Special health care needs of homeless pregnant women

As women and families join the ranks of the homeless in increasing numbers, many women find themselves confronting both pregnancy and homelessness. When pregnancy accompanies the precarious state of homelessness, the need for adequate shelter is not being met during one of the most critical periods of a woman's life. This article focuses on the unique health needs of homeless pregnant women. Detailed accounts of the daily life experiences of African American, Anglo, and Latina homeless pregnant women were derived from an ethnographic study conducted in a large metropolitan area in southern California. Their pregnancies were difficult because normal physiological changes of pregnancy often became pathological, signs of potential complications went unnoticed or unattended, and minor discomforts of pregnancy were exacerbated by the women's environment. Nursing therapeutics that support health maintenance and coping strategies of the women while on the streets or in shelters were explicated. Key words: *health care needs, homelessness, poverty, pregnancy*

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ALTHOUGH PREGNANCY IS a "normal" health condition, it nevertheless is a period of physiological and psychological vulnerability for the mother and the fetus even under optimal conditions. When pregnancy occurs in the precarious state of homelessness, the situation is particularly volatile; during one of the most critical periods of a woman's life a basic need, adequate shelter, is not being met. Despite the fact that within the past 5 years more attention has been focused on women and children as particularly vulnerable subgroups of the homeless population, there is a dearth of research and literature about homeless women who are pregnant. This is a striking gap, since the pregnancy rate for homeless women has been estimated to be twice the national rate.[1] Moreover, many of the conditions often associated with homelessness have been independently linked with adverse effects and outcomes during the entire childbearing cycle. Circumstances associated with homelessness, such as stress and

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anxiety, social isolation, poverty, malnutrition, substance abuse, psychological disorders, and poor utilization of health services,[2–6] have also been associated with complications of pregnancy, dysfunctional labor and difficult delivery, fetal distress, maternal and neonatal morbidity and mortality, and dysfunctional parenting. This article describes one of several themes that emerged from an ethnographic study designed to describe the daily life experiences of homeless pregnant women.

DESIGN AND METHODS

The study was conducted in a large metropolitan area in southern California over a 3-year period. Data were collected primarily through participant observation. The researcher "buddied" with 15 homeless pregnant women from five different shelters. The time spent with each woman varied from several weeks to more than 1 year. The researcher spent time with the women in the shelters and accompanied them to the emergency department, the housing authority, the welfare office, and health clinics and while grocery shopping, apartment hunting, and job hunting. This intense social interaction with the women in their own milieu allowed the researcher to witness the homeless experience through the eyes of the women and in a naturalistic mode.

The researcher interacted with scores of other homeless pregnant women who served as informants through health education classes taught by the researcher at some of the shelters and through informal, unstructured interviews in various settings. In addition, shelter operators and directors, landlords, social workers, nurses, physicians, housing officials, and family members or significant others of the sample members were interviewed. Finally, general and focused observations were made of shelters, neighborhoods, and agencies frequented by the participants so that the intimacy of daily routine activities could be explored against the backdrop of the wider realm of community life.

SAMPLE

The sample (N = 15) was intentionally small to allow for in-depth exploration and description. African American, Latina, and white women were represented in the purposefully selected sample. Their ages ranged from 18 to 39. Three of the women were married, two were cohabiting, four were divorced, and six were single. Each woman had at least 1 child (other than her pregnancy), and one woman had 13 children, although only 8 were with her during the time of the study.

The women were in various stages of the childbearing cycle during their participation in the project. Some were a few weeks pregnant at the time initial contact was made. One woman terminated her pregnancy during the course of the study, and another gave birth to twins. The researcher initiated contact with one mother at 28 weeks gestation and followed her through the course of the pregnancy and birth and into a subsequent pregnancy. During the time the women participated in the study, none of them were employed.

