Sheway:
Supporting Choice and Self-Determination

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Abstract

In Canada's poorest neighbourhood, the women at Sheway access services in a way that supports self-determination and choice. The program aims to enhance resilience and well-being of women during pregnancy and in the post-natal period with support from a multidisplinary team and comprehensive services where no appointment is necessary. Sheway reduces isolation, promotes mutual support, and provides practical supports including meals and clothing. Women are supported to have positive early parenting experiences and receive support until their children are 18 months of age. The program objectives have evolved in response to an increasing number of clients and changing needs of the community. The 1999 formal evaluation documented that Sheway helps women better access pre- and postnatal care, improve their housing and nutrition, and retain custody of their children.

Keywords

Self-determination, harm reduction, multidisciplinary, drop-in, outreach, substance use, prenatal, pregnancy, parenting, infant development, resilience, maternal support, empowerment

INTRODUCTION

Given the relationship between health status and health determinants, Sheway is a policy and service demonstration of the success of addressing basic needs while providing access to a variety of services to a marginalized population of women in Canada's poorest neighbourhood.

WOMEN AND SHEWAY IN THE DOWNTOWN EASTSIDE

Benoit, Carroll, and Chaudhry[1] describe the context and nature of Vancouver's downtown eastside (DTES) and the Aboriginal population living in this community:

- 70 per cent of the Aboriginal population in Vancouver lives here;
- 40 per cent of the DTES population is Aboriginal;
- 70 per cent of the survival sex trade workers are Aboriginal women and mothers of at least one child;
- 50 per cent of Aboriginal families are headed by single mothers; and
- 80 per cent of the Aboriginal children in this urban ghetto live in poverty.

The DTES is home to Canada's first supervised injection site. It is also the neighbourhood where more than 60 women have gone missing: a local pig farmer is on trial for the murder of 15 of them.

The women of Sheway who live in this community are of childbearing age. They live in hunger, poverty, poor housing, inadequate health care, and fear and mistrust of health and social services. Many have experienced multiple losses; struggle with substance abuse; lack positive parenting experiences; and suffer with guilt, shame, and low self-esteem. The majority have been the victims of violence and child abuses. They experience difficulty accessing basic amenities on a daily basis. For example, primary sources of so-called affordable housing are slum hotels lacking basic amenities like a refrigerator, stove, and private bathroom: safety and security are chronically problematic in these accommodations.[2]

In the late 1980s and early 1990s, statistics from the Vancouver Health Department indicated that 29 per cent of the babies born in this area were born substance-exposed–50 per cent of these were of Aboriginal heritage. The social services ministry apprehended at least one in four infants exposed to substances in

the DTES. As well, local birthing institutions were faced with a large number of women from the DTES arriving to give birth having had no prenatal care.[3]

Sheway was created for these women in this environment. Sheway is a Coast Salish term for growth. Sheway was created as, and remains, a community-based pregnancy outreach program, a partnership initiative of community and government agencies. Over its 11 years, it has grown into a comprehensive, multidisciplinary health and social service program targeted to meet the complex needs of the substance using pregnant and parenting women in the community. Services are delivered through outreach and drop-in where there are no appointments necessary. Since its inception, the data has indicated that 65 to 80 per cent of the women who access Sheway are of Aboriginal ancestry.[4] For an overview of the program and its services, refer to the Vancouver Native Health society website at http://www.vnhs.net.

Sheway's program model is based on the recognition that the health of women and their children is linked to the conditions of their lives and their ability to influence these conditions. This foundation is key to the way in which all services are offered and delivered. Sheway staff work in partnership with women, supporting them and the decisions they make, as well as offering information, education, and assistance as asked using a harm reduction approach.

