

How Much Help? How Much Harm?
Working class women's experiences of prenatal
care in East Vancouver

by

Martha Roberts

BMW, University of British Columbia, 2007

Thesis Submitted in Partial Fulfillment of the
Requirements for the Degree of
Master of Science

in the

Master of Science Program
Faculty of Health Sciences

© Martha Roberts 2017

SIMON FRASER UNIVERSITY

Spring 2017

All rights reserved.

However, in accordance with the *Copyright Act of Canada*, this work may be reproduced, without authorization, under the conditions for Fair Dealing. Therefore, limited reproduction of this work for the purposes of private study, research, education, satire, parody, criticism, review and news reporting is likely to be in accordance with the law, particularly if cited appropriately.

Approval

Name: Martha Claire Roberts

Degree: Master of Science

Title: *How Much Help? How Much Harm?*

*Working class women's experiences of prenatal care
in East Vancouver*

Examining Committee: **Chair:** Diego Silva
Assistant Professor

Dr. Nicole Berry
Senior Supervisor
Associate Professor

Dr. Marina Morrow
Supervisor
Professor

Dr. Mary Sharpe
Supervisor
Associate Professor

Dr. Lori Hanson
External Examiner
Associate Professor
Department of Community Health and
Epidemiology
University of Saskatchewan

Date Defended/Approved: March 6, 2017

Ethics Statement



The author, whose name appears on the title page of this work, has obtained, for the research described in this work, either:

- a. human research ethics approval from the Simon Fraser University Office of Research Ethics

or

- b. advance approval of the animal care protocol from the University Animal Care Committee of Simon Fraser University

or has conducted the research

- c. as a co-investigator, collaborator, or research assistant in a research project approved in advance.

A copy of the approval letter has been filed with the Theses Office of the University Library at the time of submission of this thesis or project.

The original application for approval and letter of approval are filed with the relevant offices. Inquiries may be directed to those authorities.

Simon Fraser University Library
Burnaby, British Columbia, Canada

Update Spring 2016

Abstract

This project sought to interrogate the institution of prenatal care in East Vancouver through the lived experiences of working class and historically marginalized women. Prenatal care in British Columbia is a complex of institutional policies and practices. This project focussed on prenatal visits between pregnant women and their chosen maternity care provider. Through the stories and experiences of nine research participants, this project affords insight into how the work of prenatal care might be improved to better the experiences and health outcomes for working class and historically marginalized women and their newborns. This could include integrating more substantive ways of centering women in the institution of prenatal care and recruiting women as active participants, such as the use of group care and lay health care workers. Pregnancy is a time of great change for working class and historically marginalized women; attempts to reduce social inequity can start with the institutions that provide women care throughout pregnancy.

Acknowledgements

I acknowledge the ongoing colonial occupation of the traditional lands of the Sk̓wxwú7mesh Úxwumixw (Squamish), s ə́lilwətaʔt (T sleil-Waututh), xʷməθkʷəy̓əm (Musqueam) and kwikwə́łəm (Kwkwetlem) nations upon which this research has taken place.

I would like to thank my thesis advisor Dr. Nicole Berry of the Faculty of Health Sciences at Simon Fraser University for her unflagging support on the long journey I took to completion of my graduate degree! I am very fortunate to have had such a patient and open-minded thesis supervisor who gave freely her insights and reflections in order to strengthen this work.

I would also like to thank Dr. Marina Morrow and Dr. Mary Sharpe for their words of wisdom and encouragement in their role on my supervisory committee and for their valuable and much appreciated comments on this thesis.

I would like to express my appreciation to the women interviewed for this project, who unselfishly gave of their time and shared their rich experiences.

Last but certainly not least, thank you Aiyanas for your love and support during my many years of graduate studies and for standing by me as I grew into teaching my own students. It is my hope that this work will contribute in some small way toward a better world that we struggle toward together.

Table of Contents

Approval.....	ii
Ethics Statement.....	iii
Abstract.....	iv
Acknowledgements.....	v
Table of Contents.....	vi
List of Figures.....	viii
List of Acronyms.....	ix
 Chapter 1. The Research Project	1
1.1. Introduction	1
1.2. Rationale.....	1
1.3. Literature Review	2
1.3.1. What prenatal care is available in British Columbia?	2
1.3.2. Why working class & systemically marginalized women?.....	3
1.3.3. Existing literature on working class and marginalized women's experiences with prenatal care	4
1.3.4. Historical and Current Solutions to Constraints on Access and Negative Experiences in Prenatal Care	8
1.3.5. Conclusion	14
1.4. Looking Ahead	14
 Chapter 2. Methodology and Epistemology.....	16
2.1. Methodology.....	16
2.1.1. Epistemology	17
2.1.2. Situating the Researcher in Feminist Standpoint.....	19
2.1.3. Research Methods.....	20
2.1.4. Presentation of Findings and Discussion.....	25
2.1.5. The Participants	25
 Chapter 3. Social Relations within the Institution	29
3.1. Introduction to Prenatal Care	29
3.1.1. A Very Brief History.....	30
3.1.2. Structure of Prenatal Care	31
3.1.3. Function of Prenatal Care	33
3.2. Technical Care and Deployment of Expertise.....	38
3.2.1. Technical Care rather than Personal Care.....	40
3.2.2. Knowledge Expertise and Institutional Power.....	44
3.2.3. The Deployment of Expertise: Lana's Story.....	46
 Chapter 4. Medicalization of Marginalization	53
4.1. Introduction: Jenny's Story	53
4.2. Unruly Bodies: Biology and Structural Injustice.....	57
4.2.1. Colonialism, Food insecurity, and Diabetes: Tia's story.....	59

4.2.2. Social Class, Structural Injustice, and Mental Health: Heather's Story.....	62
4.3. A 'Fix Women' Approach to Prenatal Care.....	66
Chapter 5. Alternatives to Current Practice	69
5.1. From Critique to Change: 'Fixing' Prenatal Care.....	69
5.2. Community-Based Models of Care	71
5.3. Integrating Women as Active Care Givers	78
5.3.1. Make space for women on the prenatal form.....	81
5.3.2. Give women a say over their health records.....	81
5.4. Conclusion	83
References	85
Appendix A. Perinatal Services BC Antenatal Record Part 1&2 (6 pages).....	96
Appendix B. Sample interview questions:.....	102

List of Figures

Figure 1.	The Antenatal Record Part 1 & 2.....	12
Figure 2.	Poetic Transcription “No relevant experience” (Tia)	28
Figure 3.	Section 8 of the PSBC standard prenatal form.....	37
Figure 4.	Poetic Transcription “Broken” (Jenny)	52
Figure 5.	Section 15: “Potential or Action Concerns”.....	67

List of Acronyms

CMBC	College of Midwives of British Columbia
EPDS	Edinburgh Postpartum Depression Scale
PSBC	Perinatal Services British Columbia
SFU	Simon Fraser University
SOGC	Society of Obstetricians and Gynecologists of Canada
WHO	World Health Organization

Chapter 1. The Research Project

1.1. Introduction

Working class and systemically marginalized childbearing women frequently have negative experiences interacting with institutions and practitioners around reproductive health and social well-being (Sword, 2003; Angus et al, 2012; Heaman et al, 2007; Downe et al, 2009). The goal of this thesis is to situate the first-hand prenatal care experiences of working class and systemically marginalized women in East Vancouver within the institution of prenatal care to better understand how relations of ruling impact women within health care (Smith, 1988). This thesis discusses how social relations both produce and reproduce inequity in health care, and will generate insight into how the work of prenatal care might be re-organized to better serve working class and systemically marginalized women.

1.2. Rationale

Policy makers, health care practitioners, and researchers lack a thorough understanding of the complex intertwining social and material circumstances that lead women to decline prenatal care or to enter into care late in their pregnancies. Maternity care is a core primary health care service, with over 40,000 women giving birth annually in BC. Canadian health guidelines recommend a minimum of 14-16 primary care visits during pregnancy (BCPHP, 2010), yet the number of women who present to 5 or fewer visits is on the rise (PSBC, 2012). Existing literature suggests working class and systemically marginalized women, including racialized immigrant women and Indigenous women, present later for prenatal care, have fewer overall visits, and face multiple barriers to care (Sword, 2003; Angus et al, 2012; Heaman et al, 2007). Most research to date documents women's reasons for not seeking care in terms of instrumental barriers and personal dislikes, with a particular

focus on material circumstances that frame women's individual behaviour. Women report that barriers in access to prenatal care range from geographic distance and cost of transportation to an inability to get time off of work (Angus et al, 2012). Personal reasons include prior negative experiences with care, too short appointment times, lack of appropriate information on medical tests and interventions, lack of culturally-appropriate care, discrimination from care providers and incidents of overt racism, over-medicalization, stigmatization of poverty, and fear of child apprehension (Sword, 2003; Angus et al, 2012; Browne, 2007; Reid & Tom, 2006; Heaman et al, 2007).

Narrowing working class and historically marginalized women's issues with prenatal care to issues of instrumental barriers and personal experiences is problematic given that the prevalent reason given by women for not returning to care was a prior negative experience with the medical care system (Lazarus, 1994). The label of 'poor', 'low income' or 'low socio-economic status' falls short when it comes to explaining the underlying processes of *why* low income women present later to care and have fewer prenatal visits during pregnancy (Sword, 2003; Sword, 1999; Angus et al, 2012). As Ricketts and Goldsmith describe, "in reality, people have many opportunities to react to needs or perceived needs, and their reaction depends largely on how they anticipate the system will react to them, how much they trust the system, and how much benefit they feel they will derive from using health care" (2005, p. 277). This research proposes to dig deeper into the problematic of how inequitable social relations shape women's experiences of, and subsequent decisions to continue with prenatal care.

1.3. Literature Review

1.3.1. What prenatal care is available in British Columbia?

Primary maternity care is a central component of primary care in British Columbia. According to Perinatal Services BC, 43,518 women gave birth to 44,256 neonates in the 2011/2012 data tracking period (PSBC, 2012). Obstetricians, who are highly-trained medical specialists and surgeons, attended 50.5% of deliveries. Family physicians provide 35.5% of care, and Registered Midwives follow far behind at 10.9 % of care provided (PSBC, 2012). This research project will examine the prenatal care experiences

of working class and marginalized women regardless of which type of health care professional provided their primary maternity care.

1.3.2. Why working class & systemically marginalized women?

This thesis focuses on working class and systemically marginalized women to explore the possible impacts that broader social and institutional relations have on women's experiences of prenatal care. This study proposes to dig deep into the structural and institutional social relations of marginality through analyzing women's experiences, in women's own words, to better grasp the issues that working class and historically marginalized and racialized women experience during prenatal care.

A brief discussion of social relations and systemic marginalization is followed by a more in-depth overview of what has been reported in the literature on women's experiences of prenatal care.

What are social relations? What is systemic marginalization?

For the purposes of this thesis, social relations are defined as relations between members of economic classes as determined by the social relations of production, as opposed to interpersonal relations between individuals. In 1977, Dorothy E. Smith called on feminists and sociologists to locate the process of women's oppression in economics and politics (Smith, 1977, p. 17). The capitalist mode of production structures the political and state institutions that shape daily life. As Marx describes: "the mode of production of material life conditions the social, political and intellectual life processes in general" (Marx, 1859). Scott has described how "institutions and relations...together, comprise the 'pattern' of social life" (2005, p. 83) and Porpora argues that both relations and institutions have a material base (1989). Identifying the root of oppression and exploitation in class-determined inequitable social relations begs an analysis, not only of experiences of those in particular social locations, but the interaction between 'ruling' or 'dominating' groups and those on the 'margins'.

The concept of marginalization looks beyond *positionality* to *relationality*. In development theory, Amin (1976) used the centre-periphery concept to explain the relationship between

parasitic social (class) relations under capitalism and oppressive and exploitative relations between nations under imperialism. The concept of national oppression is an extension of this theoretical advance; one which progressive organizations have used to differentiate systemic and institutional racism from interpersonal racism (Program Demand Group, 2002). Feminists have also used the analogy of 'margins' in relation to the 'centre' to challenge white chauvinism, Eurocentrism, and patriarchal sexism, which underpin privilege in society (hooks, 1984). This concept expands a basic class analysis to include a nuanced understanding of the historical and political contexts that disproportionately locate colonized indigenous communities and racialized and oppressed (and often) migrant communities in the working class, as well as constituting oppressed nations within the imperialist centre (Program Demand Group, 2002).

This research project attempts to centre the experiences of women who have historically been marginalized, and seeks to adopt Hartsock's "emphasis on historically specific social relations among groups rather than individuals" (2002, p. 352). Social relations are therefor understood as the relations between groups of people, rather than solely as interpersonal relationship. The process of systemic marginalization situates women, in particular racialized women of colour and internally-colonized Indigenous women, increasingly in the working class – separated as a class from ownership or control over the means of production, and as a marginalized group, lacking access to political or ideological mechanisms of power and control in society. This project seeks to explore how social relations of ruling within medicine might undercut working class and systemically-marginalized women's experiences of prenatal care, as well as explore the concept of prenatal care as a form of social relation in and of itself.

1.3.3. Existing literature on working class and marginalized women's experiences with prenatal care

I don't want to be treated like a guinea pig. (Lazarus, 1994)

Constrained Access to Care

Women report that constraints in access to prenatal care can range from physical barriers to economic constraints (Lazarus, 1994; Downe et al, 2009). The instrumental and geographic barriers in British Columbia are prevalent, given that many women living

outside of urban centres do not have choice of care provider or easy access to prenatal care and many women, in particular Indigenous women, must leave their home communities to give birth (Varcoe et al, 2013). For inner-city women in Vancouver, the focus of this study, Angus et al describe “constraints in access” to health care for poor and racialized immigrant women for reasons of economic hardship and inability to find childcare, in affordability and availability of transportation options, and financial strain and inability to pay for care when women are not eligible for provincial insurance due to lack of permanent residency status (2012, p 485-486; Downe et al, 2009).

Competing Priorities

Angus et al have found that working class women's lived experiences of poverty and marginality lead to constrained access to prenatal care (2012). Precarious and low status employment prevents women from asking employers for time off work (Best Start, n.d.). In particular, immigrant women have reported greater competing priorities due to lower social status, greater financial strains, and a greater role in family responsibilities (Gündüz, 2013). Further, racialized immigrant women have reported greater inability to attend visits due to challenges in juggling paid employment with gendered expectations of reproductive labour in the home (Downe et al, 2009).

Inadequate or Contradictory Information Provided

The literature suggests that challenges in communication with care providers resulting in confusing or contradictory messages render prenatal care stressful and potentially unhelpful. Lazarus (1997) found that care providers, in particular trainees, struggle to communicate with women from different social classes, especially in the very short time intervals that prenatal care visits are allocated – ranging from 5 to 10 minutes. Further, contradictory explanations lead to unnecessary tests (Lazarus, 1994) and contradictory opinions and information cause stress and anxiety for women (Angus et al, 2012). Women report not being informed of what tests were being ordered or why (Lazarus, 1994; Angus et al, 2012; Browne, 2007), and not being informed about test results (Lazarus, 1994). Poor and racialized women were far less likely to have medical procedures explained to them (Lazarus, 1994) and this is far worse for racialized and Indigenous women (Browne, 2007; Browne & Fiske, 2001; Henderson et al, 2013).

Mistreatment by Medical Professionals

The literature suggests that poor and racialized women face disparagement and stigmatization within the medical system. In their interviews with women, Reid and Tom (2006) found when a doctor's signature was required to complete paperwork for disability, welfare, or childcare, it led to feelings of powerlessness and anger for the women seeking help. Racialized working class women were far more likely to experience flagrant racism and abuse within the medical system (Lazarus, 1994; Browne, 2007). Racialized immigrant women struggle to find services available in their first language, and are vulnerable to poor care and judgemental attitudes from care providers (Angus et al, 2012; Henderson et al, 2013). Indigenous women have significantly reduced access to medicalized care, and when accessing services despite great barriers, report feeling misunderstood and mistreated within the system (Whitty-Rogers et al, 2006). Further, Indigenous women also report harms caused by their interactions with health care professionals, ranging from stigmatization and neglect to gross mistreatment within the medical system (Browne, 2007; Reid & Tom, 2006; Berry, 2011). Poor treatment in the medical system can lead working class and racialized women to feel inadequate and invalidated as capable mothers; feelings that can endure and undermine women's confidence in mothering in the long term (Whitty-Rogers et al, 2006).

Medicalization and Risk

The literature suggests that many women do not view pregnancy as a medical concern, and not all women see value in obtaining medical care during pregnancy. Ricketts and Goldsmith interrogate health care non-use and suggest that not perceiving a need, an illness, or a benefit to care is instrumental (2005). This is often the case for pregnant women who come from a culture or a philosophy whereby pregnancy is considered to be a normal healthy part of a woman's life-course, and either not predominantly (Angus et al, 2012; Sword, 2003) or not at all a medical event. Strikingly, Indigenous women reported that they did not present for prenatal care due to the fact that childbirth was viewed as a normal and healthy process (Angus et al, 2012) and mothering as a cultural and political responsibility (Fiske, 1992; Couchie & Nabigon, 1997).

There has been some discussion in the literature on tensions that arise in the clinical setting when health care providers deploy the concept of risk to stratify women into groups of 'normal' subjects and 'risky' subjects, sparking anxiety and internal conflict for women who are subjected to what Queniat has termed the "risk factor ideology" and an obsession with defining normalcy (1992, p. 164). Poverty, low socio-economic status, self-medication, precarious employment and housing, exposure to violence, and so on are seen as deviant (ELP, 2001; Wall, 1993) and considered to place pregnant women and neonates at high risk of adverse outcomes (Best Start, 2002). In the institution of medicine, biological conditions are seen as separate from the social and economic context. Yet, poor and marginalized women themselves perceive different risks: they are pathologized; medicine manages social conditions as illness; many women view seeing a doctor as a 'risk' & medical care may be a source of harm (Berry, 2011; Boyd, 1999).

Contradictory Discourses on Poverty and Mothering

Working class and systemically marginalized women report that their care providers lack the ability to understand their experiences of poverty and marginalization and to address these issues in the scope of their care (Sword, 2003; Lazarus, 1994). Poor women are bombarded with contradictory discourses; public health literature states poor women don't require money to bond with their babies (Best Start, 2002) and yet dominant discourses overwhelm poor women with messages of being incapable mothers (ELP, 2001; Wall, 1993; Cull, 2006) and a 'risk' to the health of children (Greaves et al, 2004). This bombardment of contradictory messages, combined with lack of caring or even judgemental attitudes from health care professionals creates both distrust and even fear of the power of the medical system to have negative impact on women's lives.

Conflictual Colonial Relations and Forced Migration

For poor Indigenous women in BC these fears are founded on an ongoing conflictual relationship with the triad of social work, state social services, and health care professionals that combined forces to oversee the 1960s scoop of Indigenous children from the biological parents and home communities (Fournier & Crey, 1997). Rather than striving to address intergenerational challenges that stem from this history of settler colonial policies and practices, individual Indigenous families and Indigenous communities are scrutinized and yet not provided adequate economic and social supports to make

significant changes (B.C.'s Representative for Children and Youth, 2015). The relationship between Indigenous families and maternity care providers remains fraught with tensions based on ongoing targeting of Indigenous children for apprehension and placement in foster care (Fournier & Crey, 1997). Poor Indigenous mothers continue to be the subject of scrutiny and have justifiable reasons for avoiding situations of power imbalance, in particular when it concerns custody of their children (Angus et al, 2012; Fournier & Crey, 1997). Women who struggle with mental health and / or addictions have very concrete fears of the involvement of state social workers and child apprehension (Boyd, 1999; Angus et al, 2003). For women from racialized immigrant communities, these fears stem from precarious or even undocumented legal status and concerns over deportation (Angus et al, 2012).

1.3.4. Historical and Current Solutions to Constraints on Access and Negative Experiences in Prenatal Care

The provision of prenatal care, and the current perinatal care guideline in B.C., is rooted in the social, political, and economic history and context of health care in this province including: a history of settler colonialism, migration, the institutionalization of the professional doctor, the growth of medical facilities, and legislation governing medical care delivery (Strong-Boag & McPherson, 1992). The history of the current institution of prenatal care can be traced through Provincial legislation governing medical acts starting early in the Twentieth Century which effectively criminalized lay practices of midwifery, including Indigenous midwifery practices (Roberts, 2014). Increasing state regulation of medical professions meant a concomitant shift of the provision of care from lay provider to health care professional (Rice, 1997). When the struggle to reincorporate midwifery emerged in the 1980's, this struggle took the form of advocating for a model of midwifery complementary to the biomedical model of prenatal care, which was institutionalized within the Canadian health care system (Nestel, 2004; Nestel, 2006).

Some responses to women's experiences of poor care exist, in particular the resurgence of midwifery and the development of the concept of cultural safety, but these responses have not significantly shifted social relations within the institutional framework of medical care in B.C. The limitations of these practices are that, rather than reshape the institution

overall, they are incorporated within the broader institution and, in fact, change according to institutional directives rather than vice versa.

Registered Midwifery as one response

The struggle to incorporate midwifery into the medical system was viewed by many as a critical struggle to counter the medicalization of birth and to address women's negative experiences within the health care system. Including midwives as legal and fully-funded health care professionals increased women's access to competent, safe, and often compassionate prenatal care. The midwifery model adopted in British Columbia has a core philosophy: "pregnancy as a state of health and childbirth as a normal physiologic process, and a profound event in a woman's life" (CMBC, 1997). This philosophy provides an alternative framework to a strictly biomedical model, and allows for greater focus on preparation for growing a family and the social aspects of care. Working "in partnership with women" is included both within the philosophy of care and the definition of midwife adopted by the CMBC (CMBC 1997; CMBC, 2013). Since regulation, midwifery practices have flourished in Vancouver and other metropolis centres of BC (MABC, 2017), though midwifery care remains very difficult for many women to access due to shortages of midwives, the need to book into care extremely early in pregnancy due to long waiting lists and high demand, and the geographical location of practices within communities.

Critiques of Registered Midwifery interrogate the changing class and social status of the professional midwife and how this impacted midwifery care for women. State-sanctioned midwifery in Canada, particularly in Ontario in 1991 followed by British Columbia in 1998 occurred through a process of re-shaping midwives as self-regulating health care professionals legitimized through acceptance into the Health Professions Act and the formation of an independent College of Midwives to licence Registered Midwives and govern midwifery rules and regulations (Van Wagner, 2004; Rice, 1997). Registered Midwives became incorporated into the existing framework of biomedical health care with its accompanying institutional frameworks. As Sharpe so clearly explains, midwives now "bring a number of invisible partners to their relationships with women – insurers, legislators, physicians, other providers and regulators" (2004, p. 163). Women who worked as lay midwives prior to the legalization of midwives in Ontario reported that the nature of their relationships with women changed following regulation (Sharpe, 2004) and

in British Columbia some midwives anticipated a similar shift in their relationships (Rice, 1997).

Further, the struggle for legalization and professionalization was dominated by white middle or upper class women (Rice, 1997) as well as existing health care professionals (Kornelsen & Carty, 2004). As Malik (2004) describes, for the “midwifery project to achieve broad-based political support, the midwife needed to be reconfigured in the public imagination as respectable: i.e., knowledgeable, modern, educated, and Canadian/white”. The history and practice of Indigenous midwifery and childbirth practices was virtually ignored (Benoit & Carroll, 1995). In that sense, the struggle for legalization and professionalization in many ways did not challenge the biomedical and professional model (Rice, 1997; Sharpe, 2004; Nestel, 2004). Throughout the 1980s and 1990s, the practices of more radical midwives, and in particular in B.C., migrant and Indigenous women ‘doing’ birth, were ignored or dismissed by those seeking professionalization (Biggs, 2004; Nestel, 2006).

