Cogent Social Sciences

ISSN: 2331-1886 (Online) Journal homepage: www.tandfonline.com/journals/oass20

Legacies of prohibition in Canada: calling for a reproductive justice approach to cannabis use during pregnancy

Rose Chabot, Kristelle Alunni-Menichini , Karen Aileen Dominguez-Cancino, Karine Bertrand, Marie Jauffret-Roustide , Christophe Huỳnh , Nadia L'Espérance , Julie Loslier , Victoria Massamba , Pablo Alberto Martínez Díaz & José Ignacio Nazif-Munoz

To cite this article: Rose Chabot, Kristelle Alunni-Menichini , Karen Aileen Dominguez-Cancino, Karine Bertrand, Marie Jauffret-Roustide , Christophe Huỳnh , Nadia L'Espérance , Julie Loslier , Victoria Massamba , Pablo Alberto Martínez Díaz & José Ignacio Nazif-Munoz (2026) Legacies of prohibition in Canada: calling for a reproductive justice approach to cannabis use during pregnancy, Cogent Social Sciences, 12:1, 2667551, DOI: 10.1080/23311886.2026.2667551

To link to this article: https://doi.org/10.1080/23311886.2026.2667551

COGENT SOCIAL SCIENCES
2026, VOL. 12, NO. 1, 2667551
https://doi.org/10.1080/23311886.2026.2667551

SOCIOLOGY | RESEARCH ARTICLE

OPEN ACCESS Check for updates

Legacies of prohibition in Canada: calling for a reproductive justice approach to cannabis use during pregnancy

Rose Chabot[a], Kristelle Alunni-Menichini[a], Karen Aileen Dominguez-Cancino[b,c], Karine Bertrand[a,d], Marie Jauffret-Roustide[d,e,f], Christophe Huỳnh[g,h,i], Nadia L'Espérance[j], Julie Loslier[k,l], Victoria Massamba[i], Pablo Alberto Martínez Díaz[m] and José Ignacio Nazif-Munoz[a,d]

[a]Université de Sherbrooke, Longueuil, Canada; [b]School of Nursing, Universidad San Sebastián, Valdivia, Chile; [c]Millennium Nucleus for the Evaluation and Analysis of Drug policies, Chile; [d]Institut universitaire sur les dépendances, Montreal, Canada; [e]Centre d'étude des mouvements sociaux (Inserm U1276/CNRS UMR 8044/EHESS), Paris, France; [f]Centre hospitalier Le Vinatier, Lyon, France; [g]Institut universitaire sur les dépendances du CIUSSS du Centre-Sud-de-l'Île-de-Montréal, Montreal, Canada; [h]Université de Montréal, Montreal, Canada; [i]Institut national de santé publique du Québec, Montreal, Canada; [j]Centre intégré universitaire de santé et de services sociaux de la Mauricie-et-du-Centre-du-Québec du Québec - Direction de l'enseignement universitaire, recherche et innovation, Canada; [k]Faculté de médecine, Université de Sherbrooke, Longueuil, Canada; [l]Direction de santé publique, CISSS de la Montérégie-Centre, Canada; [m]McGill Group for Suicide Studies, Douglas Mental Health University Institute, Department of Psychiatry, McGill University, Montreal, Canada

ABSTRACT

While the 2018 Cannabis Act adopted in Canada signaled a non-prohibitionist approach to cannabis use, governments have not yet reached consensus on how to tackle it, especially amongst groups deemed vulnerable like pregnant persons. Focusing on healthcare interventions, this article investigates institutional approaches to cannabis use implemented in Canada since legalization, as well as the experiences, responses, and coping mechanisms pregnant persons employ to navigate the system, to unveil whether historical social inequalities and norms grounded in prohibitionism have transformed. Adopting a feminist approach, we conducted 36 semi-structured interviews with healthcare professionals and cisgender women who used cannabis while pregnant in the Province of Quebec (Canada). We argue that current institutional practices and discourses in healthcare still reflect some of the gendered, classed, and raced patterns embedded in the previous prohibitionist paradigm. Indeed, we coin three "legacies of prohibition" by which social inequities pervade: i) social representations around "problematic use," ii) practices of punitive care, and iii) pregnant persons' coping strategies that are reminiscent of the era of criminalization. We call for a reproductive justice approach to cannabis use during pregnancy in Canada, through healthcare practices that account for and effectively address the structural and institutional barriers affecting the capacity of pregnant persons who use cannabis to make informed reproductive health decisions.

ARTICLE HISTORY
Received 5 October 2025
Revised 15 January 2026
Accepted 9 April 2026

KEYWORDS
Cannabis; reproductive justice; cannabis legalization; Canada; Quebec

SUBJECTS
Gender Studies - Soc Sci; Sociology & Social Policy; Criminology and Criminal Justice

Introduction

In 2018, Canada became the second country in the world to legalize non-medical cannabis use. Since the early 2000s, the country's historically prohibitive stance on cannabis has gradually shifted toward a medical approach, before evolving further, since 2018, into more liberal and public health-oriented approaches to cannabis legalization (Hammond et al., 2020). However, despite its widespread use and legal status in Canada (Rotermann, 2019), cannabis use faces ambivalent public opinion and ongoing debates still make it a controversial topic amongst governments, researchers, civil society organizations, and in the media, particularly regarding groups deemed "vulnerable," like pregnant persons (Doggett et al., 2025; Haines-Saah & Fischer, 2021; Rubin-Kahana et al., 2022; Spence et al., 2014; Watson & Erickson, 2019).[1]

CONTACT Rose Chabot rose.chabot@usherbrooke.ca Université de Sherbrooke, Longueuil, Canada.

Supplemental data for this article can be accessed online at https://doi.org/10.1080/23311886.2026.2667551.

Recent studies have shown an increase in diagnoses of cannabis use disorders during pregnancy in Canada (Nazif-Munoz et al., 2024). Yet, we still have little knowledge about the concrete and everyday institutional responses to cannabis use in this population group, particularly among those who were historically affected by criminalization (Dennis & Vigod, 2021; Ezard, 2001; Massé, 2013; Pauly, 2008; Pratschke, 2025). A focus on the practices and discourses shaping public policy in practice is crucial, considering how pregnant persons—and particularly substance users—are subject to intense public and scientific scrutiny and control. Additionally, we consider how gender shapes healthcare practices, given the social expectations that women have a central, if not unique role in insuring healthy fetal development (Ettorre 2015; McNulty 1987).

The rise in the diagnosis of problematic cannabis use during pregnancy unfolds while the growing scientific literature on the health risks and impacts that can derive from cannabis use on the pregnant person's health and fetal development has produced mixed results (Cupo et al., 2024). While some research indicates higher risks of preterm birth (Duko et al., 2022) and low-birth weight or fetal growth restriction (Lo et al., 2024), preliminary evidence also suggests the presence of adverse and clinically relevant behavioral or cognitive outcomes such as autism spectrum disorders (ASD), Attention Deficit Hyperactivity Disorders (ADHD), and anxiety (Singer et al., 2021; Torres et al., 2020). While evidence from observational studies, especially for long-term outcomes, cannot establish a clear causal role of cannabis in the observed outcomes, experimental rodent studies face challenges related to external validity and struggle to identify with precision the mechanism of action and effects linking prenatal cannabis use to health outcomes (Chaput et al., 2020; Lo et al., 2024). Therefore, if public health guidelines in Canada emphasize the risks of cannabis use for fetal development and the pregnant person's health and recommend abstinence (Government of Canada 2018), there is currently little certainty around the causal effects and mechanisms of cannabis use, and little nuance on the distinct role of THC and CBD, dosage, or the timing of consumption on affecting health risks during pregnancy.[2]

Amid ongoing scientific uncertainty, this article aims to unveil how policy change since 2018, reflects in current practices and discourses around cannabis use during pregnancy in the Province of Quebec, and how pregnant persons who use cannabis are affected by, and respond to healthcare policy. How have healthcare professionals addressed cannabis use during pregnancy since legalization, and what social norms, gaps, or inequalities are reinforced or challenged? How do pregnant persons who use cannabis experience these institutional discourses and practices, either by coping with, embracing, or resisting them?

First, we examine the literature on drug policy in Canada and Quebec, reviewing how drug prohibition has shaped reproductive health inequities in the country, building on and reinforcing historical gender, class, and racial inequities (Kozak et al., 2022; Miller & Carbone-Lopez, 2015). We illustrate how a reproductive justice framework that considers the structural barriers to the plain exercise of the right to decide if, when, how, and in which environments to procreate (Ross 2017), allows bringing to light the dead angles of major policy transitions such as the 2018 Cannabis Act for social inclusion in Canada. We then introduce the study's main conceptual and analytical framework, applying Carol Bacchi's "What's the problem represented to be?" analytical approach, followed by a discussion of our use of feminist triangulation, a methodology that allows unveiling subjugated knowledges, gaps, and tensions that emerge *between* institutional actors and their patients as they experience and enact the policy (Hesse-Biber, 2012). The subsequent section presents our findings and analysis, before concluding.