When women enter Sheway, they have access to physician and nursing services; addictions counselling and referrals; nutritional counselling; and social workers who provide guidance, advocacy, and support for those who must navigate the financial, legal, and social systems. They also have access to a multidiciplinary service support network that includes infant development support, housing support, family support, peer counselling, alternative therapies like music and energy therapies, and traditional therapies like smudging. They can receive a hot lunch, food bags, food and milk vouchers, and bus tickets to assist with transportation to necessary appointments. The services are available throughout the prenatal period and until 18 months after the birth of the child. Sheway's environment and staff respect and reflect Aboriginal heritage and history through interactions, artwork, team composition (one-third of the team members are Aboriginal people) and the availability of traditional food. While all of these services and supports are available, it is the woman who chooses and decides which services and supports she will access through her pregnancy and into her postpartum period.

CONCEPT OF CHOICE AND SELF-DETERMINATION

This concept can be quite foreign to the women initially. Often, their personal histories and their previous experiences with service agencies have left them mistrustful and fearful. At Sheway, a woman is asked if she wishes to participate in the program and is further asked what it is that she needs. She determines her priorities: housing, food, camaraderie, health, and a change of clothes to keep up with her changing body needs through her pregnancy. The staff works to accommodate her needs and support her self-determination.

The following is a composite story of a variety of Sheway participants to describe the complex lives the women lead.

> Terry grew up in a community in Northern BC and came to Vancouver with her partner four years ago when she was 17 years of age. She was pregnant with her first child and had no supports "back home." She first came to Sheway while living in a hotel in the Downtown Eastside and in need of food and housing support. She was advanced in her pregnancy and was using intravenous drugs with her partner. While at Sheway for food, she also received prenatal care from the doctors and learned she was HIV positive. The doctors and nurses worked hard with Terry and other related professionals to stabilize her drug use and to begin to manage her HIV. The Sheway team of doctors, nurses and an alcohol and drug counsellor helped her reduce her heroin use through counselling, support and education. They also helped her to get connected to Oak Tree Clinic for support on managing her HIV. As Terry coped with her recent diagnosis of HIV, she returned back to her community to get support from her family. What she found was that she was quickly stigmatized in her small rural community for having HIV and that her family and friends were not supportive. Feeling ostracized, she left. On her return to Vancouver, Terry increased her use of drugs and her relationship fell apart. She got connected back into the sex trade and was arrested. She spent the last part of her pregnancy in jail. Sheway did outreach to her in the jail. She had the baby, was released from jail and looked for drug detoxification and treatment services where she could

bring her baby with her. She couldn't find this as there is only one treatment facility for mothers and children in the province and it was full with a long waiting list. At the same time the baby was found to be HIV positive and was apprehended. Several days later Terry learned that her partner had died of AIDS.

Terry continued to use heroin and spent most of her time in hangouts in the Downtown Eastside. Despite this she always stayed in contact with Sheway and would drop by on occasion for a talk, or referral to service, or some medical attention when warranted. She began a new relationship and became pregnant again. She connected with the doctors, nurses and social workers at Sheway early in her pregnancy this time and began to get medical services and other supports immediately. When taking the bus was too much for her, the outreach worker drove her to the various appointments she needed to attend. The dietitian worked with her on her diet and nutritional needs because of her pregnancy, HIV status and methadone use.