The Midwifery Model of Care

In many ways, the incorporation of midwifery into the medical care system in British Columbia has been a tremendous success for birthing women, despite the limitations that exist. The concepts and practices of continuity of care and informed choice adopted in the British Columbia midwifery model of care are intended to assist midwives and women to become partners in care (CMBC, 2013). Critique and discussion of these elements follows.

Continuity of care

The introduction of the concept of continuity of care was meant to guide midwives to engage in personal and non-authoritarian relationships with women despite professionalization (Van Wagner, 2004). The philosophical intent of the midwifery model of care supports midwives to foster more genuine, open, and equitable relationships with women. Yet, at times, the requirement for midwives to uphold professional guidelines and remain accountable to the medical institutions and hospitals in which they practice poses a serious impediment to non-authoritarian relationships, as the medical system itself gives dominance to doctors and Western medical knowledge (Patel & Al-Jazairi, 1997). As

Sharpe describes it, “the philosophy, experience, and socio-economic status of the lay midwife and parturient women were often quite similar... we often approached this care together as friends, in the context of the woman’s primary narrative” (2004, p. 152). The professionalization of Registered Midwifery within the Health Professions Act located midwives squarely in the petty-bourgeoisie as self-regulating health care professionals whose specialized skills and high-level technical knowledge render her extremely privileged and often quite wealthy. Professionalizing midwifery institutionalized a formal gatekeeping whereby future midwives are screened based on rigorous academic criteria, required to afford expensive baccalaureate degrees in major urban centres, and have a clear criminal record. This creates a tremendous wealth-privilege gap between working class and systemically marginalized women and the Registered Midwives who care for them.

Informed Choice

The concept of informed choice arose as a challenge to the patriarchal and patronizing orientation of medicine toward women. The idea behind informed choice is to facilitate women making decisions based on their own forms of knowledge and lived experience, and finally to challenge a process whereby “erroneous knowledge with regard to women’s health, knowledge that passed for science, was sustained by the silencing and ignoring of women’s voices” (Hajdukowski-Ahmed et al, cited in Morrow et al, 2008, p. 101). However, the process of bringing midwifery within the medical establishment resulted in many of the traditional and foundational concepts and practices of generations of lay midwives being disregarded as not ‘evidence-based’ (Biggs, 2004). As a result, the adoption of existing guidelines and forms for prenatal care in the province acts as an impediment to the actualization of informed choice as the practice of midwifery shifts focus from the philosophy of pregnancy and birth as fundamentally normal healthy processes toward risk-screening women from a bio-medical perspective (Lazarus, 1994; Rice, 1997). For example, the Antenatal Record Part 1 & 2 is designed around the practice of risk screening, with multiple places on the form to quantify and qualify medical risks. Finally, the fact that midwives are pressured to function within an environment that includes the use of questionable technologies and practices, such as the inappropriate use of external fetal monitoring (Rice, 1997; Benoit, 1997), shapes the way midwives provide information and options to women during informed choice conversations.

The image displays two pages of a medical form titled 'Antenatal Record'. Page 1, 'Antenatal Record Part 1', includes sections for 'Maternal History', 'Antenatal History', and a table for 'Antenatal History'. Page 2, 'Antenatal Record Part 2', includes sections for 'Antenatal History', 'Antenatal History', and a table for 'Antenatal History'. The forms are filled out with handwritten notes and checkboxes. A yellow box highlights a section on page 2, and a green box highlights a section on page 1.

Figure 1. The Antenatal Record Part 1 & 2

The social context of choice

There is currently discussion that Registered Midwives are increasingly practicing what is becoming referred to as 'guideline centered care' (Kotaska, 2011) as opposed to woman centered care. It is increasingly challenging for midwives to practice horizontal exchange of knowledge (Jordan, 1993) when midwifery is ensconced within a broader institution of medicine. Further, class-based power and authoritative knowledge differentials that exist between health care professional (be they midwives or physicians) and working class women form a barrier to the practice of informed choice; which may suggest why it is reported that working class women put far less importance on the concept of choice than do their middle-class counterparts (Lazarus, 1994). Jordan (2004) suggests that the experiential, culturally-centred, and class-relevant knowledge that women draw on to inform their choices is too easily overlooked or dismissed by the broader institutional forces that shape women's experiences of prenatal care.

While Registered Midwifery has opened up space for women to have much more compassionate, woman-centered prenatal care, many challenges still exist. Midwives still

operate within constraints of broader social relations shaped by the institutions in which they work.

Cultural Safety as Resistance and Reification

Individuals... may change their activity in ways which move them outside the outlook embodied in these institutions, but such a move can be significant only when it occurs at the level of society as a whole. (Hartsock, 1987, 289)

Another proposed solution to women's negative experiences of prenatal care, and more specifically with interactions with care providers, can be found in the application of cultural safety to the B.C. neo-colonial context (Browne, 2007). The concept of cultural safety was first introduced by nurses and midwives in New Zealand to address the gross inequities in health outcomes among Maori communities (Woods, 2010), and has since been more broadly applied to address mistreatment and stigmatization within health care by Indigenous (Browne, 2007) and other systemically marginalized populations (Woods, 2010.). The core elements of cultural safety have evolved to include trust and respect, individual and collective autonomy, and social justice and empowerment (Woods, 2010).

The goals of cultural safety include incorporating knowledge of the health-harming consequences of historical processes of colonization, oppression, and social exclusion into the care provider's health practice to create safe clinical experiences for marginalized populations (Woods, 2010; Browne, 2007). As described by Browne and Fiske, "by examining and contextualizing the complexities of health care encounters involving First Nations women, entrenched attitudes and behaviours that may otherwise perpetuate internal colonialism in mainstream health care begin to shift" (2001).

Yet, cultural safety does not go far enough to address the factors that underlie inequitable social relations shaped by settler-colonialism and class exploitation. Proponents of cultural safety acknowledge that health care encounters and policy take place within "historically-mediated relations of power and paternalism" (Browne, 2007, p. 2167). Practitioners cannot simply be 'dislocated', 'enlightened' and their behaviour changed – we need to expand upon Browne's post-colonial theoretical understanding of women's experiences of clinical oppression by looking at the broader social relations that give rise to those experiences.

1.3.5. Conclusion

Have we come to an impasse in prenatal care? Narrow biomedical perspectives and objectives overshadow and distract from social conditions, and entrench reproduction as illness, mothers as problems, medical prenatal care and intervention as the cure (Morrow & Hankivsky, 2008; Ehrenreich & English, 1973; Fee, 1975). How can we expand our understandings of what constitutes 'good care' for working class and systemically marginalized women by looking deeply at the broader social relations that shape women's experiences of prenatal care? That is what this study seeks to contribute.

1.4. Looking Ahead

This project sought to interrogate the institution of prenatal care in East Vancouver through the lived experiences of working class and historically marginalized women. Prenatal care in British Columbia is a complex of institutional policies and practices. This project focussed on prenatal visits between pregnant women and their chosen maternity care provider (Family Doctor, Registered Midwife, or Obstetrician) that comprise the bulk of prenatal care. Through the stories and experiences of nine research participants I began to construct insights into, and two major critiques of, the institution that can contribute to improvements in women's experiences of prenatal care as well as give direction to the need for further research.

The flow of this work is as follows:

Chapter one introduces the research project and overviews the literature to date on working class and marginalized women's experiences of prenatal care, while Chapter two describes the epistemological framework and methods of research for this project.

After providing the reader with an overview of the structure and function of institution of prenatal care in the Province of British Columbia, Chapter three then explores the first critique of how power imbalances between health care professionals and patients can result in women experiencing care as overly technical and expertise as being deployed to gain compliance to standardized care. While women reported appreciation of the technical

skill and medical knowledge of their care providers, technical care could be experienced negatively when women perceived other pressing needs which undercut their ability to be healthy, such as a need for increased financial or social support.

Chapter four addresses the second major critique, the medicalization of marginalization. This chapter digs into the interrelations between pathological diagnoses such as gestational diabetes and perinatal depression, and poverty, colonialism, and social class, and how women experienced a process of medicalization of their marginalization. The totality of women's experiences points to an institution which adopts a 'fix women' approach to prenatal care.

Finally, Chapter five gives insights into how the work of prenatal care might be improved to recognize women themselves as active participants in this work through practices which facilitate greater power for women within the institutional setting. Pregnancy is a time of great change for working class and historically marginalized women; attempts to reduce social inequity can start with the institutions that provide women care throughout pregnancy.

Chapter 2. Methodology and Epistemology

This chapter lays out the methodology, the perspective on knowledge generation, and the specific step-by-step methods used in the course of this research project. Overall, this project prioritized the experiences of women as the source of institutional critique, and sought to present the findings and recommendations centered around the research participants. What emerged is a bricolage of institutional critiques displayed in the context of women's own voices and stories, and finally, recommendations on getting the institution and the work of prenatal care right for women.

2.1. Methodology

My work is based on Institutional Ethnography (IE). IE is an approach to social investigation developed by Dorothy E. Smith as an “alternative sociology” (Smith, 2005) that starts with lived experiences as the “point of entry” (DeVault, 2006, p. 294) into understanding how work processes are coordinated and aligned with broader social forces that shape our society (Smith, 2005; DeVault, 2006).

Institutional Ethnography has been effectively applied to both a clinical and a community setting as a path of discovery toward how social relations of ruling as a process are embedded in health care and social institutions. Research using IE methodology can take two substantive forms. Firstly, through an analysis of institutional discourses, IE can reveal ruling interests and ruling relations in the institutional setting. Such as in the well-known work of Timothy Diamond who drew on the IE framing of ‘textual discourse’ to expose the reorganization of nursing homes towards ruling interests (1986). Additionally, McGibbon, Peter, and Gallop (2010) used IE to elucidate the institutional origins of nurses’ stress in the workplace. Further, Janet Rankin has exposed how texts come to reorient the work of nurses towards fiscal reform over patient-centered care (2001).

Secondly, IE can be used to explore how women's work and daily experiences can be structured and organized by institutional forces represented by texts and forms, and how women's experiences as a starting place in the research can present a fulsome picture of

institutional relations of ruling. For example, Roxanna Ng's (1996) important inquiry into how non-profit organizations wind up reifying labour market categories of racialized women in Ontario. Further, Smith's own work in partnership with Allison Griffith examined how the daily work of mothers is a necessary but invisible contribution to schooling, which disadvantages working class and marginalized women (Griffith & Smith, 2005).

As a critical methodology, IE affords the researcher insight into how inequitable experiences within the social organization of work arise, and therefore opens the potential to generate meaningful structural solutions through the reorganization of said work (DeVault, 2006). IE is a research methodology aimed at identifying and facilitating institutional transformation (Smith, 2005) towards getting institutions "right for women" (Campbell, 2007, p. 2). Given this existing knowledge on the application of IE, it has been demonstrated that IE may provide a strong research framework on which to gain insight into gaps and shortcomings of maternity care in BC from the standpoint of low-income and marginalized women.

2.1.1. Epistemology

Living as we did – on the edge – we developed a particular way of seeing reality. We looked both from the outside in and from the inside out. We focused our attention on the centre as well as on the margin. We understood both. This mode of seeing reminded us of the existence of a whole universe, a main body made up of both margin and center... This sense of wholeness, impressed upon by our consciousness by the structure of our daily lives, provided us an oppositional world view – a mode of seeing unknown to most of our oppressors, that sustained us, aided us in our struggle to transcend poverty and despair, strengthened our sense of self and our solidarity. (hooks, preface).

In order to fully explore power imbalances in prenatal care from the perspective of historically marginalized and working class women, it is necessary to challenge the concept of objectivity. As Oakley described, "the notion of 'objectivity' calls up the ideological screen of 'objectification' and the adjective 'objectionable' (1998, p. 711). The epistemological starting place for this work drew on the theory of standpoint and the position that "each group lives in the world in a phenomenologically specific way that allows it to see, or, better still, that makes it unavoidable for that group to see and to know, features of the world that remain obscure, invisible, or merely occasional and secondary

for other groups” (Hartsock, 2002, p. 353). Only through taking the position of those who experience exploitation, oppression, and marginalization can a complete picture of institutions and relations of ruling emerge.

Feminist standpoint theory

This research adopts the standpoint of working class and marginalized women. The approach to standpoint adopted by this project is that which was first described by Nancy Hartsock (1987, pp. 287-288; Hartsock, 2002). The concept of standpoint is central to IE, as “from different standpoints different aspects of the ruling apparatus and of class come into view” (Smith, 1987, p. 107). Taking a subjective standpoint centres and focuses the research analysis around the lived experiences of those historically excluded from the ruling apparatus (Smith, 1987, p. 107) so that experiences can be mapped onto broader social relations, explaining how experience is shaped by ruling relations.

There are 5 core principles of a feminist standpoint as detailed by Hartsock (1983):

1. That material life structures our understanding. Knowledge of the world is developed through a dialectical process that begins from our world view and based on our lived experiences.
2. That both sides of a story must be illuminated, and weight given to the viewpoint mystified or denied by male domination and relations of exploitation and ruling. Standpoint seeks to illuminate the fundamental contradiction between what women need and what capitalists need as broad social groupings.
3. That operative power dynamics must be recognized. Ruling groups exercise power through both social control and ideological production.
4. That “standpoint is achieved rather than obvious, a mediated rather than immediate understanding.” “The standpoint of the oppressed represents an achievement both of science (analysis) and of political struggle on the basis of which this analysis can be conducted” (p. 288).
5. That standpoint is the only basis that we can move beyond oppressive social relations. “As an engaged vision, the understanding of the oppressed, the adoption of a standpoint exposes the real relations among human beings as inhuman, points beyond present, and carries a historically liberatory role” (p. 285).

By adopting a feminist standpoint, this thesis aimed to present women’s experiences and stories as the starting place for a meaningful institutional critique, one not adequately addressed in the existing literature.

2.1.2. Situating the Researcher in Feminist Standpoint

A standpoint is not simply an interested position (interpreted as bias) but is interested in the sense of being engaged... A standpoint... carries with it the contention that there are some perspectives on society from which, however well-intentioned one may be, the real relations of humans with each other and with the natural world are not visible. (Hartstock, 1983, p. 285).

Within the feminist methodological framework of standpoint, talking and listening are not class, race, and gender neutral activities (DeVault, 1999). Approaching the research question from the standpoint of one on the margins allows the researcher to ask questions that someone situated from a different standpoint would not think to ask. Additionally, a researcher who shares a particular standpoint with her interlocutors can listen to responses from a deeper perspective than others who have not shared the identities and experiences in question (DeVault, 1999). As Hartsock points out, material life “sets limits on the understanding of social relations” (1983, 285), and being “engaged” with the standpoint of working class and historically marginalized women is essential to the epistemological foundation of this project, that all evidence is political rather than neutral (Schrecker, 2016).

With this foundation, it is important to state that as the researcher, I approach this research project informed by my own experiences of marginalization and poverty. This work builds on two personal life experiences: 1) I am situated within the capitalist mode of production, with experiences as a poor working class woman and more recently as a petty-bourgeois health care professional, what Vicente Navarro has termed, a “lieutenant of the bourgeoisie” (Navarro, 1983, p. 243), and 2) I have direct experiences as a poor woman within the institution of medicine.

A Stigmatized Mother

My interest in women’s reproductive health stems from my own experiences of pregnancy and birth as a young, low-income woman. As with many low-income women, I survived on-and-off welfare as I struggled to make ends meet and worried about homelessness. My encounters with the health care system - the institution of medicine - were overwhelmingly negative; I faced derogatory assumptions and judgements, poor care, and

outright neglect within mainstream medicine. The literature on poor women's encounters with the institution of medicine illustrates that my own experiences were not unusual.

A Registered Midwife in East Vancouver

In 2007, I became a Registered Midwife in British Columbia. It was a 10-year journey to registration, but I was sustained by a passion to make a difference for the women in my geographic community of East Vancouver. I saw independent midwifery practice as a way to provide the kind of care that I had wished for when I was pregnant, and I saw my legal status as Registered Midwife as a way to legitimize my own beliefs around reproductive health care. I've now been in practice for over nine years and my overwhelming experience is one of struggling against the incorporation of midwifery within the medical-industrial complex which embeds within health care social relations of exploitation and the dominant world view of those in the center (Navarro, 2009; Navarro, 1983). While individual clinicians might practice in a way that supports collaboration between provider and patient, and may protect women from harm as they move through medical institutions and processes, ultimately structural changes are required to address unequitable relations ensconced within those institutions, practices, and cultural norms. This has definitely been my experience in providing clinical care; one that is stressful and at times *distressing*, for both care provider and patient.

2.1.3. Research Methods

While we work and struggle, our everyday acts and intentions are locked into the underlying dynamic of the relations and forces of production and governed by the powers they give rise to. (Smith, 1987, p. 135)

The methods of IE are fluid and adaptable, and allow for the study of how women's daily experiences of the work of prenatal care connect to the broader social institutions and practices which shape these experiences. The following research methods were research were used to dig deeply into experience to elucidate how social relations are represented in and perpetuated by practices within the health care system.

Setting

The setting for this research project is the geographical communities within East Vancouver. Although gentrification is increasingly pushing working class and systemically marginalized women out of East Vancouver there are still disproportionate numbers of renters and low-income families in this area and many social services agencies on which working class and systemically marginalized women and their families rely are in East Vancouver. Further, I have strong ties within this community as a mother and as a community-based organizer. The interviews were conducted at sights of the women's choosing, as I sought to meet women 'where they are at'. This included cafés, community centres, and women's own homes.

Recruitment

For this project, I sought and obtained SFU ethics approval prior to the recruitment of research participants. Recruitment to the project for the interviews with women was via snowballing, direct referral, and by invitational posters and fliers distributed at key locations where women gather. My connections to the local community centre greatly facilitated recruitment from working class and marginalized women. Seven of the nine participants were recruited for this project through posters tacked on the bulletin boards and handbills set on the counter at the local community centre. The remaining two interviewees were recruited through recommendations of a woman who had participated.

Women who were interested in participating contacted me via telephone message and phone conversation. After agreement to participate was obtained over the telephone, a meeting location was chosen. Five interviews occurred at the local community centre, two in women's own homes, and two in local cafes. Consent was obtained prior to all interviews, and consent forms signed. Women were offered a \$20 stipend to offset the costs of participating, which I paid to them. Women were given the option of using their given name or choosing a pseudonym. All interviews were conducted in a single session, ranging from forty-five minutes to two and a half hours in duration. I recorded and transcribed the interviews. Extremely unfortunately, the sound on Fanny's interview was faulty and much of this interview recording could not be transcribed. However, during the

interview the I documented a few core notes on a notepad and following the interview added them to the theme mind-map, as explained below.

Interestingly enough, while a majority of the participants lived in state-subsidized housing, none of them lived in the same complex. The sample obtained through this method was within the study criteria and seemed to reflect the ethnic demography of East Vancouver with a mix of women from Indigenous, Chinese, Vietnamese and European ancestry. No additional measures were required to recruit working class and historically marginalized women.

Data collection

In order to illuminate the voices of working class and systemically marginalized women, in-person semi-structured interviews form the bulk of the research data for this project. I conducted 9 semi-structured interviews with working class and systemically marginalized women who had accessed prenatal care within the last 5 years regarding their lived experiences and perceptions of prenatal care. Women chose the locations of their interviews.

Data Analysis

The dimensions of our oppression are only fully revealed in discoveries that go beyond what direct experience will teach us. Smith, 2005, p. 107

Analysis of the data involved four steps: transcribing, reading, and manually coding, and visually mapping the data using a mind map technique. In addition, I drew on the creative practices of poetic transcription and photography to highlight the connection between geographic place, women's experiences, and the institutional critiques taking shape through the research process.

In practice, coding involved an iterative process of reading through the transcripts and colour coding for common experiences in repetitive cycles until clear themes emerged. I then drew a mind map diagram of emerging initial major themes. To confirm and enrich the initial map, I re-read the transcripts for both confirmation of and changes to the initial themes, and for identification of sub-themes. I then drew a second mind map and used this as the skeleton for the drafting of the thesis project.

Mind mapping has been described in qualitative research literature (Butler-Kisber & Polma, 2010; Whiting & Sines, 2012) and is a process I was familiar with from a large community-based research project I had actively participated in designing (WIT Team, 2005). This method of data analysis was complimentary to the theoretical framework of institutional ethnography, facilitating the researcher to adopt an engaged standpoint, and uncover new and meaningful insights into how experiences reveal relations of ruling within dominant institutions. The process of mind mapping is one that encourages a researcher to incorporate new insights and concepts into their underlying knowledge by actively engaging with the research data they are interpreting (Wilson et al, 2016). This was particularly salient for this project as I have substantial pre-existing knowledge in my field of inquiry. Further, this active and iterative process facilitates the construction of a new complete picture out of the discreet individual experiences documented during the research process (Wilson et al, 2016).

In addition to the mind map, I played with the practice of poetic transcription as a creative and emotive practice. In order to generate the poems, I read the transcripts and where women's stories elicited an emotive response, I created a poem directly out of women's own words. While not directly related to the process of data analysis, poetic transcription did facilitate a process of highlighting women's own voices and focussing on the standpoint of the research subjects (Gasson et al, 2015). These poetic transcriptions super-imposed over photographs I took at geographic interview locations in East Vancouver are included in this text (see Figures 2 and 4).

Ultimately this work could be just the beginning of a much deeper project examining the relationship between economic and social inequities and satisfaction with prenatal care. The data presented within this thesis aims to be a reflection of women's experiences with prenatal care and a beginning insight into how the work of prenatal care could be better organized to meet the needs of working class and historically marginalized women.

Textual Analysis of the Standardized Prenatal Care Forms

In many cases of institutional 'work' and lived experience, there exist intermediaries that connect institutional ruling with daily life experiences, in the case of this study, the health care professional and the text-based forms that they, in turn, employ as institutional

directives make the link between the institution of medicine and the women who have the lived experiences of parturition.

In prenatal care in BC, institutional directives are shaped and communicated via the Antenatal Records Part 1 and 2. These forms link care providers, be they obstetricians or midwives, to the institution of medicine as the “mode of ruling whereby people’s actions are coordinated (Campbell, 2007, p1). Smith has described a process by which subjects are constructed through institutional discourse (Smith, 2001). In the textual analysis of the prenatal forms, I sought to identify how institutional discourse captured on the forms contributed to the construction of “professional” and “patient” as divergent subjects within the institutional setting of prenatal care.

Textual analysis of the PSBC Antenatal Record involved reading the blank forms and grappling with how the text and organization of the form might enter and in practice mediate the dominant social relations within the institution of prenatal care (Wilderberg, 2004). This process involved noticing how the themes elicited through the data analysis corresponded with the language and organization of the Antenatal Record. One example of this is the repetition of the term and concept of “risk” in relation to social and economic factors that impact women’s health but over which women often lack much individual autonomy or control, or for which there might be discrepancy between how a patient and how a health care professional might interpret the information the patient provides.