Drug policy, reproductive injustice, and social inequities in the Canadian and Quebec contexts

For most of the twentieth century, Canada's cannabis policy was entrenched in a moralistic drug prohibition framework, that associated its use and the groups associated with it with immorality and deviance (Hunt 1999). The 1908 and 1923 Opium and Other Drugs Act classified cannabis as a controlled substance equated with opioids and cocaine, fueling its criminalization (Mosher, 2011; S. C. Boyd et al., 2017). By the late 1960s, as cannabis use also spread among middle-class, white, and educated sectors, criminal convictions for cannabis offenses, particularly for simple possession, reached 65,000 cases (Fischer et al., 2020, p. 90). Calls for leniency grew in response to the negative effects of a penal approach,

leading to the Commission of Inquiry into the Non-medical Use of Drugs in 1969 (also known as Le Dain Commission), which pushed for a health-based cannabis and other substances. However, the "war on drugs" rhetoric that dominated political and media discourse in the United States, also blocked reforms until the mid-1990s in Canada, when the Controlled Drugs and Substances Act relaxed penalties for cannabis.

Canada's prohibitionist policies have disproportionately impacted Indigenous, Black, and economically disadvantaged communities, who have historically faced over policing and criminalization (Marshall, 2015; Owusu-Bempah & Luscombe, 2021; Valleriani et al., 2018; Wiese et al., 2023). Women, especially those from marginalized groups, were also affected by prohibitive laws in gendered and embodied ways, including through incarceration, forced sterilizations, and the removal of children from Indigenous families through perinatal healthcare and Youth Protection Services (thereafter, YPS) (Indian Residential School History and Dialogue Centre, 2025, online). Canada's drug policy has indeed been historically foregrounded by colonial norms and racial prejudice associating Indigenous, racialized, and socioeconomically marginalized women with "harmful" and "irrational" parenting habits (S. Boyd, 2019; Buydens, 2005; Lux, 2016).

In the early 2000s, discussions about cannabis' health effects resurfaced, particularly regarding growing concern over its negative impacts on the youth. Legal developments around medical cannabis emerged with the 2001 Medical Access Regulations, paving the way for a regulated medical cannabis program. Thus, Canada introduced a limited medical cannabis regulatory framework for certain conditions, generating tensions between criminalization, medicalization, and morality (Bruno & Csiernik, 2023). Yet, under the Conservative government between 2006 and 2015, implementation was limited, the criminalization trend persisted, and cannabis-related offenses still comprising 75% of drug offenses in 2013 (Fischer et al., 2020, p. 93).

Cannabis legalization: a new policy landscape?

The 2015 election of a Liberal majority and legalization trends in the U.S. reignited Canadian debates on cannabis, culminating in the 2018 Cannabis Act (Bill C-45). While the Act marked a shift from prohibition to legalization, its implementation has been uneven and often unclear across and within provinces (Dominguez-Cancino et al., 2025; Hall et al., 2023; Myran et al., 2023). Indeed, Canada's framework grants provinces significant discretion, resulting in a patchwork of policies across the territory (Fischer et al., 2020); while Canadian provinces tend to be more liberal and open to private commercialization, Québec on the other hand enforces some of the strictest constraints regarding cannabis production and commercialization, a 21-year minimum age, and a ban on its use in many public spaces. The province's distinct public health model aims to reduce harm related to the substance and to policies around it through education, restrictions, and support for specific groups considered vulnerable (Benoit and Lévesque 2022).

In addition, the Cannabis Act poses new challenges for reproductive health, especially concerning cannabis use during pregnancy. Both healthcare professionals and pregnant individuals face uncertainty due to the lack of clear, evidence-based information on the risks and benefits of cannabis use during pregnancy and lactation (Bartlett et al., 2020). While guidelines tend to favour abstinence, pregnant persons face a dilemma, since existing health considerations related to fetal development may be perceived as conflictive with the pregnant person's needs, habits, and norms (Cates, 2021).

Despite the changes introduced by the Cannabis Act, racialized and socioeconomically marginalized women still experience discrimination, surveillance, and coercive practices within Canada's healthcare system, limiting their access to and the quality of care they receive (Coen-Sanchez et al., 2022; Currie et al., 2015; El-Mowafi et al., 2021; McKenzie et al., 2022).[3] Recent research has shown that pregnant women who are perceived as engaging in risky behaviors towards developing fetuses or children, such as drug use during pregnancy, are still prone to stigmatization and face greater barriers to accessing adequate health care (Dell & Kilty, 2013; Nichol et al., 2025; Pederson et al., 2016; Stengel, 2014). Women and parents who use drugs are particularly prone to judgements that foster internalized stigma, which negatively affects their self-esteem and well-being (Nichol et al., 2025). Moreover, First Nations and Metis parents that have historically been over-targeted by child welfare services, are still overrepresented within those services, keeping Indigenous caretakers under greater scrutiny in the social and healthcare systems

(Indigenous Services Canada, 2025, online). These persistent inequities underscore the need to account for and better understand how historical, legal, social, and cultural factors may still shape present-day policy approaches to cannabis use during pregnancy.

Analytical framework

This article explores, from an intersectional feminist perspective, how healthcare workers and pregnant persons approach cannabis use during pregnancy, that is, through which social and gender representations, under which institutional, economic, cultural, and social constraints, and with what effects on pregnant persons' access to healthcare. It also examines these persons' agency through the way they resist, negotiate, or cope with healthcare interventions as they experience their pregnancy.

This article examines cannabis use during pregnancy through an intersectional approach to reproductive rights and health that centers on the capacity of individuals with reproductive capacities to make decisions regarding their sex lives, contraceptive practices, pregnancies, and child rearing (Idriss-Wheeler et al., 2021; Luna & Luker, 2013; Ross, 2017). Additionally, feminist scholars have long relied on intersectional perspectives to properly account for and capture women's different experiences as situated at the intersection of multiple systems of oppression, including colonialism, capitalism, and patriarchy (Crenshaw 2013). Rooted in the framework of intersectionality, a reproductive justice framework that emerged in the late 1980s under the impulse of African American activists from the Sisterhood Collective, acknowledges the structural, institutional, and environmental barriers to the full enjoyment of reproductive autonomy (if, when, with who, and how many children one has) for impoverished, racialized, 2SLGBTQQIA + persons, and women living with disabilities.

To unveil these power dynamics and situated experiences, we apply Carol Bacchi's post-structural analytical framework "What's the problem represented to be?" (Bacchi 2009; Bacchi & Goodwin 2016) to explore how policy representations around pregnant persons who use cannabis reflect gender, class, and racial inequalities. Bacchi's approach allows interrogating the supposed neutrality of concepts such as "health," "problematic use," "harm," and "risk," scrutinizing them as gendered political and social constructions. Grounded in Foucauldian notions of biopower, this feminist analytical approach is well-suited to unveil how institutional practices around women's reproductive health—often based on white, middle-class assumptions—may produce intersecting social exclusions (Dell et al., 1969; Ettorre, 2004; Shivas & Charles, 2005 Ceasar et al., 2023). In the context of this study, this approach captures how inequities are embedded in social and institutional constructions of a given policy object (cannabis use during pregnancy), policy subjects (pregnant persons), and places (the medical office, youth protection services, or the womb) that are gendered, classed, and raced. Specifically, we explore how cannabis use during pregnancy has transitioned from an illegal to a legal practice, becoming a different policy object, while still being understood as "risky" or "harmful." We also scrutinize how healthcare workers produce representations around pregnant persons who use substances (i.e.: policy subjects) as they engage in this behavior, relying on their professional expertise, but also on their subjective and gendered understanding of "good parenting." Last, Bacchi's approach also considers how policy places are created as sites of public health intervention in ways that re-draw the public-private divide in gendered ways. In all, by paying attention to the material and symbolic effects of such representations, we can capture how reproductive health inequities are reproduced through cannabis healthcare policy and how women experience, cope with, and resist them.

Methodology

This article is part of a broader mixed methods study on cannabis use during pregnancy in Canada. In a previous quantitative study of this research project, we used public health data to expose a statistically-significant increment in cannabis use disorders in the Province of Quebec since 2019 (Nazif-Munoz et al., 2024). In this study, we rely on interviews from different data sources to provide new qualitative insights into the discourses and practices that healthcare professionals and cannabis users sustain, shaping how cannabis policy unfolds. We use a feminist triangulation methodology (Hesse-Biber, 2012) grounded in the analysis of 36 qualitative interviews with healthcare professionals

(n = 18) and cisgender women (n = 18) who used cannabis while pregnant in the province of Québec, Canada.[3]

Based on an ethical and theoretical concern for health and social inequities, we use feminist triangulation to uncover how gender norms and inequalities are produced, reproduced, and challenged, through subjugated knowledges and gaps or differences in meanings. Grounded in the feminist epistemological assumption that knowledge is situated (Haraway, 1988), this method places different data sources—healthcare professionals and pregnant persons—in conversation with each other and with quantitative evidence previously acquired, to bring to light underexamined power dynamics and inequities. Unlike validity-oriented approaches to triangulation, this methodological tool is relevant to grasp of taboo and stigmatized issues such as cannabis use during pregnancy, accounting for discursive dissonances and tensions, but also silences and hidden practices that exist within and between institutions and pregnant persons (Hesse-Biber 2012; Sands and Roer-Strier 2006).