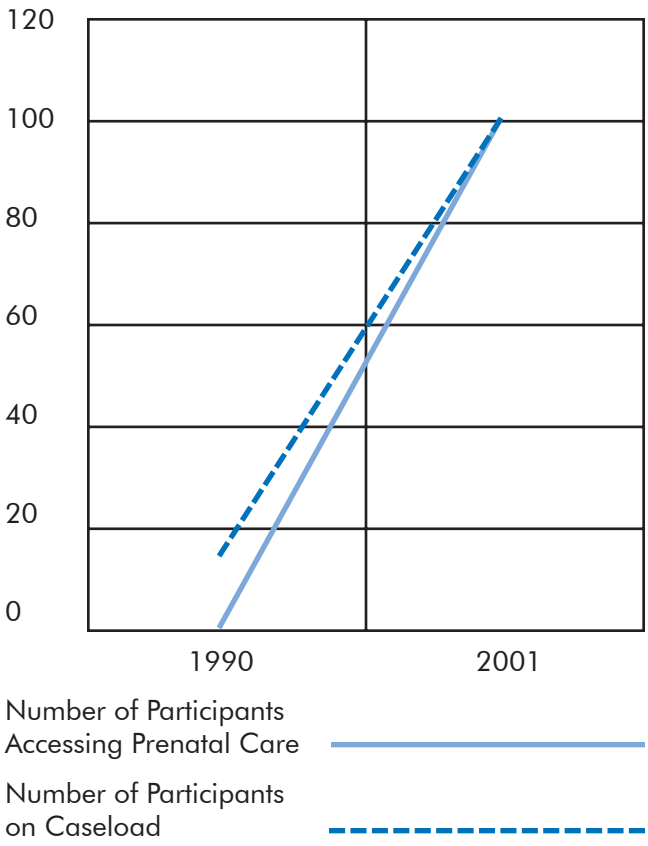
Terry started to take her AZT and vitamins regularly, and her HIV is now stable. In addition she is well connected with Oak Tree Clinic, Positive Women's Network and Positive Outlook where she is able to access more support and care. She has come in regularly to Sheway for daily hot lunches and groceries and has gained weight. She has stopped using heroin and the Sheway physicians have helped her stabilize on methadone, and manage her pregnancy and other health-related concerns. She has attended substance use treatment and continues counselling with the A&D [alcohol and drug] counsellor at Sheway. Sheway continues to provide bus tickets for her to get to other services and acts as a co-coordinator of care. She has enjoyed participating in the aboriginal crafts program offered by Sheway. She has started to envision herself as a mother and has begun to discuss with the Ministry the conditions for keeping this child. Terry has built up a relationship of trust with a Sheway physician who will be able to deliver the baby at BC Women's Hospital. The doctor and other Sheway staff have helped her devise a supportive birth and after-birth plan. Discussions on birth control have been initiated. Terry has voiced that she is glad to know Sheway staff will visit her at the hospital and she won't be alone for the birth, and that she now has a plan for the birth and after.[5]

Sheway's success lies in the fact that the team works together in this partnership with the woman. Sheway is a proven success. It has grown from 15 clients to supporting an active caseload of 100 women at any given time. Eighty per cent of the infants born to women in the program have healthy birth weights. All of the women are receiving prenatal care–90 per cent from Sheway's physicians and nurses, the remaining 10 per cent from other health services in the community (see Figure 1).

HEALTHY BIRTH WEIGHTS AND SHEWAY PARTICIPATION

Eighty-six per cent of women who had babies while accessing services at Sheway had babies with a birth weight more than 2,500 grams (five pounds

Figure 1: Prenatal Care Access and Active Caseload at Sheway (1990 to 2001)



eight ounces). This is consistent with the significant nutritional gains made by the Sheway mothers,[6] and compares favourably with levels of low birth weights in other areas of the city with lesser levels of poverty.[7] In a recent review of 1,247 Sheway maternal cases and 426 Sheway infant cases, Marshall et al.[8] identified healthy birth outcomes. There have been fewer preterm infants born to women in the program than was the case when the service opened. There has also been a drop in the incidence of low birth weight infants. However, in both instances, there has been a marked increase in the last couple of years. Marshall et al.[9] speculate that the recent increase possibly reflects maternal stress in response to decreases in provincial funding for mothers.

Longer prenatal care and reception of food bags from Sheway are correlated with a higher infant birth weight.[10]

SUPPORTING WOMEN IN THEIR INTERACTIONS WITH OUTSIDE SERVICES

An evaluation completed in 2000 included a focus group in which participants described the significant positive impact of Sheway on their lives.

