505-521.

Lambert, Binta, Melissa Scheiner and Deborah Campbell. 2010. "Ethical Issues and Addiction." *Journal of Addictive Diseases* 29: 164-174.

Lefebvre, Lisa, Deana Midmer, Jennifer Anne Boyd, Alice Ordean, Lisa Graves, Meldon Kahan and Lydia Pantea. 2010. "Participant Perception of an Integrated Program for Substance Abuse in Pregnancy." *Journal of Obstetric Gynecologic and Neonatal Nursing* 39(1): 46-52.

Leslie, Margaret and Gina DeMarchi. 2004. "Engaging Pregnant Women Using Substances: A Review of the Breaking the Cycle Pregnancy Outreach Program." *IMPrint: Newsletter of the Infant Mental Health Promotion Project (IMP).* 39:1 5. (http://www.mothercraft.ca/index.php?q=publications).

Link, Bruce G. and Jo C. Phelan. 2001. "Conceptualizing Stigma." *Annual Review of Sociology* 27: 363-385.

——— 2006. "Stigma and Its Public Health Implications." *Lancet* 367: 528-529.

Macrory, Faye and Susan C. Boyd. 2007. "Developing Primary and Secondary Services for Drug and Alcohol Dependent Mothers." *Seminars in Fetal & Neonatal Medicine* 12: 119-126.

Mahony, Tina H. 2011. "Women and the Criminal Justice System." *Women in Canada: A Gender-Based Statistical Report.* In Statistics Canada catalogue no. 89-503-X.

Marcellus, Lenora. 2004. “Feminist Ethics Must Inform Practice: Interventions with Perinatal Substance Users.” *Health Care for Women International* 25: 730-742.

Marshall, Sheila K., Grant Charles, Jane Hare, Kames Ponzetti Jr. and Monica Stokl. 2005. “Sheway's Services for Substance Using Pregnant and Parenting Women: Evaluating the Outcomes for Infants.” *Canadian Journal of Community Mental Health* 24(1): 19-33.

Martin, Patricia Yancey. 2008. “Gender as Social Institution.” *Social Forces* 82(4): 1249 1273.

Marlatt, Alan G. 1996. “Harm Reduction: Come As You Are.” *Addictive Behaviours* 21(6): 779-788.

Mawani, Renisa. 2005. “Genealogies of the Land: Aboriginality, Law, and Territory in Vancouver’s Stanley Park.” *Social Legal Studies* 14(3): 315-339.

McDonald, Katrina B. and Adia M.H. Wingfield. 2008. “(In)visibility Blues: The Paradox of Institutional Racism.” *Sociological Spectrum* 29(1):28-50.

Melis, Martina and Marie Nougier. 2010. *IDPC Briefing Paper: Drug Policy and Development: How Action Against Illicit Drugs Impacts on the Millennium Development Goals.* London: International Drug Policy Consortium.

Messer, Kristi, Kathryn Andersen Clark and Sandra L. Martin. 1996. “Characteristics Associated with Pregnant Women's Utilization of Substance Abuse Treatment Services.” *American Journal of Drug and Alcohol Abuse* 22(3): 403-422.

Navarro, Vicente. 2009. “What We Mean by Social Determinants of Health.” *International Journal of Health Services* 39(3): 423-441.

Pauly, Bernadette. 2008a. “Harm Reduction Through a Social Justice Lens.” *International Journal of Drug Policy* 19*:* 4-10.

——— . 2008b. “Shifting Moral Values to Enhance Access to Health Care: Harm Reduction as a Context for Ethical Nursing Practices.” *International Journal of Drug Policy* 19: 195-204.

Payne, Sarah. 2007. Chapter Four: Caring Not Curing: Caring for Pregnant Women with Problematic Substance Use in an Acute-Care Setting: A Multidisciplinary Approach.” Pp. 56-69 in *With Child: Substance Use During Pregnancy: A Woman-Centred Approach,* edited by S. C. Boyd and L. Marcellus. Nova Scotia: Fernwood Publishing.

Perez, Mam. 2000. “Two Methodological Perspectives for the Inclusion of Gender Perspective in the Analysis of Poverty.” *Psicothema* 12 :377-381.

Petty, Richard, Duane Wegener and Leandre Fabrigar. 1997. "Attitude and Attitude Change." *Annual Review of Psychology* 48: 609-647.

Phillips, Rachel. 2010. *Courtesy Stigma: A Hidden Health Concern Among Workers Providing Services to Sex Workers.* PhD dissertation, Department of Sociology, University of Victoria, British Columbia.

Pinkham, Sophia and Kasia Malinowska-Sempruch. 2007. *Women, Harm Reduction, and HIV*. New York: Open Society Institute.