Previous research findings have also examined the standardized prenatal forms and described comparable critiques. Sharpe identified that midwives become implicated in Dorothy Smith’s concept of “institutional discourse” by the “required use of the prenatal forms 1 and 2” (p. 160). Sharpe described how, “the professional project implicated midwives in what Dorothy Smith would call “father-tongue language: a condition of speaking beyond what we learned from our mothers” (1997, p.153), and she goes on to describe how “much of the affective care provided to women was lost on [the] record... much of the woman’s story was invisible in these records” (1997, p. 156).

2.1.4. Presentation of Findings and Discussion

The reality is that, while directed by instructional guidelines and discourses, the institution of prenatal care is largely constructed through series of discreet but connected interactions between professionals and patients. In line with Denzin and Lincoln's notion of bricolage as a challenge to conventional qualitative research, I present a "messy text", acting as a scribe for the "other", presenting a view of these institutional interactions otherwise concealed from our view (Denzin & Lincoln, 1995). Rather than me being the interpreter of women's experiences and presenting a traditional results section, I present a collage of women's stories and experiences that more fully represent the complexities and challenges women face.

Through a particular focus on women's experiences and stories, what emerged is a picture of an institution that is both shaped by and reinforcing broader social and economic inequities. The findings and discussion of this research take shape through women's stories and are presented as two major overarching institutional critiques in Chapters three and four respectively. Chapter five then presents the action component of this research; recommendations on how the institution of prenatal care might be better organized to meet women's own stated needs.

2.1.5. The Participants

The standpoint of those excluded must be illuminated in order to address the roots of the problems that exist in health care provision. It was critical to this research that the participants meet some basic demographic criteria of identifying as working class and / or historically marginalized. All women who were interviewed identified with these criteria and were generous in sharing their stories, both their hardships and their resilience, with me.

The rate of "high risk", or pathological, diagnoses among the research participants is a signal that the research sample accurately reflects the experiences of working class and historically marginalized women accessing prenatal care in East Vancouver. I interviewed nine women, and of those women seven reported diagnoses of perinatal depression and/or anxiety and five reported diagnoses with gestational diabetes. While the causality of these complications of pregnancy cannot be traced directly to poverty and

marginalization, inequities are acknowledged both in rates of perinatal depression/anxiety among poor women (Sable & Wilkinson, 1999), and rates of diabetes among historically marginalized women, in particular Indigenous women and women who have migrated from underdeveloped countries (Zhang et al, 2013; Galvez, 2011). Endocrine disorders and mental health are tightly bound with social and economic status (Zhu et al, 2010).

Short descriptions of the research participants are included below to provide the reader some context of women's lives and the challenges and struggles that pregnant women face. Women's profiles are as follows:

Tia was a self-identified Indigenous woman whose family origins lie in the Southwestern Pacific regions. Tia had recently immigrated to Canada and only very recently received her official permanent residency (PR) and was able to legally work. Throughout her first pregnancy in Canada Tia did not have access to the Provincial Medical Services Plan (MSP) insurance. Tia and her husband, who was of Indigenous background, lived in an East Vancouver Cooperative Housing complex with their family.

Katie was a Caucasian woman who recently immigrated from Bulgaria with her husband and her young daughter. Our interview was complicated by lack of English language proficiency. Katie gave birth to their second daughter shortly after immigrating to Canada, but was covered by MSP during her pregnancy as she had received her PR status and completed the 3-month residency requirement prior to getting pregnant. Her husband was a low-wage worker, and Katie herself was at home with their young daughters. They lived in a subsidized low-income social housing complex in the Downtown Eastside of Vancouver.

Jenny was a Vietnamese recent immigrant and a single mother living in a basement suite in East Vancouver. Jenny was living on welfare and struggling to survive with her young son by accessing local charitable organizations for prepared meals and food to prepare at home. Jenny did have MSP coverage, but was late to prenatal care due to an inability to find a prenatal care provider.

Jasmine was a new immigrant from China who moved to Vancouver during her pregnancy. Our interview was complicated by a lack of English language proficiency and

would have benefitted from the use of a translator. Jasmine received PR approval prior to moving to Canada, although she was late to prenatal care as she had to wait the mandatory 3-month residency period for MSP coverage. After the birth of her child, she was still waiting for her husband to receive approval for his work visa so he could join her. During this waiting period Jasmine was living on social assistance and in a basement suite in East Vancouver. Jasmine relied heavily on her Church support group for household necessities and other economic and social supports after arrival.

Heather was a Caucasian low-wage worker living with her daughter in low-income single mother's housing in East Vancouver. The housing project where Heather lived is run by a large charitable NGO and has strict residency rules. Heather had a long experience of surviving on welfare and struggling to find employment.

Denise was a Filipina woman working as a post-surgical nurse in a local hospital. Denise was a 2nd generation immigrant from the Philippines, and had established enough economic security with her husband to afford a condominium in East Vancouver. At the time of the project her husband was back to school as a full-time student.

Fanny was a self-identified West Coast Native woman living in a single-occupancy room in the Downtown Eastside. Fanny was an active drug user, and was struggling to find appropriate compassionate prenatal care, as well as working with the Ministry of Family and Child Development workers to maintain custody of her unborn baby. Fanny was facing the difficult choice of deciding between living in supportive housing or living with her husband, as the local supportive housing complex for addicted mothers did not allow male residents.

Lana: was a Caucasian woman with two young children living with her low-wage husband in a Housing Co-operative in East Vancouver where they had been accepted during Lana's second pregnancy. Although at the time of the interview Lana was not working, she had experience as a low-wage worker in the service industry.

Pamela: was a Caucasian woman who self-identified as a recovering drug and alcohol user. Pamela was living with her young daughter on social assistance in a supportive housing complex in East Vancouver for recovering single mothers.



Figure 2. Poetic Transcription “No relevant experience” (Tia)

Photograph by Martha Roberts

Chapter 3. Social Relations within the Institution

This project aimed to give insight into how the work of prenatal care could be better organized to meet the needs of working class and historically marginalized women by examining women's experiences with the institution of prenatal care in East Vancouver. Through the experiences that participants shared, I drew two overarching institutional critiques captured in the themes of the next two chapters. The first critique addressed how care was technical rather than relational, and that expertise could be deployed to gain compliance to standardized care. The second critique synthesized how the social and economic inequities that women experience can be medicalized, and how care providers can take a 'fix women' approach to prenatal care that overlooks the deeper roots of such inequities which shape women's lives.

This chapter gives an overview of the institution of prenatal care and then will discuss this first theme. While women in this study reported appreciation of the technical skill and medical knowledge of their care providers, technical care could be experienced negatively when women perceived other pressing needs which undercut their ability to be healthy, such as a need for increased financial or social support. Women interviewed described struggles and challenges they faced in their lives. At times, women had perceptions of their health or their social situation that differed from their care providers' perceptions of them. At the point that the perceptions of the health care professional and the patient diverged on the question of risk, it appeared to me that medical expertise could be deployed by health care professionals to gain compliance with standardized prenatal care.

3.1. Introduction to Prenatal Care

In order to situate the themes that emerge from this research in the institution of prenatal care, first an understanding of the institution is necessary. Institution has been defined by Dorothy Smith as "complexes of activity organized around a distinctive function" which is "understood to be part of a mode of ruling whereby people's actions are coordinated" (2005, page 165). An overview of the complex of activities (structure) and distinctive function of prenatal care is necessary to contextualize how the research participants

experienced their care. Further this will help the reader to conceptualize how technical care and the deployment of professional expertise might function as a mode of ruling for working class and historically marginalized pregnant women in British Columbia. A short overview of the origins of prenatal care gives some context to the current institutional structure and function.

3.1.1. A Very Brief History

The current system of prenatal care in British Columbia emerged at the turn of the twentieth century as North American medical doctors began focussed obstetrical practice. While historically traditional midwives, both Indigenous, African, and European-settler midwives, had attended to pregnant women (Benoit & Carroll, 1995; Nestel, 2006; Strong-Boag & McPherson, 1992), the current system of prenatal care is rooted in the development of Western medicine (Alexander & Kotelchuck, 2001). The emergence of obstetrical medicine focussed on reducing maternal and newborn morbidity and mortality; specific to prenatal care this included recommending routine physical examination, uterine measurements, and blood pressure screening to reduce complications of pregnancy, in particular maternal hypertension and low birth weight newborns (Alexander & Kotelchuck, 2001). The first Canadian standardized prenatal care guidelines were produced by the Society of Obstetricians and Gynecologists of Canada (SOGC) which formed in 1944 (SOGC,2016). The turn of the 20th Century was a time of rapid shift in practice, including the expansion of medical facilities and the adoption of the Canada Medical Act restricting the practice of medicine in Canada (College of Physicians and Surgeons of Ontario, n.d.). By the mid-twentieth century the vast majority of prenatal care was done by Family Doctors and obstetricians and virtually all babies were born in hospital. This shift from home-based and lay-provided care to the institutional setting and professional provision of care was a dramatic shift and therein lies the origins of the modern institution of prenatal care.

Globally, the World Health Organization (WHO) sets a global standard for prenatal care with the prenatal visit with a health care professional as the basis of care. The contemporary standard recommends a minimum of four such prenatal visits, which is supported by current medical evidence: one for infectious and genetic screening early in pregnancy; one for diabetes and hypertension screening and an ultrasound in the 2nd

trimester; and two appointments in the 3rd trimester where first hypertension screening is done and then fetal position is checked (WHO, 2002).

In Canada, it is the Society of Obstetricians and Gynecologists of Canada (SOGC) who set the baseline standard for prenatal care as the institutionally recognized experts in obstetrical medicine. Additionally, each province has their own perinatal health agency, which ensures common Provincial standards are followed and tracks perinatal health outcomes. In British Columbia, this agency is Perinatal Services BC (PSBC). PSBC is responsible for overarching Provincial prenatal health care and through inter-professional committees produces the guidelines (PSBC,2010) and standardized forms (PSBC, 2011), which are publicly available and which all health care professionals who are legislated by the Health Professional Act (BC) (Queen's Printer, 2016) to provide prenatal care (Obstetricians, Family Physicians, Registered Midwives, and Nurse Practitioners) are required to follow in their individual practices. National and provincial guidelines are in turn closely followed by the professional practice protocols of the Provincial Colleges of Family Physicians and Registered Midwives.

3.1.2. Structure of Prenatal Care

Prenatal care is a major component of primary care in British Columbia. The overarching function of prenatal care is the reduction in maternal, fetal, and newborn morbidity and mortality. This reduction includes biomedical screening and intervention as well as social screening and intervention by licenced professionals (see routine screening list below). Perinatal care including prenatal, intrapartum, and postnatal care is a sprawling health care institution with a complex structure, however, there are three basic semi-coordinated levels of institutional policies and practices which comprise prenatal care.

The basic structure of prenatal care is as follows:

1. The routine prenatal visit, a highly-structured encounter between primary care provider (Obstetrician, Family Doctor, or Midwife) and patient, is the core of prenatal care. These visits typically take place at the private clinics of health care professionals, though some visits do happen within the hospital setting. As noted in Chapter 1, Obstetricians provide the bulk of primary prenatal care province-wide.

2. Ancillary referrals and public health programs comprise the second level of prenatal care. There are three components to this:
 - a. Referrals of women by their primary care provider (OB, GP, RM) to allied health professionals such as endocrinologists for gestational diabetes, psychiatry for depression, social work, and so on. Women usually receive allied care in an institutional setting such as a local hospital.
 - b. Public Health services available in the community. This includes special programs targeted at low income or new immigrant mothers (such as the Healthiest Babies Possible program described later in this document) and open programs, such as drop-in classes, run by Public Health Nurses. These public health programs take place at local Public Health Units run by the regional health authorities designated by the BC Ministry of Health.
 - c. National health-related policies and Health Canada programs. This includes economic policies on maternity leave and employment insurance, as well as national health initiatives for Indigenous communities. Further national policies that target pregnancy include policies such as folic acid supplementation in grain products and vitamin D in dairy products.

While this thesis examines the first practice – the routine prenatal care visits by health care professionals – the other two practices are important to know about, in particular when it comes to discussing improvements in how the work of prenatal care is organized. For example, where focus might currently rest too heavily on technical care provided by health care professionals, possibilities exist for shifting some of the weight to another level, say by increasing programming at the level of Public Health in the community setting.

Funding

Prenatal care is organized by each Province's Ministry of Health, and the costs to individual women are covered by provincial health insurance; in BC, it is covered by the Medical Services Plan (MSP). To receive MSP coverage, pregnant women must meet the requirements as determined by the province, such as citizenship or residency requirements. If MSP is not accessible to women, they must pay out of pocket for their care, and subsequently lose access to many public health services provided by the Provincial health authorities.

3.1.3. Function of Prenatal Care

The following description will focus on the structured routine prenatal care provided by health care professionals in order to help the reader to identify the institution of prenatal care and to situate the experiences of the research participants within this institution. This description includes an overview of the major components of prenatal care and a description of standardized process prenatal care follows.

Once a woman finds out she is pregnant, the first step is to find a health care professional with space for new patients within their practice. This may mean a visit to their Family Doctor. If the Family Doctor does not offer maternity care in their scope of family practice, then generally the physician will refer their patient on to another care provider, usually an Obstetrician, though increasingly Registered Midwives are receiving referrals from Family Doctors. Secondly, women may self-refer to Registered Midwives or Obstetricians. Once a woman has found a care provider, either through referral from another provider (i.e. GP to OB/RM) or from family, friends, etc., then routine prenatal care commences.

The quality and content of routine visits vary between providers, but these visits are highly structured in frequency and core content. A routine visit varies in length of time depending on the health care professional involved, i.e. an Obstetrician might see a patient for 5 minutes whereas a Registered Midwife tends to have longer visits ranging from 15-45 minutes to allow more time for discussion of women's questions and concerns. The content of the routine visit also varies greatly between health care professionals, but all follow a minimum basic standard as outlined below.

In BC, the following is generally recommended (PSBC 2011):

1. Schedule of visits:

- Two visits before 14 weeks' gestation
- Subsequent monthly visits until 28 weeks' gestation
- Visits every 2-3 weeks between 28-36 weeks' gestation
- Weekly visits 36 weeks' gestation to delivery 40-42 weeks' gestation

2. Content of the standard visit:

- Maternal weight measurement
- Blood pressure
- Urinalysis for protein and glucose
- Uterine growth measurement
- Assessment of fetal movements
- Listening to the fetal heart rate

3. Routine screening includes:

- Dating the pregnancy with ultrasound
- Genetic screening
- Complete maternal / familial medical history
- Complete physical exam including cardiac auscultation and pap smear
- Screening for sexually transmitted and infectious diseases
- Screening for substance use, nutritional intake, finances, domestic abuse, etc.
- Screening for iron deficiency and other anemias
- Blood typing and follow up as necessary
- Routine detailed ultrasound 18-22 weeks
- Screening for gestational diabetes
- Screening for perinatal depression
- Ongoing screening for gestational hypertension
- Ongoing screening for fetal position
- Fetal non-stress testing once past estimated due date (PSBC 2011)

Routine screening may result in referrals to other health care professionals, as discussed above. Routine care may also lead to referrals for public health services (as in #2 above), such as programs for low-income families to receive nutritional counselling and food coupons, or free prenatal classes.

Medical and Professional Tensions in Function

For the purpose of this research project, it is important to state that tensions exist in opinions on the usefulness of prenatal care. Not all professional bodies agree that the

content of care is evidence-based nor best designed to support women to have physically and emotionally healthy pregnancies (PSBC, 2010, WHO, 2002).

Canadian standards include a more intensive prenatal visit schedule and a greater use of medical screening / diagnostics than the WHO standard (PSBC, 2010). Additionally, while some aspects of care are grounded in scientific literature, the evidence to support many routine prenatal screening tests or medical interventions is of poor quality or altogether lacking (PSBC, 2010, WHO, 2002). Studies on the effectiveness of prenatal care are inconclusive and the scientific evidence to support some of the specific recommendations in the guidelines is poor (WHO, 2012; WHO, 2002).

Ultimately the institution of prenatal care is rooted in institutional oversight of individual practitioner practices via standardized guidelines and forms. The findings of this research suggest that what women experience in the setting of the routine visit is largely based in the behavior and practices of individual care providers. What this research begins to uncover is how women might experience prenatal care as technical care where professionals deploy expertise to ensure compliance with standard medical and social expectations that may not even be evidence-based.

Prenatal Forms and Institutional Function

Standardized prenatal care forms are used by all prenatal care providers in the Province of BC. These forms are designed and published by PSBC and distributed free of charge. They are meant to give a concrete guide to the expected schedule of visits and the content of care, in particular, routine screening. However, the content of the prenatal form is predicated on a number of gross assumptions.

The first of these assumptions is that the standardized testing and interventions recommended on the form are based on solid evidence and follow the basic ethical principle of non-maleficence. However, as documented by PSBC, not all routine practices captured on the prenatal form are supported by high quality evidence (PSBC, 2010) and there does exist potential for unintended harm to occur. Further, when women decline to follow the PSBC guidelines (i.e. decline routine screening) a blank space or “declined” is documented on her form; this has potential to create a situation where women’s decisions

are scrutinized or challenged by health care professionals who lack knowledge about that woman's life circumstances and underlying reasons for her choices. This can lead to the woman being badgered and judged for her actions by care providers in the future.

Lana described the difficulties she faced during her prenatal care, where one decision she made led to consequences at future prenatal visits.

Lana: You know, within the medical system there will be a snowball, like if you agree to this, it could lead to this and this and this and this. You think you are agreeing to this one thing but they're connected, a world of pain...

Secondly, the prenatal forms are based on an assumption that it is beneficent to medicalize social and economic hardship. It is through that expert and privileged gaze that women's "Lifestyle & Social" circumstances are transcribed and interpreted as having potential to label women as 'high risk' and as making poor lifestyle choices. This can lead to health care professionals deploying 'expert advice', such recommendations for costly dietary supplements or unattainable lifestyle changes to fix women's behaviour rather than recognize or work to address the root causes of health inequities in social and economic injustice. These types of suggestions assume that women having a great deal of agency in their lives, and leaves out deeper questions that are more difficult to address, such as the impact of structural and economic inequities on women's' health.

8. Lifestyle & Social		
<i>Discussed</i>		<i>Concerns Referred</i>
<input type="checkbox"/> Diet/Food Safety _____		<input type="checkbox"/>
<input type="checkbox"/> Folic acid _____		
<input type="checkbox"/> Physical Activity/rest/work _____		<input type="checkbox"/>
<input type="checkbox"/> OTC drugs/vitamins _____		<input type="checkbox"/>
<input type="checkbox"/> Alcohol <input type="checkbox"/> never <input type="checkbox"/> quit (DD/MM/YYYY) _____		
Drinks/wk: before pregnancy _____ current _____		
Binge drinking <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/>
<input type="checkbox"/> TWEAK score _____ (see reverse)		
<input type="checkbox"/> Substance use <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/>
<input type="checkbox"/> Heroin <input type="checkbox"/> Cocaine <input type="checkbox"/> Marijuana		
<input type="checkbox"/> Methadone <input type="checkbox"/> Solvents <input type="checkbox"/> Other		
<input type="checkbox"/> Prescription <input type="checkbox"/> Unknown _____		
<input type="checkbox"/> Smoking <input type="checkbox"/> never <input type="checkbox"/> quit (DD/MM/YYYY) _____		
Cig/day: before pregnancy _____ current _____		<input type="checkbox"/>
<input type="checkbox"/> Exposure 2nd hand smoke <input type="checkbox"/> No <input type="checkbox"/> Yes		
<input type="checkbox"/> Financial & housing _____		<input type="checkbox"/>
<input type="checkbox"/> Support system _____		<input type="checkbox"/>
<input type="checkbox"/> IPV _____		<input type="checkbox"/>
<input type="checkbox"/> Public Health Nursing follow-up/assessment		<input type="checkbox"/>

Figure 3. Section 8 of the PSBC standard prenatal form

No space for details or a woman's own experiences or perceptions of her situation.

Institutional forms can pose particular challenges for working class and historically marginalized women that privileged women might not face. For example, health care providers are prompted to ask questions which a woman might not be able to adequately answer in the allotted time or to verbalize. There is no space on the prenatal form to give detailed background or current information, and this lack of space is often mirrored in inadequate time given for history taking in the clinical setting. When women's lives are complicated by historical trauma, histories of substance use or family abuse triggered by painful experiences and self-medication, this history is often overlooked, and challenges such as drug or alcohol use is documented by the care provider on the standardized form in crude terms such as tick mark in a check box. The lack of ability of the care provider to explore, explain, or document important details has potential to generate problems for

women when these forms are forwarded to the hospital where she plans to deliver, or where she may be transferred if home birth is planned, or are shared with other practitioners. These problems can include, but are not limited to, the receiving practitioners making uninformed pre-judgements about women they do not know based on the grossly limited information provided on the form, reports to child protection which spark painful investigations by social workers, and direct negative impacts on the care women receive in the hospital.

3.2. Technical Care and Deployment of Expertise

Through semi-structured interviews I planned to discuss how research participants felt about their interactions with their prenatal care providers and if they were satisfied with care. It stood out to me that often a women's immediate instinct was to state that they were happy with their care. Despite initial reassurances of satisfaction with care, women then back-tracked, expressing dislike or dissatisfaction with interactions with their care provider. As the interview progressed, dissatisfaction with care began to emerge in their stories, starting with a focus on how short a time in the office women were afforded by their care providers.

For example, the conversation with Jenny started like this:

Martha: So how was your experience of prenatal care?

Jenny: It was pretty good.

Martha: How long was a visit?

Jenny: Pretty short, actually, but the waiting in the waiting room was more than an hour and then when I actually saw her it was 10-15 minutes. She was in such a rush to get me out of there so she could see the next patient. It was like that, and I was only allowed to ask one or two questions, any more that that she cuts me off.

While Jenny's experience is deeply interrogated in Chapter three of this thesis, her opening remarks are typical of how participants shared conflicting messages of appreciation and dislike when asked about prenatal care. Appreciation of the attention and care they did receive from their care providers, but deeper dislike of some of the interpersonal and institutional limitations that emerged through the course of this project.

Denise's response gave a more nuanced insight on this tension of appreciation of her provider and dislike of the visit. Denise started her interview by describing her positive evaluation of the professional who attended to her.

Denise: I ended up having a locum [Obstetrician] who was amazing, this young woman of colour too, and she was actually quite good.

Denise describes her Obstetrician's identity as a "young woman of colour" as the basis of her positive valuation, revealing how perceived social similarities between patient and provider can help create trust in interpersonal interactions. Yet, by the end of her description of the visit, Denise had switched gears:

Denise: It was really short. I'm going to say less than 20 minutes, and it was very anti-climatic. You know, I was all excited to learn a little bit more on what to expect and everything but it wasn't really like that. I actually ended up, well me and my partner actually ended up going home and doing the research on our own (laughing) which is pretty much what happened. We went home and looked our questions up, you know, it is not something I felt comfortable asking at the time, I don't know...

Denise initially appreciated the potential camaraderie of the young woman of colour doctor, which had potential to be the basis for a more level or equal therapeutic relationship. However, time constraints cut short the time for relationship building and left Denise's expectations of care unmet. The restrictions of the clinical setting undermined Denise's goals going into the visit.

Pamela described a similar desire to build relationship with her providers. Pamela saw a Nurse Practitioner in the Downtown Eastside for her early pregnancy care before switching to a team of Family Doctors that specialize in prenatal care for pregnant women with a history of substance use.

