Women form the overwhelming majority of the world’s poor. In fact, of the 1.3 billion people living in poverty across the world, 70% are women (Commission on the Status of Women, 2012). In response to this situation, the United Nations (2006, cited in Burn, 2011) challenged governments worldwide “to ensure equal access of women and men to resources, opportunities and public services as a strategy for the eradication of poverty” (p. 81). The promotion of gender equality and women’s empowerment could go a long way to achieving this goal. Not only are women often a nation’s poorest citizens, they are also more likely than men to be the primary caregivers for the children of the nation.

Governments of industrialized nations should play a leading role in promoting the well-being of their citizens. Instead, many Western countries are governed by institutions that allow current conditions of poverty to exist within nations that would otherwise be defined by their prosperity. They accept and promote neoliberal notions that assign responsibility to individuals for their own poverty, or conversely their wealth, suggesting that an individual’s fiscal welfare is derived primarily from the efforts they are willing and able to put forward. In short, many governments of industrialized nations relegate poverty to the private rather than the public domain. Social welfare programs and the taxation systems needed to eliminate poverty are given low priority. Non-governmental activist groups and researchers
who recognize and are sympathetic to the inequities in the system have responded to the needs of the poor by raising awareness and by the creation of support systems such as food banks, housing co-operatives, and shelters for the homeless. However, their efforts have a limited reach.

Defining Poverty in Wealthy, Industrialized Nations

Poverty is a complex and multifaceted condition. As a concept, poverty takes into consideration not only individuals’ and families’ financial assets but, at a concrete level, what it means for people to try to survive without the basic resources needed to maintain healthy lifestyles. For mothers in particular, poverty means making compromises that affect their own as well as their children’s nutritional, educational, and overall living standards. For many women poverty is not a transient state; it is a way of life that imposes multiple and overlapping hardships. In short, poverty degrades the quality of life for mothers and their children (United Nations Development Programme, 2010).

Many nations rely on income as a simple indicator of an individual’s or a family’s financial well-being. The United States and Canada, for example, take this approach in assessing national poverty rates. Using income as an indicator, just over 15% of persons residing in the US in 2010 were identified as living in poverty (National Poverty Center, 2012). The poverty rates for groups of Black and Hispanic individuals were recorded at 27.4% and 26.6%, respectively, rates significantly higher than the national average (National Poverty Center, 2012). These figures highlight how poverty is related to ethnicity in the US. Poverty rates are at their highest for families headed by single Black or Latina women (31.6%) (Center for American Progress, 2008).

A similar situation is seen in Canada, with some groups disproportionately represented among those identified as living in poverty. While 9% of men and 10% of women in Canada in 2008 lived with low income (Statistics Canada, 2011b), 51.6% of lone parent families headed by women, 44% of Aboriginal women living off-reserve, and 47% of Aboriginal women living on-reserve lived in poverty (Women’s Legal and Education Action Fund, 2009).

These examples, from two of the world’s richest industrial nations, give us some idea of the disproportionate number of women, particularly
those from minority and Indigenous groups, with incomes falling below the poverty line. These numbers tell us something about the magnitude of the problem but leave us only to imagine what mothers who are living below the poverty line experience on a day-to-day basis as they try to provide the basics for themselves and their children.

Socio-economic status (SES), another indicator of well-being, is assessed through a combination of factors that includes income but also takes into account social concerns such as level of education, occupation, and housing conditions. SES is often used as a surrogate measurement of poverty. Findings consistently show that individuals who score lower on measures of SES also tend to have poorer physical and mental health outcomes and higher morbidity rates than those who are in higher SES groups (Do, Frank, & Finch, 2012; Morris & Gonsalves, 2005; Nagahawatte & Goldenberg, 2008). While the consequences for women living in poverty are potentially serious, for children the long-term effects of living in poverty can be dire. For example, research shows that children in lower SES groups often have poorer health outcomes, experience developmental and cognitive delays, are more likely to suffer from behavioural disorders, show poorer educational outcomes, and are more likely to become low income earners in adulthood (Cutts et al., 2011; Fleury, 2008; Moore, McArthur, & Noble-Carr, 2008; National Scientific Council on the Developing Child, 2005, 2010).