Poole, Nancy. 2000. *Evaluation Report of the Sheway Project for High Risk Pregnant and Parenting Women.* Vancouver: British Columbia Centre of Excellence for Women's Health.

——— and Lorraine Greaves. 2007. "Preface." Pp. xiii-xv in *Highs & Lows: Canadian Perspectives on Women and Substance Use,* edited by N. Poole and L. Greaves. Toronto: Centre for Addictions and Mental Health.

——— and Barbara Isaac. 2001. *Apprehensions: Barriers to Treatment for Substance-Using Mothers.* Vancouver: British Columbia Centre of Excellence for Women's Health.

Prochaska, James and Bess Marcus. 1994. "The Transtheoretical Model: Applications to Exercise." Pp. 161-180 in *Advances in Exercise Adherence,* edited by R.K. Dishman. Champaign, IL: Human Kinetics.

Ramazanoğlu, Caroline with Janet Holland. 2002. *Feminist Methodology: Challenges and Choices.* Thousand Oaks: SAGE Publications.

Raphael, Dennis. 2006. "Social Determinants of Health: Present Status, Unresolved Questions, and Future Directions." *International Journal of Health Services* 36: 651-677.

Reinharz, Shulamit. 1992. *Feminist Methods in Social Research.* New York: Oxford University Press.

Reitmanova, Sylvia, and Diana L. Gustafson. 2008. "'They Can't Understand It': Maternal Health and Care Needs of Immigrant Muslim Women in St. John's, Newfoundland." *Maternal and Child Health Journal* 12: 101-111.

Rice, Joanna. 2011. "Canadian Residential School Truth and Reconciliation Commission of Canada." *Cultural Survival Quarterly* 35(1): 22.

Robberson, Margaret. R., and Ronald W. Rogers. 1988. "Beyond Fear Appeals: Negative and Positive Persuasive Appeals to Health and Self-Esteem." *Journal of Applied Social Psychology* 18: 277–287.

Roberts, Paula, Helena Priest and Michael Traynor. 2006. "Reliability and Validity in Research." *Nursing Standard* 20(44): 41-45.

Room, Robin and Peter Reuter. 2012. "How Well do International Drug Conventions Protect Public Health?" *The Lancet* 379(9810): 84-91.

Rosenberg, Karen E. 2008. "Institution, Gender as." *Encyclopaedia of Gender and Society.* Thousand Oaks, CA: SAGE. Pp. 465-467. *SAGE Reference Online.*

Rosenstock, Irwin M. 1974. Historical Origins of the Health Belief Model. *Health Education Monographs* 2: 328–335.

Rutman, Deborah, Marilyn Callahan, Audrey Lundquist, Suzanne Jackson and Barbara Field. 2000. *Substance Use and Pregnancy: Conceiving Women in the Policy Making Process.* Ottawa, ON: Status of Women Canada.

Sandall, Jane, Cecilia Benoit, Sirpa Wrede, Susan F. Murray, Edwin R. van Teijlingen, and Rachel Westfall. 2009. "Social Service Professional or Market Expert?: Maternity Care Relations Under Neoliberal Healthcare Reform." *Current Sociology* 57(4): 529-553.

Stevens, Alex. 2011. "Drug Policy, Harm and Human Rights: A Rationalist Approach." *The International Journal on Drug Policy* 22(3): 233-238.

Strang, John, Thomas Babor, Jonathan Caulkins, Benedikt Fischer, David Foxcroft, and Keith Humphreys. 2012. "Drug Policy and the Public Good: Evidence for Effective Interventions. *The Lancet* 379(9810): 71-83.

Stubber, Jennifer and Ilan Myer, 2008. "Stigma, Prejudice, Discrimination and Health." *Social Science & Medicine* 67: 351-357.

Sword, Wendy, Alison Niccols and Aimei Fan. 2004. "New Choices' for Women with Addictions: Perceptions of Program Participants." *BMC Public Health* 4: 10-20.

Symons-Downs, Danielle and Heather Hausenblas. 2005. "The Theories of Reasoned Action and Planned Behaviour Applied to Exercise: A Meta-Analytic Update." *Journal of Physical Activity and Health 2*: 76-97.

Trace,Mike. 2010. *Drug policy – Lessons learnt, and option for the future.* Rio de Janeiro: Global Commission on Drugs Policies.

Takahashi, Saul. 2009. “Drug Control, Human Rights, and the Right to the Highest Attainable Standards of Health: By No Means a Straightforward Issues.” *Human Rights Quarterly* 31: 748-776.

Uziel-Miller, Nina D. and John S. Lyons. 2000. “Specialized Substance Abuse Treatment for Women and Their Children: An Analysis of Program Design.” *Journal of Substance Abuse Treatment* 19: 355-367.