Pamela: ...I was glad...Not that I had any problems with [Family Doctor] but I was glad when I went back to [her Nurse Practitioner] because it was like a warm cozy place, she was extremely supportive and had seen me at my worst...yeah.

In the interview, Pamela gives suggestion toward what built her positive relationship with her Nurse Practitioner. A cozy setting and the ability to let herself be seen "at her worst",

suggest an openness and a willingness to create the setting and give the time to build personal, relational care that focuses on women's own perceived needs.

Both Denise and Pamela expressed appreciation of care providers who shared perceived similarities that might have helped level the power dynamics between patient and care provider. Existing research also suggests that the power imbalance between pregnant women patients and health care professionals is a major challenge for working class and historically marginalized women to overcome (Best Start, n.d.). Accordingly, women in this project sought a therapeutic relationship with their care providers but these relationships were constrained by institutional limitations. Care providers themselves are expected to follow standard care guidelines and to document care as required; the limitations in individual clinical interactions can be traced back to the institution of prenatal care which frames each individual encounter. Through analysis of the stories, the focus on time was closely related to participants' overarching institutional critiques of an over-focus on technical care and the deployment of expertise to expedite consent to standardized care. I read these critiques not as they pertain to individual care providers, but rather as how they point to broader institutional dynamics that undercut both the giving and receiving of care.

3.2.1. Technical Care rather than Personal Care

Women who were interviewed for this project expressed conflict in describing their prenatal care experiences. Some participants acknowledged appreciation of the technical medical care they were receiving and, such as Jasmine in the following illustration, gave credit to the skill of the practitioner, the use of screening technology and know how in averting a possible medical complication like gestational diabetes. Yet, this research also points to the need to address the limitations of technical care and generate change within the institution of prenatal care to address what additional social and economic supports working class and historically marginalized women need to survive and thrive in. Technical care could be experienced simultaneously as positive and negative; the negative aspect of technical care becoming predominant when not offset by caring or efforts to connect with social supports.

This short interaction with Denise illustrates how the technical aspects of care could be perceived as a negative.

Martha: Can you think of any interactions you had with your obstetrician that were helpful?

Denise: I think for me she was pleasant enough but at the same time I didn't find like... I didn't need, I didn't need her to tell me how... I could have just put that monitor on me, because that's pretty much all she really did, right? So I wasn't pleased, personally I wasn't really pleased with my experience with her.

Denise initially described her care provider as “pleasant enough”, however, the interaction between herself and her care provider became focussed around the fetal monitor. Denise perceived that she could just do that herself, questioning the basis of the interaction with her provider as technical, rather than relational. It was then, perhaps, more the lack of relational or personal care that created Denise's dislike of care.

How technical care predominated could be seen in the example of Jasmine. Jasmine was a new immigrant to Canada when she was pregnant. Her husband was still in China working and waiting for his Canadian visa to come through. Jasmine was living in a basement suite in East Vancouver. Jasmine was already pregnant when she came to Canada and thus she needed to wait for her three-month residency requirement to be fulfilled before she could present to prenatal care.

Jasmine described her doctor:

Martha: Are there things about your care that you appreciated?

Jasmine: I appreciated the doctor, she is a good doctor for the technical side, a good doctor. For the personal side she is cold, but she prevented me from having diabetes, she told me my blood sugar is high so she told me how to solve the problem.

Jasmine's initial description of her doctor illuminates these two aspects of prenatal care: the technical and the social. Jasmine gave appreciation of how her doctor might have prevented her from developing gestational diabetes and appreciation of medical expertise

that may improve prenatal outcomes. However, simultaneously Jasmine acknowledges that her doctor's bedside manner was cold.

Jasmine describes an experience with her doctor that stuck in her mind and impacted her perception of herself as a mother:

Jasmine: Because I was new she's asking me for those ultrasound pictures from China. I said, "Oh, I didn't bring those records," because in China we don't have those system you need to keep everything, so it's different. So she said, "Oh, you don't care about your baby." But I do care! I feel so upset.

During the interview, it was apparent to me that this interaction was very upsetting to Jasmine; she spoke passionately and appeared teary. While Jasmine appreciated her doctor's technical skill, it appeared to me that their interpersonal interactions undermined Jasmine's confidence.

And, in fact, Jasmine worried a great deal about how she was going to care for her baby. She struggled with poverty and social isolation throughout her pregnancy. She relied heavily on the support of a local church for food and baby items. She told me:

Jasmine: Yeah, the times I worry is how I can provide for my baby at that time? And when I'm giving birth my husband couldn't come here so nobody to look after me. That's the hard part.

A caring interaction with her doctor might have helped Jasmine navigate living in poverty as a new immigrant and a new mother. A caring interaction might look like an expression of empathy, a therapeutic conversation, or an appropriate referral. Yet what predominated in Jasmine's experience of her prenatal care was an attitude of judgement from her doctor, an immediate assumption that Jasmine didn't care about her baby, a suggestion that Jasmine's difficult social situation signaled neglect. Jasmine's doctor might be technically proficient but seemed to lack understanding or empathy with for her difficult social situation.

Katie had a similar experience with a lack of relational care. Katie's first baby was born in Bulgaria. She and her husband immigrated to Canada and shortly thereafter Katie became pregnant for the second time. At the time of our interview Katie, her husband, and her two

young daughters were living in low income social housing in the Downtown Eastside. Katie described having very low mood and a lot of financial stress in her second pregnancy.

Martha: Was your doctor good at answering all of your questions?

Katie: Yeah, I think so, she explained everything. Also if I have problems she told me what I should do. For example, I have stress between 5 and 6 months of my pregnancy and I feel very depressed. I came to her office, I remember that time I was having contractions and she said "what's going on" or "what is the problem?" She wanted to know what happened with me, why I am not smiling, do I have a problem at home or something with your husband... I have problems not with my husband but with my husband's parents who blame me from Bulgaria that I'm not working... this hurts me very much...

Martha: Did she offer you referrals to other services? Did she recommend you do anything else?

Katie: No... Oh yeah, she said to me if I wanted to go visit a... the people who are talking ...

Martha: Like a psychiatrist?

Katie: Yeah... but it's expensive! I can do this, but it's expensive, so I don't go.

Katie was offered referrals for yoga classes, but Katie was unable to attend. For Katie, financial strain increased tension in the home, and yet several of her doctor's recommendations required significant expenditure and out of pocket payments. What might have made a difference for Katie was recommendations that took into account her financial situation as she got from her social network below. Existing literature demonstrates a connection between poverty and preterm labour as well as poor mental health in the perinatal period (Sable & Wilkinson, 1999). Katie described throughout the interview that she did find out about subsidized programs was through her social network. Learning about food security programs at a local community centre and obtaining social housing were the big moments Katie identified as being the most helpful for alleviating stress.

Prenatal care has the potential to either level to some degree social and economic inequities or to promote the status quo of gross inequities among women. In my own clinical experience as a midwife it is often not economically feasible for working class women to reduce their stress, prevent workplace injuries, improve nutrition, increase

physical fitness and exercise, or rest more. Therefore, balancing technical and relational care is important for working class and historically marginalized women. This balance includes meeting the standard technical prenatal care criteria as outlined in this chapter, as well as examining women's differential access prenatal care (timing, ability to get to care, etc.) and in how women are able to respond to the demands and recommendations of their health care providers (eat "all organic", etc.). This balance extends into how health care professionals deploy their medical expertise to encourage compliance with their recommendations.

3.2.2. Knowledge Expertise and Institutional Power

This project revealed that the women interviewed seemed to accept that they submitted themselves to prenatal care as something that was given to them or performed on them, rather than something that they collaborated with. The institution of prenatal care is set up to have experts, professionals who provide health care, and patients, those who receive care. The experts are the legislated self-regulating health care professionals who provide prenatal care in maternity practices: obstetricians, family physicians, midwives, and nurse practitioners. The work of experts has both high monetary value (Medical Services Commission, 2015) as well as high social prestige and respect.

A significant step in privileging the role of medical expertise in pregnancy was to label pregnancy as a potentially pathological state requiring frequent screening and diagnostics testing as well as medical intervention (Quénart, 1992). By defining pregnancy and childbirth as medical problems as opposed to a healthy part of the reproductive life cycle, it opened the door for the institution of medicine to "treat them as forms of medical illness to be removed from the "patient's" control" (Fee, 1975, p. 412). Once the state began to restrict the practice of "medical acts" to physicians, medical expertise was not only authoritative knowledge but was enshrined in legislation (Rice, 1997). As Jordon explains, "to identify a body of knowledge as authoritative speaks, for us as analysts, in no way to the correctness of that knowledge. Rather, the label 'authoritative' is intended to draw attention to its status within a particular social group and to the work it does in maintaining the group's definition of morality and rationality. The power of authoritative knowledge is not that it is correct, but that it counts" (Jordan, 1997, p58 – as cited in Galvez, 2011, p.

11). While other professional groups, such as Registered Midwives and Nurse Practitioners are currently legislated to provide prenatal care, the acceptance of midwives into the institution of medicine came at the end of a long struggle and only through midwives' compromise over acceptance that biomedical knowledge is authoritative knowledge on pregnancy and birth (Rice, 1997; Davis, 2008).

The acceptance of medical expertise is a powerful social norm (Quénart, 1992) that has the potential to impact pregnant women's experiences in clinical settings providing prenatal care. The power of authoritative knowledge has great potential to "dislodge women's confidence in embodied knowledge" (Browner & Press, 1996, p. 141 – as cited in Galvez, 2011). Authoritative knowledge in prenatal care is centered around a care providers medical and technical expertise, but the authority of the care provider in the clinical setting extends to the advice given during the course of care. For historically marginalized migrant women authoritative knowledge has a double-significance, as the power imbalance very often extends beyond the imbalance of expert-patient into other social factors such as race, ethnicity and class. It has been documented that historically marginalized women feel additional pressure to conform to medical standards and the non-medical advice care providers give in the clinical setting. Lazarus described this imbalance, "because the doctor-patient relationship is asymmetrical, power becomes domination; one actor is more autonomous and the other more dependant. This power disparity is further widened by social class. Thus, there is an interdependence between knowledge, one's ability to act on such knowledge, the social institutions that constrain actions, and one's position in the larger structure of a society." (Lazarus, 1994, p. 139). In particular, for migrant women, such as some of the research participants interviewed in this project, women accept the authority of health care providers as a "part of the very package of improved life circumstances they hoped to access when they migrated in the first place" (Galvez, 2011, p.12).

For Denise, who is a Registered Nurse herself, the power imbalance she perceived between care provider and patient limited her ability to participate in her care.

Denise: When you are in that clinical setting you are just there, you know what I mean, you have a time limit, you don't have any time or you don't even think about asking questions that you want to ask. Like I would have a list of questions I

would have and when the time came I would freeze and not ask and Carlo [husband] would be the same way. Like he would be silent, there is a, like, a shift in power once you walk into the room because this so call educated expert is there, it's weird.

Denise and her partner perceived this power imbalance as a limiting factor in their ability to participate in their care.

Tia described some of her experiences with this power imbalance in the hospital environment:

Tia: I had all these visits, I don't know and so there were all these doctors and nurses, it felt like it was always at the [Hospital] um it felt like, I can't even explain it... the way that they treat you when you walk into the hospital... like I knew nothing, I just felt like they looked down at me, like I didn't have any knowledge, because they were educated doctors and nurses and I knew nothing and the fact that I was brown and tattoos they automatically judged that I mustn't be educated. And because I was immigrating...

Tia illustrated how the power differential around knowledge and expertise can contribute to women's feelings of inadequacy and can reinforce already existing social inequities. The consequences of the culmination of interpersonal interactions can be significant for working class and historically marginalized women. This power imbalance also sets the stage for the deployment of medical expertise in order to obtain compliance with standardized prenatal care and medical interventions.

3.2.3. The Deployment of Expertise: Lana's Story

Lana was a young Caucasian woman currently caring for her two children both under the age of 5. Lana and her family lived in low-income social housing in East Vancouver and her partner worked a low-wage job. Their family earned below a living wage for metro Vancouver.

Lana heard about my research project through a poster put up by a mutual friend who lives in their social housing complex. Lana agreed to be interviewed for this project and we met in a local café so Lana could use our time as a break from caring for her kids. Lana was forthright during her interview, and was eager to share her experiences. We

discussed the marked differences she experienced in the care she received in her two pregnancies. As the interview progressed it became clear that Lana's own sense of ownership and the boundaries she put up between herself and her care providers largely accounted for these differences between her experiences of prenatal care with her first pregnancy and her experiences with her second pregnancy.

Previously Lana had worked as a youth sexual health educator and thus she had experience with female fertility, menstrual cycles, and pregnancy. When Lana was a first-time expectant mother she was very eager to be involved in the decision-making around her prenatal care and her birth.

Lana explains:

Lana: I discovered I was pregnant and we were both really excited. It was an intentional conscious decision and we were very happy. I lived in the Commercial drive area and I decided to hire midwives in the neighbourhood and [I had] a lot of romance around the idea of living locally and walking over to my midwives' practice, taking a prenatal class and all of those things. I had already found that I was confident around my rights.

But right from the get-go things didn't go as Lana had imagined they would.

Lana: I was starting to have a lot of questions about things that were starting to take place. So one of the first experiences I started to pay attention to were the questions around what my due date was going to be. I hired [local midwives], they were in my neighbourhood and we decided my due date was going to be some day, they had the little wheel thing [due date calculator based on Naegele's rule]. "When was your last period" you know, like according to this wheel this is when you are going to have the baby.

My background actually is as a sexual health educator with a speciality in the menstrual cycle. I had been charting my menstrual cycle and looking at my menstrual cycle for years and I knew that the 28-day cycle that the wheel is based on didn't apply to me and I knew that my ovulatory phase was indicating that my due date was different to the date they thought it was going to be, and that's when I started to ask questions. I knew in the context of having a baby a due date that's too early, you know, might create some pressure at the end of the pregnancy around you know waiting for

this baby to show up even though it's not due yet, right? So I started to explain to them that I'm going to choose my own due date I don't agree with yours but I maintained a happy relationship with several of the established midwives.

Lana emphasized that though she asserted her own knowledge in setting a due date that fit with her understanding of the menstrual cycle and her own lived experience of her own cycle, she sought to maintain a working relationship with her care providers. Lana's insistence on her control of clinical situations brought my attention to how hard working class mothers have to fight to defend themselves from negative perceptions and beliefs about their abilities to mother and to provide for their families. There was a power struggle in the clinical setting of Lana's prenatal care as Lana resisted medicalization.

Lana: I went into some of those consultations really eager, looking for a relationship, looking for some connection and finding that much of the screening that was happening was focused on some of the pathology around pregnancy and around whether or not I was going to consent to certain tests.

I was connected to midwives and they were not passively attending to me, there was actually feedback I was getting and it was negative feedback, I started to feel alienated and stressed.

Lana: I was still functioning, I was still working night shift, I was still working really hard! And then, ummm, going into that meeting all of a sudden the word anemia came up and, you know, there questions around my health - like was this becoming a sickness, this pregnancy? What is happening to me?

Lana's resistance to the diagnosis of anemia might seem like a minor clinical disagreement, but for Lana it appeared to spark doubt and misgivings about her relationship with her care provider and the doubts that might have existed about Lana's fitness for motherhood. Lana describes the diagnosis as "something happening" to her, something she perceived as a judgement on the health of her pregnancy. Ultimately Lana described her experience of prenatal care with her first baby as an unequal exchange between care provider as expert (active) and pregnant woman as (passive) patient. Lana described her care providers as coercive, deploying authoritative medical knowledge to gain consent for standard tests and technical interventions. This coercive use of authoritative knowledge is contextualized by the social status of care providers, whose

expertise in their field of practice gives weight to their recommendations, even if the scientific literature is lacking or inconclusive.

In the context of what Lana seemed to perceive as an unwarranted medical diagnosis, Lana struggled harder to maintain a relationship with her care providers:

Lana: At that point I started to lose trust in those health care providers because I said, ah "I feel good, I'm an active woman, I don't think I'm anemic." Actually this is a natural transition that's occurring in my body, my blood volume has increased. I think it's natural actually to have a transition to the blood volume. I felt like they were over emphasising some of the, some of the 'risks' that were occurring, and the way we talked about that ... [pause] they could make it complicated. But then I stood up for myself, and said "no I don't actually think that I'm anemic right now."

So I went into more and more meetings with them about my pregnancy with you know a strong attitude of defending myself and making sure I was consenting and agreeing every step along the way.

The coercive use of medical knowledge which Lana references at several points during the interview undermined her ability to have trust with her health care providers. Lana perceived an overemphasis on risk, and this overemphasis put Lana in a defensive state. In fact, existing literature suggests that this type of defensive posturing is common among working class women seeking health care (Reid, 2003; Best Start, n.d.). Working class and historically marginalized women are vulnerable to the medicalization of the health outcomes of social inequities. Class, race, and powerlessness to change social circumstance do impact health outcomes. Medical institutions and many individual practitioners assume a rich, white body is a healthier body for reproduction (Galvez, 2011). This process of idealizing applies equally to the social perceptions of the ideal mother and it is impossible to disconnect these experiences – negative clinical encounters disempower working class and historically marginalized mothers (Galvez, 2011, Reid, 2006; Browne, 2007). Poor mothers' knowledge and experience is often ignored in favor of privileged voices (McCormack, 2004) which can lead to tension, shame, and feelings of exclusion within the health care setting (Reid, 2006).

It is striking that at this point in her story Lana shifts to the concept of consent, juxtaposing the Registered Midwives' model of informed consent to a passive acceptance that health care diagnoses and interventions are neutral. In this shift, Lana asserted her wishes for her pregnancy and birth experience, using the question of consent to medical procedures or interventions to move herself into the active role in her prenatal care.

Lana: Then came the stuff where we were talking, I was asking lots of questions around giving birth. I was getting ready to give birth to my first baby I had a lot of questions around that. And there were I guess suggestions that when you give birth to a baby the easiest thing to do after you give birth is to take a shot of oxytocin because that means that your risk of hemorrhaging is going to be greatly reduced and so I was asking a lot of questions about that you know that type of intervention, what are some of the risks involved? What is that called? Active management. That is when I realised, oh this isn't for me, I don't want active management, I would just like to avoid as many injections and as many drugs as possible. What I am envisioning for myself is a natural birth at home and so that was in my notes, that's not what I wanted.

I had a natural birth after many hours I eventually pushed out my baby um but what had happened after I pushed out my baby was the active management so even though I didn't consent to having an oxytocin shot, in the euphoria of the moment someone asked me now, you know "now's the time for an oxytocin shot" and I said "yeah, ok, whatever" because I was so excited and so relieved and fatigued after 25 hours of labour.

At this point in her story, Lana began to introduce the concept of coerced consent, how repetition was used as a method of gaining consent for standard medical interventions that she had previously declined. In the process of coerced consent medical knowledge and expertise is deployed against women to enforce compliance to recommendations or to standardized care.

Lana explained how she started to think about informed refusal as a counter-point to informed choice.

Lana: There was repetition used as a technique to gain my consent and what I call coercion...

When I had said no again and again and again that through their technique of repetition they were able to get the consent that is when I started to believe in the concept of informed refusal and the idea around refusal being a very important skill that is required in the prenatal period so that not only the idea that it is normal to refuse but that there can be information and time in respect around refusal um from that experience.

As a midwife, I could see the point of view of the midwives in wanting to give oxytocin after a long labour in order to prevent negative consequences of post-partum hemorrhage. In some situations, medical institutions might use informed refusal forms to off-set medico-legal risk when patients decline recommended treatments or interventions. The intention of these forms is not to protect the patient from unwanted intervention but rather to protect the institution from poor medical outcomes or legal consequences. Yet, Lana shared that this experience reflected for her a broader theme of how medical expertise was deployed to gain her compliance. Power imbalances between experts and patients and an over-focus on technical or standardized care at minimum contribute to women's negative feelings about their care, and create potential for lasting impacts on their perceptions of themselves as individuals and as mothers.

The next chapter will more deeply interrogate the experiences women shared on the themes of medicalization of marginalization, poverty, and experiences of colonization and forced migration. Technically-focussed care and the deployment of medical expertise set women up for negative experiences in prenatal care, particularly when being told they need to fix their individual behaviours without any acknowledgement by health care professionals of the very real economic and social constraints on women's ability to change their situations.



Broken

My care was pretty good.
Saw my doctor
every month, she would
weigh me,
measure me.

I had got the diabetes
so I got referred
to see a doctor at the hospital,
they weighed me
measured me
gave me a diet to follow
rushed me out.

I had lack of funds,
I'm broke.
I was crying in the office
like this baby could have been a mistake
and maybe something inside me
is broken.

Referred
once again
to the hospital, but this time
a social worker.

I felt isolated,
alone.
I just broke down
in this office
with no help for me.

Figure 4. Poetic Transcription "Broken" (Jenny)

Photograph by Martha Roberts

Chapter 4. Medicalization of Marginalization

4.1. Introduction: Jenny's Story

I met Jenny in the small lounge of our local community centre during her lunch break from volunteering at a nearby parent's resource centre. This was my shortest interview, but it was rich in experience. I found Jenny's story illustrative of commonalities connecting the women interviewed for this research. All women shared examples of how their health care providers avoided acknowledging social inequities, and instead turned to standardized forms and referral protocols to sidestep dealing with complex issues. Jenny's story illustrated well the common experience of women's social conditions being cast by provider as individual concern. Medicalization of marginalization occurred when health care professionals translated social conditions into biological risk and then subsequently medicalized perceived risks. Women reported experiencing specialist referrals, most commonly to endocrinology and psychiatry, as sterile, medicalized, and overly-focussed on a decontextualized individual etiology and a pharmacological treatment for their messy, complex lives.

Complexities are the norm for marginalized and working class women. Of the nine women interviewed, all five women of colour were diagnosed with gestational diabetes, five women self-reported a diagnosis of depression and / or anxiety, and all described chronic worry and stress. Yet, through the course of their interviews women themselves often related their diagnoses to their financial and social situations and much less or not at all to their physical- biochemical processes. Women discussed economic class inequity and structural racism as highly problematic, resulting in social stigma and isolation, housing and food insecurity, and the generalized powerlessness that comes from poverty.

It is within a common experiential frame of institutional control by professional experts that marginalized women's lives are interrogated by their care providers. In somewhere between five and fifteen minutes, broad and complex social and economic conditions are translated onto standardized forms and reduced to checks in boxes and point-form notations on tiny lines. The entire complexity of working class and marginalized women's lives are reduced to notations of risk and need for medical referral.

Woven through Jenny's story was an image of Jenny as a broken woman and medical authorities as stepping in to fix her. Jenny was a young single mother recently immigrated from Vietnam who struggled to survive on grossly inadequate welfare rates. When arranging the location for our interview, Jenny explained that she lived in a substandard basement suite in East Vancouver, and relied heavily on collective strategies to make ends meet and put food on her table. Hence our lunch-time meeting at our local community centre. During the course of our interview, Jenny revealed that she was diagnosed with gestational diabetes and struggled with low mood and excessive worry during her pregnancy. "Broke(n)" was thematic in her story. This perception of herself as a broken woman and of society as viewing her as an inadequate mother started early in her pregnancy.

