

Research Article

Delivering Care to Women who are Homeless: A Narrative Inquiry into the Experience of Health Care Providers in an Obstetrical Unit

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ABSTRACT

The purpose of the study was to explore the experiences and perceptions of health care providers in an acute care setting delivering care to pregnant women who are experiencing homelessness. In recent years, the number of women experiencing homelessness has significantly increased. In North America, the emerging homeless profile is that of a younger person and more often women. Living in precarious housing situations increases one's risk for serious health conditions. Women who are homeless often experience complex health issues but many intersecting barriers exist between homeless women and health care providers, which impacts the care provided. A better understanding of the health care providers who provide care is urgently needed. A narrative inquiry design was implemented. We recruited 10 health care providers from antenatal, postpartum, and labour and delivery units in a large, urban tertiary care hospital. Using narrative

inquiry methodology, and a conversation guide we explored care providers' personal and professional experiences over time, place, and within social contexts. Conversations with participants were held 2 or 3 times. From participants' narrative accounts, we identified four threads that were evident across their experiences: shaping and being shaped by institutional mandates, the importance of conversational spaces, the lack of interprofessional interactions and living with conflicted views about practice. Care practices are shaped by complex personal, interpersonal, and institutional factors. Contextualized learning experiences within health care settings may serve to encourage narrative reflective practices and support communities of practice with the ultimate goal to improve health care delivery for women in precarious housing situations.

Keywords: Care; Experiences; Health care providers; Homeless women; Perceptions

What is known about this topic?

- Homeless women experience discrimination when interacting with health care providers.
- Homeless pregnant women are less trusting of service providers. They feel often unsupported and misunderstood.
- Health care providers find it difficult to interact with homeless pregnant women and understand that taking care of their health needs is competing with other priorities, such as housing and food.
- Homeless women are often victims of sexual abuse, which affects their physical and mental health as well as their behavior patterns to seek health care.

What does this paper add?

- Health care providers have inadequate clinical knowledge in working with marginalized populations.
- Education for health care providers need to be guided by a health equity focus, incorporating issues of social justice practice and understanding the complex interplay of the social determinants of health.
- A misalignment exist between what health care providers imagine is best for their clients and the needs of the system.
- Health care providers need to recognize that each interaction with marginalized people shapes their care experience and may affect their future health seeking activities.

Introduction

Becoming homeless is a convergence of many individual vulnerabilities and structural factors. Homelessness has serious implications for the health of individuals and populations [1]. In the North American context, and globally the majority of people who are homeless are men (71%); when women are homeless they are more likely to be homeless with children [2,3].

In recent years, the number of Canadian women experiencing homelessness has increased slightly [4]. Gaetz et al. [4] reported that women and youth are more likely to experience hidden homelessness. There is little gender-specific research on homelessness, yet housing and gender are both important social determinants of health. Health care disparities are more pronounced and distressing for homeless women [5].

Many women who experience homelessness find the health care setting dehumanizing and stigmatizing causing a barrier to accessing health care [6-8]. Frontline care providers encounter women in precarious housing situations in multiple settings and find caring for this population challenging, they especially find the difficulty with coordination and engagement and not having the proper skills to care for them difficult and note the lack of outreach support to help women who are homeless [1]. Many complex and intersecting barriers exist between women experiencing homelessness and health care providers (HCP).

Background

Generally, the mortality ratios for people who are homeless is typically 2-5 times higher than the age-standardized general population [9]. Fazel et al. [9] noted that other than the comorbidities of mental health and substance abuse, other risk factors secondary to homelessness are the high rates of victimization, exposure to communicable diseases and poor access to health. Over the last two decades, homeless people are increasingly more visible on the streets of Canada [10]. Taking in the diversity of the homeless population, Canadian researchers have updated the homeless definition to include “the diversity by situating homelessness along a continuum of living arrangements” [11].