The education level of the women ranged from some years of high school to an associate degree. The women were homeless for a variety of reasons including inability to afford rent; discrimination in housing because of their ethnicity, number of children, re-

ceipt of welfare, or pregnancy; undocumented resident status; the convoluted consequences of substance abuse; flight from abuse and violence; estrangement from family of origin; escape from dysfunctional relationships; or a combination of these factors. Many were living in shelters in an effort to have time out from a bad situation and to "tide themselves over" and gather their wits until they could stabilize their lives and finances.

SETTING

The shelters from which the sample was drawn were located throughout the metropolitan area and varied widely in terms of physical structure, policies and philosophy, and services offered. Shelters included a single room occupancy (SRO) hotel in the downtown area, a church converted into a shelter, a Victorian mansion located in an older neighborhood at the city's core, an apartment building near the beach, and a two-story frame house located in an area adjacent to but separate from a middle-income subdivision in the northeast section of the city. The services provided by the shelters ranged from simply a bed and a meal to a myriad of services including child care services, job training, transportation, life management skills training, substance abuse counseling, mental health services and referrals, layettes for infants, and Boy Scout troops. Policies of the shelters also varied substantially: Some shelters had curfews, limits on length of stay, house chores for the residents, savings programs, and specific rules for visitors. Two of the shelters included in the study had policies against accepting pregnant women. (The usual concern had to do with liability in the event women experienced complications or problems while in the shelter.) They accepted the women not knowing their pregnancy status but retained them once their condition was known.

FINDINGS

In each phase of the childbearing period distinct health-related needs were identified that evolved out of the daily life experiences of the homeless women.

Conception

The women usually conceived under less than desirable conditions. Rarely was there evidence that a pregnancy was consciously planned during the transient period of homelessness. When one pregnant woman was asked how she dealt with her menstrual period when she was living on the street, her response was, "I never had my period 'cause I was pregnant the whole time I was homeless!" The timing, the place, the partner in conception, the manner in which conception took place, and the circumstances surrounding the conception were often not the woman's choice or within the realm of her control. Although a domiciled woman's pregnancy was sometimes the precipitating factor that caused the woman to become homeless, the majority of women in the study became pregnant during the time they were homeless. From the self-reports of the women, several preeminent factors contributed to their becoming pregnant: victimization, economic survival, lack of access to contraceptives, the need for closeness and intimacy, uncertain fertility, and hope for the future.

Victimization, survival, and access issues

A small number of women became pregnant after linking with men on the streets in

hopes that the men would share with them, provide for them, and protect them. Relatedly, women clung to old boyfriends and mates whose presence and support were sporadic and unstable with the expectation that the men would eventually "come through." Other sample members became pregnant while in dependent relationships in which their partners were controlling, exploitive, and abusive. The women, because of their economic dependence, were afraid and often ambivalent about leaving. They felt that they were not in a position to insist on decent treatment, or, in many cases, to demand that a condom be used during sexual relations.

Some of the women were so poor that they had to make choices about whether to buy food and other necessities or contraceptives. Many women were unaware of how to acquire contraceptives at low or no cost. Others were too preoccupied with the hassles and strife of trying to survive on a daily basis to secure contraceptives.

Some homeless shelters had condoms available; however, disbursement was often through a caseworker. Although many women (and men) availed themselves of the free condoms, others were reluctant to obtain them in this manner because they were embarrassed or concerned that their sexual conduct was being monitored or that they were being judged. While some women willingly became involved with a partner or were having sex in an abusive relationship, others were coerced to have sex or were raped in shelters or on the street.

Need for closeness and intimacy

Some of the homeless women simply had a need for closeness and intimacy during a difficult time. Sexual liaisons were sometimes formed in shelters, and casual indiscriminate sex sometimes occurred. In some shelters every effort was made to keep couples and families together, but in others married couples could not stay together because of gender-specific policies. Most shelters had curfews and rules about visitors, whether or not the visitor was a spouse. For example, one shelter for women required male visitors to attend a religious service in the shelter to have visiting privileges with female residents. Also, male visitors were not allowed to visit in the residents' room. Thus, liaisons even of married couples were often contrived. Sexual encounters and opportunities for intimacy were often hurried and set the stage for lack of planning and protection.