Between 2022 and 2023, our team conducted 18 interviews with healthcare professionals, including medical doctors, nurses, social workers, nutritionists, psychologists who have assisted pregnant persons who reported using cannabis during their pregnancy. While some healthcare professionals—who mostly practiced in the Montérégie and Greater Montreal area regions in Québec—served in drug-use specialized services, others attended patients in regular services and pregnancy follow-ups. Interview questionnaires related to the workers' approach to cannabis use and intervention strategies, opinions, knowledge, and concerns. We also conducted, simultaneously, 18 interviews with pregnant persons who have reported using cannabis at least three months before and during their pregnancy, asking about their life trajectories with cannabis use, decision-making processes during pregnancy, as well as their socioeconomic, institutional, relational, and cultural experiences. A sociodemographic questionnaire allowed participants to self-identify their gender, sexual, and ethnic identity, as well as their housing situation, education, income, and whether they have had an experience with YPS—facilitating our use of intersectionality.

All French-speaking cisgender women, the participants were of different socioeconomic backgrounds, ages, sexual orientations. Eleven participants were of Caucasian origin, and four were racialized—including two Black women, one Asian woman, and one Indigenous woman. Three women had also had experiences with YPS, either for themselves or their children.[4] Individual annual incomes included the lowest income bracket (n = 2), low income (n = 2); medium income (n = 7), and high income (n = 6). Moreover, many healthcare workers interviewed worked with Indigenous and/or socioeconomically marginalized women, allowing us to further capture institutional representations of these groups.

Participants were recruited through healthcare centers and the social media, until reaching empirical saturation. Interviews were conducted both online and in person based on the participant's preference, in French, by white, cisgender women interviewees trained in qualitative interviewing; they were recorded, transcribed, analyzed, and translated to English by bilingual research team members. Considering the sensitive nature of the topic, the interview questionnaires were designed to provide a non-judgemental and safe space for an open discussion. Participants were also encouraged to reflect on their participation to the study before and after the interview and invited to alter the questionnaire as needed. All participants provided written informed consent, which included the right to withdraw from the interview at any time and to decline to answer any questions. Participants were also offered a financial compensation for their time.[5] To preserve the participants' confidentiality, interview data were anonymized and preserved on a secured online drive accessible only to the research team.

To triangulate the interviews using feminist methodology, we relied on a two-staged, iterative process. We started with within-group interview analysis to identify the patterns and differences amongst health care professionals and women, considering their diverse socioeconomic and racial backgrounds. We then conducted between-group and sub-group comparison, to capture how institutional expectations, norms, and practices are formed, accepted, challenged, and reshaped during pregnancy (Sands and Roer-Strier 2006). Themes and subthemes that were identified in the first stage of within-group analysis were thus added, complemented or modified in the subsequent stage, for a more comprehensive understanding of power dynamics embedded in cannabis policy in its everyday implementation.

Results and analysis

The interviews revealed that while recreational cannabis use has become more accepted as a legal practice, during pregnancy, healthcare professionals struggle to determine which use, if any, is acceptable and when it should be tackled in healthcare interventions. To assess cannabis use during pregnancy, most professionals lack reliable information on health risks and benefits for the pregnant person and their pregnancy.

Through institutional representations of policy objects, subjects, and places, we identify the presence of three enduring legacies of the former prohibitive paradigm that continue to shape healthcare interventions with pregnant persons: 1) social differentiation grounded in the notion of "problematic use"; 2) lingering forms of punitive care; and 3) strategies of avoidance and resistance that reflect the previous model of criminalization. We show that despite the emergence of new policy paradigms since 2018, including public health and harm reduction approaches, legacies of prohibition are sustained amid high levels of informational deficit, stigma, power inequalities between healthcare providers and their patients, limited access to specialized training in substance use amongst healthcare professionals, as well as the sometimes-early involvement of YPS in maternal healthcare.

Patterns of social differentiation around cannabis use during pregnancy

This first section shows that uncertainty around the effects of cannabis use during pregnancy leads to sometimes conflicting understandings of what constitutes "problematic" and "recreational" use. Indeed, while "recreational" cannabis use—historically associated with white, educated, and middle-class sectors—is perceived as relatively harmless, "problematic use" has somehow replaced the notion of illegality to ground more active healthcare interventions with patients, yet, with little tools and resources to help navigating these delicate conversations.

"Problematic cannabis use": a moving policy object

During pregnancy, evaluations of problematic cannabis use appeared largely grounded in healthcare professionals' relative attention placed on multiple policy subjects—the pregnant person, and their embryo or foetus. Despite being now legal, cannabis use during pregnancy has thus remained a moving target for healthcare interventions.

In a context of high informational gaps, healthcare professionals situated cannabis on a spectrum opposing it being viewed as a harmful substance or as a relatively harmless one. Our interviews indeed show that while seen as largely normalized in society, recreational cannabis was portrayed as a lifestyle habit or a "consumer choice"[6] that could be part of a balanced management of risks, while "problematic" use was instead seen as an uncontrolled form of self-medication, associated with mental health challenges, addiction, and reflective of a person's inability to lead a balanced life.[7] A more nuanced consideration of patients' individual decisions, life trajectories, and lifestyle preferences related to cannabis use, acquired a new logic in the context of a pregnancy, with a new set of risks and responsibilities attributed to the pregnant person's behaviour.

Cannabis during pregnancy: competing policy subjects

During pregnancy, cannabis use emerged as a distinct policy object amongst healthcare professionals, with a unique public health imperative. Despite having gained social acceptability, especially since legalization, for this nurse during pregnancy cannabis remained a "serious issue": "when you're pregnant you know it's very serious all the same, whether it's illegal or not."[8] If somehow normalized in 'usual' circumstances, many healthcare professionals indeed perceived cannabis as inherently problematic during pregnancy, regardless of the frequency of use, assuming that abstinence is the most rational and safest option.[9] For example, a social worker saw cannabis use during pregnancy as symptomatic of an addiction that necessarily reflects a person's impaired judgement.[10]Yet, to categorize cannabis use as "acceptable" or "problematic," healthcare professionals relied on their knowledge about other substances—including alcohol, tobacco, and other drugs—sometimes conflating them and often unsure of how to tackle it

versus other substance-specific healthcare recommendations. As a legal yet potentially harmful substance, the distinction between recreational and problematic use became blurrier; in our interviews, most healthcare professionals recognized the complexity and variety of consumers, but still favoured abstinence as a starting point, before considering any other harm-reduction strategies.

During pregnancy, cannabis perceived as more harmful emerged in relation to the presence of a new policy subject—a growing embryo or fetus—who became at the heart of health interventions. For example, the social worker considered the unborn child at the center of their interventions with pregnant persons: "the child is at the center, it's the child we mustn't lose sight of."[11] Even for healthcare professionals who embraced harm-reduction approaches, once pregnant, fetal health emerged as the central concern in the intervention, displacing the pregnant person's wellbeing: "But for me, it's the fetus. Really you know, because you're an incubator. It's what you put in your body that has a direct influence on the development. […] And that means avoiding consumption."[12] By comparing women to incubators, this healthcare professional ultimately sidelined the pregnant person as main policy subject. Fetal personification also appeared explicitly in this social worker's interview, in which they claimed they were representing the "voice of children," defending their "future society."[13]

While the embryo or fetus occupied a new key role in the health intervention with pregnant persons, many professionals still attempted to balance their interventions, though not without tensions. For example, a healthcare professional considered both subjects—the pregnant person and the fetus—as equally deserving of care.[14] But in other interventions, particularly in postpartum and pediatric care, the child appeared to have entirely replaced the mother as a policy subject: "Pediatricians aren't going to discuss problems with moms, they're going to be in a solution mode, we treat the baby and then the rest we don't really care about."[15]

For those opened to harm-reduction, uncertainty on how the health effects of cannabis during pregnancy still casted doubts about the threshold for the frequency and quantity of a safe usage. Some professionals also wondered about the addiction and withdrawal effects of the substance and the potential long-term effects on the future child, while putting cannabis below other substances deemed more addictive and dangerous for the fetus, such as alcohol, speed, and cocaine. For different healthcare professionals we interviewed, however, the amount and regularity of cannabis use by the pregnant person considered problematic was decided arbitrarily. For example, this medical doctor, while discouraging the practice, suggested that low consumption is not necessarily problematic during pregnancy, yet struggled to establish criteria to draw the line between acceptable and unacceptable use:

> I don't recommend it in pregnancy, I wish the patient wouldn't do it but. No, well, how can I put it, with a pregnancy or with young children, yes, I think it's problematic, but…well, is it problematic? Well, it's not a good habit, it's not something I encourage, but maybe it's not problematic. Maybe I should not have used the word problematic.[16]

Scholars have claimed that Canada's model still promotes a neoliberal emphasis on individual risk management which may reinforce health inequities and further stigmatise drug users (Brown et al., 2013; Crépault, 2018; Power & Polzer, 2016; Quirion, 2002). While focusing on quantity and frequency of use or conflating cannabis with alcohol, few healthcare professionals considered other factors such as THC and CBD concentration, the role of the mode of consumption (i.e.: smoked, ingested, used as oil), and different gestational periods to assess health risks. This ambivalence, as we have shown, is linked to the perceived presence of another policy subject—the embryo, the foetus, and the child—that sometimes sidelined pregnant persons' health needs and agency in the management of their substance use. Thus, even when adopting harm reduction principles, healthcare interventions remained embedded in these gendered and classed notions of individual responsibility, risk-management, and self-sufficiency that reproduce forms of surveillance while failing to solve deeply rooted inequities (Quirion and Bellerose 2008).