An integrative review of homeless research conducted in Canada found studies that included both men and women cohorts; and although gender is known as a determining factor in health outcomes, few studies have focused specifically on women who are homeless [12]. Today’s emerging profile indicates that people who experience homelessness are younger, and more often women [13]. A better understanding of the nature of women’s homelessness and their intersection with the health care system is urgently needed.

In Canada, where a system of universal health insurance exist, homeless people still encounter barriers to obtain meaningful health care [14]. We know that harmful beliefs and attitudes influence care delivery to people experiencing homeless but very little is known about the experience as perceived by nurses and other HCP, when caring for people who are homeless.

For people who are homeless, the experiences of accessing health care are often negative, and health care staff were seen as unsympathetic, stigmatizing and had confusing and inflexible care plans [1]. Bungay further stated that the engagement of women who are street involved, homeless and addicted, with the health care system is rife with imbalances of economic, social, personal and political power that reinforces the ideologies that they are deviant and of lesser status [15]. The delivery of effective health care services for women who are homeless closely link to the ability to create a welcoming environment. Homeless women experienced discrimination when interacting with HCP [8]. Sznajder-Murray and Slesnick reported that mothers who are homeless addicted were less trusting of service providers because they felt they were not supportive and could not understand their situation. They further felt frustration when they had to explain embarrassing situations multiple times [16,17].

Studies about the perceptions and attitudes of HCP when caring for homeless populations have been conducted previously [18-20]. Realizing that health care is not necessarily the top priority for women who are homeless, HCP also experience challenges when interacting with them [21]. Health care providers are likely to experience value conflicts with people who are homeless because they often have unique sets of values and a mode of social interaction that they acquired to survive on the streets [22]. Health care providers own personal bias and attitudes are important in how people who are homelessness experience their care. Crowe maintained that nurses’ attitudes toward people who are homeless are in constant development and transformation and connected to their personal and professional experiences. Parkinson noted “both personal experiences of interacting with people who are homeless and formal education are important factors in improving nurses’ attitudes towards homeless people” [18,20].

There is a dearth of studies, which specifically focus on the experiences of HCP in their encounters with women who are homeless. Through a narrative study, Fordham a community public health nurse illuminated the experience of homelessness and women’s feelings about their health and wellbeing. She acknowledged the challenges HCP face in order to engage effectively with homeless women but highlighted that homeless women are not ‘hard to reach’ instead health services were [6]. Thus, bridging the experiences of women who are homeless and HCP can be an important focus in translating struggles of both groups.

Homelessness heightens the risk of adverse pregnancy outcomes for mother and infant and is linked to poor physical health, depression and unmet health care needs [23]. Women who are homeless have a high possibility to experience sexual abuse and unwanted pregnancy, which in turn can deeply affect both their physical and mental health as well as their behavioral patterns to seek health care [24]. Working with ten participants the aim of the study was to explore the experiences and perceptions of HCP delivering care to pregnant women who are experiencing homelessness at a large acute care hospital in a western Canadian city.

Methods

Research Design

We used a narrative inquiry approach to explore care providers’ personal and professional experiences over time and within context. Narrative inquiry is both phenomenon and methodology for understanding experience [25,26]. Narrative inquiry focus on understanding experiences by building in-depth and trusting relationships between participants and researchers. It is different from research in which “researchers” study “subjects”. Narrative inquiry positions people alongside one another, sharing stories of experiences, listening to, learning from, and inquiring into, how our lived and told stories help us to understand ourselves, the places where we are and have been, and interactions with people and situations within past and present contexts [25]. Narrative inquiry enables the formation of

intensive relationships with participants, in our case with HCP. As narrative inquiry researchers, we closely attended to place, temporality, and the social contexts of participants' lives as well as relational spaces between researchers and participants. Attending to HCP' lives on both personal and professional landscapes was an important aspect. Further Caine et al. postulate that narrative inquiry can be used to provide understandings of social justice practice [27]. Being grounded in pragmatism and emphasizing relational understanding of experience situates narrative inquiry as a site for social justice practice, especially when investigating experiences with pregnant women who experience homelessness.