When Jenny realized she was pregnant, she had a hard time finding a care provider. This is both a common experience and a common concern to many working class women who have complex reasons for presenting late to prenatal care, including lack of medical insurance and inability to find a care provider (Downe et al, 2009; Heaman et al, 2007). Despite structural issues which prevent women from accessing care in what is considered to be an appropriate time frame, being "late to care" is like a red alert on a prenatal record, and can trigger a social work referral during pregnancy or even later at the hospital during delivery (Sable & Wilkinson, 1999). From my own experience, this notation also peaks many clinician's suspicions of the readiness of a woman to be a mother, and can lead to judgements about parental adequacy, as was in Jasmine's experience. Having a health care professional questioning parental adequacy has the potential to undermine women's confidence and self-esteem, as well as implications that may involve investigation by social services and more devastating long-term impacts on motherhood.

After realizing that the walk-in clinic would not see her for her pregnancy, Jenny was referred by a friend to a Family Doctor who accepts maternity patient transfers.

Jenny describes her typical visit:

Jenny: The waiting room was more than an hour and then when I actually saw her [the doctor] it was 10 -15 minutes she was in such a rush to get me out of there so she could see the next patient. It was like that; I was only allowed to ask 1 or 2 questions any more than that she cuts me off.

Despite the fact that her doctor was impersonal and distant, Jenny consistently attended her monthly and then bi-weekly appointments. Like all women interviewed, Jenny appreciated the reassurance that her baby was growing as to hear the sound of the fetal heartbeat. But complications arose, as many working class and marginalized moms experience.

After Jenny screened positive for gestational diabetes, her primary care provider referred her to the local maternity hospital to see an endocrinologist:

Jenny: I had gestational diabetes so she had to refer me to go see another doctor at the hospital. Same thing there; they would weigh me and they would measure me and then they gave me like a diet to follow so that my baby wouldn't get so big.

Passively handing Jenny diet sheets and nutrition information did nothing to change the material circumstances of Jenny's poverty and food insecurity. The economic situation of Jenny's life remained the same. The reality is that women who rely on the food bank and free or low cost meals offered by charities have no choice of when and what to eat. Jenny's social and economic situation was at the root of her medical diagnosis, as is confirmed by numerous studies examining the relationship between diabetes diagnosis and social and economic injustice (Unnatural Causes, n.d.).

While research suggests a link between social class, stress, and glucose intolerance (Krieger et al, 2001) there is no room on the clinical chart to detail the social and economic circumstances that lead to higher rates of gestational diabetes for historically marginalized women, and these connections are not considered in the treatment plans for gestational diabetes (Canadian Diabetes Association, 2013). Neither is the dialectic between disruptions in traditional food preparation and consumption, migration, and loss of traditional land base (Davis, 2013; Waldstein, 2010).

Like many working class and marginalized mothers, social networks shift in pregnancy. It takes time and effort to re-establish networks of support and obtain obscure information on survival programs available in the community. In her interview, Katie describes how difficult it is for new immigrants to decipher pamphlets given to them by well-meaning care

providers. It can feel like another task they are not fit to fulfill given how much confidence it takes for non-English speakers to enter the spaces of social service agencies.

Jenny describes a common experience of social isolation during the perinatal period.

Jenny: I felt isolated cause after I became pregnant I couldn't really talk to my single friends they didn't want to hang out with me anymore we had nothing in common anymore.

It turned out that in the endocrinologist's office Jenny experienced the most caring:

Jenny: I thought he was more caring than my [doctor]; it seemed like he cared.

Part of this caring stems from the social work referral he offered Jenny after she broke down crying in his office:

Jenny: I was seeing my gestational diabetes doctor one time. I was in his offices and I was crying about something right, and that's when he said, "Is something wrong?" And I said yeah. So then I said something like, "I think this baby could have been a mistake." I was just saying that because [long pause] ... yeah... and then he's like, "Well, maybe I should refer you to a social worker in the hospital." That's kind of how it happened yeah.

The chain of events that led Jenny to the social work referral is an aspect of her care she described as helpful. It was an opportunity to take the focus away from medical care and provided a window of attention on how she was coping with the challenges of poverty and racism in her life. Yet, despite the visit to the hospital social worker, and even with a *diagnosis of gestational diabetes*, it wasn't until *after* the baby was born that Jenny was referred to the public health office in her neighbourhood where she was able to receive coupons for milk, eggs, and fresh vegetables to support healthy breastfeeding and infant development.

When asked if she was happy with her experiences of prenatal care, Jenny paused for a long minute, and answered:

Jenny: Um, satisfied?

And when asked if there was anything her doctor did that she felt happy or satisfied with in particular, she answered:

Jenny: I can't really think of anything.

Jenny's repetition of variations of the word broken was powerful and moving. Broke as in, no money, and broken as in the way her body and mind were responding to her social situation and the way her pregnancy was progressing. Rather than addressing the roots of Jenny's situation, health care professionals look to physical symptoms and treat those as individual problems in isolation of a broader context. Jenny's story is illustrative of why we need to more deeply understand what is actually happening to women throughout their prenatal period. Through the clinical encounter women become aware of how their marginalization shapes their prenatal care. Each individual encounter is one line on a map of broader inequitable relations that some women perceive but are at a loss to explain or manage.

4.2. Unruly Bodies: Biology and Structural Injustice

It has long been theorized that there is a relationship between economic injustice and illness disparities. Western medicine and medical science has a history of problematic biological reductionism (Lewontin & Levins, 2007). Evidence has consistently suggested that perinatal health inequities are rooted in social, political, and economic inequities (Reuter et al, 1995). Perinatal health inequities among working class and systemically marginalized women include higher rates of stillbirth and infant mortality, as well as higher rates of morbidity including: intrauterine growth restriction; low birthweight neonates, gestational diabetes, hypertension, and postpartum depression. Rather than focussing on preventative social measures, social 'risk factors' trigger medical interventions (Quéniart, 1992). Medical institutions are symptom oriented and reliant on medical expertise so that it is necessary to narrow women's social experiences into containable treatments. This narrowing exacerbates women's experiences of social injustice and inequity. Ultimately, health care institutions leave root causes unaltered and structural economic inequities and racism persist.

The prenatal form works to compartmentalize women's lives through a rigid formulaic course of care guided by and documented on a two-page form. Health care professionals take a new patient's social history in somewhere around fifteen minutes. We scratch tiny

notes on prenatal forms. Health care professionals use screening tools to weigh and measure individual women's bodies and lives, often oblivious to the broader structural locations and limitations that the childbearing women themselves must navigate and learn to survive. If the primary prenatal care provider determines that follow up is needed for further discussion and / or counselling, more appointments are made, and more experts are consulted.

When a referral is needed, social realities become individual complications. Women's personal lives are seen as sources of conflict and stress. Taken out of broader structural context, women's lives are broken down into individual problems to be solved, and the solutions tend to involve (or lead to) complex medicalization by prenatal care givers and the prenatal care system in British Columbia. Pre-formulated solutions to complex social problems are handed to women like prescriptions as if to fight bacteria or chemical imbalance.

A motivating factor for this research project was my profound dissatisfaction both as a Registered Midwife and as a mother of three with how care providers wind up medically managing the social complexities that lead to health inequity. I am frustrated with how little I am able to accomplish as a midwife in the course of care. I keep hitting a wall of structural inequity in that my individual actions as a care provider could not accomplish enough to make a substantive difference in women's material circumstances. What good do these little screening boxes do on our standardized forms? They lead us to delve into complex situations with no capacity to deal with the structural realities of women's lives. As a health care professional, how can I interpret and treat biological outcomes of poverty and structural racism, such as gestational diabetes and intrauterine growth restriction? Of colonialism and forced migration? How do those women experience these interactions? As helpful, or potentially as harmful?

From the stories and experiences of the women interviewed for this research, it would seem that there is a great potential for our prenatal care system to backfire. Childbearing women don't necessarily experience prenatal care as *caring*. In fact, the perceived reactions and actions of the health care professionals can be experienced as "cold," distant, and even racist, as health care and social service professionals make judgements

and come to view working class women, and in particular Indigenous women and women of colour as high risk and risky mothers (Browne, 2007; Browne & Fiske, 2001; Downe et al, 2009; Heaman et al, 2013, Heaman et al, 2007). The women interviewed in the course of this research reported difficulties with low income, unemployment, housing insecurity, food insecurity, isolation and lack of social support, separation from extended family, and trauma from migration and separation from cultural base and community. Yet, I was still surprised when all of the women of colour interviewed reported they had been diagnosed with gestational diabetes, and every woman interviewed experienced some degree of depression and / or anxiety. These diagnoses can lead to racist and anti-working class attitudes and behaviours from health care professionals, such as some of the examples illustrated in Browne and Fiske on how negative stereotypes of Indigenous mothers' lead to assumptions of individual fault or failing when it comes to poorer health outcomes, or as in the shocking story of a mother whose child was apprehended in a local emergency room when she presented for medical help with diaper rash (2001, pp. 136).

4.2.1. Colonialism, Food insecurity, and Diabetes: Tia's story

Tia was a 42-year-old mother of six. I met Tia in her busy living room as her younger children played around us. Tia migrated to Canada and received prenatal care for her sixth baby through a clinic at the hospital that provides free care for women without access to medical insurance at the time of their pregnancies.

Tia describes her experience of seeing a hospital-based Family Doctor for her care:

Tia: I had all these visits, I don't know and so there were all these doctors and nurses, it felt like it was always at the Women's Hospital um it felt like, I can't even explain it... the way that they treat you when you walk into the hospital... like I knew nothing, I just felt like they looked down at me, like I didn't have any knowledge, because they were educated doctors and nurses and I knew nothing and the fact that I was brown and tattoos they automatically judged that I mustn't be educated. And because I was immigrating.

As Tia is describing her experiences of prenatal care, what emerges is a story of how her social location as a poor Indigenous mother shaped her interpersonal interactions with the health care professionals she encountered. Health care professionals were focussed on

a diagnosis, whether it be diabetes, depression, or theoretical risk of chromosomal anomaly, and on reinforcing treatment without consideration of cultural relevance, of embedded racist bias in their assumptions of Tia's existing knowledge base, or of very real structural and economic constraints on the abilities of a poor mother to fulfill multiple and at times overlapping demands and requests.

She describes:

Tia: I was feeling a little overwhelmed with appointments basically tired of people in positions of power telling me I have to do things. I felt like my intelligence and instincts were undermined and the fact that I'm having my 6th baby was of no relevant experience.

You know it could have been in my own head but it was how I felt, how they talked at me, giving me simple instructions as if I wouldn't know. I had to go through the whole nutrition class.

And then when she received her diagnosis of gestational diabetes, things escalated:

Tia: It was stressful that they wanted me to prick myself all the time and check my sugar levels, um I didn't have to inject anything, thank god but I had to do all these prick tests and I thought that was unnecessary. I had to fill out a chart (laughing) I don't know if I did it all the time but I did something to make them happy, yeah.

Martha: You did this to make them happy?

Tia: Yeah it was just so they wouldn't hassle me yeah... Oh my goodness yeah. But at the end of the day I do appreciate that they were there for me but I didn't feel like I needed so much attention (laughing) and maybe it was because I didn't feel good in the hospital and that environment that I didn't want to keep going back. There's no spiritual... balance, the whole physical, emotional, mental... there was no spiritual side to anything they did.

There is a growing body of research examining the relevance of medical diabetes management programs for Indigenous and migrant communities who are cut off from traditional food sources and cultural food traditions which promote metabolic balance and endocrine health (Waldstein, 2010). Indigenous and migrant communities themselves are starting to identify lack of land base and loss of traditional food sources and preparation methods as a deeper root of the problem of endocrine imbalance (Davis, 2013). Yet, our

prenatal care institutions are unable to incorporate these perspectives, and care providers continue to make individual assessments and judgements.

Martha: You mentioned you felt, perhaps, judged, around nutrition?

Tia: Yeah. We have quite a good understanding on nutrition and especially with the sort of work that Curtis does with Indigenous foods, we've done a lot of research. Maybe we can't always eat that way because of income. I feel like I knew a lot already and they were just talking *at* me and *wouldn't acknowledge me*. I don't know, maybe it was partly my fault that I didn't speak up more and say "actually I know all this, I don't want to hear it again."

It is significant that Tia's own knowledge and experience was unacknowledged. This lack of acknowledgement is a common occurrence described by the women interviewed for this project, and women describe how care providers made assumptions about their lives while ignoring their experiential knowledge and expertise.

Martha: Did feelings of judgement shape the way you felt about prenatal care?

Tia: It did. Yeah. Maybe it was just walking into that whole environment. They presumed that I just ate really bad but I was eating really well and I educated myself a lot on food and the spiritual side of it too and I thought yeah I could make a soup and do all that stuff but there was all these other reasons why it wasn't happening yeah um I think money was a lot of it, we couldn't buy the food we really wanted. They try and make it look affordable.

At the public health clinic where Tia meets with public health nurses in a program designed to support healthy pregnancy and infant development for low income women, Tia experiences racism and judgement of her poverty:

Tia: I've been attending the Healthiest Babies appointments, mainly for the \$20 food vouchers. I find it a very painful experience listening to the woman treat me as if I'm of lower status and intelligence than her, telling me how to eat and being sympathetic towards my 'hardship' of a large family. Every time I feel like that's the last time, why do I do that to myself and I don't want to go back.

In addition to being diagnosed with gestational diabetes, Tia scored high on the Edinburgh Postpartum Depression Scale (EPDS) in a prenatal visit, a standardized tool used to screen women for depression in the perinatal period [references].

Tia: I did a 'prenatal depression' survey and I scored higher than usual... I said yes sure I'm open to discussing my challenges in life but they are hardly something to be concerned about. She sits in her assimilated, colonial, privileged space she has no idea about where I come from.

Judgement and racism and poverty frames her experiences of prenatal care:

Tia: When I [went] for the ultra sound [the tech] was really mean, this one woman that took us in. She was frustrated because Curtis didn't turn up, he forgot and I had the two babies and she was like "they have to sit there and they can't talk, and they can't cry." I'm thinking, "Oh my god I'm in a Women's Hospital with babies and she's talking to me like this?" I was too stressed out to confront it because I was on the verge of tears because Curtis had pissed me off. She [the tech] was worried I was going to have a Down Syndrome baby or whatever and she wanted me to screen, and I refused, and I said, "because I don't want to know because it doesn't matter", and she's like "oh", like she couldn't contemplate, couldn't get it in her head that I didn't care if it was or wasn't I was still going to have this baby, yeah. Laughing. And she's like "oh". I can remember the look on her face... like a lot of people looking down upon you because you're brown. I know that sounds like blatantly like...I don't know...

Tia's hesitation to name deeper structural problems was common amongst the women interviewed. Long pauses and "I don't know..." or "yeah..." are sprinkled throughout the interviews in places where women struggle to put words to the deeper issues undercutting their individual experiences of being blamed or judged for being poor, or brown, or a migrant. Negative interpersonal interactions with health care providers add up to a pattern of that reflects structural racism within the institution of prenatal care. The lack of focus within the institution of prenatal care on the social determinants of health for working class and historically marginalized women has the potential to leave women feeling like they are the problem, rather than the broader social and economic conditions in which they live and raise their children.

4.2.2. Social Class, Structural Injustice, and Mental Health: Heather's Story

Heather was a Caucasian single mother with a young daughter named Kaley. I met Heather in the public library for our interview. Heather described her pregnancy and birth

as uneventful, however, during the course of our interview what emerged was a story of struggling to survive on welfare, unable to find employment, and grappling with depression and anxiety.

Heather started her prenatal care with a doctor at a walk-in clinic. Heather states:

Heather: The first time I went in for a pregnancy test I wasn't pregnant and they said it was a good thing that I wasn't pregnant.

After the first negative test, Heather returned for a second test, and in fact, she was pregnant.

Heather: I think there was a lot of fear that, um, the doctors scared me, I was afraid they were doing to try and take my baby away... I had a really hard time getting enough money for nutritious food. And a lot of times I would get things from the food bank and feel like they were contaminated and I was really scared to eat them; there's that dilemma, do I eat this because I am hungry or do I avoid it because it might be contaminated, like they gave me a whole salmon, which I just gave to someone else, I didn't know if it had been frozen the whole time. My housing really sucked, I had a tiny little fridge...

...and welfare is a really sad joke. It's, um, you just starve on welfare. It's really humiliating, you just don't feel you have any dignity...

She describes how she struggled to avoid people's gaze during her pregnancy:

Heather: I didn't tell most people because I just automatically assumed because I was poor that they would think it was unfortunate I was pregnant. I know a lot of people walk around like, oh, I'm happy that I'm pregnant and people treat them like they're special, but I spent most time just not wanting to talk about it, just trying to avoid people's gaze.

At 28 weeks, Heather transferred her care to midwives. While the midwives provided more compassionate care, Heather still described her midwives as lacking experience with poverty and missing a long-term perspective on how to support women who face single motherhood and the prospects of raising a child in poverty. Differential class and economic privileges make it difficult for care providers to relate to their patients (Lazarus, 1994). In

this situation, there are two different foci; Heather's midwives focussed on preparations for pregnancy and birth, where Heather sought support and advice on what was to come after her baby was born.

Heather gives an example:

Heather: I really felt that I had this huge thing happening and I was going to have a child and I didn't have any idea what to do, it was really scary, and my midwife kept giving me books about birth and pregnancy, and it was really interesting, and my midwife would be like, "How's the book?". And I'd say, "Great". But I'm going to have a baby! I'm not worried about giving birth, I'm worried about the many years after that (laughter). Birth is going to be but a short part of that experience.

Our prenatal care system is not equipped to help individual clinicians to acknowledge and address women's broader and longer term concerns. Heather's reaction to being diagnosed with depression based on the Edinburgh Postpartum Depression Scale is illustrative of this:

Heather: I'm depressed and it's situational, I'm in a bad situation, I finished school and I can't find a job, I'd been living off my VISA card until I got to the limit and I had to go on welfare and that's depressing, and I can't even find a shitty job! They won't even hire me at Superstore and I am depressed because of that! Where's that question on your survey!

Heather identifies her economic and social situation as the root of her depression, but in no way are the prenatal care system or the provincial reproductive mental health program able to address social context. While the intention of the care providers is to support women to make positive life changes, frequently their control over the conditions in which they live and their ability to make change is severely limited. In fact, it frequently may be risky for poor women to try and make change; leaving a bad situation may lead to a worse situation in the long run. Heather speaks to this when she discussed trying to find more suitable housing.

Heather: No. No, it's too risky to change. I don't have the luxury of just doing that for the fun of it. I can only change little things. Housing too has become extremely expensive and I want to move but I don't know where to move.

Constrained in her abilities to address her poverty, Heather was presented with options to treat her depression. These are the standard options for women diagnosed with depression and / or anxiety: lifestyle changes, medication use, and either individual or group cognitive behavioral therapies (CBT). But for working class women, CBT has the potential to backfire as blaming, for when women continue to struggle to manage their emotions using CBT, their inability manage anxiety or depression is seen as the improper use of technique rather than underlying poverty, racism, or social alienation which perpetuates the underlying problems that contribute to poor mental health.

Unprompted Heather described what it was like for her:

Heather: They say, here`s how to defeat anxiety, here`s how to defeat depression, go through these steps in your mind, be really positive, I just think that`s not like how I am.

I spend a lot of time really depressed about my economic situation. It`s really hard to focus on the fact that it`s going to be better someday when you just keep falling down into bad times economically, and I feel like the depressing thing is I`m a really bad example for Kaley ... she doesn`t really have a good model for how to think positively from day to day because I`m constantly sort of beaten down about it.

Heather`s frustration at the powerlessness she felt was palpable during our interview. Individually, health care providers are unable to help pregnant women who experience the health impacts of poverty or structural racism address or dismantle the inequitable structures that impact them.

In fact, as the interviews in this project suggest, attempts to address some of the biological sequelae of poverty and racism, such as higher rates of depression and anxiety or diabetes, lead women to experience their care as over-medicalization of their social or economic circumstances. Medical care is expected to improve prenatal outcomes in isolation of substantive efforts to address the gross structural injustices which shape working class and historically marginalized women`s lives. I came to view this as a `fix women` approach to prenatal care.

4.3. A 'Fix Women' Approach to Prenatal Care

Martha: Do you know why you went for prenatal care?

Denise: Because I thought it was expected and I think that is another thing that just didn't agree with me, is "you're pregnant, it has to be wrong!"

A 'fix women' approach to prenatal care occurs when the upstream health impacts of poverty, colonization, forced migration, and structural racism are addressed solely or predominantly through medical screening and interventions and suggested or recommended individual behavioural changes. This approach views women's individual social and economic circumstances as medical "risk factors" and poor and historically marginalized women as "high risk" individuals. Women are encouraged to take up healthier lifestyles without any or with little support to improve their social and economic situation or to address gross structural and social inequities.

In our current context, a "risk factor ideology" has come to dominate prenatal care. Quéniart defines risk factor ideology as "the set of doctrines that legitimate new social behaviours, constructing objective conditions of danger in order to justify new modes of intervention" (Quéniart, 1992, p. 164). The flip side of the risk factor ideology is the labelling of individuals as "high risk populations" (Quéniart, 1992, p. 164) often correlated with class and historical marginalization.

Economic and social inequity and injustice lie at the root of women's experiences of poverty and marginalization, but women can experience prenatal care as blaming when the etiology of their health concerns is viewed by health care professionals as a matter of poor lifestyle choices.

15. Potential or Actual Concerns:

Lifestyle

Pregnancy

Labour

Breastfeeding

Postpartum

Newborn

Figure 5. Section 15: “Potential or Action Concerns”

This form leaves almost no room to contextualize women’s lives and struggles

The prenatal care system is set up so that individual care providers, using a standardized form with tick boxes or tiny writing spaces, ask huge questions to women, with no substantive way within the system to address women’s actual material circumstances. Women interviewed for this project expressed concern that such questions lead to questioning them for their inequitable life circumstances and some participants expressed concern that this line of questioning has potential to open up courses of action that then quickly move beyond women’s control.

Lana: You know, within the medical system there will be a snowball, like if you agree to this, it could lead to this and this and this and this. You think you are agreeing to this one thing but they’re connected, a world of pain...

While there are elements of prenatal care women identified as helpful, for example, learning about the health of their baby and bonding through hearing their baby’s heart beat. Yet, it is important to recognize and acknowledge the very real constraints on poor women to make any sort of change. For Tia, for Heather, and for the other women interviewed, being told that they needed to make difficult individual changes overshadowed the caring aspect of prenatal care. Further, women did not report that their physician or midwife provided practical advice on how to make such lifestyle changes. There was not enough acknowledgement that these supposed lifestyle changes, in fact, were rendered severely limited by economic inequities generated by the exploitation inherent within capitalism. That it is very difficult for individual working class women to break out of their class constraints and elevate their economic position. A broader

discussion of the benefits and the *harms* of prenatal care could point the way to improved caring for women.

Professionals have a delineated medical expertise and yet doctors and midwives can speak with authoritative voice about lifestyle changes and behavioural changes that become a message of *what is best for you and the baby*. Yet existing research has found that health care professionals' privilege and social status can give them a shallow understanding of the social and structural contexts and constraints women face in their daily lives (Sword, 2003). When health care professionals give (too often off-hand) advice to their patients about how to improve their economic and social circumstances, there can be unintended consequences or negative messages attached. As with the stories of Katie, Tia, and Heather, the unintended consequences can appear as judgement of poverty or as interpersonal racism. Health care professionals can unintentionally push women to conform to a socially-acceptable frame. This 'fix women' as opposed to a 'fix a broken system', or a 'bootstraps' approach to social disadvantage can be a very negative experience for women.