Lingering punitive care

"Parenting potential" and youth protection services involvement

In this second section, we unpack the policy subject and places, showing that women who use cannabis during pregnancy and particularly those who are constructed as "problematic users," are seen less as

patients in need of care than as potentially poor parents for their unborn children in ways that enhance fear of YPS involvement. The uneasiness reported by many healthcare workers in establishing their subject of intervention is also reflected in practices that shift between care of the pregnant person and the impetus to protect the unborn child from potential harm through more repressive approaches. Institutional articulations and networks involved, for both pregnant persons and new parents, both the healthcare and YPS involvement through pregnancy follow-ups and delivery. For more socioeconomically marginalized women, this included specialized programs such as integrated perinatal and early childhood services, programs specialized in substance use, and direct articulations with YPS.

The uneasiness reported by many healthcare workers in establishing their subject of intervention reflected in an ambivalent focus on care for their patient and the impetus to protect the unborn child from potential harm through YPS. For example, this worker mentions feeling like a police officer towards women who recently gave birth, a feeling they reported finding deeply uncomfortable and contradictory with their role as healthcare worker.[17] While according to our interviews, most healthcare professionals did not engage YPS when it came solely to cannabis use, they considered so in cases where they had serious concerns about the pregnant person's parenting capacities.[18] Yet, cases with unclear consumption use and harm assessments were consequently ambiguously delt with, often on a case-to-case basis and relying on judgement more than objective criteria. This medical doctor, for example, argued that: "if we think the child is going to be neglected, abused, in a violent environment… If the patient didn't follow up on her pregnancy, you know, if it was very disorganized, but that's the kind of thing that, you know, we do, we can make a report to the youth protection [services]."[19] They went on listing elements such as missing prenatal tests, not looking engaged or wanting treatment, looking confused, intoxicated, or depressed, or domestic violence as warning signs. In all, determining what constitutes recreational and problematic use remained a challenge for the healthcare professionals we interviewed, who often relied on their professionals' judgement to decide whether to preventively file a report to the YPS or not.

Patients perceived as recreational cannabis users would be considered less prone to having their parenting capacities questioned than those categorized as problematic users. For example, this medical doctor states that, "cannabis probably makes less of it, I think we won't even write it at the top of the file still, you know for someone who would have a recreational use."[20] Overall, healthcare professionals considered that a parent's capacity to self-manage their pleasures and consumption in ways that would not harm their child: "A parent can do anything as long as they don't neglect their child's needs, […] that they manage their life and put their child at the center and are able to manage their pleasures."[21] Filing to the YPS was, based on the testimonies, relatively frequent practice in the delivery room, when healthcare professionals had "serious doubts" about someone's parenting capacities: "Of course, the fetus is not a child, in the sense of the law, but all the same, if we really have great doubts that he'll be able to take care of this child when he leaves the hospital, right? At that point, yes, we do, we can't report, but we can notify the YPS to do an assessment before this baby leaves the hospital."[22] Therefore, for women whose cannabis use is perceived as problematic for their parenting capacities, usually the most socioeconomically marginalized, perinatal and postnatal healthcare are places where potential YPS interventions can occur.

Between care and scare

Clients of the addiction services included in this study were often polyusers, including alcohol and tobacco as well as illicit drugs, with cannabis typically regarded as a comparatively minor concern compared to other substances such as crack use or injection drugs. In practice, cannabis use alone was rarely considered sufficient grounds for YPS reporting, as one nurse explained: "I've never had to report someone for pregnant cannabis use, but it's certainly more likely when the person is injecting and living in crack houses and all that."[23] Still, the amount consumed did influence professional judgments with regards to parental skills, with heavy use seen as justifying YPS involvement, while low to moderate use was often managed within specialized services.[24] But the possibility of reporting remained, even when approached through a harm reduction approach, when the professional judged necessary to do so, when for example, the person presented high levels of intoxication.[25] Consequently, according to a healthcare professional from the perinatality and early childhood program, for example, many patients associated the service with the YPS: "we are often somewhat associated with youth protection, so I think

there's also a fear of us indirectly."[26] Therefore, professionals' approach to cannabis use evaluation often included a concern for the pregnant patient's parenting capacities—a notion which, in the Canadian context, has historically led to a disproportionate surveillance of Indigenous, racialized, and impoverished women (S. Boyd, 2019; Buydens, 2005; Lux, 2016).

Indeed, despite legalization, marginalized women and future parents have remained particularly prone to YPS involvement when their cannabis use is deemed problematic for their child's wellbeing, sometimes since their pregnancy or immediately following childbirth. This medical doctor for example, would file a report when considering that "there has to be something else, the drug use has to be harmful to your parenting potential."[27] More than cannabis use itself, many professionals evaluated the person's broader context of vulnerability and how it affected their capacity to be a good parent: "Not cannabis as such, it's more the patient I was telling you about that, yes she smokes but it's not so much that, as the patient who doesn't come to appointments, who doesn't look after her children […] it's more if there's an associated context."[28] For another medical doctor, YPS constituted another "safety net" for the child to come, for persons who, as they stated, are unemployed, financially precarious, and put their child's safety at risk.[29] This social worker similarly claimed that reporting parents to YPS meant continuing supporting parents in need, by providing them with more specialized services and resources.[30]

Overall, professionals related how drawing the boundary between precarious living conditions and the role of cannabis use in threatening parental skills constituted a difficult task. Yet, despite lacking information on the real health risks of cannabis use for foetal development, specialized programs tended to entrench maternal healthcare with YPS in ways that generate fear and suspicion that are not favorable to a relationship of care. Whether or not reporting to the YPS is a frequent practice or one that really provided more support to parents, the fear of YPS involvement seemed prevalent amongst patients. For example, this nurse mentions: "Because of course, with pregnant women, there's also the issue of the youth protection, maybe they're very afraid of what they might say, because otherwise we might report them, it happens."[31] Fear of YPS involvement also had negative consequences on women's mental health. This participant, who had a history with the YPS and struggles with multiple substance use, including cocaine, speed, and ecstasy, mentions:

> But then again, the guilt of, you know, like, you say to yourself, if I keep smoking, they're going to see that the kids have drugs, that the babies have drugs in their blood, but I don't want to have my kids taken away from me, so it gave me a good boost to stop. But it's true that my anxiety is on the rise, it's twice as high now, because I've kind of put it down for a long time because of pot, but now I'm really experiencing it more intensely than before.[32]

Based on the interviews conducted with pregnant women and mothers, having the YPS involved constituted an additional stressor and, for example, as a form of control and reprimand:

> This year, [YPS] became part of our file. […] In fact, it was a relief in itself, because not having meetings every month, not having someone come to your home and evaluate you and the kids, it's never really fun. You've got nothing to reproach yourself for, you know, but it's almost like you're being challenged [chicannée] […].[33]

In all, the policy subjects and place created by healthcare and social welfare interventions during pregnant women's pregnancies reveal different policy effects for future mothers considered as "recreational users" and those considered "problematic" ones. While the first group was represented as capable of responsibly managing their own health and their future child's safety and was not targeted by healthcare interventions, women whose cannabis consumption was seen as "problematic" were more easily prone to having their parenting potential questioned.

As a form of "embodied deviance," substance use by women who are pregnant was therefore seen as violating gendered roles and expectations related to reproduction, but also as a threat and a potentially lethal behavior for their offspring (Ettorre 2015). In turn, relying on somehow arbitrary criteria in a context of high informational deficit, these social categories, which associate individualized notions of self-control with good parenting, in fact risk relying on classed, gendered, and racialized norms on good/healthy and bad/unhealthy motherhood. These institutional practices are reflected in assumptions regarding abstinence as a universally healthy solution, a lower acknowledgement of marginalized women's agency and a sometimes-early involvement of YPS in prenatal healthcare services.

Pregnant persons' responses, coping, and resistance strategies

The last analytical component of this article unpacks policy effects by focusing on the strategies, responses, coping mechanisms of pregnant persons use, consciously or not, while experiencing healthcare services. As we show, overlapping and sometimes contradictory policy approaches marks by historical legacies generate gaps, barriers, and challenges to many pregnant persons' reproductive health and rights, shaping their coping and response strategies in important ways. Our interviews revealed practices such as the decision not to disclose (n = 5) or partially disclose their cannabis use to healthcare professionals (n = 2); choosing alternative resources such as midwifes or friendlier medical doctors (n = 3); negotiating their substance use by requesting a medical cannabis prescription (n = 1), changing their use in ways that would at least partially comply with their healthcare professional's recommendations (n = 1), or challenging and pushing back against unwanted recommendations or judgements (n = 2). Thus, pregnant persons and especially racially and socioeconomically marginalized ones tend to adopt strategies that seek to avoid undesired surveillance, stigma, and YPS involvement in ways that echo the previous paradigm of criminalization. In turn, the silence and mistrust that still inhabits healthcare interventions related to cannabis use during pregnancy negatively affect access to quality and comprehensive healthcare, especially for marginalized women.

