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# Examining Factors Impacting the Service Needs of Unhoused Women

Holly Brott
*Portland State University*

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# Examining Factors Impacting the Service Needs of Unhoused Women

by

Holly Brott

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Dissertation Committee:
Greg Townley, Chair
Keith Kaufman
Eric Mankowski
Stéphanie Wahab

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# Abstract

Women account for a sizeable proportion of the unhoused population in the U.S. Over one-third (38.7%) of unhoused individuals are women, which is a 17% increase from 2016 (United States Department of Housing and Urban Development, 2019). The increased prevalence of women experiencing homelessness calls for a renewed examination of their service needs. This dissertation presents three studies examining factors impacting the service needs of unhoused women. The first manuscript examined factors contributing to unhoused mothers' successful completion of transitional housing; highlighted participant-identified programmatic strengths; and investigated differences in facilitators to success across two geographic contexts: one rural and one urban. Quantitative findings indicated that level of social support and education were significant predictors of successful program exit. Qualitative interviews with program residents highlighted differences in supportive factors across the two contexts. The second manuscript is a literature review examining unhoused women's barriers to reproductive justice (i.e., contraception, prenatal care, and abortion), which were identified across multiple (i.e., individual, relational, and context) levels of analysis. The third manuscript is a qualitative study that identified barriers to optimal service delivery, unmet service needs, meaning assigned to contraceptive practices, and linkages between empowerment and reproductive experiences. Collectively, these three manuscripts contribute to a deeper understanding of unhoused women's service needs and inform research and programming aimed at improving the housing and healthcare experiences of this population.

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# Chapter I: Introduction

## Introduction

Since the inception of the field, community psychologists have been interested in the relationship between individuals and contexts (Beehler & Trickett, 2017). Key theories position individuals as being nested within larger interacting systems that influence their day-to-day lives (Ecological Systems Theory; Bronfenbrenner, 1977), and as members of interconnected environments situated within dynamic communities (Ecological Theory; Kelly, 1968). In the lives of unhoused women, interactions with services are influenced by individual-level factors such as gender, parenting status, health needs, and life histories, and more broadly, macrosystem factors such as patriarchism, classism, and racism (Bullock et al., 2020). Accounting for larger societal factors in addition to individual-level considerations generates research findings that help to inform contextually appropriate intervention strategies (Beehler & Trickett, 2017). For example, in rural Appalachia, the experience of homelessness is impacted by conflicting cultural values of familial interdependence and self-reliance, in addition to a strong sense of place that may make individuals hesitant to leave the area to receive services elsewhere (Shamblin et al., 2012). Understanding the cultural importance of independence, place attachment, and familial ties, and incorporating these values into service provision within that setting, fosters successful service delivery.

This dissertation is comprised of three studies that examine individual and contextual factors impacting unhoused women’s service experiences. The current chapter provides a broad overview of unhoused women’s efforts to meet their basic physiological needs (e.g., shelter, health) and documents some of the individual and contextual factors impacting their service needs and experiences. The chapter concludes with an overview of two previously published studies and discusses a third study that expands upon this work. The first manuscript examines differences in service needs and factors that contribute to programmatic success among rural and urban unhoused mothers enrolled in transitional housing programs. Manuscript two is a literature review that documents individual, relational, and contextual barriers to fertility management (i.e., contraception, abortion, prenatal care) experienced by unhoused individuals capable of pregnancy. The third paper explores the contraceptive experiences of unhoused individuals capable of pregnancy who are living unsheltered (e.g., in encampments and other unsheltered locations) to identify barriers to optimal service engagement and determine whether contraceptive choice enhances feelings of empowerment while living unsheltered. Collectively, the three manuscripts contribute to a more nuanced understanding of how to best support women and others capable of pregnancy during episodes of homelessness.

## Precursors of Homelessness Among Unhoused Women

Common precursors of homelessness among unhoused women in the United States include intimate partner violence (IPV), histories of childhood trauma, substance use, poverty, and poor health (e.g., mental and physical health conditions; Phipps et al., 2018). Others become homeless after being released from prison or mental health facilities (Tutty et al., 2013). Unhoused families, which are typically headed by single mothers, share similar life histories and pathways into homelessness, including histories of childhood poverty, low levels of education, lack of employment, inadequate living spaces, and mistimed parenthood (Hilton & Trella, 2014; Hinton & Cassel, 2012). Trans women are particularly vulnerable to housing insecurity, often becoming homeless due to a lack of safety in their home environments and familial rejection, which typically occurs during adolescence (Shelton & Bond, 2017).

## Shelter Considerations for Unhoused Women

Given that the experience of homelessness entails a loss of one's dwelling, spaces to rest are a key service need. Shelters are a typical point of entry into longer-term accommodations. Unhoused women may have different experiences with the shelter system depending on various life factors including experiences of IPV, parenting status, engagement in sex work, and gender identity, which are described in greater detail below.

