Homeless and Pregnant: A Public Health Unit's Innovative Response

Dear Editor:

In Toronto, estimates suggest approximately 300 children are born to homeless mothers annually.¹ Homeless women often lack access to basic needs, encounter social and physical barriers to prenatal care, and have an increased risk of pregnancy complications and adverse outcomes.²⁻⁴ To address this important public health issue, Toronto Public Health launched the Homeless At-Risk Prenatal Program (HARP) in 2008, a city-wide initiative that aims to promote positive prenatal and birth outcomes among homeless, transient women.

A dedicated team of five public health nurses (PHNs) provides individual nursing services to homeless women during pregnancy and up to six weeks postpartum. PHNs employ harm reduction and client-centred approaches. The program focuses on direct client service, and PHNs engage in outreach to promote collaborative networks with other service providers. To better understand the population reached and services provided, a formative evaluation was conducted through an in-depth review of 24 client records and administrative data, interviews (n=4), and a focus group with PHNs.

HARP clients present with multiple and complex health and social needs, including mental health issues, food insecurity, and limited social support. Most clients were primigravida (n=15/23, 65%). Among multigravida clients, three (n=3/8) were grand multigravidas with 6, 8 and 11 pregnancies, respectively. None was actively parenting upon entry. Services were delivered both in person and via telephone. Almost half of all interactions included the client (45%); half occurred in absence of the client, mostly with other service providers to address case management issues.

A range of interventions were provided to address clients' needs and situations (see Table 1). Case management was the most commonly documented intervention, and it increased with the type and complexity of risk factors and the number of service providers involved in a client's care. Scheduling and confirming appointments was used to reduce potential missed visits, and was the second most frequently documented activity. Although not well documented, PHNs spent considerable time developing and maintaining trusting relationships.

Among the 16 clients who continued in HARP until the birth of their babies, 75% delivered at term (n=12/16) and mean birth weight for deliveries at term was 3030 g. Three clients did not carry the pregnancy to term, either due to elected termination (n=2) or miscarriage (n=1). Five clients were lost to follow-up or moved out of the service area before delivery. At discharge, the majority of clients had improved their housing status. Thirteen clients (n=13/18, 72%) were housed and four were living in shelters. Nine clients were parenting at discharge. Six had their children apprehended by child protection services, and parenting information was missing for six clients (See Table 2).

HARP supports a client population with multiple and multifaceted health and social needs using a diverse suite of interventions and outreach strategies. Findings suggest HARP contributes to healthy birth outcomes and improved housing status among homeless pregnant women. HARP may serve as a promising model for other interventions targeted to similar populations; however,

Table 1. Percent of Interventions Delivered to HARP Clients, Record Review Data

	% of Clients Who Received Intervention (N=24)	% of Interventions Delivered (N=2029)
Case management	96	27
Scheduling/confirming appointments	100	19
Assessment and screening	69	13
Health teaching	83	11
Referral and follow-up	92	10
Counselling	71	7
Instrumental supports*	71	5
Locating client	54	3
Supportive accompaniment	42	2
Advocacy	38	1
HARP information provided	54	1
Case finding	17	0.2
Other†	54	0.2

* Instrumental supports include tangible items (such as food vouchers and transit tokens) to help clients meet their immediate needs, and to build rapport between the nurse and the client.

† Other includes various supportive activities indirectly related to service, such as communicating with a family member.

Table 2. Profile of HARP Clients at Program Exit

Category	Indicator	Percent (N=24)
Program completion	Completed program to postpartum	67
	Declined further service	13
	Moved/lost to follow-up	21
Housing status	Housed	54
	Living in shelter	16
	Living on the street	4
	Missing	25
Birth outcomes	Mean birth weight – all clients (n=16) (grams)*†	2790 (range: 1045-3915)
	Mean gestational age at delivery – all clients (n=16) (weeks)*	36 (range: 25-41)
	Mean birth weight – clients who delivered at term (n=12) (grams)‡	3030 (range: 2006-3806)
Parenting§	Actively parenting at program completion	43
	Child protection apprehensions	29
	Missing	29

* Birth data were not available for 8 clients: 3 clients did not go to term with their pregnancies either due to an elected abortion (n=2) or miscarriage (n=1), and data were missing for 5 clients.

† One client delivered twins. Mean birth weight is for 17 infants delivered by 16 clients.

‡ Twelve clients delivered at term (≥37 weeks). One client delivered twins. Mean birth weight is for 13 infants delivered by 12 clients.

§ Parenting data were not available for 3 clients as they did not go to term with their pregnancy.

further research is needed to understand the outcomes of supportive public health intervention with high-risk pregnant women.

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