There is potential to make significant change to the way prenatal care is provided. For example, to shift the use of authoritative texts, such as the prenatal form which structures interactions between health care professionals and patients, decontextualizes women's lives and individualizes social inequities by narrowing broad social factors to a few lines on a form. Or, to question why it is that prenatal care should be provided within individual practitioner's offices, further reinforcing prenatal care as an experience of institutional ruling over women's lives. It is possible to imagine ways of providing care that shifts the focus from individual women's lives to addressing the economic and social context in which women conceive, bear, and raise children. The stories women shared through this research point to the need for further investigation into how the institution that is prenatal care can be changed for the benefit of working class and marginalized women. Rather than looking narrowly, at the individual and the cellular levels, policy makers and care providers can lift our gaze and search upstream to the social structures that undercut poor women's experiences, and imagine a different way of caring which contextualizes women's lives.

Chapter 5. Alternatives to Current Practice

This research interrogated the prenatal care experiences of nine working class and historically marginalized women in order to start to identify underlying relations of ruling with the institution of prenatal care.

There are two core findings in this work. The first is that standardized and technically focussed care misses many of the needs that women themselves identify. Not only was medical and technical expertise deployed in order to gain compliance to testing and intervention, very little space was made for moving beyond standardized care and addressing women's own perceived needs. The second is that women themselves identify the medicalization of their poverty and racialization as a problem, and prenatal care comes to be an experience of health care professionals trying to fix social inequities in health outcomes by pressuring women to conform to expected health behaviours with little additional help despite their often times grossly inequitable social situations. I came to term this approach to prenatal care as a 'fix women' approach.

This chapter gives insights into how the work of prenatal care might be improved to recognize women themselves as active participants in this work through practices which facilitate greater power for women within the institutional setting.

5.1. From Critique to Change: 'Fixing' Prenatal Care

Moving from women's experiences, to institutional critique, and then finally to action in the form of recommended changes are important components of this research project. A stated goal of this project was to help get the institution of prenatal care right for the women who it is supposedly designed to care for. The overarching recommendation for change is to move toward institutional practices which increase women's power and control, to level the playing field between health care professionals, who are experts in pregnancy and birth at a population level and childbearing women and their communities, who have expertise of their own to offer in the work of prenatal care.

Change needs to occur at three levels: in the individual clinical encounter between care provider and patient, within the clinical setting that women and care provider meet, and at the level of broad structural policies and practices.

At the levels of interpersonal interactions and immediate clinical settings, culturally-safe and trauma-informed care help reshape the relationships between pregnant woman and health care provider. Both of these models of care encourage health care professionals to lift their gaze from the immediate prenatal interaction with patients, and to acknowledge how historical and structural injustice shape women's experiences of pregnancy, birth, and motherhood.

Yet, ultimately, researchers and health care professionals must look upstream. There are possible changes to the structure of the institution which begin to address not only interpersonal relations in clinical care, but also start to help reshape the broader social and economic conditions in which working class and historically marginalized women bear and give birth to their babies.

Improvements to the structure of prenatal care could be gained by shifting from an institutional to a community-based model. Community-based health care practices can include community involvement in design and evaluation of services, greater community involvement in care, and the introduction of group work into the health care practice. Additional improvements might be gained by integrating pregnant women into the institution as active care providers, recognizing the expertise that women bring to care, and acknowledging that, in fact, it is pregnant women themselves who are doing the vast majority of care for their babies.

Finally, this project has identified that these areas of potential institutional change require and deserve attention in future research into improving morbidity and mortality among working class and historically marginalized women and their newborns.

5.2. Community-Based Models of Care

Community-based models of health care often have at the core greater involvement of community and peers through the facilitation of social groupings such as parenting classes, women's groups, and other structured social networks (Williamson et al, 2006). Community-based services which involve social networking and mutual aid as a component of care have the potential to reduce women's reliance on the medical system for referral and advocacy. It is possible to bring the community into prenatal care, such as by identifying 'natural helpers' and involving them in advocacy and outreach, and adopting measures to deeply involve fathers and other family members in preparation for parenting. Involving the community in prenatal care also has the potential to fill gaps experienced by migrant or displaced women who are away from their cultural communities and extended families and potentially reduce post-partum depression and improve coping and mood, and increase access to existing services and encourage mutual aid (Best Start, n.d.; Stewart et al, 2012, Bhagat et al, 2002). In particular, supporting the development of peer-networks was identified by Indigenous women as an important part of health-supportive practices (Benoit & Carroll, 2001). It is essential that such community groupings be freely accessible and have no cost associated.

During the course of the interview women began to identify social supports as central to their needs, and a few of the women interviewed shared examples of how they struggled on their own to find social supports or faced social isolation in their pregnancies.

- Jenny: All of that stuff I got after I had the baby that was when I got referred to all these resources, for instance one of the programs I attended was Healthiest Babies Possible, and that program was awesome because of the coupons they were giving. I would get 4 or 5 four liter jugs of milks per month, and then I'd get some for eggs and some for vegetables, and that really helped out financially because I had lack of funds and also cause his dad wasn't involved so...
- Martha: Do you wish you had had that referral earlier? Would that have been helpful?
- Jenny: Probably yeah, probably because I felt isolated because after I became pregnant I couldn't really talk to my single friends, they didn't want to hang out with me anymore. We had nothing in common anymore, and then some of my other friends that do have children, they're different ages so

we don't really get along cause they're not the same age, some of the kids are 5 or 6 and I'm just having a baby. So then, yeah, going to group I met a few mums and that actually helped out.

Jenny found herself preparing to be a single mother, and in addition to grappling with her poverty in the context of a growing financial need, Jenny struggled with social isolation as her needs for social support changed. All mothers are vulnerable to social isolation particularly in the first year after birth, but especially than working class and historically marginalized women who lack financial ability and face social stigmatization which exacerbates isolation.

Much of the work women do on their own to address their prerequisites for health is not included within the current institution of prenatal care; indeed, much of what participants identified as helpful was the care, advice, and support they received outside of the prenatal visit from their extended social networks.

Jasmine explained how this worked for her.

Martha: And how often did you see your care provider?

Jasmine: The earliest time was this reason, because I'm a new immigrant so the care card I can only use after 3 months or a certain time. So I started to the doctor after that month, then I start seeing the doctor quite often I remember like once a week at the beginning and later on once every 2 weeks.

Martha: And you were already 6 months when you saw her?

Jasmine: Yeah

Martha: So you say a regular was very short: 5 minutes or 10 minutes? What happened in the visits?

Jasmine: Normally it was checking the urine and then checking me very quick.

Martha: Did you talk about getting ready to be a mom?

Jasmine: No time, only the basic things. She's kind of not so connected to patients.

Martha: Your son is at [the local low cost childcare centre]?

Jasmine: Yeah.

Martha: How did you find out about [this program]?

Jasmine: From my friend [name removed].

Martha: How did you meet [your friend]?

Jasmine: At the Food Bank.

Martha: And then who told you about the Food Bank?

Jasmine: Oh, the nurse after I give birth. There is a home visit nurse, so she went to visit me saw my living condition, so she recommend me because I asked her help for diapers, so she told me about the food banks.

Martha: So your doctor when you were pregnant didn't refer you to any services?

Jasmine: Not at all I wish she had told me about some of those classes. Now I know there are some in Vancouver. At Coastal Health they have those program for pregnant woman, I didn't know at that time.

Martha: That's one thing I hear from many women, that the doctors are not telling them about available supports through Public Health.

Jasmine: I didn't know any resources from the doctor.

Martha: What helped you at becoming a mom? Were there things that were supportive of you when you were pregnant?

Jasmine: Supportive... what support I got was from the Church. I went to Church, and mostly it was the Church that was supportive. If I didn't go to Church I probably no support.

Martha: So when you think about the support the Church provided, what kinds of things were helpful?

Jasmine: Like people like showing they care, sharing how to prepare for the baby, some people even bring their children's and baby's stuff they donate to me, children's clothes, some people even buy me diapers!

Jasmine explained how she relied heavily on her Church for emotional and financial support during her pregnancy. It was the postpartum visit from the Public Health Community Health Nurse afforded to 'high risk' mothers that led to Jasmine's connection to Public Health and community resources. Further, it was an off-chance meeting at the

food bank that led to the development of her friendships with other single mothers in her neighbourhood.

As these interview excerpts suggest, there is a need to generate greater social supports and build community for pregnant women. How can the structure of care be shifted to better establish building blocks for healthy mothers, healthy newborns, strong families, and resilient communities? Creating space for social care within the institution of prenatal care in BC could involve shifting the focus of visits to the expressed needs of women and families over the time-determined medical screenings and tests which are recommended at that time frame. Addressing social needs first as the greatest priority can contribute to a reduced sense of hyper-medicalization and facilitate trusting and meaningful relationships with women.

Taking Prenatal Care into Social Spaces

Further research is needed to address the question of whether or not it really makes sense in terms of health outcomes and health economics to continue to provide prenatal care in physicians' or midwives' offices. Moving from an institutional setting to a focus on community-based services can take a myriad of forms. It may include meeting women literally where they are at (home, community, coffee shop, or other public places) and figuratively meeting women where they are at in terms of world outlook, social status, and experiences of marginalization (Little et al, 2007; Angus et al, 2012). Community-based services increase intentional and structured social supports, intentional advocacy, and a reduction in the medicalization of social issues and a lack of the social determinants of health.

Creating Community Through Prenatal Care

Martha: If you were going to do prenatal care again what would you like?

Denise: I have thought about it! I actually would like to start my own, a group of mothers at the same, around the same point of pregnancy as me so we can support each other. I think that would be a big help to share experiences the next time. Definitely now that I know my blood pressure and heart rate went smoothly and I could have a more natural birth next time around, for sure. Yeah, like everything is not so much about getting the baby room ready and all that

shit, you know there is all these expectations you have, if you go online there is all this list of crap you need to buy it's... you know what I mean, you really don't need that. I want more of a support group than a clinic.

Martha: That's what we'd like here too for us, just to, I mean in September we will offer groups for women (inaudible) like should it be a care provider even leading the group, right. Like in your mind you see a group you don't see care provider in that group.

Denise: I don't see care provider in the group. Second time around, it would have been good the first time around, but this time around I think it would be better if there wasn't 'cause then again there is this shifted power dynamic because one person is expert and knows what they are supposed to... everything, and all of us are just patients.

Group prenatal care was brought up spontaneously during the course of the interview with Denise, but in fact, the concept of group prenatal care is an institutional change that has already undergone great study, experimentation, and implementation.

In 1995 Registered Nurse Sharon Schindler Rising piloted a model of group prenatal care, called CenteringPregnancy, targeted at providing improved access to prenatal care for socially-vulnerable populations combining clinical care and prenatal education in a group setting (Rising, 1998). CenteringPregnancy ideally shifts focus from the traditional professional role, creating much needed space for women to network, share stories and experiences, contribute and strengthen their own knowledge, and develop lasting relationships (Rising, 1998; SCBP, 2006). 'Centering Pregnancy' has been described as an interdisciplinary model of empowerment whereby individual women are empowered to take control over their health, to share resources, strengthen problem-solving skills, and in turn increase the capacity of the community as a whole.

The relationships women build in a CenteringPregnancy group contribute to a strong sense of community, promote community organization, reduce social isolation, and improve women's experiences and perceptions of health (Ickovics et al, 2003). Numerous studies demonstrate that group care is empowerment-based care, promoting community, increasing social supports, improving short-term health indicators such as reducing low-birth weight, and ultimately mobilizing women to tackle broader prerequisites for health (Ickovics et al, 2003).

Research from the 'All Our Babies' group prenatal care program in Alberta found that 'demographically vulnerable' group participants who scored lower on psychological health in comparison with a control group at the beginning of care scored on par with the control group at the conclusion of care, suggesting that participation in group prenatal care may contribute to improved mental health (Benediktsson et al, 2013). Yet, CenteringPregnancy is not the only group Model of Practice. Limitations to participation for marginalized women in CenteringPregnancy can include lack of language ability, lack of ability to take time off of work, difficulties in maintaining a set schedule, and being 'crowded out' by middle-class or white women.

Another method of building community through prenatal care could be to involve community members as members of the care team. Integrating social networks into prenatal care reduces the chance that women might move through their entire pregnancies without connecting to a social network to enhance their financial and social well-being and reduce isolation. Katie's experience highlighted how important community members are to women's ability to survive and thrive during pregnancy.

Martha: How did you find out about the [family centre]?

Katie: Through my friend from ... the school, [the volunteer who is] working in the [low cost food program] now at the community center. She is very nice, she saw me one day, "you look so tired, do you know about the [family centre]?" No, what is this? Now I usually go to [this program]! If we take the bus from [Katie's house] we stop [very near the family centre]. Probably many times I am going right by, but I never knew about this organization. "Oh I can come with you?". She offered to come with me! To show me because I needed more time for her to explain about what they offer. We met some people there who described exactly the opportunity for volunteering, and I was like, Oh, it's something to do to distract me.

Martha: And how did you find out about BC Housing?

Katie: Through my friend from Bulgaria... we have a manager in [Housing Organization], a Bulgarian woman, and she probably tried to help some people who came with small children, because the beginning is so difficult if you didn't have this information.

Martha: And that's part of what I'm trying to figure out is how women get that information, about housing and childcare, because many women tell me that these are important things.

Katie: Even if someone is Canadian, it's hard to explain, and if you didn't know very well the language and if you don't understand exactly what they're talking about. So we help each other, this was our plan. Not from the services, they have a lot of information, they usually give a lot of papers, but you can't understand everything even if you know the language! This is a totally different culture, country, we need more explanation.

Existing literature has identified that relying solely on health care professionals to provide knowledge and appropriate referrals for social support creates significant limitations. For example, “pregnant asylum-seeking and refugee women often have complex health and social needs which midwives may have difficulty in meeting due to limited resources, but also due to poor attitudes and lack of understanding of their needs” (McCarthy & Haith-Cooper, 2013: 74).

Involving Community Members as Care-Givers

There are a number of innovative examples of how community members can be involved in the provision of care for childbearing women and families.

Some programs in Ontario have built into their team a role for advocacy workers, ‘natural helpers’ or other community members who have been identified as someone who women trust and rely on to increase social capital and enhance psycho-social well-being. The role of the advocacy worker has been identified as one that is critical for many women can involve two levels of care: individual support - such as phone calls and referrals, and community action - through mutual support groups of low-income women (Best Start, n.d.).

In Quebec, a successful pilot program assigned “Godmothers” to poor women. Despite the name, which sets a patronizing tone, Godmothers strove to address social inequities as well as provide individual support. Godmothers worked on two levels: individual support – making home visits, bringing supplemental food, and providing one-on-one individualized social support, and the collective level – organizing social and recreational activities and informative health promotion meetings whose purpose was to foster non-hierarchical relations and encourage the sharing of life experience (Milligan et al, 2002). Another example is that of “volunteer befrienders” from Northern England where asylum-

seeking migrant women were referred by either midwives or refugee organizations and paired with a volunteer, called a “befriender” who then help women navigate a myriad of social services, connect women with social networks already in existence, provide trusted emotional and psycho-social support, and increase reported self-esteem and self-confidence (McCarthy & Haith-Cooper, 2013). The Best Start review of successful outreach programs identified increasing mutual aid between women as something that women greatly valued and appreciated.

5.3. Integrating Women as Active Care Givers

Community-based care is the first overarching suggestion for institutional change. Community-based care could involve taking care out of the clinical setting, using a group care model, and involving community members in active roles in the prenatal care team. The second suggestion for institutional change involves recruiting women as active partners in their care through practices that give women greater power within the institutional setting. As Lazarus notes, “models of sickness and health are often ambiguous and inconsistent. It may be more useful to focus on knowledge that people bring to an experience and to factor in issues of power and social class.” (Lazarus, 1994, p. 138). This certainly applies to generating healthy conditions for pregnancy and for establishing the basis for a healthy mother and newborn in the postpartum period. Setting women up to have greater control of their circumstances of their lives could start with having women have more control in their prenatal care experience.

Lana’s experience of her second pregnancy highlights this point.

Lana: I went into my experience with my second child 2 years later not with a paranoia about medical care or midwifery care, or a reservation, but with just a different attitude. I made the decision that I wanted to have ... the opportunity to hire health care practitioners who were potentially better, who were going to serve me better than [the first Registered Midwives] so I didn’t go back to them. I started to interview others ... I actually did go into [other local Registered Midwives] asking, like I remember going into the interview where I wasn’t being interviewed, I was interviewing them! There was a student there again and there was a more experienced midwife where I was asking them you know “what was your birth like?” or “where are

you from?" "what do you do?" and ah "so you are associated with this organisation well I know the Executive Director." You know, using every venue I had to assert my power, and um, they responded well.

Lana used what she perceived as her experiences to potentially level the power dynamic between care provider and patient, which was her experience in being a sexual health worker and knowing professionals in this field. Lana goes on to share more about how this assertion of her own power impacted the dynamic in her prenatal care visits.

Lana: It wasn't alienating, it actually brought up a lot of interesting conversations where I started to feel "ok" we can have a working relationship together because I would like to have your expertise and I can't afford to hire a private midwife. You know, within the system I think that you guys are a pretty safe bet, I'm gonna go into this with caution.

Despite the fact that Lana expressed potential for a positive therapeutic relationship with her Registered Midwives, Lana went into this relationship "with caution". Lana was familiar with the standard arc of prenatal care testing and intervention, and set the terms of her care, what she would consent to and what she would not consent to, right from the outset.

Lana: So we talked about what some of the milestones were going to be for different tests which I declined some of those tests. I didn't agree to any ultrasounds; I didn't agree to any blood work um I went based on my sensations. I was feeling good, I was taking care of a very active 2-year-old, um I was walking a lot, I was eating really, really well like tonnes of organ meats and juices and doing my best to sleep. I felt, I felt powerful and I felt good. And so if I needed something from them I would call. I made that known and they respected that space it was great.

This level of control set the stage for Lana's positive participation in prenatal care in her second pregnancy.

Lana: We ended up having a really positive relationship and so as time went on and they started to come to my home to do some palpating of the belly which I actually enjoy as a ritual I enjoy people coming and touching me somewhat.

Lana: I feel like I achieved something that was really, really important for my development as a woman which I didn't achieve with my daughter and that development of myself as a woman was stunted by the prenatal care that I had first time around. It was also stunted by my lack of wisdom

going into that, into that world that the second time around
I corrected all of those mistakes ...

Lana described her process of taking charge and situating herself as an active member of the prenatal care team. However, Lana seemed to me to be an exceptional example of a woman who put a great deal of thought as well as research into her goals and expectations for her second pregnancy. Many women, in particular first time mothers who come from working class and historically marginalized communities will face many barriers to this type of assertion of authority. However, it is possible to take small steps toward improving women's role in their own prenatal care.

The main way I suggest this could be done is by giving women greater control over the flow of information. Registered Midwives use an informed choice model of practice to give women information they need to make a decision and then support women to make a choice. However, I believe that this process could be partnered with other measures to increase women's autonomy and control over their own prenatal information and empower women to see themselves as active participants in the overall process.

As touched on throughout this project, standardized prenatal forms, such as the PHBC antenatal form 1&2, are the primary method of tracking and documenting the course of prenatal care. Standardized forms are the guide care providers use to ensure prenatal care is on track, to document what occurs during visits and the results of testing and interventions. Prenatal forms are also the primary method of communication between primary health care providers and the hospital where the woman is going to deliver, including any specialists consulted during the pregnancy or during the birth. Therefore, given their widespread use, to make the prenatal forms a collaborative practice involving women as the owners of the form itself, could be explored as a way to encourage and even necessitate other institutional reforms.

This project reveals two recommendations for changing the content and use of the standardized prenatal form.

5.3.1. Make space for women on the prenatal form

It is my belief that the content of the forms Antenatal Record Part 1 & 2 could be drastically improved, and this is a major area where further research has the potential to be of great benefit toward improving women's experiences of prenatal care. However, an initial change could involve creating space on the prenatal form for women to write their own comments and feedback, in particular on the social screening that takes place during prenatal care as a place to start. I believe that giving women space to complete their own health histories with guidance from an experienced care provider has the potential to support women to know where potential health concerns might arise during their entire life course. Additionally, giving space to women to document the outcomes of their physical examinations with their care providers might provide similar results.

Making the process of filling out the form would require longer visits with health care providers, and necessitate deeper informed choice discussions and support for women to make their own decisions and document their choices. This would also pose greater challenges to situations where inadequate translation is available to women and their families. These challenges of time and language, while revealed through considering changes to standardized forms, are deeper critiques and can only be addressed through changes in the structure of practice, such as the provision of translation services and longer appointment times.

5.3.2. Give women a say over their health records

Electronic charting is quickly becoming the institutional norm, and open source medical records software such as the *Open Source Clinical Electronic Records* (OSCAR) program developed by Dr. David Chan out of McMaster University (OSCAR EMR, 2016) are in widespread use. This opens up new possibilities to facilitate women's access to and control over their entire medical record. While care providers would still have access to the chart, women would be able to review the chart, make changes and additions, and to challenge information where they believe it to be incorrect or inadequate.

This record could actually be their entire life-cycle medical record where women gain access at age 18, with the prenatal record as a component of this chart. Or the process

could involve just the prenatal record. This is an area of exploration that warrants further attention.

At least two exciting challenges could be opened up if women were to have total control over their medical records:

1. It would require greater communication between the medical team and the patient, which would require more time in each clinical visit, and greater attention to building patient knowledge and a more meaningful process of informed choice.
2. It would draw attention and scrutiny to social screenings, such as questions about finances, social supports, and substance use. Additionally, it could have great potential to encourage more meaningful follow up to these screenings, rather than simply checking a “referred” box, patient control of records might push care providers to greater collaboration with Public Health and non-profit organizations in the community.

While this recommendation requires far more research and investigation, changes to the standardized prenatal forms and changes to flow and documentation of women’s medical information could work in tandem with shifting the base of prenatal care from the clinical to the community setting.

By centering women’s perceptions and experiences with the institution of prenatal care, this research project affords beginnings of important insights into how the work of prenatal care might be improved to both contribute to better experiences for working class and historically marginalized women and potentially improve health outcomes for mothers and their newborns. This could include integrating more substantive ways of centering women and their families in the institution of prenatal care such as the use of group care and lay health care workers. Further, more can be done to recruit women as active partners in their care through practices that give women greater access and control within the institutional setting. Pregnancy is a time of great change for working class and historically marginalized women, attempts to reduce social inequity can start with the institutions that provide women care throughout pregnancy.

5.4. Conclusion

This project traces the history of prenatal care as a medical institution and attempts to examine the outcome of this history through taking the standpoint of how working class and historically marginalized women experience this institutional health care. While there exists good evidence that a minimum standard of medical care in the prenatal period reduces morbidity and mortality, there is also contention on who should provide prenatal care, how it should be provided, and what the content of care should be. The bottom line is that within British Columbia, as in most wealthy countries, control over medical institutions is placed in the hands of state-legislated health care professionals who have a vested material interest in that same institution. This is not a neutral position from which to determine the need for the medicalization of physical states such as pregnancy. Therefore, the standpoint of oppressed and exploited groups becomes a window into another viewpoint, with potential to recognize relations of ruling that might be concealed from the dominant group.