Avoiding stigma and control through silence

First, many participants reported not disclosing their cannabis consumption to their medical doctors and other healthcare professionals during their pregnancy. This participant, for example, revealed how her perception of her doctor's closed-minded approach to cannabis generated reticence to be transparent about it: "It's like everything I tell you, everything that's consumed with the healthcare system, I've never had a good experience. I'm not inclined to open up to them. You know, even my doctor who's treating me for my pregnancy doesn't know that I smoke. I haven't told him."[34] For her, stigma, judgement, and pathologization of her cannabis use made it hard to build trusting relationships with healthcare professionals. This other participant, a middle-class, white woman in her twenties, who also decided not to disclose her cannabis use, mentioned the negative consequences of this lack of trust on her well-being; she recalled feeling stressed about not knowing what the consequences on her future child's development would be.[35] Therefore, stigma and fear of disclosing cannabis use increased women's anxiety and feeling of isolation, negatively impacting the quality and depth of the reproductive healthcare they received.

These experiences reflect those of many healthcare professionals we interviewed, who argued that fear of YPS involvement amongst their patients led many of them to underreport or even not disclose their cannabis use, since "everyone is afraid of the youth protection."[36] This medical doctor has a similar hypothesis: "I imagine that patients have thought about saying, do I say it, do I not say it, often because of the fear of the famous report to the youth protection. […] I remember one lady who had taken cocaine when she was pregnant, in a crisis situation. She was crying, crying, crying for the, because she was afraid for the condition of her baby, but also because she was afraid of what I was going to do with this information, so it's a dilemma of, I'm telling you because I want to make sure, I want to make sure that my baby is okay. But I don't want to tell you because I'm excessively ashamed and I don't want there to be any consequences in terms of my parenting skills."[37]

Thus, beyond fear of judgement, many women who encountered themselves in precarious financial situation also feared losing access to services and resources. This participant, for example, feared losing access to healthcare by disclosing her cannabis use: "I found myself lying. […] At first, I didn't understand why I'd done it, but for one thing, I'd seen too much of the health system's distrust and mistrust of people who use drugs in the past […] Secondly, I had such a good service that I didn't want to lose it."[38] Fear of YPS and mistrust, for this nurse, was higher amongst women who already had previous experiences with the institution: "often when they're in difficult environments, well it's not the first time they've seen their children taken away because of the YPS, so they're afraid it'll happen to them too."[39] Similarly, this professional argued that, "when people fear the youth protection, it's often because they've had it in their family."[40] As she told us in the interview, in her service, about 50% of parents lose their child's custody – a very high proportion compared to the provincial average. This Indigenous woman of

middle income who experienced YPS during childhood, perceived the disclosure of her cannabis use to healthcare professionals as taking the risk of having her child removed from her custody:

> I've never really felt confident enough, I'd say, to talk about using cannabis. I've always said 'yes, I've used it, and now I don't.' I didn't ask the doctor any more questions, I didn't…maybe my experience with [YPS] also put me off saying, 'OK well I'm not going to say too much because I don't want to find myself in a situation like that again.'[41]

Among those who chose not to disclose their cannabis use, some with sufficient social, cultural, and material resources found alternative resources they deemed safer, including midwifes or a friendlier doctor. This participant, for example, mentions that changing her doctor led her to feel more supported and comfortable to open about her consumption and eventually, reducing her cannabis use.[42]

Strategic partial disclosure

Second, while many women did not disclose their consumption at all, some decided to strategically and partially disclose it to gain information that would help them making more informed decisions, or to push for harm reduction strategies. For example, one woman revealed discussing with their doctor the possibility of obtaining a medical cannabis prescription, to shield themselves for being further stigmatized by other healthcare professionals (n = 1). Others mentioned reducing or selecting their consumption frequency or substance, complying at least partially with the YPS or their healthcare professional's requests. For example, this participant—a Black woman who also is living on welfare support—explicitly reduced her consumption when with her son, collaborating and complying partially with the YPS to prove her efforts and good faith.[43] This other participant—who is in an unstable housing situation and living in high socioeconomic precarity—successfully negotiated her substance use with her doctor, cutting on cocaine use, while maintaining cannabis to continue managing her anxiety.[44] While those in a relationship of trust with their healthcare professionals were able to negotiate their cannabis use, only a minority of women reported pushing back directly against medical judgement and stigma.

In all, pregnant persons with different levels of social and material resources as well as life trajectories used strategies to navigate the healthcare system as cannabis users according to the degree of stigma and threats of YPS involvement they faced.

Additionally, many healthcare professionals reported using strategies to address their patients' mistrust and fear of potential YPS involvement. This involved, sometimes, marking a clear difference between their healthcare service and the YPS by reaffirming the confidentiality of their relationship, and avoiding engaging with them if it threatened their relationship of trust with their patient. For example, this nurse mentions: "I'm always trying to detach myself from the youth proection, it's like, I understand that the youth protection has made a recommendation, but we're going to go with what you want too, you know, because we don't work according to what the youth protection wants, but according to what the person wants."[45] This social worker reported a similar strategy: "If [the patient] says: 'I've been through a lot of shit with social services, I don't want to know anything about social workers, they piss me off at the youth protection…' well, that's a sign that I might back off a little, and leave more room for my nurse colleague. Often, it's less threatening, but I'll still stay present. It's more to give the opportunity to create a bond, despite the mistrust."[46]

In sum, this last section showed that pregnant persons' strategies to cope with or avoid YPS involvement often included practices of silence, partial disclosure, and avoidance that are most prevalent in contexts of drug criminalization.

Conclusions: envisioning cannabis use during pregnancy as a reproductive justice issue

Despite a formal shift from prohibition to legalization in Canadian cannabis regulation, our study reveals that different policy paradigms still overlap in practices and social representations embedded within them. In Quebec, pregnant individuals—particularly those facing socioeconomic and racial marginalization—have remained at the crossroads of punitive approaches and newer ones, including neoliberal, public health, and harm reduction. Through an analysis of the policy objects, subjects, places, and effects that are produced through healthcare services, we have highlighted the ongoing presence of: i) a

vaguely-defined and normative notion of "problematic cannabis use"; ii) ongoing forms of punitive care, particularly through actual, potential, or mere fear of YPS involvement; and iii) strategies of coping, adaptation, and resistance to stigma and punitive care adopted by women, that echo those of the cannabis criminalization era. It could thus be argued that the Cannabis Act still constitutes a "missed opportunity" for the provincial, territorial, and federal governments to advance a deeper social and racial justice agenda throughout the country (Valleriani et al., 2018).

While a social and reproductive justice framework has allowed better understanding drug and health policy effects for marginalized groups in Canada and the United States (Cooper et al., 2023), this approach had not yet been applied to cannabis policy in the context of pregnancy. This article thus joins its voice to a rising scholarship on cannabis policy that acknowledges the role of historical inequities entrenched in drug criminalization in Canada, in shaping post-legalization policy frameworks (Dertadian & Askew, 2024; Virani & Haines-Saah, 2020).

We advanced that cannabis use during pregnancy should be addressed from a reproductive justice perspective, centering the pregnant person's health needs, rights, and agency and ultimately, reducing gender, racial, and class inequities (Pederson et al., 2015). This study thus contributes to the feminist research on cannabis policy by bridging discussions on drug policy with bodily and reproductive autonomy (Diaz & Perrone, 2025; Greene et al., 2023; Idriss-Wheeler et al., 2021; Mathias et al., 2024). As clinical diagnoses of cannabis use disorder have increased since 2018 (Nazif-Munoz et al., 2024), we raise questions that future studies should further explore, including about the role of gendered, raced, and class representations in shaping cannabis-related medical diagnosis and YPS reporting decisions.

From a policy perspective, the study's insights illustrate the necessity to address social stigma within healthcare and social services, especially towards racialized and socioeconomically marginalized women who use cannabis, in order to fully move away from prohibitionism. The study also reveals how women's negative perceptions and experiences with YPS limits their ability to make informed, safe, and healthy decisions during pregnancy, a barrier that policymakers should consider and address when developing cannabis-related measures. In all, we recognize the need to address cannabis use in the context of pregnancy healthcare for all women and pregnant person—building on and expanding harm reduction approaches by emphasizing collective and individual empowerment, as well as care (Young, 1994).

To conclude, this study presents some limitations that could be addressed in future research. Despite our central concern for the inclusion of Indigenous, Métis, Inuit, gender diverse persons, and migrant persons' experiences, our recruitment of these population groups has been overall challenging, possibly indicating these groups' lower access to safe health and social care (Wiese et al., 2023). Future studies should seek to observe more systematically and comparatively how different legal frameworks shape healthcare and social policy approaches during pregnancy across different groups of racialized women and 2SLGBTQQIA+.