In many Western countries the burden of the poor is further heightened by the economic inequality existing within the nation. Wealth inequality in the US is at a historic high, “with some estimates suggesting that the top 1% of Americans hold nearly 50% of the wealth, topping even the levels seen just before the Great Depression in the 1920s” (Norton & Ariely, 2011, p. 9). For some mothers, living in poverty in a wealthy country where there are evident discrepancies in lifestyles between oneself and those who enjoy even modest wealth can lead to a state of despair. In fact, the incidence of mental illness in the US is extremely high, with figures showing that one in four Americans are suffering from some form of mental health disorder (Wilkinson & Picket, 2010). While not all mental health problems can be attributed to poverty, higher-income countries that, in contrast to the US, enjoy greater wealth equality also see much lower proportions of their populations struggling with mental illnesses (Wilkinson & Pickett). In short, while being poor is never a desirable space to inhabit, being poor
in a country where others are enjoying the benefits of wealth exacerbates the effects of poverty, which often materialize in mental health problems for mothers and their children.

POVERTY AND ITS DIRECT EFFECTS ON PREGNANCY OUTCOMES

Women living in poverty endure many hardships, for women in their childbearing years, the hardships are even worse. Many poor women will not receive the physical and emotional care needed to ensure healthy pregnancies and positive childbirth experiences (Braveman et al., 2010). Although childbirth is a universal biological event, it is obviously not independent of the economic, social, and cultural context in which it occurs. Nagahawatte and Goldenberg (2008), through an extensive review of the literature assessing pregnancy outcomes in relation to poverty, found evidence for increased perinatal mortality associated with maternal poverty. In Canada, the overall infant mortality rate dropped below 6 per 1000 live births in 1996 (compared to 27.3 in 1960), but the rates vary in direct relation to women’s SES; the lowest infant mortality rates are found in groups of women living in the highest-income urban areas, whereas higher than average rates are seen in women in the lowest-income neighbourhoods (Phipps, 2003). In particular, “infant mortality rates for the Aboriginal population are twice those for the non-Aboriginal population” (Phipps, p. 11). The correlation between SES and infant mortality helps to explain why Nagahawatte and Goldenberg found that, “pregnancy outcomes, often considered a litmus test for the health of a nation, are worse in the United States than in nearly all developed nations” (p. 80).

There are a number of reasons that account for the disparity in pregnancy outcomes between the rich and the poor. Regardless of whether health care is a universal benefit of citizenship, as is the case in Canada, or health care costs are largely assumed by individuals, as is often the case in countries like the US, poor women in wealthy countries are less likely to be connected with any form of obstetric care during their pregnancies than are women who are not living in poverty; poor women will experience negative pregnancy outcomes as a consequence (Flenady et al., 2011). A lack of obstetric care during pregnancy, childbirth, and for the weeks immediately following the birth of a child contributes to negative maternal health and infant outcomes (Nagahawatte & Goldenberg, 2008). While lack of money,
which affects women’s ability to pay for transportation and daycare costs, is one factor informing access to obstetric care, there are other powerful but somewhat invisible barriers that explain why women may not seek out prenatal and perinatal care. From their own work, Nagahawatte and Goldenberg suggest that depression as well as women’s negative experiences with the healthcare system, including having previously received culturally inappropriate or unsatisfying services as well as reproach for their poor health habits, act as strong deterrents to seeking help during pregnancy. While obstetric care will not guarantee positive pregnancy outcomes, treating pre-existing health conditions such as hypertension, diabetes, or anemia can reduce the rates of adverse outcomes, including preterm births and still births, as well as neonatal and maternal deaths (Flenady et al., 2011; Nagahawatte & Goldenberg).

In addition to a lack of obstetric care during pregnancy, there are a host of other issues directly related to living in poverty that place poor women at risk for negative maternal, neonatal, and child outcomes (Bombard et al., 2012). By themselves, stress, anxiety, and depression during pregnancy have been shown to have a negative effect on maternal and neonatal outcomes (Beeber, Perreira, & Swartz, 2008). Paired with other behaviours deemed risky during pregnancy (e.g. smoking, alcohol consumption, and illicit drug use), the probability for poor health outcomes for both mothers and infants increases dramatically.