Data collection

We conducted our research at a large acute care hospital in Western Canada. The hospital is located in downtown area and serves a diverse community including a large percentage of the city's homeless population. The hospital is surrounded by many of the city's shelters for people who are homeless and a large proportion of the population treated at the hospital is from low income families and/or homeless or at risk of becoming homeless groups.

Recruitment was facilitated through a third party, nurse educators at the hospital. Convenience sampling was implemented with a special focus on the antepartum, postpartum, and labour and delivery units. In this health care setting, HCP were invited to participate in the conversations through disseminating the recruitment emails and the advertising posters. HCP were recruited to participate in conversations using recruitment emails and posters. We had ten participants, which included nurses, physicians, Aboriginal counselors, and social workers. We engaged with each participant two or three times, for one to one and a half hour long conversations. Guiding questions for the conversations were developed with all team members. The guiding questions were only used at the begin of the first conversation, any follow up conversations were responsive to issues raised by participants. The transcribed conversations and field notes, including observations formed our field texts (data). We composed narrative accounts from the field texts and took it back to each participant to negotiate interim research texts, also referred to as narrative accounts. Once the narrative accounts were negotiated, we looked across the different accounts for resonant threads.

Data analysis

The analysis of the individual conversations occurred simultaneously with data collection. We inquired narratively into experiences and perceptions of HCP; this approach honored the voices of the participants and built relationships between the researchers and the participants. Final narrative accounts were interpreted alongside research team members from within the three-dimensional narrative inquiry space, with attention to temporality, the personal and social contexts, and place [28]. The criteria outlined by Meleis were used to enhance the rigor and credibility of the current project. These criteria included contextuality, relevance, reciprocity, awareness of identity and power differentials, empowerment, communications styles,

time, and disclosure [29].

Ethics approval and considerations

The proposal was approved by the Health Research Ethics Board (HREB) at the University of Alberta and the Alberta Health Services Board. We adhered to the principles of informed consent, confidentiality and anonymity at all times (including storage of materials). Participants were made aware of the benefits and risks of participating and their right to withdraw. Pseudonyms were used for participants.

Results

As we engaged with HCP, we became increasingly attentive to the importance of inquiring into experience over time, in place, and in social context. Part of this understanding grew out of our awareness to attend to lives as unfolding, as always in the making [18]. Members of the research team who worked closely with participants discussed the narrative accounts for each participant and then identified narrative threads that resonated across accounts. While some threads resonated throughout all narrative accounts, others are more prominent for some than they are for others.

Emerging threads

We looked at the narrative accounts for resonant threads that reverberated across the participant's experiences. As we looked across we considered experiences over time, place and in context, and recognised the embodied, emotional, moral, and cognitive dimensions of experience [26]. In this paper, we take up four interrelated threads, which we named: shaping and being shaped by institutional mandates, the importance of conversational spaces, the lack of interprofessional interactions and living with conflicted views about practice.

Shaping and being shaped by institutional mandates

Alongside participants, we learned how much trust needed to be built before HCP were comfortable to share their experiences. Participants showed us how tensions lived in their daily practice and shaped some of the care they were able to provide. A misalignment between institutional needs and care practices was evident.

Definitely a competing agenda, I mean the hospital, I mean it's dollars to dollars. They don't want people there that are gonna take up a bed and difficult patients. I mean some of the people are not likable, but we ultimately have to still kind of provide them with the appropriate care.

Participants found themselves often justifying what they saw as necessary and essential care, which was not supported by institutional policies and mandates.

So somebody comes in, they're dirty from head to toe and they're starving to death and so you know what's right and you know what's wrong, so you feed them, you clean them up, you give them a bed to sleep in and sometimes their family.

This constant tension with policies and mandates, as well as real and perceived budget constraints forced HCP to engage

in secret practices. Some of these practices were sneaking sandwiches to clients, allowing family members or friends to stay overnight, or to rest in hospital beds during the day. Some of these secret practices were justified within an understanding of societal obligations and responsibilities.