### *Shelter Experiences of Women Escaping IPV*

Housing can be used as a form of control by abusive partners. Indeed, it is not uncommon for abusive partners to prohibit employment to maintain financial control and threaten the loss of housing (Tutty et al., 2013). Consequently, leaving an abusive partner often requires sacrificing housing. Survivors of IPV often find themselves staying doubled-up with friends or family—a solution that is often temporary (Long, 2015). Domestic violence (DV) shelters provide survivors with a sense of safety through increased security measures (e.g., hidden locations, security guards) relative to other shelter settings; access to mental health support; childcare; education on managing money; and opportunities to expand social networks (Clark et al., 2019; Fisher & Stylianou, 2016). However, participants have also expressed frustration with shelter rules (e.g., curfews and mandatory check-ins), lack of privacy, decreased agency over parenting practices, and increased loneliness while residing in shelter environments (Fauci & Goodman, 2019; Fisher & Stylianou, 2016).

### *Considerations for Women with Children*

Entering a shelter environment disrupts pre-established family schedules (Fraenkel, 2020). Common shelter regulations, such as curfews, bedtimes, and designated mealtimes often conflict with preexisting motherhood practices (Mayberry et al., 2014), while cramped living conditions and uncertainty about the future contribute to increased stress (Fraenkel, 2020; Marcal et al., 2020). Programming requirements absorb time that could be otherwise spent bonding with children (Azim et al., 2018), who often exhibit increased emotional and behavioral problems during episodes of homelessness (Herbers et al., 2017). Meanwhile, shelter residents have reported feeling their parenting choices were being negatively judged by other residents and program staff (Reppond & Bullock, 2020). However, participants have also reported positive aspects of shelter engagement, including expanded social support, increased self-efficacy in parenting practices through engagement in parenting classes, and support in setting goals (Brott et al., 2019; Hinton & Cassel, 2012).

### *Shelter Experiences Among Women Engaged in Sex Work*

Some women who find themselves without resources such as food, safety, and money exchange sex to meet their basic needs (Warf et al., 2013; Watson, 2011). Emergency shelter hours often overlap with their working hours, which serves as a barrier to shelter engagement (Kurtz et al., 2005). In turn, individuals engaged in sex work often lack storage, shower access, and drinking water, and have expressed a desire for program staff who understand their experiences and needs (Kurtz et al., 2005). Unhoused women who enter shelter settings after engagement in sex work have expressed service needs that are similar to individuals who are mothering without a home. Among a sample of women who reported engaging in sex work, desired services included support in obtaining permanent housing, employment, and custody of children, as well as education on personal finance, strengthening relationships, maintaining sobriety, and aspects of well-being (Hankel et al., 2015).

### ***Shelter Experiences of Transgender Women***

Shelter spaces that feel safe and gender-affirming are not guaranteed for transgender women. The ability to access gender-specific shelters is contingent upon expressing oneself as feminine enough to belong in spaces designated for women. Trans women have reported being asked specifically about their gender expression when inquiring about shelter spaces (Lyons et al., 2016; Sakamoto et al., 2009). Trans women have also experienced being turned away from gender-specific service centers designated for women (Begun et al., 2016; Lyons et al., 2016). Meanwhile, instances of sexual violence have been reported when accessing shelter spaces designated for men (Lyons et al., 2016). Trans women must often endure transphobia within the shelter system in order to have their basic needs met or disengage from services altogether as a form of self-protection (Côté & Blais, 2019).

In sum, while there is considerable overlap in service needs among people experiencing homelessness, experiences within shelter environments differ based on various individual factors. Attending to these differences during service delivery is of particular importance in light of findings that discrepancies between available resources and an individual's shelter needs can contribute to service disengagement (Shinn et al., 2017).

## Healthcare

Lack of permanent shelter can have detrimental consequences on health. Previous findings suggest that unhoused individuals experience poorer health relative to their housed counterparts (Reilly et al., 2019). Health concerns among unhoused women can be broadly classified into two categories: mental and physical health needs.

### *Mental Health*

Previous research findings suggest that childhood trauma occurs at greater rates among unhoused women compared to men (Milaney et al., 2020; Sundin & Baguley, 2015). In addition to the high prevalence of pre-existing trauma which can contribute to experiencing homelessness in the first place, homelessness in and of itself is a traumatic experience. Loss of shelter often coincides with ostracism, increased stress, exposure to safety risks, and a loss of autonomy (Buck-McFadyen, 2022; Diduck et al., 2022; Goodman et al., 1991; Hamilton et al., 2011; Padgett et al., 2006). Navigating various service systems to meet basic needs and provide for dependent children exacerbates stress (Hilton & Trella, 2014). Experiences of sexual and physical violence, stigma, and lack of social support, all of which are common among unhoused women, can also contribute to poor mental health (Chambers et al., 2014; Padgett et al., 2006; Tischler et al., 2006). Consequentially, high incidences of post-traumatic stress disorder (PTSD), suicidal thoughts, substance use, and depression have all been reported among samples of unhoused women (Arangua et al., 2005; Rayburn et al., 2005; Tischler et al., 2006). Pre-existing mental health conditions can also be exacerbated during episodes of homelessness (Corrigan et al., 2015).