Despite warnings about tobacco use as a risk factor for preterm birth, a significant minority of women continue to smoke throughout their pregnancies. In Canada, pregnant smokers are more likely to be young, single, and to have lower income levels than are non-smokers (Al-Sahab, Saqib, Hauser, & Tamin, 2010). As well, use of illegal substances during pregnancy, such as cocaine and heroin, are also associated with preterm birth (Goldenberg, Culhane, Iams, & Romero, 2008). Research findings suggest that lower education and lower income are both factors associated with an increased use of illicit injection drug use (Nagahawatte & Goldenberg, 2008). Findings also show that pregnant women who use illicit substances are also more likely to use tobacco and alcohol during pregnancy. Excessive alcohol consumption during pregnancy is linked to negative fetal outcomes, most notably infant fetal alcohol syndrome (Lewis, Shipman, & May, 2011) although findings regarding the relationship between the volume of alcohol
consumed during pregnancy and the occurrence of spontaneous abortions or preterm births have been mixed (Chiodo et al., 2012).

Thus, there is a complex web of factors, of which poverty is at the centre, that have been shown to contribute to poor infant outcomes. For many women living in poverty, being poor is associated with a lack of obstetric care as well as a higher probability of engaging in health behaviours that put themselves and their infants at risk for poor health outcomes. These are the facts. However, this is not to say that women who are living in poverty are making informed choices that lead them to engage in risky behaviours. Instead, what is being suggested here is that poverty strips women of their dignity, autonomy, and consequently the agency to make healthy and informed life choices.

PREGNANCY, POVERTY, AND VIOLENCE

While intimate partner violence (IPV) is a threat to all women’s security, research shows that prevalence rates are higher for women living in poverty than for those women living with greater income security (Goodman, Smyth, Borges, & Singer, 2009). This fact notwithstanding, worldwide, IPV is the most prevalent form of abuse against women (Watts & Zimmerman, 2002). Watts and Zimmerman note that over the past two decades, more than 50 surveys examining the incidence of intimate partner violence have been conducted in various parts of the world. These surveys showed that somewhere between 10% and 50% of women who had ever been in an intimate partner relationship (e.g., married, common-law marriage, dating) were physically assaulted by their male partner at some point during their relationship. Between 3% and 52% of women reported physical violence occurring within the past year of their relationship. Other studies paint a similarly bleak picture worldwide (Flake & Forste, 2006; Hadi, 2005; Lawoko, 2006; Panchanadeswaran & Koverola, 2005; Yoshihama, 2005).

In Canada, Europe, the United Kingdom, and the United States, concerns about the increasing incidence of intimate partner violence have also been expressed (Harwin, 2006). As appalling as these figures are, most researchers agree that they represent only minimum estimates.

It should come as no surprise that IPV, which most frequently involves an act of violence against a women perpetrated by a husband or intimate partner, does not stop when a women is pregnant. Some figures suggest that
between 3% and 7% of pregnant women in the US are victims of IPV; other reports suggest figures up to 20% (Bailey & Daugherty, 2007). Whatever the rate, it is too high, and it exceeds the incidence of preeclampsia and gestational diabetes for pregnant women (Nagahawatte & Goldenberg, 2008). IPV has a strong association with poverty, occurring with increased frequency and severity in lower SES groups (Khalifeh, Hargreaves, Howard, & Birdthistle, 2013). Victims of IPV are also associated with other risk-taking behaviours during pregnancy. Women who are victimized are more likely to smoke, abuse substances, avoid prenatal care, and eat poorly. All of these risks are associated with adverse pregnancy outcomes for both mothers and their infants, including increased risk of preterm birth (Bailey & Daugherty). As well, IPV often involves sexual assault, and this can result in the sexual transmission of infections, which may also contribute to the increased rates of preterm deliveries for mothers who have been sexually assaulted (Nagahawatte & Goldenberg). The association between adverse maternal and perinatal outcomes with socioeconomic deprivation has been well established. Negative outcomes for mother and infant are often associated with women’s lack of access to obstetric health care, mental health problems, and engaging in risky behaviours, as well as being the object of violent acts perpetrated against them.

NUTRITION, POVERTY, AND PREGNANCY

While lower SES groups of women are more likely to engage in risky behaviours during pregnancy and to be the victims of violence compared to women in higher SES groups, these are not the factors that take the greatest toll on the majority of pregnant women who are living in poverty. “Every year more than 20 million infants are born with low birth weight worldwide. About 3.6 million infants die during the neonatal period. More than one third of child deaths are thought to be attributable to maternal and child under nutrition” (Zerfu & Ayele, 2013, p. 1). Although two thirds of these child deaths occur in southern Asia and sub-Saharan Africa, millions of people living in households in the US, Canada, and other wealthy Western countries are dealing with food insufficiency on a daily basis. The immediate consequence of food insufficiency for an individual is hunger; the long-term consequence is malnutrition. For pregnant women suffering from malnutrition, the outcomes can include low infant birth weight and
preterm births, both of which are critical factors associated with perinatal and infant mortality (Glinianaia et al., 2013).