Wagner, Marsden. 1998. “The Public Health Versus Clinical Approaches to Maternity Services: The Emperor Has No Clothes.” *Journal of Public Health Policy* 19(1): 25-35.

Weaver, Sydney. 2007. “Chapter Six: ‘Make it More Welcome’: Best-Practice Child Welfare Work with Substance-Using Mothers – Diminishing Risks By Promoting Strengths.” Pp. 76-90 in *With Child: Substance Use During Pregnancy: A Woman Centred Approach,* edited by Susan C. Boyd and Lenora Marcellus. Nova Scotia: Fernwood Publishing.

Williams, Gareth H. 2003. “The Determinants of Health: Structure, Context and Agency.” *Sociology of Health & Illness* 25: 131-154.

Wrede, Sirpa, Cecilia Benoit, and Thorgerdur Einarsdottir. 2008. “Equity and Dignity in Maternity Care Provision in Canada, Finland and Iceland.” *Canadian Journal of Public Health* 99: S16-S21.

Young, Iris Marion. 1994. “Punishment, Treatment, Empowerment: Three Approaches to Policy for Pregnant Addicts.” *Feminist Studies* 20(1):33-57.

Appendix A: Recruitment Poster

HerWay Home Program

Are there maternity and other services you needed or could have used but were not available?

Pregnant and parenting women facing substance use and other life challenges are wanted for an UVic research project. Interviews will last for about one hour and a $30 honorarium will be provided. Your feedback is important to us!

ANONYMOUS AND CONFIDENTIAL

Questions? Interested? Please contact
Camille [redacted]

CIHR IRSC
Canadian Institutes of Health Research | Instituts de recherche en santé du Canada

Centre for ADDICTIONS RESEARCH OF BC | University of Victoria

Appendix B: Information Sheet for Women

HerWay Home Program Info Sheet

What is HerWay Home?

HerWay Home is a program that wants to help women in our community who are pregnant and who, for many reasons, might not be receiving the care and services they need. Over 30 community groups and healthcare providers have been working together to create a program that offers services at one location, for women with complex lives. Services will include meals, health care, information and care services during pregnancy, counselling, parenting, child and baby check-ups, drug and alcohol counselling, help with housing, life skills and training for jobs.

Who Can Use These Services?

The services are for pregnant women and women with young children who are effected by drugs and alcohol, violence in their lives, and mental health issues.

How Can I Help?

The HerWay Home Research Group is looking for women who may have found a program like HerWay Home helpful when they were pregnant or looking after young children and struggling with drug and alcohol use, violence in their life, or mental health issues. Or, maybe you are a woman who might check out this program if it was up and running in Victoria now – we'd love to hear your ideas.

How Do I Get Involved?

The HerWay Home Research Group would like to hold private interviews with interested women to ask you about what your needs are and how you think the new HerWay Home Victoria Program should be created to best meet the needs of women and their families. If you would like to take part in one of these private interviews, please contact ***Camille Stengel*** at [redacted] or [redacted] for more information.

A small thank you of $30 will be provided, plus bus tickets if needed.

CIHR IRSC Canadian Institutes of Health Research / Instituts de recherche en santé du Canada

Centre for ADDICTIONS RESEARCH of BC — University of Victoria

Appendix C: Interview Guide

HERWAY HOME PROGRAM: INDIVIDUAL INTERVIEW QUESTIONNAIRE

The following questions are about your life, health, pregnancy and birth experiences. If you do not feel comfortable with a question you do not have to answer, and if you like we can either skip the question or write the answer down on a piece of paper and put it in an envelope for me to read later. All of your responses remain confidential and anonymous. Do you have any questions before we begin?

Pregnancy

Q1. Please tell me about how you found out when you were pregnant.

Birthing experience

Q2. Please tell me about your experience with giving birth.

Your Health

Q3. What kinds of things are affecting your health and well being these days?

Your Children's Health

Q4. Is your child/children's health? How's their sleeping pattern, mood, eating habits?

HerWay Home Program

HerWay Home is an acronym for
***H**ousing first,*
***E**mpowering,*
***R**espect,*
***W**oman,*
***A**cceptance,*
***Y**our choice,*
***H**ealth,*
***O**pportunity,*
***M**othering and*
***E**quality*

Q5. What services do you think should be at the HerWay Home Program?

Anything Else?

Q6. Is there anything else you would like to talk about that hasn't been mentioned, or talk about something else in more detail?

Q7. Are you interested in potentially being part of the Women's Advisory Committee?

*****THIS IS THE END OF THE INTERVIEW. THANK YOU FOR YOUR TIME!! *****