### ***Physical Health***

Physical health can also be negatively impacted by episodes of homelessness. Limited places to sleep contributes to poor sleep hygiene, while usual stress is compounded by the loss of one's home (Buck-McFadyen, 2022; Gonzalez & Tyminski, 2020). Locating accessible drinking water, spaces to use the restroom, and spaces to engage in personal hygiene behaviors is often difficult and can contribute to declines in health (Ballard et al., 2022; Buck-McFadyen, 2022). Common physical health concerns among unhoused women include pain, chronic illnesses, exposure to toxins, high stress levels, poor sleep, inadequate nutrition, and food insecurity (Buck-McFadyen, 2022; Craft-Rosenberg et al., 2000; Doran et al., 2014; Hilton & Trella, 2014).

Accessing healthcare services while unhoused can be challenging due to transportation-related issues, lack of insurance, lack of money, and the necessary prioritization of survival-related tasks (Arangua et al., 2005; Gelberg et al., 2004; Fryling et al., 2015; Linton et al., 2014). Individuals engaged in heavy substance use while homeless may neglect preventative healthcare visits (Moravac, 2018). Inside the clinic, long wait times are commonplace, and interactions with healthcare staff can be stigmatizing (Gelberg et al., 2004; Lewis et al., 2003). These factors likely contribute to the high utilization of emergency departments and lower engagement in preventative or primary health care services observed among unhoused populations (Abramson et al., 2021). Despite significant challenges to accessing healthcare, unhoused women have also reported engagement in health promotion behaviors, such as efforts made during inclement weather to keep dry and fostering alliances with other unhoused individuals as a means of protection and social support (Bukowski et al., 2011).

**Reproductive Health Needs.** Individuals who can become pregnant have additional, distinct healthcare needs, including menstrual products, fertility management services (e.g., contraception, abortion, prenatal care), and preventative gynecological screenings and mammograms (WHO, 2022). Managing menstruation while unhoused is difficult in the absence of access to clean restrooms (Sommer et al., 2020). Reproductive healthcare services tend to go underutilized by women experiencing homelessness. Daily survival tasks, such as obtaining food or a safe place to rest, take precedence and leave minimal time for other pursuits (Gelberg et al., 2004; Killion, 1998). The high prevalence of sexual trauma reported by unhoused women can also impact engagement with reproductive services. For example, cervical cancer screenings can be a triggering experience for women who have been sexually assaulted, causing some women to delay having them done (Moravac, 2018).

## Context Considerations

A large proportion of research focusing specifically on the experiences of unhoused women has been conducted in urban areas with shelter samples. Limited research suggests key differences in experiences across rural and urban areas, as well as between sheltered versus unsheltered subsamples of unhoused women, which are described in greater detail below.

### ***Rural Versus Urban Homelessness***

Regarding population density, women comprise a smaller proportion of the overall unhoused population in urban areas relative to rural areas (National Alliance to End Homelessness, n.d.). Compared to their urban counterparts, women in rural areas often face greater difficulty obtaining support due to increased distance to services, fewer employment opportunities, and fewer available transportation options (Buck-McFadyen, 2022; Carpenter-Song et al., 2016; Hilton & Trella, 2014). Homelessness in rural areas can also be prolonged by limited housing options and inadequate housing conditions, which are quite common among available rental units (BuckMcFadyen, 2022; Pijl & Belanger, 2020).

### ***Sheltered Versus Unsheltered Homelessness***

Differences in service needs have been identified between unhoused women in sheltered versus unsheltered contexts. Unsheltered women have been found to have poorer physical and mental health compared to women in shelter settings (Nayamathi et al., 2000). While hygiene concerns are commonplace across both groups, unhoused women residing in unsheltered environments (e.g., staying in encampments and other unsheltered spaces) often experience greater difficulty accessing spaces to clean up and use the restroom (Sommer et al., 2020). Compared to unsheltered women, sheltered homeless women are more likely to have spaces to store birth control, which promotes contraceptive engagement (Gelberg et al., 2002). Differences in experiences between unsheltered and sheltered unhoused women highlight the importance of conducting additional research with unsheltered women.