Adverse pregnancy outcomes can be a result of either a pregnant woman’s overweight or underweight status. At one end of the weight spectrum, there is a growing concern about the number of women who are overweight or obese in their childbearing years. The World Health Organization (WHO: 2013) reports rising overweight and obesity rates in both developed and developing nations worldwide and suggests that the problem has reached epidemic proportions. Overall, figures show that 35% of adults worldwide are overweight; 11% are obese. In 2008, the WHO reported that close to 24% of women in Canada were obese; in the US, the figure was just over 33%. Not surprisingly, developed nations see that women in lower SES groups have the highest rates of obesity (Nagahawatte & Goldenberg, 2008). Upwards of 25% of pregnant women enter into pregnancy with a body mass index (BMI) that would define them as obese (Chu et al., 2008; Norman & Reynolds, 2011). Being overweight or obese during pregnancy is associated with a host of adverse reproductive health outcomes for the mother, including infertility, gestational diabetes, pregnancy-induced hypertension and preeclampsia, caesarean sections, prolonged labour, and postpartum anemia; there are adverse outcomes for the infant as well, with the incidence of birth defects higher for infants born of women who are obese compared to those born to women who are within a normal weight range (Denison et al., 2014; Kosa et al., 2011; Norman & Reynolds; Siega-Riz & Laraia, 2006; Yu, Teoh, & Robinson, 2006).

The percentage of women in developed nations with BMIs defining them as underweight is less well reported. A study conducted in the US of more than 13,000 women, categorized just under 2% of the women as underweight—a BMI score of less than 18.5 (Chu et al., 2008). Notwithstanding the lower incidence of underweight pregnant women compared to those who are overweight or obese, an abnormally low BMI is also associated with negative obstetric outcomes. These can include preterm birth, birth of infants too small for their gestational age, and anemia (Heaman et al., 2013; Kosa et al., 2011; Norman & Reynolds, 2011; Ota et al. 2011; Siega-Riz & Laraia, 2006). In short, women’s nutritional habits, before as well as during pregnancy, play a key role in their own reproductive health and in the health of their unborn children (Denison et al., 2014; Ramakrishnan,
Grant, Goldenberg, Zongrone, & Martorell, 2012; Yu, Teoh, & Robinson, 2006). As with poverty rates in both the US and Canada, we see obesity rates impacting different cultural groups in different ways. Higher obesity rates in the US are seen amongst Hispanic and black women and migrant populations than for white populations (Delavari, Sønderlund, L., Swinburn, Mellor, & Renzaho, 2013; Kirby, Liang, Chen, & Wang, 2012; Rendall, Weden, Fernandes, & Vaynman, 2012); in Canada, obesity rates are highest in Aboriginal communities (Atlantic Centre of Excellence for Women’s Health, 2009; Willows, Hanley, & Delormier, 2012).

Certainly limited income plays a key role in the nutritional disadvantages confronted by all women living in poverty. While money is a critical factor, it is not the sole contributor. As with the relationship between access to and use of obstetric services, low income also underlies women’s nutritional disadvantages although, low-income pregnant women rarely talk about lack of money in discussing their beliefs about the relationships between diet, health, and obesity. In a study conducted by Paul, Graham, and Olson in 2013, women frequently referred to emotional eating as a strategy they used to feel better about themselves. In conjunction with this, pregnant women shared their beliefs that not only do healthy foods taste bad but it is acceptable when pregnant to indulge food cravings and to “eat-for-two.” Poverty, coupled with these sorts of beliefs, puts low-income women at an even greater risk of excessive gestational weight gain during pregnancy. Like other risk factors discussed earlier, food insufficiency and resulting poor nutrition are associated with poverty.