As Hartsock encourages, scientific research is needed to “see beneath the surface of social relations” (1983, 285) and Institutional Ethnography provides a methodological framing for such future research with a theoretically explicit orientation toward institutional critique. Although this study involved a small number of participants, the standpoint taken throughout this project teases out two important interconnected findings, which require further elaboration in future research: a) inequitable power relations between health care professional and patient do frame the experiences of working class and marginalized patients; and b) the deployment of medical expertise can be a negative experience, in particular when it pertains to women’s perceived ‘risky’ lifestyles. These findings raise a question of whether the deployment of this type of lifestyle expertise has potential to exacerbate marginalization rather than improve medical outcomes.

Secondly, much of the content of prenatal care is determined by professional guidelines and forms which act as authoritative texts that shape women’s experiences of prenatal care. As with Registered Midwives in Ontario developing their own clinical guidelines as an alternative form of midwifery-oriented education to promote struggle to change inequitable relations between the midwifery model of care and an obstetrical model of care

(Davis, 2008), so it seems possible that potential exists to re-model the Antenatal Record from the viewpoint of working class and historically marginalized women as a process of struggle to influence and shift power imbalances in prenatal care, centre women's needs and experiences, and provide alternative forms of education for health care professionals in areas, such as 'lifestyle' where women themselves are, in fact, the experts.

While this project suggests some ways in which working class and historically-marginalized women could have improved experiences of prenatal care, this project also raises important questions of how health care systems are structured and managed, and how health is interpreted and acted upon at the professional and institutional levels. As Hartsock states, "the vision available to an oppressed group must be struggled for and represents an achievement which requires both science to see beneath the surface of the social relations in which all are forced to participate, and the education which can grow only from struggle to change those relations" (1983, p. 285).

Although prenatal care was the focus of this project, the methods and findings could be applied to similar circumstances where great potential exists for the medicalization of the downstream outcomes of social and economic inequities. For example, taking an engaged standpoint of colonized Indigenous communities could reveal solid institutional critiques around health care provision for non-communicable diseases such as diabetes which have a similar demonstrated correlation between poor outcomes, economic inequities, and structural racism and where much contention exists over social and supposed 'lifestyle' versus biological risk factors.

While prenatal care for working class and historically marginalized women in East Vancouver, British Columbia, does seem to have potential to inflict psychological and emotional harm on women, in revealing this potential so too is revealed a potential for positive change toward healthier women, families, and communities.

References

- Alexander, G.R. & Kotelchuck, M. (2001). Assessing the Role and Effectiveness of Prenatal Care: History, challenges, and directions for future research. *Public Health Reports*, 116(4), 306-316.
- Amin, S. (1976). *Unequal Development*. New York: Monthly Review Press.
- Angus, J.E., Lombardo, A.P., Lowndes, R.H., Cechetto, N., Ahmad, F, and Bierman, A.S. (2012). Beyond Barriers in Studying Disparities in Women`s Access to Health Services in Ontario, Canada: A qualitative metasynthesis. *Qualitative Health Research*, 23(4), pp. 476-494.
- Armstrong, P. & Armstrong, H. (2008). *Health Care* [About Canada Series]. Winnipeg, MB: Fernwood Publishing.
- B.C.'s Representative for Children and Youth. (2015). *Growing up in B.C. – 2015* [Government Report]. Victoria, BC: B.C.'s Representative for Children and Youth.
- Benediktsson, I., McDonald, S.W., Vekved, M., McNeil, D.A., Dolan, S.M. & Tough, S.C. (2013). Comparing CenteringPregnancy to Standard Prenatal Care Plus Prenatal Education. *BMC Pregnancy & Childbirth*, 13(Suppl 1), p. S5.
- Benoit, C. & Carroll, D. (1995). Aboriginal Midwifery in British Columbia: A narrative untold. In P.H. Stephenson, S.J. Elliot, L.T. Foster, & J. Harris (Eds.), *A Persistent Spirit: Towards Understanding Aboriginal Health in British Columbia* (pp. 223-248). Victoria: Canadian Western Geographical Series 31, University of Victoria.
- Benoit, C. & Carroll, D. (2001). *Marginalized Voices from the Downtown Eastside: Aboriginal women speak out about their health experiences* [NNEWH Working Paper Series #12]. York University, Toronto, ON: The National Network on Environments and Women's Health, A Centre for Excellence on Women's Health.
- Benoit, C. (1997). Professionalizing Canadian Midwifery: Sociological perspectives. In, Shroff, F.M. (Ed), *The New Midwifery: Reflections on renaissance and regulation* (pp 93 - 114). Toronto, ON: Women's Press.
- Berry, N.S. (2011). Unsafe Motherhood: Mayan Maternal Mortality and Subjectivity in Post-War Guatemala. *Fertility, Reproduction and Sexuality*, v. 21. New York: Berghahn Books.
- Best Start. (2002). *Socio-Economic Status and Pregnancy – fact sheets*. Ontario: Author. Retrieved October 3, 2004, from http://www.beststart.org/resources/anti_poverty/pdf/ses_factsheets.pdf

- Best Start. (n.d.). *Reducing the Impact: Working with pregnant women who live in difficult life circumstances*. Toronto, ON: Best Start.
- Bhagat, R., Johnson, J., Grewal, S., Pandher, P., Quong, E. & Triolet, K. (2002). Mobilizing the Community to Address the Prenatal Health Needs of Immigrant Punjabi Women. *Public Health Nursing*, 19(3), pp. 209-214.
- Biggs, L. (2004). Rethinking the History of Midwifery in Canada. In, Bourgeault, I.L., Benoit, C., & Davis-Floyd, R. (Eds.), *Reconceiving Midwifery* (pp. 17-45). Montreal, QC: McGill-Queen's University Press.
- Boyd, S.C. (1999). *Mothers and Illicit Drugs: Transcending the myths*. Toronto: University of Toronto Press.
- Browne, A.J. & Fiske, J. (2001). First Nations Women's encounters with mainstream health care services. *Western Journal of Nursing Research*, 23(2), pp. 126-147.
- Browne, A.J. (2007). Clinical encounters between nurses and First Nations women in a Western Canadian Hospital. *Social Science and Medicine*, 64, pp. 2165-2176.
- Butler-Kisber, L., & Poldma, T. (2010). The power of visual approaches in qualitative inquiry: The use of collage making and concept mapping in experiential research. *Journal of Research Practice*, 6(2), Article M18. Retrieved from <http://jrp.icaap.org/index.php/jrp/article/view/197/196>
- Campbell, M. & Gregor, F. (2008). *Mapping social relations: A primer in doing institutional ethnography*. Toronto, ON: University of Toronto Press.
- Campbell, M.L. (2007). *Taking the standpoint of women to study the enacted institution: the case of internationally funded "empowerment" projects in Kyrgyzstan*. Excerpt of a paper presented in a panel at the Gender Research Network Launch Conference, University of Manchester, June 20-21, 2007. Downloaded August 13, 2013, from:
- Canadian Diabetes Association Clinical Practice Guidelines Expert Committee. Canadian Diabetes Association 2013 Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada. *Can J Diabetes* 2013;37(suppl 1):S1-S212.
- Canadian Institute for Health Information. (2006). *Giving Birth in Canada: the costs*. Ottawa, ON: CIHI.
- Canadian Midwifery Regulators Consortium. (2011). *Working Conditions*. Website. Retrieved from: <http://cmrc-ccosf.ca/node/60>

- Carroll, D. & Benoit, C. (2004). Aboriginal Midwifery in Canada: Merging Traditional Practices and Modern Science. In, Bourgeault, I.L., Benoit, C., & Davis-Floyd, R. (Eds.), *Reconceiving Midwifery* (pp. 263-286). Montreal, QC: McGill-Queen's University Press.
- CBC News (2013). Who are Canada's top 1%? Membership in the exclusive 1% club tops 272,000. *CBC News On-line Edition*, September 13, 2013. Available from: <http://www.cbc.ca/news/canada/who-are-canada-s-top-1-1.1703321>
- Colen, S. (1995). "Like a Mother to Them": Stratified reproduction and West Indian childcare workers and employers in New York. In, Ginsberg, F.D. & Rapp, R. (Eds.), *Conceiving the New World Order: the global politics of reproduction* (pp. 78-102). Berkeley, CA: University of California Press.
- College of Midwives of British Columbia (CMBC). (1997). *Philosophy of Care*. Available from: <http://www.cmhc.bc.ca/pdf.shtml?Registrants-Handbook-11-03-Philosophy-of-Care>
- College of Midwives of British Columbia (CMBC). (2013). *Midwifery Model of Practice*. Available from: <http://www.cmhc.bc.ca/pdf.shtml?Registrants-Handbook-11-05-Midwifery-Model-of-Practice>
- College of Physicians and Surgeons of Ontario. (n.d.). *CPSO Timeline*. Retrieved from <http://www.cpso.on.ca/CPSO/media/images/Home/Look-Back/CPSOTimeLine.pdf> on August 16, 2016.
- Couchie, C. & Nabigon, H. (1997). A Path Towards Reclaiming Nishnawbe Birth Culture: Can the midwifery exemption clause for Aboriginal midwives make a difference? In, Shroff, F.M. (Ed), *The New Midwifery: Reflections on renaissance and regulation* (pp 41- 50). Toronto, ON: Women's Press.
- Cull, R. (2006). Aboriginal Mothering Under the State's Gaze. In, Lavell-Harvard, D.M. & Lavell, J.C. (Eds.), "Until Our Hearts Are On The Ground: Aboriginal mothering, oppression, resistance and rebirth" (pp. 141-156). Toronto, ON: Demeter Press.
- Davis, B.M. (2008). How authoritative texts reinforce the medical model of birth. *British Journal of Midwifery*, 16(4), pp 212-217.
- Davis, R.A. (2013). Coping with Diabetes and Generational Trauma in Salish Tribal Communities. *Fourth World Journal*, 12(1), pp. 45-78.
- Denzin, N.K. & Lincoln, Y.S. (1995). Transformative Qualitative Research Methods: Is it a revolution? *Journal of Contemporary Ethnography*, 24, pp. 349-358.
- DeVault, M.L. (1999). *Liberating Method: Feminism and social research*. Philadelphia, PA: Temple University Press.

- Devault, M.L. (2006). Introduction: what is Institutional Ethnography. *Social Problems*, 53(3), pp. 294-298.
- Devault, M.L. (2013). Institutional Ethnography: a feminist sociology of institutional power. *Contemporary Sociology: A Journal of Reviews*, 42, pp. 332-340.
- Di Lallo, S. (2014). Prenatal Care Through the Eyes of Canadian Aboriginal Women. *Nursing for Women's Health*, 18(1), pp. 38-46.
- Diamond, T. (1986). Social Policy and Everyday Life in Nursing Homes: A critical ethnography. *Social Science and Medicine*, 23(12), pp. 1287-1295.
- Downe, S., Finlayson, K., Walsh, D. & Lavender, T. (2009). Weighing up and balancing out: A metasynthesis of barriers to prenatal care for marginalized women in high-income countries. *BJOG*, 11(6), pp. 518-529.
- Ehrenreich, B. and English, D. (1973). *Witches, Midwives, and Nurses: A history of women healers*. New York: Feminist Press.
- End Legislated Poverty. (2001). *Women in Poverty Kit: Educating for systemic change*. Vancouver: author.
- Fee, E. (1975). Women and health care: a comparison of theories. *International Journal of Health Services*, 5(3), pp. 397-415.
- Feminist Alliance for International Action (FAIA). (2007). *Pay Equity in Canada*. Accessed November 4, 2011, from: <http://www.fafia-afai.org/en/story/pay-equity-and-women-canada>
- First Call. (2014). *2014 Child Poverty Report Card*. Vancouver, BC: First Call BC Child and Youth Advocacy Coalition.
- Fiske, J. (1992). Carrier Women and the Politics of Mothering. In, Creese, J. & Strong-Boag, V.J. (Eds.), *British Columbia Reconsidered: Essays on women* (pp. 198-216). Vancouver, BC: Press Gang Publishers.
- Fournier, S. & Crey, E. (1997). *Stolen from our embrace: The abduction of First Nations children and the restoration of aboriginal communities*. Vancouver, BC: Douglas & McIntyre.
- Galvez, A. (2011). *Patient Citizens, Immigrant Mothers: Mexican women, public prenatal care, and the birth-weight paradox*. New Jersey: Rutgers University Press.
- Gasson, N.R., Sanderson, L.J., Burnett, G. & van der Meer, J. (2015). 'It's all he's going to say': Using poetic transcription to explore students' mainstream and residential school experiences. *Disability and Society*, 30(5), pp. 731-742.

- Greaves, L., Pederson, A., Varcoe, C., Poole, N., Morrow, M., Johnson, J. & Irwin, L. (2004). Mothering under duress: Women caught in a web of discourses. *Journal of the Association for Research on Mothering*, 6(1), pp. 16-27.
- Griffith, A.I. & Smith, D.E. (2005). *Mothering for schooling*. The Critical Social Thought Series. New York, NY: Routledge-Falmer.
- Gündüz, Z.Y. (2013). The Feminization of Migration: Care and the New Emotional Imperialism, *Monthly Review*, December, 2013.
- Hartsock, N.C.M. (1987). The Feminist Standpoint: Developing the ground for a specifically feminist historical materialism. In, Harding, S. (ed.), *Feminism and Methodology* (pp. 157-180). Bloomington, Indiana: Indiana University Press.
- Hartsock, N.C.M. (2002). The Feminist Standpoint Revisited. In, Holmstrom, N. (Ed.), *The Socialist Feminist Project: A contemporary reader in theory and politics* (pp. 350-359). New York, NY: Monthly Review Press.
- Heaman, M., Bayrampour, H., Kingston, D., Blondel, B., Gissler, M., Roth, C., Alexander, S. & Gagnon, A. (2013). Migrant Women's Utilization of Prenatal Care: a systematic review. *Maternal and Child Health Journal*, 17(5), pp. 816-836.
- Heaman, M.I., Green, C.G., Newburn-Cook, C.V., Elliot, L.J., & Helewa, M.E. (2007). Social Inequalities in Use of Prenatal Care in Manitoba. *Journal of Obstetrics and Gynecology of Canada*, 29(10), pp. 806-816.
- hooks, b. (1984). *Feminist Theory: From margin to center*. Boston, MA: South End Press.
- Hunter, J. (Feb 24, 2014). Despite promises, B.C. Liberals haven't cracked down on doctors' fees. *Globe and Mail*. <http://www.theglobeandmail.com/news/british-columbia/despite-promises-bc-liberals-havent-cracked-down-on-doctors-fees/article17061526/>
- Ickovics, J.R., Kershaw, T.S., Westdahl, C., Rising, S.S., Klima, C., Reynolds, H., & Magriples, U. (2003). Group prenatal care and preterm birthweight: Results from a matched cohort study at public clinics. *Obstetrics & Gynecology*, 102(5), pp. 1051-1057.
- International League of Peoples Struggles (ILPS). (2001). Dare to Struggle for a New World [Conference Proceedings]. *Documents of the First International Assembly of the International League of Peoples Struggles*. Zutphen, The Netherlands: ILPS.

- International League of Peoples Struggles (ILPS). (2011). Build a Bright Future! Mobilize the people to resist exploitation and oppression amidst protracted global depression, state terrorism, and wars of aggression [Conference Proceedings]. *Documents of the Fourth International Assembly of the International League of Peoples Struggles*. Manila, Philippines: ILPS.
- Ivanova, I. & Klein, S. (2014). *Working for a Living Wage: Making paid work meet basic family needs in Metro Vancouver* [2014 Update]. Vancouver, BC: Canadian Center for Policy Alternatives, First Call, and the Living Wage for Families Campaign.
- Jordan, B. (1993). *Birth in Four Cultures: A cross-cultural investigation of childbirth in Yucatan, Holland, Sweden, and the United States* (4th Ed.). Prospect Heights, IL: Waveland Press.
- Jordan, N. (2004). Force of Nature, Force of Law: Regulating Midwifery in British Columbia: An ecofeminist testimony. *Journal of the Association of Research on Mothering*, 6(1), pp. 85-92.
- Kornelsen, J. & Carty, E. (2004). Challenges to Midwifery Integration: Interprofessional Relationships in British Columbia. In, Bourgeault, I.L., Benoit, C., & Davis-Floyd, R. (Eds.), *Reconceiving Midwifery* (pp. 111-130). Montreal, QC: McGill-Queen's University Press.
- Kotaska, A. (2011). Guideline-Centered Care: A two-edged sword [Guest Editorial]. *BIRTH*, 38(2), pp. 97-98.
- Krieger N., Chen, J.T. & Selby, J.V. (2001). Class Inequalities in Women's Health: Combined impact of childhood and adult social class – a study of 630 US women. *Public Health*, 115, pp. 175-185.
- Lazarus, E.S. (1994). What Do Women Want? Issues of choice, control, and class in pregnancy and childbirth. *Medical Anthropology Quarterly*, 8(1), p. 25.
- Lewontin, R. & Levins, R. (2007). *Biology Under the Influence: Dialectical essays on ecology, agriculture, and health*. New York, NY: Monthly Review Press.
- Little, M., Gorman, A., Dzendoletas, D. & Moravac, C. (2007). Caring for the Most Vulnerable: A collaborative approach to supporting pregnant homeless youth. *Nursing for Women's Health*, 11(5), pp. 459-466.
- Malik, L. (2004). Giving Birth to New Traditions. *Herizons*, 17(3), 47.
- Massey, Z., Rising, S.S., Ickovics, J. (2006). Centering Pregnancy group prenatal care: Promoting relationship-centred care. *Journal of Obstetrical, Gynecological and Neonatal Nurses*, 35(2), pp. 286-294.

- McCarthy, R. & Haith-Cooper, M. (2013). Evaluating the Impact of Befriending for Pregnant Asylum-seeking and Refugee Women. *British Journal of Midwifery*, 21(6), pp. 404-409.
- McCormack, K. (2004). Resisting the Welfare Mother: The power of welfare discourse and tactics of resistance. *Critical Sociology*, 30(2), pp. 355-383.
- McGibbon, E., Peter, E. & Gallop, R. (2010). An Institutional Ethnography of Nurses Stress. *Qualitative Health Research*, 20(10), pp. 1353-1378.
- Medical Services Commission. (2015). *Financial Statement for the fiscal year ended March 31, 2015* [Gov't Publication]. Victoria, BC: BC Ministry of Health.
- Midwives Association of British Columbia (2017). Find a Midwife [webpage], available at: https://www.bcmidwives.com/find-a-midwife.html?map_search=
- Milligan, R., Wingrove, B.K., Richards, L., Rodan, M., Monroe-Lord, L., Jackson, V., Hatcher, B., Harris, C., Henderson, C. & Johnson, A.A. (2002). *Perceptions About Prenatal Care: Views of urban vulnerable groups*. *BMC Public Health*, 2(1), p. 25-34.
- Minkler, M. & Wallerstein, N. (1997). Improving Health through Community Organization and Community Building. In, Minkler M ed., *Community organizing and community building for health*, 1st edition, pp. 279-307. New Brunswick: Rutgers University Press.
- Morrow, M. & Hankivsky, O. (2007). Feminist methodology and health research: Bridging trends and debates. In, Morrow, M., Hankivsky, O. & Varcoe, C. (Eds), *Women's Health in Canada: Critical perspectives on theory and policy* (pp. 93-123). Toronto, ON: University of Toronto Press.
- Nagahawatte, N.T. & Goldenberg, R.L. (2008). Poverty, Maternal Health, and Adverse Pregnancy Outcomes. *Annals of the New York Academy of Sciences*, 1136, pp. 80-85.
- Navarro, V. (2009). What we mean by the social determinants of health. *Global Health Promotion*, 16(1), 6-16.
- Navarro, V. (1983). Radicalism, Marxism, and Medicine. *International Journal of Health Services*, 13(2), 179-202.
- Nestel, S. (2006). *Obstructed Labour: Race and gender in the re-emergence of midwifery*. Vancouver, BC: UBC Press.

- Nestel, S. (2004). The Boundaries of Professional Belonging: How race has shaped the re-emergence of midwifery in Ontario. In, Bourgeault, I.L., Benoit, C., & Davis-Floyd, R. (Eds.), *Reconceiving Midwifery* (pp. 287-305). Montreal, QC: McGill-Queen's University Press.
- Ng, R. (1996). *The Politics of Community Services: Immigrant Women, Class and the State*. Nova Scotia: Fernwood Press.
- Oakley, A. (1998). Gender, Methodology, and People's Ways of Knowing: Some problems with feminism and the paradigm debate in social science. *Sociology*, 32(4), pp. 707-731.
- OSCAR EMR. (2016). OSCAR [website]. Accessed September 9, 2016, from: <https://oscar-emr.com/oscar/>
- Patel, S. & Al-Jazairi, I. (1997). Colonized Wombs. In, Shroff, F.M. (Ed), *The New Midwifery: Reflections on renaissance and regulation* (pp 51 - 81). Toronto, ON: Women's Press.
- Porpora, D.V. (1989). Four Concepts of Social Structure. *Journal of the Theory of Social Behaviour*, 19(2), pp. 195-211.
- Program Demand Group. (2002). Towards a Program of Resistance. Los Angeles: Labour/Community Strategy Centre. Available from: http://www.ahorano.org/Toward_a_Program_of_Resistance.pdf
- PSBC (2010). *Maternity Care Pathway*. [BCPHP Obstetric Guideline 19]. Vancouver, BC: B.C. Perinatal Health Program.
- PSBC (2011). *Antenatal Record 1 and 2*. Vancouver, BC: BC Perinatal Health Program. Available for download here: http://www.perinatalservicesbc.ca/Documents/Form/Form1582_AntenatalRecord1and2.pdf
- PSBC (2012). *BC Perinatal Surveillance, 2002/2003 to 2011/2012: Birth indicators by place of residence for British Columbia*. Vancouver, BC: Perinatal Services BC.
- Queen's Printer. (2016). *Health Professions Act* [[RSBC 1996] CHAPTER 183]. Victoria, BC, available from: http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96183_01
- Quénart, A. (1992). Risky Business: Medical definitions of pregnancy. In, Currie, D (Ed.), *Anatomy of Gender: Women's Struggles for the Body*, pp. 160-173. Ontario: Carleton University Press.