Notes

1. We use the term "pregnant person" to refer in general to all persons with the capacity to gestate—including cisgender women, non-binary persons and trans men. However, when referring to the participants of this study, we employ the term "women", since all the participants identify as cis-gender women.
2. While many of the identified psychiatric conditions appear to be sex-specific, affecting women or female non-human animals particularly, several anxiety studies in rodents do not include female subjects. Few studies investigate or distinguish the effects of CBD from those of THC, causal evidence to-date relies on nonhuman animal testing, and finally, in human studies frequency of use is used as a proxy for dosage while disregarding timing of consumption (Cupo et al., 2024).
3. See Dominguez-Cancino, Alunni-Menichini et al. (*under review*) for a detailed overview of the interviewing methods.
4. See Appendix I for a detailed overview of the participants' socioeconomic and professional profiles.
5. The project was approved by Université de Sherbrooke's *Comité institutionnel d'éthique de la recherche* (CIER) (MP-04-2023-765), as well as from the Comité d'Éthique en Recherche du *Centre intégré de santé et de services sociaux* (CISSS) of Montérégie (MP-04-2023-765). We also received ethical approval from the *Centre intégré universitaire de santé et de services sociaux* (CIUSSS) in Mauricie and Centre-du-Québec (CIUSSS-MCQ-MEO-04-2024-697) and Centre-Sud de l'île de Montréal (CIUSSS-CSMTL-MEO-31-2024-2019).
6. E15.

7. E6.
8. E17.
9. E18.
10. E12.
11. E12.
12. E11.
13. E12.
14. E4.
15. E2.
16. E6.
17. E2.
18. E17; E11.
19. E5.
20. E16.
21. E12.
22. E12.
23. E17.
24. E12.
25. E10.
26. E18.
27. E15.
28. E6.
29. E15.
30. E12.
31. E17.
32. FE12.
33. FE04.
34. FE05.
35. FE11.
36. IM09CS.
37. E5.
38. FE17.
39. E17.
40. E16.
41. FE04.
42. FE11.
43. FE01.
44. FE12.
45. E17.
46. TSMC13.

Acknowledgements

We are deeply thankful to the women and healthcare professionals who participated in this study through an interview. We would also like to thank research assistants Yolaine Frossard de Saugy and Genève Guilbert-Gauthier, as well as research coordinator Lysiane Robidoux Léonard. Additionally, we thank Lani Cupo for her insightful comments and revisions on the manuscript. Each author certifies that their contribution to this work meets the standards of Cogent Social Sciences.

Author contribution statement

CRediT: **Rose Chabot**: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Validation, Writing – original draft, Writing – review & editing; **Kristelle Alunni-Menichini**: Conceptualization, Formal analysis, Investigation, Methodology, Project administration, Writing – review & editing; **Karen Aileen Dominguez-Cancino**: Conceptualization, Formal analysis, Investigation, Methodology, Project administration, Writing – review & editing; **Karine Bertrand**: Conceptualization, Methodology, Writing – review & editing; **Marie Jauffret-Roustide**: Writing – review & editing; **Christophe Huỳnh**: Conceptualization, Methodology, Writing – review & editing; **Nadia L'Espérance**: Conceptualization, Methodology, Writing – review & editing; **Julie Loslier**: Conceptualization, Methodology, Writing – review & editing; **Victoria Massamba**: Conceptualization, Methodology, Writing – review & editing; **Pablo Alberto Martínez Díaz**: Writing – review & editing; **José Ignacio Nazif-Munoz**: Conceptualization, Funding acquisition, Methodology, Supervision, Validation, Writing – review & editing.

CRediT roles

Rose Chabot: Writing – original draft, review & editing, methodology, data collection, formal analysis, conceptualization. Kristelle Alunni-Menichini: Project administration, methodology, data collection, formal analysis, conceptualization, manuscript review & validation. Karen A. Dominguez-Cancino: Project administration, methodology, data collection, formal analysis, conceptualization, manuscript review & validation. Karine Bertrand: Conceptualization, methodology, manuscript review & validation. Marie Jauffret-Roustide: Conceptualization, manuscript review & validation. Christophe Huỳnh: Conceptualization, methodology, manuscript review & validation. Pablo Martínez: Manuscript review & validation. Victoria Massamba: Conceptualization, methodology, manuscript review & validation. Nadia L'Espérance: Conceptualization, methodology, manuscript review & validation. Julie Loslier: Conceptualization, methodology, manuscript review & validation. José Ignacio Nazif-Munoz: Project supervision and administration, methodology, data collection, formal analysis, conceptualization, manuscript review & validation.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Ethical approvals

The project was approved by Université de Sherbrooke's *Comité institutionnel d'éthique de la recherche* (CIER) (MP-04-2023-765), as well as the *Comité d'Éthique en Recherche* of the *Centre intégré de santé et de services sociaux* (CISSS) of Montérégie (MP-04-2023-765). We also received ethical approval from the *Centre intégré universitaire de santé et de services sociaux* (CIUSSS) in Mauricie and Centre-du-Québec (CIUSSS-MCQ-MEO-04-2024-697) and Centre-Sud de l'île de Montréal (CIUSSS-CSMTL-MEO-31-2024-2019).

Funding

This work was supported by the Fonds de recherche du Québec - Société et culture, under Grant #322560.

ORCID

Rose Chabot http://orcid.org/0000-0002-1941-3679
Karen Aileen Dominguez-Cancino http://orcid.org/0000-0002-4264-8476
Karine Bertrand http://orcid.org/0000-0002-1452-2454

Data availability statement

Due to the sensitive nature of the research and absence of participant consent, interview data are generally not publicly available. However, anonymized sections of the data and analysis may be shared upon reasonable request, that is, in absence of any security, ethical, or privacy concerns.

References

Bacchi, C. (2009). *Analysing policy: What's the problem represented to be?* Pearson Higher Education.

Bacchi, C., & Goodwin, S. (2016). Making politics visible: The WPR approach. In *Poststructural policy analysis: A guide to practice* (pp. 13–26). Palgrave Macmillan US.

Bartlett, K., Kaarid, K., Gervais, N., Vu, N., Sharma, S., Patel, T., & Shea, A. K. (2020). Pregnant canadians' perceptions about the transmission of cannabis in pregnancy and while breastfeeding and the impact of information from health care providers on discontinuation of use. *Journal of Obstetrics and Gynaecology Canada: JOGC = Journal D'obstetrique et Gynecologie du Canada: JOGC*, *42*(11), 1346–1350. https://doi.org/10.1016/j.jogc.2020.04.015

Benoit, 1M., & Lévesque, G. 2 (2022). La légalisation du cannabis au Canada: Les stratégies de résistance du Québec à une politique unilatérale du fédéral. *Revue Gouvernance*, *19*(2), 77–98. https://doi.org/10.7202/1094077ar

Boyd, S. (2019). Gendered drug policy: Motherisk and the regulation of mothering in Canada. *The International Journal on Drug Policy*, *68*, 109–116. https://doi.org/10.1016/j.drugpo.2018.10.007

Boyd, S. C., Carter, C. I., & MacPherson, D. (2017). *More harm than good: Drug policy in Canada*. Fernwood Publishing.

Brown, S., Shoveller, J., Chabot, C., & LaMontagne, A. D. (2013). Risk, resistance and the neoliberal agenda: Young people, health and well-being in the UK, Canada and Australia. *Health, Risk & Society*, *15*(4), 333–346. https://doi.org/10.1080/13698575.2013.796346

Bruno, T., & Csiernik, R. (2023). From laggard to leader? Drug policy in Canada. Responding to the Oppression of Addiction Canadian Social Work Perspectives24–36.

Buydens, N. L. (2005). Bad Mothers as "Brown" Mothers in Western Canadian Policy Discourse: Substance-Abusing Mothers and Sexually Exploited Girls. In S. Meagher & P. Diquinzio (Eds.), *Women and Children First: Feminism, Rhetoric, and Public Policy*. State University of New York Press. https://doi.org/10.1353/book4977

Cabinet du ministre responsable des Services sociaux. (2023). Fin de la pratique du signalement des naissances—Mise en place d'un plan de services préventifs et intensifs en période prénatale Gouvernement du Québec. https://www.quebec.ca/nouvelles/actualites/details/fin-de-la-pratique-du-signalement-des-naissances-mise-en-place-dun-plan-de-services-preventifs-et-intensifs-en-periode-prenatale-47068

Cates, J. M. (2021). *Cannabis use on Turtle Island [Master of Arts]*. University of British Columbia.