WHAT FOOD INSECURITY REALLY MEANS FOR MOTHERS AND THEIR CHILDREN

Poverty paired with pregnancy is never an optimal situation for women or for their unborn children. And while not all pregnant women living in poverty will experience the severe negative effects associated with poor diet, there is no doubt that food insecurity is a health risk for pregnant women living in poverty as well as for their unborn children. Coping with poverty prior to the birth of a child presents many challenges for women. Food insecurity, a term used to describe modern-day hunger conditions, involves “a nonsustainable food system that interferes with optimal self-reliance and social justice” (US Department of Health and Human
Services, 2000, cited in Kregg-Byers & Schlenk, 2010, p. 279). For mothers this translates into an inability to obtain nutritionally adequate food for themselves and for their children. Individuals cope with food insecurity by not eating or eating small, irregular, or inadequate meals, by diluting foods and liquids, eating unsafe, spoiled, or discarded foods, or by relying on private or public food agencies such as food banks to obtain their food (Kregg-Byers & Schlenk).

Poor nutrition is a public health concern. Mothers living in poverty, like all mothers, understand the importance of nutrition for healthy child development. Unhealthy diets, defined as those high in fats, sugar and salt, and low in fruit and vegetables, have long-term negative health consequences for everyone, but especially for children. The health inequalities seen in wealthy nations can in large part be attributed to the disparity in diets between the rich and the poor (Attree, 2005). In the UK, for example, one in five families report not having enough money for food. For many low income mothers this will mean that children will not be eating fresh green vegetables, salads, or fresh fruits.

In a review of studies assessing the impact of food insecurity on mothering practice, Attree (2005) identified three ways in which low-income mothers manage poverty in relation to the diet and nutrition needs of their children. Some mothers adjust their food purchasing needs strategically through prioritizing purchases, juggling other bills, and resourceful purchasing of food. The term “strategic adjustment” implies that mothers living in poverty can exercise an element of choice in how they spend their limited resources. Using this sort of terminology makes it sound as if mothers are coping, but it does not guarantee that employing these strategies will ensure adequate nutrition for themselves or for their children. When poverty becomes a chronic state, mothers seem to become largely resigned to the situation and depressed by their inability to provide for their children. In this scenario, mothers talk about an adaptation period, how economizing becomes a way of life. As one mother in Attree’s study says, “It’s the whole psychological thing. We’ve got no reason to bother, to save or anything, because we know things won’t change. You begin not to expect anything. You live from day to day” (p. 235). Whether one is strategically adjusting to short-term poverty or resigning oneself to the reality that poverty is a chronic state, there are significant physical and emotional costs associated with these adjustments.
Attree found that managing poverty for most low-income mothers means most often compromising their own nutritional needs—going without food or making do—in order to feed their children. And still, making do is no guarantee that their children’s nutritional needs will be met.

While food insecurity puts mothers at risk for physical and mental health challenges, nutritional deprivation accounts in large part for their children’s increased risk of hospitalization, their poor health, developmental delays, and anemia (Cutts et al., 2011). In discussing the feminization of poverty, Symonds (2011) notes how “women have been described as the ‘shock-absorbers’ of poverty through their ability to juggle debt, and manage households and their willingness to go without food, or other items, to ensure that their children are fed and clothed” (p. 569). And while mothers living in poverty do sometimes manage, “making it” often comes at a great personal cost (Wright, 2013).

Just over one in five children in the US live below the poverty line, and one in two children live in families relying on food stamps and experience hunger during childhood (Fraad, 2012). The United Nations Children’s Fund (UNICEF) established a research centre in 1988 to support advocacy for children worldwide. UNICEF’s (2013) report on Child Well-being in Rich Countries: A Comparative Overview measures child well-being using a number of different dimensions, including their material well-being (monetary and material deprivation), health and safety (health at birth, preventative health services, childhood mortality), education (participation, achievement), health and risk behaviours, exposure to violence, housing, and environmental safety. With regard to their material well-being, children in the US rank 26th out of 29 rich nations assessed; Canada’s children were ranked 15th in terms of their well-being on these criteria. By contrast, the Nordic countries—Netherlands, Finland, and Norway—were ranked as the top three countries in terms of children’s material well-being. And while not all economically deprived children living in these poorly ranked countries will be continuously exposed to a life of poverty, any exposure has an impact on children’s well-being, with long-term exposure increasing children’s risk of poor health outcomes (Ryu & Bartfeld, 2012).
For many mothers living in poverty, food insecurity often goes hand in hand with housing insecurity. “Having a ‘home’ is a fundamental need of all children” (Taylor & Edwards, 2012, p. 58). Housing status, like nutritional status, is a strong social determinant of health. Poor housing conditions are linked to multiple negative health outcomes for both children and adults (Cutts et al., 2011). Even when housing conditions are adequate, many individuals spend far too much of their monthly income on accommodation for themselves and their children. While these families may not be living in poor housing conditions they are considered to have “housing affordability issues” (Laird, 2007). In Canada, for example, “almost one-quarter of Canadian households—more than 2,700,00 households—are paying too much of their income to keep a roof over their heads” (Canadian Council on Social Development, 2007, cited in Laird 2007, p. 4). The situation is far worse for Aboriginal and new Canadians; both groups are hardest hit by housing insecurity. Aboriginal Canadians are disproportionately represented among the homeless, and nearly a quarter of new Canadians are paying more than half their family income on rent (Laird).