Uncertain fertility

A few of the homeless women reported that menses had stopped or had become irregular. With these changes, women often engaged in sex but were uncertain of their fertility and could not gauge the possibility of their becoming pregnant.

Hope for the future

As foreboding as the situation of being homeless and pregnant was, some mothers found their pregnancies to be their only source of joy. They marveled at quickening, and the special movements of the fetus reminded them of the hope that was in new life. For some women, the only time they demonstrated any semblance of happiness was when comments were made about their children. For them, their pregnancy was the main impetus for them to resolve past problems and to continue to seek a better life. Said one mother, "My children are my best example, my role model for the future." The feelings of empowerment, control, and ownership engendered by being pregnant

and giving birth countered the powerlessness they felt in losing their worldly possessions and not having suitable housing.

Physiological changes of pregnancy

When pregnancy coexists with homelessness, there are multiple simultaneous challenges. One is the normal physiological changes of pregnancy. Most women have physical complaints or minor discomforts of pregnancy related to physiological changes. None of the women had consistent prenatal care so that they could be assured that what they were experiencing was normal, nor was the opportunity provided to differentiate what was normal from what may have been pathological. Sometimes normal changes were confused with pathological conditions, and sometimes normal changes were exacerbated by the daily life circumstances of homelessness and led to a pathological condition. Moreover, they had limited means to relieve their discomforts. The physical discomforts were in some cases the least of their worries or merely another aspect of life over which they had little control. "I just deal with it" was the comment of one homeless woman.

Urinary tract infections

Urinary tract infections, one of the primary causes of preterm labor, is a key example.[7] Urinary stasis is to be avoided during pregnancy to prevent urinary tract infection. Pregnant women are encouraged to void every 2 to 3 hours, and they naturally have the urge to urinate frequently, especially in the first and third trimester. In addition, many pregnant women experience nocturia.[7] For some women in the shelters, voiding when they needed to was difficult because of communal bathrooms that were not clean or safe. Sample members stated that they were reluctant to use the facilities and avoided using them except when absolutely necessary. The women often held their urine as long as possible to avoid walking the distance to the bathroom because they lacked privacy or were afraid to get up in the middle of the night to walk to the toilet. When on the streets, they simply had to go when and where facilities were found (eg, gas stations, fast food restaurants, libraries, or other public buildings). The backache that often accompanies urinary tract infection was often mistaken for discomforts associated with sleeping on cots or thin, lumpy, sagging mattresses.

Cindi, who with her husband and two toddlers slept in a friend's car for a few weeks, gave this account of her experience with preterm labor: "That's when I slept in the car, believe it or not. I had my son on top of me and all of a sudden my stomach started getting hard and soft, hard and soft, hard and soft. When I went in [to the emergency department] they gave me a shot to stop the contractions. Then they let me go." When I asked Cindi whether the hospital staff knew she was sleeping in a car, she responded that she did not tell them because she was afraid her children might be taken away from her.

Keeping dry and clean

Vaginal discharge increases during pregnancy, and for these pregnant homeless women it was difficult to stay dry and clean. They could not always launder their clothes whenever they needed to. Women who had yeast infections were particularly uncomfortable and waited until they were "up a wall" before they sought medical help. For others, vaginal discharge was a symptom of

a sexually transmitted disease that often went untreated or for which treatment was delayed.

Morning sickness

These women also had difficulty in dealing with the nausea and vomiting that often occur in the early months of pregnancy. The standard advice of eating small frequent meals was not apropos, since in many instances the women had to eat at regimented times. Although morning sickness is a self-limiting nuisance that usually disappears at about 14 to 16 weeks of gestation, Suzanne's episodes of nausea and vomiting developed into hyperemesis gravidarum,[7] which caused dehydration and malnutrition and necessitated hospitalization. When her symptoms subsided, she was released from the hospital with no further follow-up.