> In the focus group, the clients described themselves when first arriving at Sheway, as both struggling with many issues and also capable of accessing help:
>
> I was having trouble with (Ministry) workers, and trying to get things, like what I was supposed to be getting. The staff here was really helpful and was doing a lot of phoning and being an interpreter in that sense in order for a lot of single women and single parents to get things they deserve. When they were struggling trying to get it for themselves, with their workers, they made you jump through hoops like you wouldn't believe, but Sheway, they helped interpret, be that medium between the two–and that's really a good thing to have when you're just starting off and coming off your drugs and trying to become a parent again. So I think that's what happened to me. I mean, I was a parent before but I had lost both of my kids through my addiction and stuff. Because of that I was finding it hard, trying to be a mom again and to stay off drugs. The first year, of course, I struggled, I went back out a few times. But eventually I got sick and tired of being sick and tired and they got me in a (alcohol and drug treatment) program.
>
> What brought me to Sheway when I was pregnant with my daughter is that three-month thing where you can't get on assistance because of the situation (waiting period), and I came from Kenora. And I'll never forget the first time I went to Sheway, I thought, "Oh, no, they're sending me back to Ontario, I have no food." I was seven months' pregnant, I was all scared, eh, freaking out. And okay, (Sheway said), "we'll help you the best we can." And I ended up staying at the shelter. But I know what really impressed me about them was just, you know, they were willing to help me, they didn't even know me![11]

WOMEN EXPRESS THAT THEY HAVE MADE POSITIVE CHANGES

In the evaluation, women talked about the most important change they made while getting help from Sheway. Below are several responses, each made by a different woman.

> The self-esteem I guess, like, you know, when you're first coming off the street for the first year, it's kind of rough and Sheway's there to support you and you start getting some of your self-esteem back.
>
> Because I know when we were using, did we have patience? No. "I want it now and I want it right now and if I can't have it right now, I'm going somewhere else to get it right now." You know, like we didn't have the patience, we didn't have the understanding of calming the baby, you know, instead of getting angry, or just trying to work through, you know, them teething and things like you just needed to learn patience for them, you know, like you just–you needed some patience and if you didn't get them, then it was like, forget it. So for me the most important thing that I've learned around here is patience.
>
> And them talking through things with you instead of going, "Oh, well, just, don't worry about it and blah blah blah" or

something–like they asked me how to work through the situation and they got you to do most of the work on it, you know, like the talking of whatever was going on and how to work through it, rather than just giving you answers. And that helped, right? Because of course by doing that, you keep it inside, right?

For me it was listening and connecting with other parents, because they put me into ACCESS [parenting program for young parents], they helped me so I would not be alone because I'm younger, so I guess basically they just helped me to realize that I'm not the only young parent there, kind of thing, and I could actually do it, and that basically as long as you show love to yourself and to the baby that it'll come out okay.

Being able to talk and be open with no support, you know, like you're sitting there by yourself and then going to Sheway and then with the other women there and just talking with everyone, you know, you got something in common somewhere.

To stop using drugs was the most important change.

To respect yourself.

Remember your spiritual values. Finding your real beliefs.

And don't listen to anyone who says that you can't do it–that's one big thing. I learned to value myself as a person other than just as an object, an object to go out and use men to get whatever I needed–so that's why being around all these women you know, I realized that's not all there is to life.[12]

CURRENT CHALLENGES FOR SHEWAY AND THE WOMEN SERVED

Sheway's evaluation highlighted the need for ongoing evaluation and significant improvements to data collection.[13] While Sheway is consistently described as a success and a model for working with marginalized women and families,[14] the challenge to capture data representing success in key areas like child removals and addictions presents ongoing problems. For example, current rates of removal of infants by the Ministry of Children and Family Development can include removals at birth, in the hospital, or at any point during infancy. As well, removals can be temporary or ongoing. Anecdotally, the staff is aware that the frequency of removals is less and, when a child is removed, the mother is much more involved in the decision-making processes–placing their child in care voluntarily and/or influencing decisions about placements of their child in the care of others.