Cutts and colleagues (2011) note how crowding and multiple moves from home to home can have a negative impact on children. Both living situations have been associated with poor mental health, an inability to cope with stress, and distressed child and parent interactions and social relationships, as well as children’s sleep problems, an increased risk for childhood injuries, elevated blood pressure, respiratory conditions, and exposure to infectious disease. Further, adults and children living in crowded households are less likely to access health care services than those living in uncrowded households. Families forced into multiple moves are less likely to establish a medical home and to seek out preventative health services for their children than securely housed families. In their own study, which looked at the effects of housing insecurity among children younger than three years of age, Cutts and colleagues found that housing insecurity was directly associated with measures of poor health, growth, and development in young children. They also found that very young children living in families who had moved multiple times had far worse caregiver-reported health status, were at an increased risk of developmental delays, and showed average weight for their age that was lower than expected. Some of these findings,
particularly those related to health status and weight gain, were evident because, as noted earlier, food insecurity is closely tied to housing insecurity. Taylor and Edwards (2012), from their research on housing insecurity in Australia, suggest that the developmental outcomes for children are particularly sensitive to multiple moves that occur between the ages of four and five years. These authors also found that not only multiple moves but housing situations associated with instability (such as doubling up and overcrowding) are also related to adverse effects. They reported that children living in public housing had poorer receptive vocabularies and much higher levels of emotional and behavioural problems than children in other types of housing.

While poor housing conditions resulting from poverty present major challenges for mothers and children, homelessness is far worse. In recent years, shortages in affordable housing coupled with elevated poverty rates have contributed to an increase in the number of individuals in industrialized nations who find themselves homeless (Finfgeld-Connett, 2010). Family homelessness means living or sleeping outside on the street or in emergency shelters, hostels, or transition homes, living in transitional housing, doubling up temporarily with others, or renting a hotel room by the month (Canada Mortgage and Housing Corporation: CMHC, 2003). In 2007, the number of homeless people in Canada was an estimated 150,000 (Laird, 2007). While homeless families in Canada are a diverse group, many are headed by single mothers between the ages of 26 and 29 (CMHC). In the US, an estimated 3.5 million people experience homelessness each year, and of this group 17% are single women, and almost one third are families with children (Finfgeld-Connett). The main causes of family homelessness were identified by CMHC as a “lack of affordable housing, poverty, family violence and inadequate funding for social programs” (p. 3). Other factors that have been isolated to account for homelessness include, for example, discrimination, mental health issues, addictions, and physical health problems. However, it is interesting to note that homelessness in childhood is predictive of homelessness in adulthood (CMHC). Not surprisingly, family violence is strongly associated with homelessness for women and their children (Finfgeld-Connett). It is often the case that when women leave violent partners they have no other home to go to and consequently end up living on the streets.
The negative consequences for women and children of homelessness are serious, as is the stigma associated with homelessness (Meanwell, 2012). Finfgeld-Connett (2010), using a meta-synthesis analysis of 45 qualitative research reports, concluded that life as a homeless woman involves dealing on a day-to-day basis with multiple, complex, and interconnected stressors. Homeless women have a higher incidence of chronic health conditions, and their children suffer from higher than normal rates of physical and mental health problems as well as problems at school. Homeless mothers, in attempts to provide healthier living environments for their children, often choose to relinquish their children’s care to supportive agencies, family, or friends. Many homeless women, like those living in insecure housing situations, suffer from physical and mental health problems, anxiety, low self-esteem, substance abuse, mood disorders, and psychosis. Homeless women are often forced to cope with unwanted and unmonitored pregnancies, sexually transmitted disease (STDs), malnutrition, and other chronic conditions such as diabetes, hypertension, and HIV. Violence is one of the most prevalent themes defining the lives of homeless families with young children. Violence comes in various forms, including exposure to domestic and street violence as well as witnessing others being subjected to violence. Living in a homeless situation can also be associated with intimate partner attachments that lead to self-destructive behaviours and victimization by controlling and abusive partners as well as sexual victimization that can include unplanned and unprotected sex, forced sex, and sex in exchange for subsistence (Finfgeld-Connett). Not only does violence have a profound effect on individuals but it also disrupts the normal bonding between parent and child, further isolating and degrading families (Swick, 2008).