- Rankin, J. (2001). Texts in Action: How nurses are doing the fiscal work of health care reform. *Studies in Cultures, Organizations, and Societies*, 7, pp. 251-267.
- Reid, C. & Tom, A. (2006). Poor Women's Discourses of Legitimacy, Poverty, and Health. *Gender & Society*, 20(3), 402-421.
- Reuter, L., Neufeld, A. & Harrison, M.J. (1995). Using Critical Feminist Principles to Analyze Programs for Low-Income Urban Women. *Public Health Nursing*, 12(6), p. 425.
- Rice, A.J. (1997). Becoming Regulated: The re-emergence of midwifery in British Columbia. In, Shroff, F.M. (Ed), *The New Midwifery: Reflections on renaissance and regulation* (pp 149 - 179). Toronto, ON: Women's Press.
- Ricketts, T.C. & Goldsmith, L.J. (2005). Access in Health Services Research: The battle of frameworks. *Nursing Outlook*, 53(6), pp. 274-280.
- Rising, S.S, Kennedy, H.P., & Klima, C.S. (2004). Redesigning prenatal care through CenteringPregnancy. *Journal of Midwifery and Women's Health*, 49(5), pp. 398-404.
- Rising, S.S. (1998). Centering pregnancy: An interdisciplinary model of empowerment. *Journal of Nurse-Midwifery*, 43(1), pp. 46-54.
- Sable, M.R. & Wilkinson, D.S. (1999). The Role of Perceived Stress on Prenatal Care Utilization: Implications for Social Work Practice. *Health and Social Work*, 24(2), pp. 138-146.
- Scott, John. (2005). Where Is Social Structure? Pp. 77-84, In José López and Gary Potter (Eds.). *After Postmodernism: An Introduction to Critical Realism*. London: Continuum International Publishing.
- Sharpe, M. (1997). Ontario Midwifery in Transition: An exploration of midwives' perspectives of the impact of midwifery legislation in its first year. In, Shroff, F.M. (Ed), *The New Midwifery: Reflections on renaissance and regulation* (pp 201 - 244). Toronto, ON: Women's Press.
- Sharpe, M. (2004). Exploring Legislated Midwifery: Texts and Rulings. In, Bourgeault, I.L., Benoit, C., & Davis-Floyd, R. (Eds.), *Reconceiving Midwifery* (pp. 150-168). Montreal, QC: McGill-Queen's University Press.
- Smith, D.E. (2005). *Institutional ethnography: A sociology for people*. The Gender Lens Series. Lanham, MD: AltaMira Press.
- Smith, D.E. (2001). Texts and the ontology of organizations and institutions. *Studies in Cultures, Organizations and Societies*, 7(2), pp 159-198.

- Smith, D.E. (1988). *The everyday world as problematic: A feminist sociology*. Toronto, ON: University of Toronto Press.
- Smith, D.E. (1977). *Feminism and Marxism: A place to begin, a way to go*. Vancouver, BC: New Star Books.
- South Community Birth Program. (2006). *The South Community Birth Program final report: 2003-2006* (A Primary Health Care Transition Fund program). Vancouver, BC: author.
- Stark, E. (1982). Doctors in Spite of Themselves: The limits of radical health criticism. *International Journal of Health Services*, 12(3), pp. 419-457.
- Stewart, D.E., Gagnon, A.J., Merry, L.A., & Dennis, C. (2012). Risk Factors and Health Profiles of Recent Migrant Women Who Experienced Violence Associated with Pregnancy. *Journal of Women's Health*, 21(10), pp. 1100-1106.
- Strong-Boag, V. & McPherson, K. (1992). The Confinement of Women: Childbirth and hospitalization in Vancouver, 1919-1939. In, Creese, G. & Strong-Boag, V. (Eds.), *British Columbia Reconsidered: Essays on women* (pp. 143-171). Vancouver, BC: Press Gang Publishers.
- Sword, W. (1999). A Socio-Ecological Approach to Understanding Barriers to Prenatal Care for Women of Low Income. *Journal of Advanced Nursing*, 29(5), pp. 1170-1177.
- Sword, W. (2003). Prenatal Care Use Among Women of Low Income: A matter of `taking care of self`. *Qualitative Health Research*, 13(3), pp. 319-332.
- Townson, M. (2009). *Women's Poverty and the Recession*. Ottawa, ON: Canadian Centre for Policy Alternatives.
- Van Wagner, V. (2004). Why Legislation? Using regulation to strengthen midwifery. In, Bourgeault, I.L., Benoit, C., & Davis-Floyd, R. (Eds.), *Reconceiving Midwifery* (pp. 71-90). Montreal, QC: McGill-Queen's University Press.
- Varcoe, C., Brown, H., Calam, B., Harvey, T., and Tallio, M. (2013). Help Bring Back the Celebration of Life: A community-based participatory study of rural Aboriginal women's maternity experiences and outcomes. *BMC Pregnancy and Childbirth*, 13(26), available from: www.biomedcentral.com/1471-2393/13/26
- Waldstein, A. (2010). Popular Medicine and Self-Care in a Mexican Migrant Community: Toward an explanation of an epidemiological paradox. *Medical Anthropology*, 29(1), pp. 71-107.

- Wall, N.B. (1993). The Beautiful Strength of My Anger Put To Use: Women against poverty in Canada. In, L. Carty (Ed.), *And Still We Rise: Feminist political mobilizing in contemporary Canada*. Toronto, Women's Press.
- Whiting, M. & Sines, D. (2012). Mind maps: establishing 'trustworthiness' in qualitative research. *Nurse Researcher*, 20(1), pp. 21-27.
- Whitty-Rogers, J., Etowa, J., & Evans, J. (2006). Childbirth Experiences of Women from One Mi'kmaq Community in Nova Scotia. In, Lavell-Harvard, D.M. & Lavell, J.C. (Eds.), *"Until Our Hearts Are On The Ground: Aboriginal mothering, oppression, resistance and rebirth"* (pp. 34-61). Toronto, ON: Demeter Press.
- WHO Prenatal Care Trial Research Group (2002). *WHO Prenatal Care Randomized Trial: Manual for the Implementation of the New Model*. Geneva: World Health Organization.
- WHO. (2012). *Recommendations on Maternal and Perinatal Health*. Geneva: WHO.
- Widerberg, K. (2004). Institutional Ethnography: Towards a productive sociology. An interview with Dorothy E. Smith. *Sociologisk Tidskrift*, 12(2), 2004.
- Williamson, D.L., Stewart, M.J., Hayward, K., Letourneau, N., Makwarimba, E., Masuda, J., Raine, K., Reutter, L., Rootman, I. & Wilson, D. (2006). Low-income Canadians' Experiences With Health-related Services: Implications for health care reform. *Health Policy*, 76, pp. 106-121.
- Wilson, J., Mandich, A. & Magalhaes, L. (2016). Concept Mapping: A dynamic, individualized and qualitative method for eliciting meaning. *Qualitative Health Research*, 26(8), pp. 1151-1161.
- Women in Transit (WIT) Team. (2005). *Women in Transit: Organizing for social justice in our communities*. Vancouver, BC: Bus Riders Union.
- Zhang, S., Cardarelli, K., Shim, R., Ye, J., Booker, K.L. & Rust, G. (2013). Racial Disparities in Economic and Clinical Outcomes of Pregnancy Among Medicaid Recipients. *Maternal and Child Health Journal*, 17, pp. 1518-1525.
- Zhu, P., Tao, F., Hao, J., Sun, Y., and Jiang, X. (2010). Prenatal life events stress: implications for preterm birth and infant birthweight. *American Journal of Obstetrics & Gynecology*, 34, e1-8.

Appendix A.

Perinatal Services BC Antenatal Record Part 1&2 (6 pages)



TWEAK Score

Questionnaire on Alcohol Use During Pregnancy

*To be completed **early** in **all** pregnancies*

When having a baby one of the areas your care provider will talk about is your use of alcohol. The following questions will help with the discussion.

- | | |
|---|--|
| How many drinks does it take to make you feel high? | Number of drinks _____ |
| Have close friends or relatives worried or complained about your drinking in the past year? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Do you sometimes have a drink in the morning when you first get up? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Do you sometimes feel the need to cut down on your drinking? | <input type="checkbox"/> No <input type="checkbox"/> Yes |

Talk about your answers to the above questions with your health care provider.

Source: Russell, M (1994). New Assessment tools for risk drinking during pregnancy: T-ACE, TWEAK and others. Alcohol Health and Research World.



Perinatal Services BC

An agency of the Provincial Health Services Authority

Edinburgh Perinatal/Postnatal Depression Scale (EPDS)

For use between **28–32 weeks** in **all** pregnancies

Name: _____ Date: _____ Gestation in Weeks: _____

As you are having a baby, we would like to know how you are feeling. Please mark “X” in the box next to the answer which comes closest to how you have felt in the past 7 days—not just how you feel today.

In the past 7 days:

- | | |
|---|--|
| 1. I have been able to laugh and see the funny side of things
<input type="checkbox"/> As much as I always could
<input type="checkbox"/> Not quite so much now
<input type="checkbox"/> Definitely not so much now
<input type="checkbox"/> Not at all | 6. Things have been getting on top of me
<input type="checkbox"/> Yes, most of the time I haven't been able to cope
<input type="checkbox"/> Yes, sometimes I haven't been coping as well as usual
<input type="checkbox"/> No, most of the time I have coped quite well
<input type="checkbox"/> No, I have been coping as well as ever |
| 2. I have looked forward with enjoyment to things
<input type="checkbox"/> As much as I ever did
<input type="checkbox"/> Rather less than I used to
<input type="checkbox"/> Definitely less than I used to
<input type="checkbox"/> Hardly at all | 7. I have been so unhappy that I have had difficulty sleeping
<input type="checkbox"/> Yes, most of the time
<input type="checkbox"/> Yes, sometimes
<input type="checkbox"/> Not very often
<input type="checkbox"/> No, not at all |
| 3. I have blamed myself unnecessarily when things went wrong
<input type="checkbox"/> Yes, most of the time
<input type="checkbox"/> Yes, some of the time
<input type="checkbox"/> Not very often
<input type="checkbox"/> No, never | 8. I have felt sad or miserable
<input type="checkbox"/> Yes, most of the time
<input type="checkbox"/> Yes, quite often
<input type="checkbox"/> Not very often
<input type="checkbox"/> No, not at all |
| 4. I have been anxious or worried for no good reason
<input type="checkbox"/> No, not at all
<input type="checkbox"/> Hardly ever
<input type="checkbox"/> Yes, sometimes
<input type="checkbox"/> Yes, very often | 9. I have been so unhappy that I have been crying
<input type="checkbox"/> Yes, most of the time
<input type="checkbox"/> Yes, quite often
<input type="checkbox"/> Only occasionally
<input type="checkbox"/> No, never |
| 5. I have felt scared or panicky for no very good reason
<input type="checkbox"/> Yes, quite a lot
<input type="checkbox"/> Yes, sometimes
<input type="checkbox"/> No, not much
<input type="checkbox"/> No, not at all | 10. The thought of harming myself has occurred to me
<input type="checkbox"/> Yes, quite often
<input type="checkbox"/> Sometimes
<input type="checkbox"/> Hardly ever
<input type="checkbox"/> Never |

Talk about your answers to the above questions with your health care provider.

Translations for care-provider use available on PSBC website: perinatalervicesbc.ca.

The Royal College of Psychiatrists 1987. From Cox, JL, Holden, JM, Sagovsky, R (1987). Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*. 150, 782–786. Reprinted with permission.

PSBC 1582 Addendum 2 – OCTOBER 2011 ©Perinatal Services BC

British Columbia Antenatal Record Part 1

1. Hospital		Attending physician/midwife:		Referring physician/midwife:	
Mother's name			Date of birth (DD/MM/YYYY)	Age at EDD	Surname
Mother's maiden name			Ethnic origin	Language preferred	Given name
Occupation			Work hrs./day	No. of school yrs. completed	Address
Partner's name		Age	Ethnic origin of newborn's father	Partner's work	Phone number
					Personal health number

2. Allergies <input type="checkbox"/> None known <input type="checkbox"/> Yes (reaction)		Medications/herbals		Beliefs & practices	
---	--	---------------------	--	---------------------	--

3. Obstetrical History		Gravida		Term		Preterm		Abortion (Induced Spontaneous)		Living		Children			
Date	Place of birth/abortion	Hrs. in labour	Gest. age	Type of birth	Perinatal complications				Sex	Birth Weight	Breastfed	Present health			

4. LMP (DD/MM/YYYY)	Menses cycle	Contraceptives	When stopped (DD/MM/YYYY)	EDD by dates (DD/MM/YYYY)	Confirmed EDD (DD/MM/YYYY)	1st US (DD/MM/YYYY)	GA by US (WEEKS + DAYS)
---------------------	--------------	----------------	---------------------------	---------------------------	----------------------------	---------------------	-------------------------

5. Present Pregnancy		7. Medical History		8. Lifestyle & Social	
No		No		Discussed	
Yes (specify)		Yes (specify)		Concerns Referred	
<input type="checkbox"/> IVF pregnancy <input type="checkbox"/> Bleeding <input type="checkbox"/> Nausea <input type="checkbox"/> Infections or fever <input type="checkbox"/> Other		<input type="checkbox"/> Surgery <input type="checkbox"/> Anesthesia <input type="checkbox"/> Uterine/Cx procedure <input type="checkbox"/> STIs/infections <input type="checkbox"/> Susceptible to chicken pox <input type="checkbox"/> Thromboembolic/coag. <input type="checkbox"/> Hypertension <input type="checkbox"/> GI <input type="checkbox"/> Urinary <input type="checkbox"/> Endocrine/diabetes <input type="checkbox"/> Neurologic <input type="checkbox"/> Hx of mental illness		<input type="checkbox"/> Diet/Food Safety <input type="checkbox"/> Folic acid <input type="checkbox"/> Physical Activity/rest/work <input type="checkbox"/> OTC drugs/vitamins <input type="checkbox"/> Alcohol <input type="checkbox"/> never <input type="checkbox"/> quit (DD/MM/YYYY) Drinks/wk: before pregnancy _____ current _____ Binge drinking <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> TWEAK score _____ (see reverse) <input type="checkbox"/> Substance use <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Heroin <input type="checkbox"/> Cocaine <input type="checkbox"/> Marijuana <input type="checkbox"/> Methadone <input type="checkbox"/> Solvents <input type="checkbox"/> Other <input type="checkbox"/> Prescription <input type="checkbox"/> Unknown <input type="checkbox"/> Smoking <input type="checkbox"/> never <input type="checkbox"/> quit (DD/MM/YYYY) Cig/day: before pregnancy _____ current _____ <input type="checkbox"/> Exposure 2nd hand smoke <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Financial & housing <input type="checkbox"/> Support system <input type="checkbox"/> IPV <input type="checkbox"/> Public Health Nursing follow-up/assessment	
6. Family History No Yes (specify)		Maternal Newborn's Father		Plans to breastfeed	
<input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Depression/psychiatric <input type="checkbox"/> Alcohol/drug use <input type="checkbox"/> Thromboembolic/coag. <input type="checkbox"/> Inherited disease/defect <input type="checkbox"/> Ethnic (e.g. Tay Sachs, Sickle) <input type="checkbox"/> Other		<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Bipolar <input type="checkbox"/> PP depression <input type="checkbox"/> Unknown <input type="checkbox"/> Other		<input type="checkbox"/> Prenatal Genetic Screening <input type="checkbox"/> Genetic counselling offered <input type="checkbox"/> HIV & other tests <input type="checkbox"/> Yes <input type="checkbox"/> Baby's Best Chance <input type="checkbox"/> Prenatal education <input type="checkbox"/> Breastfeeding <input type="checkbox"/> No <input type="checkbox"/> Seat belt use <input type="checkbox"/> Sexual relations <input type="checkbox"/> Maybe	

9. Physical Examination					10. First Trimester Topics Discussed:				
Date (DD/MM/YYYY)	BP	Height (cm)	Pre-pregnant weight (kg)	Pre-pregnant BMI	Plans to breastfeed				
Head & neck					Musculoskeletal				
Breasts & nipples					Varicels & skin				
Heart & lungs					Pelvic exam				
Abdomen					Swabs/cervix cytology				

11. Summary	
SIGNATURE:	MD/MW

[illegible]

Edinburgh Perinatal/Postnatal Depression Scale (EPDS)

SCORING GUIDE

1. I have been able to laugh and see the funny side of things
 - 0 As much as I always could
 - 1 Not quite so much now
 - 2 Definitely not so much now
 - 3 Not at all
2. I have looked forward with enjoyment to things
 - 0 As much as I ever did
 - 1 Rather less than I used to
 - 2 Definitely less than I used to
 - 3 Hardly at all
3. I have blamed myself unnecessarily when things went wrong
 - 3 Yes, most of the time
 - 2 Yes, some of the time
 - 1 Not very often
 - 0 No, never
4. I have been anxious or worried for no good reason
 - 0 No, not at all
 - 1 Hardly ever
 - 2 Yes, sometimes
 - 3 Yes, very often
5. I have felt scared or panicky for no very good reason
 - 3 Yes, quite a lot
 - 2 Yes, sometimes
 - 1 No, not much
 - 0 No, not at all
6. Things have been getting on top of me
 - 3 Yes, most of the time I haven't been able to cope
 - 2 Yes, sometimes I haven't been coping as well as usual
 - 1 No, most of the time I have coped quite well
 - 0 No, I have been coping as well as ever
7. I have been so unhappy that I have had difficulty sleeping
 - 3 Yes, most of the time
 - 2 Yes, sometimes
 - 1 Not very often
 - 0 No, not at all
8. I have felt sad or miserable
 - 3 Yes, most of the time
 - 2 Yes, quite often
 - 1 Not very often
 - 0 No, not at all
9. I have been so unhappy that I have been crying
 - 3 Yes, most of the time
 - 2 Yes, quite often
 - 1 Only occasionally
 - 0 No, never
10. The thought of harming myself has occurred to me
 - 3 Yes, quite often
 - 2 Sometimes
 - 1 Hardly ever
 - 0 Never

A score of 1–3 to item 10 indicating a risk of self-harm, requires immediate mental health assessment and intervention as appropriate.

Scoring of 11–13 range, monitor, support, and offer education.

Scoring of 14 or higher, follow up with comprehensive bio-psychosocial diagnostic assessment for depression.

*Source: Cox, JL Cox, Holden, JM, Sagovsky, R (1987)
Department of Psychiatry, University of Edinburgh*

TWEAK SCORING GUIDE

T	Tolerance: "How many drinks does it take to make you feel high?" (Or this can be modified to "How many drinks can you hold?") Record number of drinks.	3 or more drinks = 2 points
W	Worry: "Have close friends or relatives worried or complained about your drinking in the past year?"	Yes = 2 points
E	Eye-Opener: "Do you sometimes have a drink in the morning when you first get up?"	Yes = 1 point
A	Amnesia (Blackout): Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?	Yes = 1 point
K (C)	Cut Down: "Do you sometimes feel the need to cut down on your drinking?"	Yes = 1 point

A score of 2 or more points indicates a risk of a drinking problem.

*Source: Russell, M (1994). New Assessment tools for risk drinking during pregnancy:
T-ACE, TWEAK and others. Alcohol Health and Research World.*

RISK ASSESSMENT GUIDE

PAST OBSTETRICAL HISTORY

- ☐ Abortion (12–20 weeks)
- ☐ Cesarean birth (uterine surgery)
- ☐ Habitual abortion (3+)
- ☐ Hypertensive disorders of pregnancy
- ☐ IUGR baby
- ☐ Macrosomic baby
- ☐ Major congenital anomalies (e.g. Cardiac, CNS, Down Syndrome)
- ☐ Neonatal death
- ☐ Placental abruption
- ☐ Postpartum hemorrhage
- ☐ Preterm birth (< 37 weeks)
- ☐ Rh isoimmunization (affected infant)
- ☐ Rh isoimmunization (unaffected infant)
- ☐ Stillbirth

PROBLEMS IN CURRENT PREGNANCY

- ☐ Abnormal maternal serum screening (HCG or AFP > 2.0 MOM)
- ☐ Alcohol and/or drugs
- ☐ Anemia (< 100 g per L)
- ☐ Antepartum bleeding
- ☐ Blood antibodies (Rh, Anti C, Anti K etc.)
- ☐ Breasts—no change in size, inverted nipple(s)
- ☐ Decreased fetal movement
- ☐ Depression
- ☐ Diagnosis of large for dates
- ☐ Diagnosis of small for dates (IUGR)
- ☐ Gestational diabetes
- ☐ Hypertensive disorders of pregnancy
- ☐ Malpresentation
- ☐ Membranes rupture before 37 weeks
- ☐ Multiple pregnancy
- ☐ Polyhydramnios or oligohydramnios
- ☐ Poor weight gain 26–36 weeks (< .5 kg/wk or weight loss)
- ☐ Pregnancy > 42 weeks
- ☐ Preterm labour
- ☐ Proteinuria 1+ or greater
- ☐ Smoking any time during pregnancy

MEDICAL HISTORY

DIABETES

- ☐ Controlled by diet only
- ☐ Insulin dependent
- ☐ Retinopathy documented

HEART DISEASE

- ☐ Asymptomatic (no effect on daily living)
- ☐ Symptomatic (affects daily living)

HYPERTENSION

- ☐ 140/90 or greater
- ☐ Anti-hypertensive drugs
- ☐ Chronic renal disease

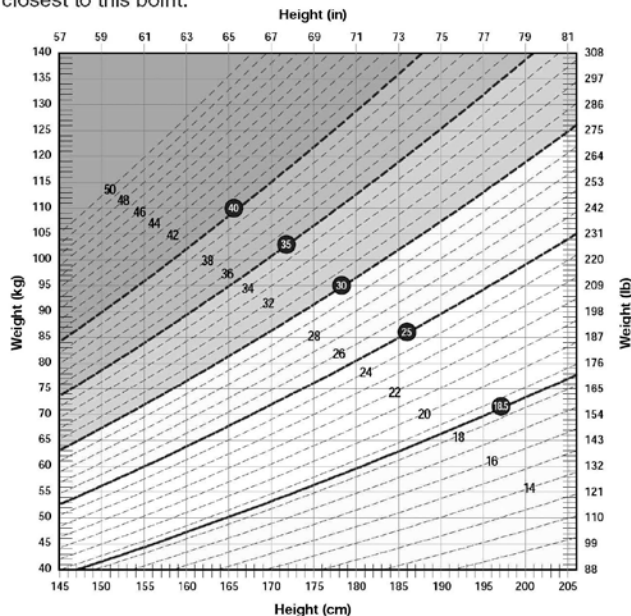
OBESITY (BMI > 30)

- ☐ Medical complications eg. diabetes, hypertension, cardiac, pulmonary disease, obstructive sleep apnea
- ☐ Venous thromboembolism risks
- ☐ Anesthetic risks

OTHER

- ☐ Age under 18 at delivery
- ☐ Age 35 or over at delivery
- ☐ Alcohol and/or drugs
- ☐ BMI less than 18.5 (Underweight)
- ☐ Depression
- ☐ Height (under 152 cm or 5 ft. 0 in.)
- ☐ Hx breastfeeding difficulties
- ☐ Smoking
- ☐ Other medical/surgical disorders eg. epilepsy, severe asthma, Lupus etc.

To estimate Pre-pregnancy BMI, locate the point on the chart where height and weight intersect. Read the number on the dashed line closest to this point.



Source: Health Canada. Canadian Guidelines for Body Weight Classification in Adults. Ottawa: Minister of Public Works and Government Services Canada; 2003.

Health Risk Classification According to BMI

Classification	BMI	Risks of developing health problems
Underweight	< 18.5	Increased
Normal	18.5–24.9	Least
Overweight	25–29.9	Increased
Obese I	30–34.9	High
Obese II	35–39.9	Very High
Obese III	> = 40	Extremely High

Appendix B. Sample interview questions:

1. Tell me about your experiences of prenatal care.
2. How did you decide to see (a particular) care provider?
3. Describe to me what happened when you went to see (your care provider).
4. What did you like or dislike about prenatal care? What was helpful?
5. Did you ever feel judged? Supported? Were there times when you needed help?
6. Was there anything you were worried about?
7. Did you have a good relationship with your care provider?
8. How did your relationship with your care provider shape your experience of care?
9. Did anything happen that you particularly appreciated? Was there anything that you particularly disliked?