Eating well

Maintaining an adequate diet that includes the recommended caloric intake and proper nutrients, one of the cardinal principles for optimal pregnancy outcome, was a challenge for the majority of these homeless pregnant women.[8] For women who lived in shelters, getting meals was usually not a major problem. Food was available at scheduled mealtimes. Most shelters attempted to serve nutritious meals, but often the need to buy and prepare in bulk on a limited budget resulted in a preponderance of unappetizing meals that were high in fat and limited in variety.

In some shelters and in transitional housing with kitchens or kitchenettes, the women had to purchase their own food with cash or food stamps but encountered myriad problems. Sometimes their food was eaten or stolen by other residents. Choice is limited in poor neighborhoods and industrial areas. The closest grocery stores were often privately owned neighborhood stores or convenience stores, which tend to be expensive and often do not carry fresh meat, vegetables, and fruit. Transportation was inadequate, so they usually could buy only what they could carry. Often the women bought and ate what was the most inexpensive, most filling, and most quickly prepared and consumed: junk food and fast food.

Roselle, a 23-year-old mother, rode her bike to the store. She perched her 4-year-old daughter in a large basket in the front and anchored her groceries in a double-pouched knapsack in the rear. As the woman's pregnancy advanced, however, she had to abandon this mode of transportation. Other women sent their children to the store. Women who lived in SRO hotel rooms had to buy or attain food right before consumption because of lack of storage space and refrigeration. Soup kitchens and other public areas designated for feeding homeless people were other options for food.

The worst scenario involved the women who had to panhandle. Sometimes rather than give the women cash, passersby took them to a restaurant and bought them a meal. In fact, a number of individuals commiserated with these pregnant, homeless women. The women were rarely ignored, and instances of strangers attempting to link pregnant women with services or their families were reported by the respondents.

Women who lived in shelters benefited from services offered by the shelter and were linked with programs such as the Special Supplemental Food Program for Women, Infants, and Children (WIC) so they could get adequate food for themselves

and their children. Although no member of the sample was known to be diabetic or preeclamptic, these conditions are possibilities among homeless pregnant women with erratic dietary habits and personal environmental stresses. The more extreme instances of undernutrition or malnutrition were often related to substance abuse. Alcoholic women would simply drink more than they ate, and those on cocaine and other drugs often were so driven by their addictions that they bypassed meals even when food was readily available.

The last trimester

Late in the third trimester, most pregnant women not only experience general fatigue but also tire of their condition. They experience shortness of breath, insomnia, and general discomfort. Homeless women are no exception. Most of the women in the sample simply put up with it. Few of them had access to the small things, like herbal tea, extra pillows, or a warm shower, that make this period more livable. Nor did the majority of them have a partner to rub their back, tie their shoes, or perform other niceties. Many of them had to continue the pace of looking for an apartment and other services even though they were exhausted.

Some shelter operators and social workers contended that during this difficult period, in particular, women who used drugs would shoot up with cocaine to speed up the initiation of their labor. There was no evidence that this happened among the women in the sample. However, at least two women stated that they took castor oil in the hopes that this would ease them into labor. Other women, although uncomfortable during this time, were less concerned about speeding up the birth date of their infant than about "racing with their gestational clock." They made every attempt to find a permanent living space for themselves, their infant, and other children or family members. They did not want their infant born in a shelter, in unfamiliar surroundings among strangers.

Mood swings

The mood swings that many pregnant women experience are related to normal fluctuations in hormones, uncertainty about role changes, and fatigue.[9] In these pregnant homeless women, however, the hassles and strains of surviving from day to day were superimposed on the normal emotional changes. The fact that some women had histories of mental illness and others had problems with substance abuse further complicated the situation. It was difficult to disentangle the source or sequential order of emotional distress. Regardless of the derivation of emotional upheavals, avenues for relieving their distress were minimal. A few shelters had well-developed case management plans and were able to enroll women in mental health programs either in the shelter or in outside agencies. However, most women had no recourse.