Children living a homeless life suffer from a myriad of childhood ailments. The negative outcomes for children who are forced to live with homelessness, like those for their mothers, can be attributed to the toxic stress of living in poverty. Stress comes from a variety of sources that can include an absence of consistent and supportive relationships, lack of high-quality child care, deprivation of learning resources, and extreme familial hardships leading to neglect, abuse, parental substance abuse or mental illness, or exposure to abuse (National Scientific Council on the Developing Child, 2005, 2010). For children raised in poverty, dealing with toxic stress becomes a way of life. Compared to their housed peers from low SES backgrounds, homeless children are worse off in terms of their
physical health, as well as with respect to social, emotional and behavioural outcomes (Moore, McArthur, & Noble-Carr, 2008). Obviously, the more chronic the situation, the greater are the negative effects on children (Phipps, 2003).

CONCLUSION

Poverty affects huge numbers of children in industrialized nations. “About 1 in 5 children in the United States experience poverty in any given year” (Duncan, Magnuson, & Shonkoff, n.d., p. 3); rates are particularly high for the most vulnerable group of children, those under the age of six, with 22% of children in this age group living in families with incomes below the poverty line (National Scientific Council on the Developing Child, 2010). In Canada, 13% of children under the age of 18 live in low-income families, families who would need a minimum of an additional $8,000 per year to not be considered low-income (Fleury, 2008). Almost half of these low-income children live in severe poverty situations. Further, children from single-parent families, especially those headed by lone mothers, are much more vulnerable to poverty than are children from two-parent families (Phipps, 2003). In the year that women become single parents, they are the most likely of any group to enter poverty, and once they have entered into poverty, they have a very slim chance of exiting (Phipps). To put these figures and the severity of the problem into perspective, Fleury noted that in Canada, “In 2004, low-income families with children would have needed more than $3 billion in additional income (from market income, transfers or other sources) to surpass the low-income cut-offs” (p. 22). Although Canadian children fare somewhat better than their counterparts in the US and the UK—but not as well as those in many other affluent countries like Denmark, Finland, Belgium, France, Netherlands, Norway, and Sweden—still we see that “the richest 10% of children have incomes 7.6 times those of the poorest 10% of children” (Phipps, p. 8).

The dramatic differences in the experience of poverty across affluent countries have been attributed to differences in social transfers, with countries like Norway making social benefits a priority. Phipps (2003) simulated what would happen if Canadian mothers were given the same social transfers received by mothers in Norway, and showed that women currently in the bottom of the Canadian income distribution would see their incomes
increased by 121%. Protecting mothers and young children from economic hardship, including food and housing insecurity as well as the myriad of other negative outcomes, should be a policy priority for all industrialized nations (Cutts et al., 2011). Expanding the supply of affordable housing, increasing funding for housing assistance programs, creating affordable daycare spaces, and increasing social transfer payments and social assistance are all concrete strategies that would help to ameliorate some of the hardships imposed on mothers and children living in poverty. The fact that “prevailing ideas about child care and child-rearing are underpinned by theories and beliefs about parenting, the role of women in raising children, and the duties and functions of families and the nation state” (Burger, 2012, p. 1005) keeps our attention focused on individual women and their problems. And it asks that mothers living in poverty be “fixed” or rehabilitated or educated to become better mothers for the sake of their children’s well-being. Similarly, focusing on child poverty, while it has a humanitarian ring, obscures the need for effective social policy (Wiegers, 2007). Turning our attention to the social, economic, and political structures that overwhelmingly inform and contribute to poverty in Western industrialized nations asks instead for socially responsible, government-supported and funded solutions to the elimination of poverty for all.