I know a lot of people say they're accountable for themselves, but when you really truly think about the situation that they've gotten themselves into or whether that be by fault of themselves or no fault of themselves. Somebody's gotta say we're taking that on.

Often small gestures sustained HCP in believing that they were able to provide good care.

Like we're so limited in what we can do, if we can give a sandwich and a bowl of soup, that's doing something.

Some of the participants pointed to an institutional culture that was reinforced and mandated not only by specific policies and mandates, but also controlled and reinforced by their colleagues. In some instances participants noted that discriminatory attitudes and stereotypes towards patients who are in precarious housing situations were rationalised based on institutional mandates. As one participant pointed out, intentional discussions about client populations who experienced a greater degree of health inequities were not supported by colleagues, as these were perceived to challenge the status quo.

They're movers and shakers right in there all of a sudden. Anybody that comes in with a big idea, and they're thinking outside the box, well on the frontline you don't think outside the box. And that's a culture thing. And nobody's gonna provide them time on the frontlines to even think about the fluff in health care. It's all about the task at hand right then and there

Several of the participants were also challenged by the narrow focus of care, which limited the scope of the care they could provide for women. As researchers, we too wondered to what degree the reality of being very busy influenced this. No time was allocated for follow up, which impacted the care givers sense of continuity of care. We noticed that participants were distressed not knowing what happened to clients in precarious housing situations in the long term. Some participants raised questions about whose long-term responsibility it was to address social conditions such as housing. There was a sense of discharging clients to a vacuum, where it was not evident what resources were accessible to clients. Given the constraints imposed by the hospital setting, participants felt that appropriate discharge did not often happen. They also noted that there are not enough community resources to provide the appropriate care and discharge.

If we weren't so quick to jump and to having a patient discharge we might be able to come up with a little bit more stable and successful plan than maybe risk having someone readmitted. I think there is a push to discharge before prior planning can occur.

The importance of conversational spaces

We highlighted the absence of conversational spaces, both

inside and outside of acute care units, as an important thread in the narrative accounts. This became evident as we listened to participants' distress, and the tensions their work had caused them. All of the participants told us that sharing their personal lives, beliefs and opinions with other care providers in meaningful ways was not something that happened regularly. Despite these challenges, the participants believed that things could change and realised how important conversational spaces are for sustaining and shifting care practices.

Participants identified that they often learned how to work with pregnant women who were homeless from their colleagues, who in places like the coffee room and at the desk made derogatory jokes and judgmental comments. These comments were seen as a way to impart a hidden curriculum. The term hidden curriculum was used by one of the participants to refer to practices and learnings that are troublesome and that are often imparted in informal ways. Participants stated that they did not want to stand out in their work environment and most times found it difficult to speak up and challenge the hidden curriculum. They did not want to be seen as 'different' or as 'difficult' by others.

Yeah, it's like I've heard it called the hidden curriculum, like the things that are not taught in classes obviously but you kind of learn. You know how do you fit in with your peers, you join the same jokes or you make the same comments. You don't want to stand out.

Using words from transcripts with Brenda we composed a poem as part of her narrative account that expressed her feelings about conversational spaces:

*Torment
nurses are very mean
not to patients, to each other
back in the coffee room
you have all the chatter
asking for help, that's almost like admitting you can't
handle the job
prove your credibility
that's what nurses do
trip you up
something is not right on that unit
we'll do some more education
educate them
but that is not the problem, they are educated
once you hit the floor it is not about you any longer
regardless of what is in my heart and soul
it's not about me any longer
it's about providing safe care
nurses are very mean*

*not to patients, to each other
back in the coffee room
you have all the chatter*

Despite the importance to sustaining meaningful and ethical practices, working to build a safe conversational space, was not tension free for participants. This was particularly detrimental for those who work with vulnerable homeless pregnant women. There was a sense for Brenda that it was not appropriate to ask difficult questions, questions that would challenge current care practices.

I think in the practice setting, there isn't a lot of intentional discussion about that client population ... like, there's just kind of, ..., individual to individual.