Some women slipped deeper into a cycle of substance abuse to escape their predicament and deal with their pain. Estelle was so desperate that during her eighth month of pregnancy, she dragged her two children with her as she went from crack house to crack house and drug dealer to drug dealer to nourish her addiction. She tearfully recounted how even the drug dealers that she encountered were disgusted with her for potentially harming her unborn child and for jeopardizing the safety of her children. In fact, they threatened to report her to the Department of Children's Services.

NURSING THERAPEUTICS

There are specific established regimens of care for each of the conditions identified in the previous section. For example, urinary tract infections are treated with antibiotics, and instructions about personal hygiene, the need to frequently empty the bladder, and increased hydration are usually given. This therapeutic approach may not be adequate for homeless pregnant women, however, without addressing the context of the pregnancy and the symptoms. For example, the nurse may help the woman identify bathrooms she could use during the day and safety measures that would facilitate the use of the shelter bathrooms.

The special health needs of these homeless pregnant women derived from the pregnancy itself and were accentuated by the women's living conditions. The crowdedness, unsanitary surroundings, lack of privacy, exposure to unpleasant environmental elements (eg, weather, noise, odors), lack of safety, moving from place to place, lack of personal space, and the limited ability of the women to participate in everyday life as "regular people" jeopardized the pregnancy and the outcome for the mother and the newborn. No attempt will be made to explicate nursing strategies to directly match these conditions. However, general nursing therapeutics that encompass and align usual regimens of care with others appropriate to the homelessness experience will be discussed.

Identify and dignify

It should not be assumed that homeless pregnant women seek health care only at storefront clinics or in public facilities. An inestimable number with Medicaid are seen in private offices and private hospitals that accept this form of reimbursement. Regardless of the setting, pregnant women rarely voluntarily reveal their lack of housing. A pertinent question, therefore, is whether a more aggressive attempt should be made to identify these women. Once they are identified, what should be done from the standpoint of nursing? If the life circumstances of pregnant homeless women are known, what differences should it make in their care?

Despite the fact that most health care professionals are empathic and compassionate and often go far beyond what is normally prescribed, the dynamics of the interactions between these homeless pregnant women and health care providers were sometimes problematic and nontherapeutic, according to some of the informants. The women went to great lengths to conceal their extreme poverty and homelessness. In health care settings they attempted to present an image of normalcy and avoided situations that would be stigmatizing, embarrassing, or cause them more shame. While being homeless or poor is not in and of itself grounds for a child to be reported to the Department of Children's Services, the women were convinced that they risked having their children taken away. On health care entry or admissions forms, the women often gave erroneous addresses. Some nurses and physicians knew of colleagues who recognized seriously impoverished women and knew or suspected that they were homeless but "turned their heads the other way." They rationalized that the care they provided ended in the clinic or hospital, and they felt absolved of any responsibility once the woman left or was discharged.

The combined effect of concealment on the part of the women and denial on the part

of the health care provider led to a kind of collusion that promoted nonaction. The homeless pregnant woman unknowingly became a participant in her own neglect and consequently was not identified. Her living conditions were not acknowledged and her special health needs not adequately addressed. This pattern was perhaps a survival strategy—a means for a woman, despite meager resources, to maintain some dignity and control over her life. However, in some instances, when the woman revealed her homeless status, the professional who managed her care shifted between being controlling and protective. Also, the health care professional's notions about why a woman was homeless (or simply the fact that she was homeless) seemingly guided the extent to which the woman was deemed worthy or unworthy of certain services and quality of care.