Sheway strives to address the many challenges women face. Some of these issues are beyond Sheway's reach and scope of services. What adds to the situation is the increasing complexity of the lives of the women served at Sheway over the years. There has been a general increase in risk factors recorded at women's entry into Sheway. These include basic living requirements (housing, income, food), incidence of hepatitis B and C and HIV and mental illness over 10 years, as shown in Marshall et al.'s evaluation report.[15]

A NEED FOR INCREASED SERVICES FOR WOMEN AND THEIR CHILDREN AGED 18 MONTHS TO FIVE YEARS

Sheway staff find it difficult to discontinue service to women at the 18-month point as there are few services for children in the 18-month to five-year period. In the words of one of the clients:

> A suggestion I could give would be that if they could change their age bracket to, like, five. Once a kid gets into school, you've got the resources through the school to be able to help you, but up until they're five years old, you still need help with a lot of development things that are happening.[16]

Two other programs in North America provide comparable comprehensive services to pregnant and parenting women with past or present substance use issues. Breaking the Cycle is in Toronto and supports the family until the child is five years old. The Seattle program Birth to Three is now called Parent-Child Assistance Program and provides support until the child is three years old.

Ideas for support of both parents and children in this critical period of early intervention include:

- therapeutic child care programs;
- housing programs operating as satellites to outreach, withdrawal management, and treatment programs;

- approaches to foster care that involve fostering of both mother and child; and
- a Sheway 2 drop-in model (identified by the clients) that would serve as a base for parents to access ongoing developmental assessment and programming for their children and would meet the changing needs of parents as they progress to a more stable life and parenting style.[17]

Sheway participants suggested: a regular art program, more formal child care while they were meeting with staff on health issues, expanded provision of food, emotional support groups, outings, and information groups for new parents. They also suggested a room to view videos and read books on parenting, help on parenting older children and children with special needs, more time to access alcohol and drug counselling, and longer term support.[18]

CONCLUSION

Sheway is a success as seen in participation rates and health data. Service use has risen and birth weights continue to be comparable to rates of women in communities with lower levels of poverty despite the marked increase in preterm babies and low birth weights in the last couple of years noted in the recent research. This continues to be true even as women turn to Sheway with an increase in risk factors over the past 11 years. Birth weights are higher when women participate in Sheway.

Sheway supports self-determination, giving priority to the women's right to choose her engagement with all aspects of the programming. Women then rebuild a sense of ownership of self, a sense of personal worth, self-esteem, and confidence in her ability to make decisions as a woman and as a parent.

Sheway provides the backdrop, support, and safety net that allows women to take the time to get in touch with themselves, honour themselves as mothers-to-be, explore a path not yet taken, and build the confidence to step out and onto the path with strength of spirit, body, and mind. Women report that Sheway's model is akin to more traditional services in its fluid and informal method of service and non-hierarchical relationship between the team and program participant.[19]

Women come to understand that, despite the challenging daily situations they face, they can hold their heads high, be proud of their pregnancies, become the parent they want to be, and be recognized for all they contribute to their families and the community.