The lack of interprofessional interactions

We have learned that creating interprofessional relationships requires open, mutual dialogue, the consistency of attending to lives, and the centrality of sustaining relationships and also professional practices.

Yeah, a lot of it (ethical challenges or dilemmas) I think come when there are conflicts between when you're dealing in a multi-disciplinary team, competing agendas ... certainly competing value of sorts ... I mean you can't fight with psychiatry.

To allow for open and imaginative dialogue and to create more relevant interprofessional relationships requires a shift in perspective, and the commitment and input of many different people from diverse places and disciplines. It is imperative to have supportive and diverse teams to be able to engage in educative and thoughtful work alongside women in precarious housing situations.

I think it (reflections) happens at home. Yet, where it should happen should be in the multidisciplinary educational sessions. Where people can actually get together as different disciplines and actually talk about what works for them. I think that is where it should happen, but we don't have that.

All participants noted that interprofessional relationships at current reflect issues of power, hierarchy, and lack of collaboration. For some participants this added to their ethical distress and the difficulty to address particular issues. Social work was often singled out and it was described that social workers are often seen as able to address all of the difficult issues, like *waving a magic wand*, and they were perceived to be able to resolve any conflict between clients and care providers.

Living with conflicted views about their practice

Karin considered herself a novice nurse on the unit. In her narrative account Karin reflected:

I think most of our staff, like everybody, they're caring and they're kind, no one really wants anyone to get left behind. But just, you know, our different ways of dealing with some of these issues are. Sometimes we refer, have our little, code name, "[Hospital name] Special" for someone who's come in with all these, with social issues, and perhaps is homeless, or, drug

addict, or something. And so then as soon as that name has been attached to a person, you kind of know that it's going to be challenging and it's going to take a little bit more care. And then of course, because they're not necessarily doing the most healthy things, while they're, while they're pregnant. Like they're smoking, or they're doing all sorts of other things, so sometimes there's some pretty judgmental comments that are made, like, about those sorts of things. Or if women come in having like, no, I don't know if this necessarily applies to homeless women, but if they come in and they've had like, many therapeutic abortions, there's often some stereotypical comments that are made too, but it's just, I think part of it, is just our way of coping with our own distress about it. I've sort of come to accept the term "[Hospital name] Special", not necessarily as being derogatory, but sort of, a term of identification like, so we know that this person, often times there are many other derogatory comments that are made, in response, in reference to that, but I think, if, when you go in there, you have to just sort of be aware. Like it sort of just lets you know ahead of time that you need to be aware that there are many other things going on. And so, your care is going to be different.

During our conversations Karin also described some of her experiences that called forth moral distress and shaped her understandings of practices on the unit.

I had one senior nurse say to me one time, because I was upset, like about this patient that had had a loss, and I was upset about the fact that she didn't really, she was very standoffish about it, she didn't really care, like afterwards, she delivered the baby, we talked about the baby for about ten minutes, and then after that, she was just on to the next thing. And I was really upset about that, that she didn't really, that it didn't really feel like she had really taken it seriously almost, but I, I had one of the older nurses tell me like, "you know, maybe, you need to be thankful that this baby died because it would be much better, it wouldn't be much better for this baby to be alive in this sort of situation". And it's like, I dunno, like, I can see where she's coming from, but still, it's sort of...

For several of the participants their imagined stories of providing care bumped up against the expectations of the institutional and professional worlds. These often conflicting views of what constitutes good care caused tension and moral conflict for participants. Some participants talked about what they had to leave behind or give up when they provided care; some wondered for how long they could provide care, given that they felt they compromised their own and at times their professional standards and values.

Participants talked about the importance to attend to mechanisms that would support personal and professional lives of HCP.