The interface between health care professionals and poor people in general should be examined more closely. In too many instances this interaction epitomizes the ideology that permeates the political economy, which dichotomizes the "haves" and the "have nots" and is overlaid with racism and sexism. Changes in attitudes and actions toward women, poor people, and people of color, who rank disproportionately among the homeless, must precede and parallel all efforts to improve the health and living conditions of women like those described in this study. At the same time, efforts should be made to assist the women in effectively asserting their health care needs and navigating the health care system.

Seize the moment

"Seizing the moment" is a critical approach for nurses to take. Every strategy should be purposeful and offered to the woman with the awareness that this one encounter may be the only encounter the nurse, or perhaps any other health care professional, may have with the woman. This approach is to be distinguished from a "magic bullet" approach, whereby a one-time administration of a curative intervention may be given. The woman may be relieved of her symptoms and sent on her way, only to return for the same condition because the environmental or social situation that caused her condition remains the same.

Seizing the moment involves attempts to provide the necessary tools to sustain a woman through a particular illness episode so that other episodes can be prevented in the future. Some balance must be maintained between providing critical information and strategies of self-care versus bombarding the woman with a series of dos and don'ts that may be forgotten, confused, or dismissed. Finding this balance requires a rapid yet accurate assessment of a woman's situation. Because homelessness is multifaceted and homeless pregnant women are heterogeneous, nurses should have a repertoire of strategies or a template of alternatives from which they can draw so that their care is tailored to each individual. This includes providing care within the context of a multidisciplinary team and participating in the coordination of services so that not only are the woman's health care needs met, but also other essentials that may affect health are acquired.

Seizing the moment also sets the stage for nurses to take full advantage of opportunities to serve homeless women when they enter a health care facility and also to go directly where services are needed. Nurses who adapt treatment modalities to reflect

the life experience of the recipients of care have the greatest impact. Therefore, efforts to establish nursing clinics within shelters and in locations frequented by the homeless should be expanded.

Educate and empower

Poor women, like women of other socioeconomic groups, generally are interested in maintaining wellness and having a good pregnancy outcome. They often lack the wherewithal to engage in healthy behaviors, however. Therefore, in seizing the moment to give homeless pregnant women the information they need to have a healthy pregnancy, it is imperative that information be not only culturally relevant, but also situationally specific. That is, strategies for staying well must be feasible within the context of their living situation. Pregnant women who smoke, for example, should of course be encouraged to at least reduce the number of cigarettes they smoke. However, to insist that a woman quit smoking without providing other strategies to reduce her stress is likely to be ineffective. Also, with regard to counseling about diet, it is important not only to determine what resources and barriers a woman faces in maintaining an appropriate diet, but also to find out what her likes and dislikes are. Poor women should have choices at all levels of their existence and care.

Nurses need to convey that women have ownership of their bodies. By directly involving women in their physical and obstetrical examinations, the women will feel more comfortable about asking questions, volunteering information, and discussing concerns. Moreover, as the women gain more knowledge of how their bodies work, particularly with regard to sexuality and pregnancy, their sexual self-defense is likely to be enhanced. They are more likely to be more assertive with regard to their own protection in sexual encounters, and they also may more readily identify and report aberrations found in self-examination. Encouraging the women to share with other women what they learned in the brief encounter they may have had with the nurse is also empowering.

Maintain respite space

If hospitals can construct labor and delivery rooms to create an environment for birthing that demedicalizes childbearing and is more homelike, surely health care facilities can create "respite rooms" for women to use during their pregnancies. Homeless pregnant women could be the primary but not sole beneficiaries of this space. A room in a clinic setting could be set aside for women who come for their prenatal visits or postpartum checks to relax, collect their thoughts, and "calm their nerves." Ideally, the room would be comfortably furnished to resemble not an office or clinic room, but a home with plants, pictures, and colorful walls. A shower and bathroom adjacent to the room would be important to have, as well as herbal teas, reading material, and tapes of soft music. Women could spend time in the room before or after their office visit and while their children were being looked after by child care services offered by the health care agency. A respite room would be a safe environment that would symbolize a caring atmosphere. Women, after being seen for their visit, would not be thrust so readily back into the turmoil or demoralizing environment from which they came. Ultimately, use of the respite rooms could contribute to more

women coming for prenatal care and other health services.