ENDNOTES

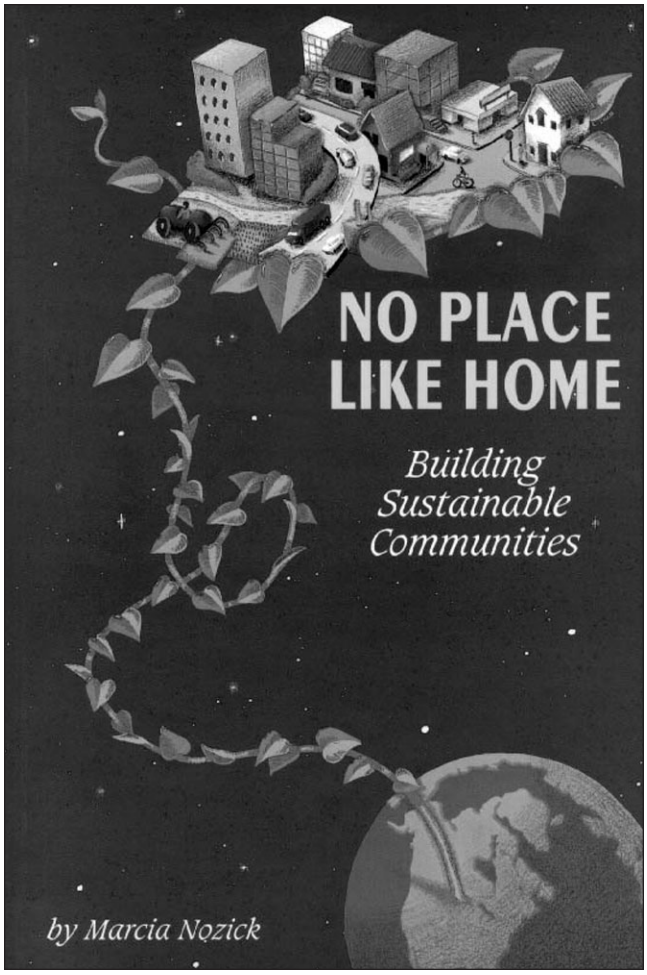
1. C. Benoit; D. Carroll, and M. Chaudhry, "In Search of a Healing Place: Aboriginal Women in Vancouver's Downtown Eastside," *Social Science and Medicine*, Vol. 56 (2003) p. 821-833.
2. Benoit; Carroll, and Chaudhry, "In Search of a Healing Place."
3. Vancouver Health Department and Downtown Eastside Community Coalition for Prevention of FAS/NAS, Hospital Community Partnership Program 1991/1992, *Drug Exposed Infants and Children: Community Outreach for Early Intervention and Prevention* (Vancouver: BC's Children's Hospital,1991).
4. Sheila Marshall et al., *Evaluation of Sheway's Infant Services* (Vancouver: School of Social Work and Family Studies, University of British Columbia, 2003).
5. Nancy Poole, *Evaluation Report of the Sheway Project for High-Risk Pregnant and Parenting Women* (Vancouver: British Columbia Centre of Excellence for Women's Health, 2000) p. 15-16.
6. Poole, *Evaluation Report of the Sheway Project*.
7. Vancouver/Richmond Health Board, *Birth-Related Statistical Summaries for Specified Areas of British Columbia, 1991-1997* (Vancouver/Richmond Health Board, 1999).
8. Marshall et al., *Evaluation of Sheway's Infant Services*.
9. Marshall et al., *Evaluation of Sheway's Infant Services*.
10. Marshall et al., *Evaluation of Sheway's Infant Services*.
11. Poole, *Evaluation Report of the Sheway Project*, p. 12.
12. Poole, *Evaluation Report of the Sheway Project*, p. 25.
13. Poole, *Evaluation Report of the Sheway Project*.
14. Benoit; Carroll, and Chaudhry, "In Search of a Healing Place."
15. Marshall et al., *Evaluation of Sheway's Infant Services*.
16. Poole, *Evaluation Report of the Sheway Project*, p. 29.
17. Poole, *Evaluation Report of the Sheway Project*.
18. Poole, *Evaluation Report of the Sheway Project*.
19. Benoit; Carroll, and Chaudhry, "In Search of a Healing Place."

Further Reading

NO PLACE LIKE HOME

Building Sustainable Communities

By Marcia Nozick
Canadian Council on Social Development, 1992
ISBN 0-88810-415-4
237 pages



"The Holiday Inn ad tells us 'you can travel round the world and never leave home.' Home today has come to mean the wide world at large, a 'global home' which is both everywhere and nowhere. This global home we come to identify by the corporate images sold to us on mass media and repeated with regular sameness from city to city–suburbs of spaghetti design, shopping malls with glass peaks, McDonald's, Holiday Inns, domed stadiums. The shift from understanding home as a special place of origin–a community where we live, work, belong and feel a sense of responsibility–to the perception of home as a World Class City such as New York or Los Angeles is a result of complex global forces promoting cultural uniformity." So writes Marcia Nozick in a book that challenges the conventional wisdom on social and economic development.

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Nozick lives in Winnipeg where she is active in urban, ecological, and community issues through her work with Greening the Forks (dedicated to saving historic lands) and the Manitoba Institute for Community Ecology. She holds a master's degree in City Planning, has taught at the University of Manitoba, and is the publisher of City Magazine, a national magazine on community and planning issues in Canada.

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