You lead two different lives on the units. You lead your life in the coffee room and around the desk, and that's where people let their guard down. And then as soon as you step out into the hallways and you've got your health care provider coat back on then it's like that your other life. Yeah, you hear people say negative things and stuff like that in behind the scenes, but that

who we are as people, that's based on their experience, and their values, and their upbringing, and that type of thing ... and that's where peoples real personality comes out, and nobody wants to get into a conversation in the coffee room over some value or moral about looking after drug abuse or homelessness, or something like that, that's not the place.

Some of the participants mentioned how challenging it was to engage in certain practices, which conflicted with their personal and professional values. It often left them feeling helpless and also hopeless; in these moments some participants tried to remedy their actions when interacting directly with clients.

I think as nurses we have a really hard time with, we don't want to tell the patients what we're doing in that kind of situation (apprehension of baby), right? ... it is almost like espionage, like you have to sneak this child out ... the charge nurse told me "I need you to go take the baby down to the nursery but don't let anybody follow you" ... so I just decided that I was gonna like, give her care like any, like any sort of postpartum care, where we don't have to take the baby ... I am going to be like "oh, what've you named him?" "Did you get a chance to breastfeed?" ... it's better than sort of just, brushing her off.

Conflicting views about practices resonated across all of the narrative accounts and often called forth difficult to tell stories. It was in these moments that personal and professional obligations became visible for participants.

Discussion

We explored the experiences and perceptions of HCP delivering care to pregnant women who are homeless. As we began to look for resonances in the narrative accounts, we identified as four key threads, we moved further away from the individual experiences of our participants. We could see how notions of imagined stories and difficult work were present in all of the four threads.

Imagined stories

The stories participants lived by as care providers were complex, temporal, and fluid; they showed that they adapted to a professional landscape that did not always support them in challenging or difficult to live care practices e.g., when we work with difficult clients, it can be challenging to practice in particular ways (i.e. people get more impatient or judgemental). The imagined stories of who the participants saw themselves as care providers were interrupted. Frequently their personal, practical, and professional stories collided with institutional, cultural, and professional stories [25]. The experiences of participants that made these collisions visible often led them to reframe their imagined stories of who they were. We saw that some care providers storied themselves as being in solidarity with women who are homeless. We worried often about the impact of these bumps and shifting stories in the lives of the participants; we wondered: for how long could they sustain their care practices? How long could one work within an inhuman system? One of the participants, who had worked on the unit the longest, spoke

about post-traumatic stress disorder and also indicated that she had seen many HCP leave, due to the unresolved tensions they had experienced between their imagined and lived stories. For some, it had become difficult to negate the care they knew was necessary, but impossible to provide.

Difficult work

Participants felt they had inadequate clinical knowledge in working with this population and how difficult it was to work in such a challenging environment. As we engaged with participants, we realized and remembered our past practices on units that are extremely busy, where people often work long hours, fill in for colleagues, work nights and weekends, and do not always take breaks. We could hardly imagine the workloads some of our participants carried, particularly in complex, high risk environments, where clients experienced life changing events, such as the birth and death of their children. We also see the words 'difficult or hard' as more than workloads and demands, but that their imagined stories of providing care bumped up against the everyday reality of working in clinical care in an acute care facility. What was hard and also distressing for us as researchers was that most of the participants we worked alongside had very little sense of agency and were forced to live secret practice: practices that were marginalized or sanctioned by policies and mandates, as well as colleagues who reinforced these mandates. In many ways, it was hard to continuously re-imagine and improvise who one is, and is becoming. These tensions took their toll on participants; particularly for participants who could not imagine new or different careers.

Challenges and Barriers

In this section we will focus on the challenges and barriers experienced in conducting this research.

Recruitment

The sensitive nature of the research contributed to a very slow recruitment rate. One participant explained that a contributing factor, could be:

Many of the nurses especially are worried about expressing their judgment towards this population ... I think that they are worried that it's going to reflect poorly on the hospital if they say anything judgmental about (this hospital in your study).

We had to implement alternative methods of recruiting participants. We initially sent a recruitment email to potential participants; it was repeated twice. It was then supplemented with visits to the labour and delivery unit to introduce the study and the development of a recruitment poster that was posted in the different units. Additionally we sent individual letters of invitation to physicians. The recruitment only allowed discussions with individuals from different disciplines but not cross- and interdisciplinary discussions.