Build on strengths

Many factors influenced how each woman handled her predicament. The reason a woman was homeless in the first place, the availability and use of resources, the context of social support, and the woman's perception of her pregnancy were particularly pivotal in determining how she coped. With regard to antecedents of homelessness, for example, a woman who was homeless because of a temporary economic setback fared far better than a woman who was evicted because of a drug habit.

Once a woman found it necessary to stay in a shelter, decisions had to be made about how to regain or move toward stability. In addition to providing a temporary place to stay, the shelters often served as a primary repository of resources and set the stage for how well (or how poorly) a woman and her family would be launched. Throughout the metropolitan area there was a hierarchy of shelters, and in most cases the shelters mirrored the neighborhoods of which they were a part. Some had caring, well-qualified staffs, a myriad of programs and services, and a physical structure and social environment that resembled a home. Others were merely a place to go to get off the streets—a barrier from the elements—with policies and surroundings that were so oppressive and depressing that residents referred to them as "prisons" or "plantations." However, it was apparent that the breadth and quality of resources and a woman's use of them improved her condition at least while she had access to them.

The support that individuals derived from others also played a significant role. A consistent finding in the literature regarding homeless people is that despite their diversity, a shared characteristic is disaffiliation. Bahr contended that homelessness "is a condition of disaffiliation, a lack of bonds, a pathology of connectedness and not an absence of proper housing" or a necessary concomitant of poverty or of deviant lifestyles.[10(pxxi)] Homeless pregnant women in the study appeared to lack social support. Some had lived in foster care for a significant part of their lives. Others had parents or other family members and friends who were just as needy as themselves. Sources of support were either physically or otherwise incapacitated, financially or emotionally overburdened, or dead; the women's spouses or partners were unemployed, estranged, abusive, incarcerated, or also homeless. Yet there were individuals available to the women who provided varying levels of support.

In families that were in conflict, family members sometimes suspended negative feelings harbored toward the pregnant woman and provided whatever help they could to ensure that the woman and her unborn child would get through the birthing experience safely. The opposite was also true, however. Sometimes the pregnancy was the "last straw" that led to family breakdown and resulted in a pregnant woman voluntarily or involuntarily leaving home. In general, strangers on the street were not as calloused toward pregnant women as they were toward other homeless individuals. In one instance a woman offered to buy an airline ticket home for one pregnant homeless woman.

The women in the sample reconstructed networks to help meet their needs. This need and ability to connect with others parallel findings in other studies of homeless

women and women in adverse situations and in writings concerning feminist psychology.[11–15] Often the help or support sought or given went unrecognized or was unnoticed because of its nature and source. For example, women who were purportedly estranged from their family of origin actually had regular contact with their family while they resided in the shelter. In fact, sometimes a grandmother would keep one or two of her grandchildren in her home while her pregnant daughter stayed in the shelter with one other child. This was probably a survival strategy for both the grandmother and the mother. Women in the shelter also helped one another. Material support was limited, but emotional support among the women was a source of strength. On the other hand, many connections were tenuous and exploitive and sometimes resulted in women becoming revictimized.

Women used religion and spirituality as a source of strength and guidance and a means of putting their situation into a meaningful context. Of significance were the number of women who relied on self as a personal resource. They relied not only on their inner strength, which very often was enhanced by their religious beliefs, but also on their previous experience in dealing with adverse situations. This personal toughness enabled some women to keep their family functioning, even when they should have been the focus of attention. For example, Inez, a young mother of five who was 32 weeks pregnant with her sixth child, planned and carried out a birthday party for her 6-year-old. All the children in the shelter were invited. Without the fanfare often available for an occasion like this (except a cake baked by the cook in the shelter), Inez created a delightful celebration for her child. In another situation, Darla, a pregnant mother of four (ages 8 and younger), always took all four children when she went apartment hunting on foot. Each child was given a specific responsibility and participated in the search. For example, one child carried the baby's bottle, another kept track of the addresses visited, and so on. The manner in which Darla disciplined her children, who also were good students in school, could have served as a model for others. Yet Darla's own recuperation and self-care during the postpartum period suffered because of her focus on her children, her commitment to her substance-abusing husband, and her determination to make it completely on her own.