Ceasar, R. C., Gould, E., Laughter, J., Granacki, J., Kirsch, K., Chauca, E., Santos, J. J., Becerra, L., Cazares, L., Habre, R., Farzan, S., Tamatam, S., Nguyen, R. M., Breton, C. V., & Bastain, T. M. (2023). "They might take my baby away:" Black and Latina peoples' experiences of using cannabis during pregnancy in California while engaged in perinatal care. *Journal of Perinatology: official Journal of the California Perinatal Association*, *43*(12), 1497–1499. https://doi.org/10.1038/s41372-023-01781-7

Chaput, K. H., Lebel, C., & McMorris, C. A. (2020). Commentary: Totality of the evidence suggests prenatal cannabis exposure does not lead to cognitive impairments: A systematic and critical review. *Frontiers in Psychology*, *11*, 1891. https://doi.org/10.3389/fpsyg.2020.01891

Coen-Sanchez, K., Idriss-Wheeler, D., Bancroft, X., El-Mowafi, I. M., Yalahow, A., Etowa, J., & Yaya, S. (2022). Reproductive justice in patient care: Tackling systemic racism and health inequities in sexual and reproductive health and rights in Canada. *Reproductive Health*, *19*(1), 44., s12978-022-013287 https://doi.org/10.1186/s12978-022-01328-7

Cooper, H. L. F., Rice, W., Cummings, J., Livingston, M. D., Peddireddy, S., Rogers, E., Dunlop, A., Kramer, M., & Hernandez, N. D. (2023). Overdoses, reproductive justice, and harm reduction. *American Journal of Public Health*, *113*(9), 933–935. https://doi.org/10.2105/AJPH.2023.307379

Crenshaw, K. W. (2013). Mapping the margins: Intersectionality, identity politics, and violence against women of color. In *The public nature of private violence* (pp. 93–118). Routledge.

Crépault, J.-F. (2018). Cannabis legalization in Canada: Reflections on public health and the governance of legal psychoactive substances. *Frontiers in Public Health*, *6*, 220. https://doi.org/10.3389/fpubh.2018.00220

Cupo, L., Dominguez-Cancino, K. A., Nazif-Munoz, J. I., & Chakravarty, M. M. (2024). Prenatal cannabis exposure in the clinic and laboratory: What do we know and where do we need to go? Available at SSRN 4853554. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4853554

Currie, C., Wild, T. C., Schopflocher, D., & Laing, L. (2015). Racial discrimination, post-traumatic stress and prescription drug problems among Aboriginal Canadians. *Canadian Journal of Public Health = Revue Canadienne de Sante Publique*, *106*(6), e382–e387. https://doi.org/10.17269/CJPH.106.4979

Dell, C. A., Desjarlais, V., & Kilty, J. M. (1969). This is who I am: Aboriginal women's healing from criminalization and problematic drug use. *Journal of Prisoners on Prisons*, *20*(1), 58–71. https://doi.org/10.18192/jpp.v20i1.5274

Dell, C. A., & Kilty, J. M. (2013). The creation of the expected Aboriginal woman drug offender in Canada: Exploring relations between victimization, punishment, and cultural identity. *International Review of Victimology*, *19*(1), 51–68. https://doi.org/10.1177/0269758012447215

Dennis, C.-L., & Vigod, S. (2021). Cannabis use in pregnancy: A harm reduction approach is needed with a focus on prevention and positive intervention. *Evidence-Based Nursing*, *24*(2), 58–58. https://doi.org/10.1136/ebnurs-2019-103177

Dertadian, G. C., & Askew, R. (2024). Towards a social harm approach in drug policy. *The International Journal on Drug Policy*, *127*, 104425. https://doi.org/10.1016/j.drugpo.2024.104425

Diaz, M. A., & Perrone, D. (2025). The war on drugs is a war on women: Louisiana's Abortion Law. *The International Journal on Drug Policy*, *140*, 104804. https://doi.org/10.1016/j.drugpo.2025.104804

Doggett, A., Belisario, K. L., McDonald, A. J., De Jesus, J., Vandehei, E., Gillard, J., Lee, L., & MacKillop, J. (2025). Changes in cannabis attitudes and perceptions in the five years following recreational legalization in Canada: Findings from an observational cohort study of community adults. *The International Journal on Drug Policy*, *140*, 104782. https://doi.org/10.1016/j.drugpo.2025.104782

Dominguez-Cancino, K. A., Chabot, R., Saugy, Y. F. D., Alunni-Menichini, K., Robidoux-Léonard, L., Guilbert-Gauthier, G., Bertrand, K., Huỳnh, C., Martínez, P., Vasiliadis, H.-M., L'Espérance, N., Massamba, V., Loslier, J., & Nazif-Munoz, J. I. (2025). Talking with pregnant women exposed to cannabis use after cannabis legalization: Experiences of professionals working in Québec's Social and Healthcare system. *SSM - Qualitative Research in Health*, *7*, 100524. https://doi.org/10.1016/j.ssmqr.2025.100524

Duko, B., Pereira, G., Tait, R. J., Betts, K., Newnham, J., & Alati, R. (2022). Prenatal tobacco and alcohol exposures and the risk of anxiety symptoms in young adulthood: A population-based cohort study. *Psychiatry Research*, *310*. https://doi.org/10.1016/j.psychres.2022.114466

El-Mowafi, I. M., Yalahow, A., Idriss-Wheeler, D., & Yaya, S. (2021). The politest form of racism: Sexual and reproductive health and rights paradigm in Canada. *Reproductive Health*, *18*(1), 59. s12978-021-01117–01118 https://doi.org/10.1186/s12978-021-01117-8

Ettorre, E. (2004). Revisioning women and drug use: Gender sensitivity, embodiment and reducing harm. *International Journal of Drug Policy*, *15*(5-6), 327–335. https://doi.org/10.1016/j.drugpo.2004.06.009

Ettorre, E. (2015). Embodied Deviance, Gender, and Epistemologies of Ignorance: Re-Visioning Drugs Use in a Neurochemical, Unjust World. *Substance Use & Misuse*, *50*(6), 794–805. https://doi.org/10.3109/10826084.2015.978649

Ezard, N. (2001). Public health, human rights and the harm reduction paradigm: From risk reduction to vulnerability reduction. *International Journal of Drug Policy*, *12*(3), 207–219. https://doi.org/10.1016/S0955-3959(01)00093-7

Fischer, B., Russell, C., & Boyd, N. (2020). A century of cannabis control in Canada: A brief overview of history, context and policy frameworks from prohibition to legalization. Legalizing Cannabis (pp. 89–115).

Government of Canada. (2018). Est-il sécuritaire de consommer du cannabis pendant la période précédant la conception, la grossesse et l'allaitement?. Ministry of Health. https://www.canada.ca/content/dam/hc-sc/documents/services/publications/drugs-health-products/is-cannabis-safe-during-preconception-pregnancy-breastfeeding/est-il-securitaire-consommer-cannabis-conception-grossesse-allaitement.pdf

Greene, S., Vaccaro, M., Bernier, A., Griffith, G., Ion, A., Maurice, R., Gabel, C., & Blake, M. (2023). "Digging in": Stigma and surveillance in the lives of pregnant and breastfeeding mothers who consume cannabis. *Critical Public Health*, *33*(5), 697–708. https://doi.org/10.1080/09581596.2023.2262739

Haines-Saah, R. J., & Fischer, B. (2021). Youth cannabis use and Legalization in Canada–Reconsidering the fears, myths and facts three years in. *Journal of the Canadian Academy of Child and Adolescent Psychiatry = Journal de L'Academie Canadienne de Psychiatrie de L'enfant et de L'adolescent*, *30*(3), 191–196.

Hall, W., Stjepanović, D., Dawson, D., & Leung, J. (2023). The implementation and public health impacts of cannabis legalization in Canada: A systematic review. *Addiction (Abingdon, England)*, *118*(11), 2062–2072. https://doi.org/10.1111/add.16274

Hammond, D., Goodman, S., Wadsworth, E., Rynard, V., Boudreau, C., & Hall, W. (2020). Evaluating the impacts of cannabis legalization: The International Cannabis Policy Study. *The International Journal on Drug Policy*, *77*, 102698. https://doi.org/10.1016/j.drugpo.2020.102698

Haraway, D. (1988). Situated knowledges: The science question in feminism and the privilege of partial perspective. *Feminist Studies*, *14*(3), 575. https://doi.org/10.2307/3178066

Hesse-Biber, S. (2012). Feminist approaches to triangulation: Uncovering subjugated knowledge and fostering social change in mixed methods research. *Journal of Mixed Methods Research*, *6*(2), 137–146. https://doi.org/10.1177/1558689812437184

Hunt, A. (1999). *Governing morals: A social history of moral regulation*. Cambridge University Press.