Rewards and recognition

The participants who were willing to share their experiences and stories did so because they believed that this would make a difference to their practice; they valued research as part of

their practice. Some of the participants felt a sense of reward when their supports made a change to clients' lives; they saw the potential of this research to improve care for their clients. Most importantly the participants expressed hope that health care will become a more welcoming place for women who experience homelessness or live in precarious housing situations. For some there was also recognition that shifting care practice held personal significance.

And I think that that's the most important thing to teach people in nursing or medicine or whatever field is that that (person who is homeless) could be your brother or sister or a family member or friend.

Recommendations

It is important not to view HCP as a homogenized group as care provider is full of potential, possibility, has ideas, and is a unique professional. Care providers can be sustained in their career, act with agency, and negotiate the care they provide. Care environments must attend to complex feelings of belonging with colleagues and administrators. Relationships with colleagues were often difficult, seen as competing with different moral values and lacking support. Spaces where mutual relationships, openness, and authentic conversations can occur need to be fostered.

Interdisciplinary supports and approaches are necessary to make a change. There was a misalignment between the needs of the system and the care which HCP imagined was best for their clients. Health care providers at times had to engage in secret care practices to provide care they felt was necessary and sustained them as good practitioners. Attention to the misalignment between system needs and HCP' professional and practical knowledge is necessary. Education for HCP needs to be guided by issues of health equity, social justice, and the complex interplay of the social determinants of health. Beginning a series of discussions among stakeholders about what this education can look like is important. Meaningful involvement of clients who have experienced inequities in the education, of new health professionals is essential. We learned that new nurses often have no or only few exposures to caring for patients who are homeless.

Education needs to offer more direct opportunities to interact with these populations. HCP need to understand the structural barriers and the lived reality of poverty. A safe space in which positive discussions are welcomed is important. There is a need to see leadership involved in creating this space in order to shift institutional cultures of silencing diversity and innovation in care approaches. Health care providers need to care for people in many ways, especially women and children who are marginalized – they often need many invisible (non-task oriented) supports. We are reminded that hidden or secret work of HCP (such as “sneaking a sandwich” to a client) happens. The secrecy is often constructed by policies, which need to be made visible and challenged. The ‘hidden curriculum’ needs to be challenged. Places to live both meaningful personal and professional identities need to be created. Health care providers need to recognize that each interaction shapes people's health

care experience and that they impact the lives of people regardless of the time spent with clients.

Future research and interventions

Possibilities for further research/interventions could include: integrate narrative reflective practices; ensuring that HCP can practice in environments that support the ways in which they can live out who they imagined to become as a care provider. Further examining the role of mentorship; exposure to meaningful and relevant experiential learning opportunities as part of ongoing professional education; to develop practices that allow HCP to work across institutional boundaries and to become more aware to care that happens in communities; shifting policies that interrupt optimal health care practices and that favor economic discourses, to discourses that are client-centred.

Health care providers, as part of a team that includes clients and their families, are in the ideal position to advocate on behalf of people and, more specifically, women who live in precarious housing situations, be effective role models, and reinforce positive behaviour towards people in precarious housing situations. Furthermore nurse managers can strategically influence interventions to help develop care models for people experiencing inequities. Knowledge of the experiences and attitudes of HCP will help us to develop contextualized learning programs within practice setting, encourage reflective practice, and support communities of practice with the ultimate goal to improve health care delivery for women in precarious housing situations [19].

Conclusions

The lack of knowledge in how to care for women who are homeless holds the potential to result in negative attitudes toward them, and potentially contributes to adverse health effects and outcomes. Knowledge of the experiences and attitudes of HCP in caring for women who are homeless will inform the development of contextualized learning programs within health practice settings, encourage reflective practice, and support communities of practice with the ultimate goal to improve health care delivery for women who are experiencing homelessness.

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