Nurses should build on the strengths and positive coping strategies of the women. Nurses can be supportive by conveying that they have a vested interest in the woman's health and well-being. Active listening without imposing solutions is a beginning. Finding ways to assist women to reconnect in areas where they have become disaffiliated is critical and may range from the nurse simply making a phone call to testifying on behalf of the poor population at a legislative hearing. Acknowledging the spiritual centeredness of the women and linking them with religious organizations that may be supportive are also important. Nurses can also provide the mechanism whereby homeless women can safely and productively network with other women who share the homeless experience. Providing positive reinforcement and encouragement to women who make small yet significant gains toward altering their situation is just as important as praising women who have made it against the odds. Finally, the nurse can highlight and share with other women the

innovative survival strategies other women have devised and successfully used.

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Women who are homeless and pregnant are in a dangerous predicament and face many critical dilemmas. The first-hand accounts of the life experiences of these homeless pregnant women contribute significantly to nursing knowledge and practice. If the general clinical considerations described are acknowledged and the proposed therapeutic strategies used, the special health care needs of homeless pregnant women are likely to be met. Maintenance of health during pregnancy may be optimized and pregnancy outcomes improved. Most important, good health habits also may be established that are sustaining in adverse and ordinary situations.

REFERENCES

1. Whitman BY, Accardo P, Sprankel JM. Homeless families and their children: health, developmental, and educational needs. In: Jahiel RI, ed. *Homelessness: A Prevention-Oriented Approach.* Baltimore, Md: John Hopkins University Press; 1992.
2. McDonald DD. Health care and cost containment for the homeless: curricular implications. *J Nurs Educ.* 1986;25:261–264.
3. Bassuk EL. Characteristics of homeless families. *Am J Public Health.* 1986;76:1097–1101.
4. Hope M, Young J. The politics of displacement. In: Erickson J, Wilhelm C, eds. *Housing the Homeless.* New Brunswick, NJ: Centers for Urban Policy Research; 1988.
5. Marwick C. The sizable homeless population: a growing challenge for medicine. *JAMA.* 1985;253:3217–3225.
6. Fischer PJ, Shapiro S, Breakey W, Anthony J, Kramer M. Mental health and social characteristics of the homeless: a survey of mission users. *Am J Public Health.* 1986;76:519–524.
7. Varney H. *Nurse Midwifery.* Boston, Mass: Blackwell Scientific Publications; 1987.
8. Suitor C. Nutritional assessment of the pregnant woman. *Clin Obstet Gynecol.* 1994;37:501–513.
9. Dickasson EJ, Schult MO, Silverman BC. *Maternal-Infant Nursing Care.* St Louis, Mo: Mosby; 1990.
10. Bahr HM. Introduction. In: Momeni JA, ed. *Homelessness in the United States: State Surveys.* New York, NY: Praeger; 1990.
11. Gilligan C. *In a Different Voice.* Cambridge, Mass: Harvard University Press; 1993.
12. Montgomery C. Swimming upstream: the strengths of women who survive homelessness. *ANS.* 1994;16(3): 34–45.
13. Francis M. Homeless families: rebuilding connections. *Public Health Nurs.* 1991;8:90–96.
14. Killion CM. Self-perceptions and sources of support among Creole Belizean parents of mentally retarded children. *J Black Nurses Assoc.* 1990;6:23–28.
15. Mercer RT. *First-Time Motherhood: Experiences from Teens to Forties.* New York, NY: Springer; 1986.