Idriss-Wheeler, D., El-Mowafi, I. M., Coen-Sanchez, K., Yalahow, A., & Yaya, S. (2021). Looking through the lens of reproductive justice: The need for a paradigm shift in sexual and reproductive health and rights research in Canada. *Reproductive Health*, *18*(1), 129. https://doi.org/10.1186/s12978-021-01169-w

Indian Residential School History and Dialogue Centre. (2025). The Sixties Scoop. University of British Colombia. https://irshdc.ubc.ca/learn/the-child-welfare-system-and-the-sixties-scoop/

Indigenous Services Canada. (2025). Reducing the number of Indigenous children in care [Fact sheet]. Government of Canada. https://www.sac-isc.gc.ca/eng/1541187352297/1541187392851

Kozak, T., Ion, A., & Greene, S. (2022). Reimagining research with pregnant women and parents who consume cannabis in the era of legalization: The value of integrating intersectional feminist and participatory action approaches. *Cannabis and Cannabinoid Research*, *7*(1), 11–15. https://doi.org/10.1089/can.2020.0086

Lo, J. O., Shaw, B., Robalino, S., Ayers, C. K., Durbin, S., Rushkin, M. C., Olyaei, A., Kansagara, D., & Harrod, C. S. (2024). Cannabis use in pregnancy and neonatal outcomes: A systematic review and meta-analysis. *Cannabis and Cannabinoid Research*, *9*(2), 470–485. https://doi.org/10.1089/can.2022.0262

Luna, Z., & Luker, K. (2013). Reproductive Justice. *Annual Review of Law and Social Science*, *9*(1), 327–352. https://doi.org/10.1146/annurev-lawsocsci-102612-134037

Lux, M. K. (2016). *Separate Beds: A History of Indian Hospitals in Canada, 1920s-1980s*. University of Toronto Press. https://doi.org/10.3138/9781442663114

Marshall, S. G. (2015). Canadian drug policy and the reproduction of Indigenous inequities. *International Indigenous Policy Journal*, *6*(1), 1–19. https://doi.org/10.18584/iipj.2015.6.1.7

Massé, R. (2013). Réduction des méfaits et tolérance en santé publique: enjeux éthiques et politiques. Presses de l'Université Laval.

Mathias, H., Foster, L. A., & Rushton, A. (2024). Programs and practices that support pregnant people who use drugs' access to sexual and reproductive health care in Canada: A scoping review. *BMC Pregnancy and Childbirth*, *24*(1), 72. https://doi.org/10.1186/s12884-023-06225-w

McKenzie, H. A., Varcoe, C., Nason, D., McKenna, B., Lawford, K., Kelm, M.-E., Wajuntah, C. O., Gervais, L., Hoskins, J., Anaquod, J., Murdock, J., Murdock, R., Smith, K., Arkles, J., Acoose, S., & Arisman, K. (2022). Indigenous women's resistance of colonial policies, practices, and reproductive coercion. *Qualitative Health Research*, *32*(7), 1031–1054. https://doi.org/10.1177/10497323221087526

McNulty, M. (1987). Pregnancy police: The health policy and legal implications of punishing pregnant women for harm to their fetuses. *New York University School of Law Review of Law & Social Change*, *16*, 277.

Miller, J., & Carbone-Lopez, K. (2015). Beyond 'doing gender': Incorporating race, class, place, and life transitions into feminist drug research. *Substance Use & Misuse*, *50*(6), 693–707. https://doi.org/10.3109/10826084.2015.978646

Mosher, C. J. (2011). Convergence or divergence? recent developments in drug policies in Canada and the United States. *American Review of Canadian Studies*, *41*(4), 370–386. https://doi.org/10.1080/02722011.2011.623409

Myran, D. T., Roberts, R., Pugliese, M., Corsi, D., Walker, M., El-Chaâr, D., Tanuseputro, P., & Simpson, A. (2023). Acute care related to cannabis use during pregnancy after the legalization of nonmedical cannabis in Ontario. *CMAJ: Canadian Medical Association Journal = journal de l'Association medicale canadienne*, *195*(20), E699–E708. https://doi.org/10.1503/cmaj.230045

Nazif-Munoz, J. I., Martínez, P., Huỳnh, C., Massamba, V., Zefania, I., Rochette, L., & Vasiliadis, H.-M. (2024). Changes in prenatal cannabis-related diagnosed disorders after the Cannabis Act and the COVID-19 pandemic in Quebec, Canada. *Addiction (Abingdon, England)*, *119*(10), 1784–1791. https://doi.org/10.1111/add.16564

Nichol, E., Pauly, B., Milligan, K., & Urbanoski, K. (2025). Help-seeking among pregnant and parenting women who use drugs: Mitigating stigma through relationships. *The International Journal on Drug Policy*, *140*, 104818. https://doi.org/10.1016/j.drugpo.2025.104818

Owusu-Bempah, A., & Luscombe, A. (2021). Race, cannabis and the Canadian war on drugs: An examination of cannabis arrest data by race in five cities. *The International Journal on Drug Policy*, *91*, 102937. https://doi.org/10.1016/j.drugpo.2020.102937

Pauly, B. (2008). Harm reduction through a social justice lens. *The International Journal on Drug Policy*, *19*(1), 4–10. https://doi.org/10.1016/j.drugpo.2007.11.005

Pederson, A., Greaves, L., & Poole, N. (2015). Gender-transformative health promotion for women: A framework for action. *Health Promotion International*, *30*(1), 140–150. https://doi.org/10.1093/heapro/dau083

Pederson, A., Raphael, D., & Johnson, E. (2016). Gender, race, and health inequalities. In K. Bezanson & M. Webber (Eds.), *Rethinking society in the 21st century, fourth edition: Critical readings in sociology*. Canadian Scholars' Press.

Power, E., & Polzer, J. (2016). *Neoliberal governance and health: Duties, risks, and vulnerabilities*. McGill-Queen's Press - MQUP.

Pratschke, J. (2025). Harm reduction strategies for cannabis-related problems: A literature review and typology. *European Archives of Psychiatry and Clinical Neuroscience*, *275*(2), 379–388. https://doi.org/10.1007/s00406-024-01839-3

Quirion, B. (2002). Réduction des méfaits et gestion des risques: Les frontières normatives entre les différents registres de régulation de la pratique psychotrope. *Déviance et Société*, *26*(4), 479–495. https://doi.org/10.3917/ds.264.0479

Quirion, B., & Bellerose, C. (2008). Discours néolibéral d'émancipation dans le champ de l'usage des drogues: Réduction des méfaits et empowerment. *Sociologie et Sociétés*, *39*(1), 29–50. https://doi.org/10.7202/016931ar

Ross, L. J. (2017). Reproductive justice as intersectional feminist activism. *Souls*, *19*(3), 286–314. https://doi.org/10.1080/10999949.2017.1389634

Rotermann, M. (2019). Analysis of trends in the prevalence of cannabis use and related metrics in Canada. *Health Reports*, *30*(6), 3–13. https://doi.org/10.25318/82-003-x201900600001-eng

Rubin-Kahana, D. S., Crépault, J.-F., Matheson, J., & Le Foll, B. (2022). The impact of cannabis legalization for recreational purposes on youth: A narrative review of the Canadian experience. *Frontiers in Psychiatry*, *13*, 984485. https://doi.org/10.3389/fpsyt.2022.984485

Sands, R. G., & Roer-Strier, D. (2006). Using data triangulation of mother and daughter interviews to enhance research about families. *Qualitative Social Work*, *5*(2), 237–260. https://doi.org/10.1177/1473325006064260

Shivas, T., & Charles, S. (2005). Behind bars or up on a pedestal: Motherhood and fetal harm. In S. Meagher & P. Diquinzio (Eds.), *Women and children first: Feminism, rhetoric, and public policy*. State University of New York Press. https://doi.org/10.1353/book4977

Singer, L. T., Lewis, B. A., & Noland, J. S. (2021). Commentary: Totality of the evidence suggests prenatal cannabis exposure does not lead to cognitive impairments: A systematic and critical review. *Frontiers in Psychology*, *12*. https://doi.org/10.3389/fpsyg.2021.651064

Spence, N., Wells, S., George, J., & Graham, K. (2014). An examination of marijuana use among a vulnerable population in Canada. *Journal of Racial and Ethnic Health Disparities*, *1*(4), 247–256. https://doi.org/10.1007/s40615-014-0031-5

Stengel, C. (2014). The risk of being 'too honest': Drug use, stigma and pregnancy. *Health, Risk & Society*, *16*(1), 36–50. https://doi.org/10.1080/13698575.2013.868408

Valleriani, J., Lavalley, J., & McNeil, R. (2018). A missed opportunity? Cannabis legalization and reparations in Canada. *Canadian Journal of Public Health = Revue Canadienne de Sante Publique*, *109*(5-6), 745–747. https://doi.org/10.17269/s41997-018-0121-y

Virani, H. N., & Haines-Saah, R. J. (2020). Drug decriminalization: A matter of justice and equity, not just health. *American Journal of Preventive Medicine*, *58*(1), 161–164. https://doi.org/10.1016/j.amepre.2019.08.012

Watson, T. M., & Erickson, P. G. (2019). Cannabis legalization in Canada: How might 'strict' regulation impact youth? *Drugs: Education, Prevention and Policy*, *26*(1), 1–5. https://doi.org/10.1080/09687637.2018.1482258

Wiese, J. L., Watson, T. M., Owusu-Bempah, A., Hyshka, E., Wells, S., Robinson, M., Elton-Marshall, T., & Rueda, S. (2023). Overpoliced and underrepresented: perspectives on cannabis legalization from members of racialized communities in Canada. *Contemporary Drug Problems*, *50*(1), 25–45. https://doi.org/10.1177/00914509221142156

Young, I. M. (1994). Punishment, treatment, empowerment: Three approaches to policy for pregnant addicts. *Feminist Studies*, *20*(1), 32. https://doi.org/10.2307/3178429