## Present Investigation

As the prevalence of women experiencing homelessness continues to increase (United States Department of Housing and Urban Development, 2019), research efforts ought to continue to examine factors impacting the service needs of unhoused women to inform future programming and ensure that available resources and interventions are contextually appropriate.

The following section provides an overview of two completed manuscripts and one proposed new study examining unhoused women's experiences with, and barriers to, services. Study One investigated whether there were differences in service needs and graduation rates among single mothers residing in transitional housing between two settings: one rural and one urban. Study Two examined literature documenting individual, relational, and contextual barriers to reproductive justice (i.e., abortion, contraception, and prenatal care) experienced by unhoused individuals. Informed by this work, a third study examined the contraceptive experiences of individuals experiencing homelessness in unsheltered locations to document barriers to service delivery and identify whether contraceptive choice fosters feelings of empowerment during episodes of homelessness. Findings lend themselves to practical recommendations to enhance service delivery and directions for future research.

## Chapter II Overview: Leveraging Research To Inform Prevention and Intervention Efforts: Identifying Risk and Protective Factors for Rural and Urban Homeless Families Within Transitional Housing Programs

Study One is a published manuscript in *Journal of Community Psychology* that presents a mixed-method examination of factors supporting urban and rural families within transitional shelter settings. The quantitative component utilized pre-existing client data, while interviews with residents were conducted to shed further light on their experiences.

Study findings indicated significant differences in education levels between rural and urban participants; rural participants on average had completed higher levels of education relative to their urban counterparts. Rural participants also reported greater levels of social support, substance use histories, and interactions with the criminal justice system. Results of a binary logistic regression revealed that education significantly predicted successful completion of programming; participants who reported higher levels of education were nearly twice as likely to complete programming. Social support was identified as a marginally significant predictor; those who reported greater levels of social support were more likely to successfully graduate.

Qualitative interviews identified programmatic supports and a sense of community as programmatic strengths. Programming needs differed across contexts. For instance, urban participants identified job readiness and employment programming as key supports, whereas rural participants discussed opportunities to obtain a GED and enroll in higher education as beneficial.

Together, the findings shed further light on the programming needs of unhoused families residing in transitional shelter environments and highlight how needed supports differ across geographic contexts.

## Chapter III Overview: Reproductive Justice for Unhoused Women: An Integrative Review of the Literature

Study Two is an integrative literature review that examined published research documenting barriers to reproductive justice during episodes of homelessness. It is currently being considered for publication in the *Journal of Community Psychology*. A review of 21 articles examining contraception, prenatal care, and abortion access identified service barriers at the individual, relational, and contextual levels.

At the individual level, identified barriers to contraception included misconceptions about how either contraception or the reproductive system worked (Begun et al., 2019; Gelberg et al., 2004; Gelberg et al., 2008); concerns about side effects (Corey et al., 2020; Dasari et al., 2016; Gelberg et al., 2002; Kennedy et al., 2014); and substance use histories (Gelberg et al., 2002; Gelberg et al., 2008; Tucker et al., 2006). Difficulties managing birth control while unhoused (Begun et al., 2019; Ensign, 2001; Kennedy et al., 2014); concerns about cost (Begun et al., 2019; Corey et al., 2020; Dasari et al., 2016; Killion et al., 1995); lack of time left over after attending to more pressing, survival-related needs (Gelberg et al., 2004; Gelberg et al., 2008; Kennedy et al., 2014; Killion et al., 1998); and being unaware of where contraceptive services were available (Begun et al., 2019) also prevented access to and utilization of services. Fear of Child Protective Services (Smid et al., 2010) was identified as a barrier to prenatal care, while misunderstandings about how the healthcare system worked and concerns about financial costs served as a barrier to medical abortions (Ensign, 2001).

Relationships were identified as a factor that could motivate or prevent the use of contraception. At the relational level, contraceptive use was related to social support; individuals who lacked supportive friendships were less likely to utilize reproductive services, including contraception (Gelberg et al., 2008; Ensign & Panke, 2002; Mackeller et al., 2000). Women in committed relationships were less likely to utilize contraception (Begun et al., 2019; Cedarbaum et al., 2012; Ensign, 2001; Gelberg et al., 2008; Kennedy et al., 2010), while some participants reported being coerced by their partner to not use contraception (Cedarbaum et al., 2012; Dasari et al., 2016; Gelberg et al., 2004; Gelberg et al., 2008; Kennedy et al., 2010; Tucker et al., 2006).

Contextual factors impacting contraceptive accessibility included shelter status (i.e., whether the individual primarily resided outdoors or utilized shelter spaces; Gelberg et al., 2002; Gelberg et al., 2004; Gelberg et al., 2008); transportation-related issues (Begun et al., 2019; Gelberg et al., 2004); systemic issues within the healthcare system (e.g., long wait times, difficulties obtaining appointments; Wenzel et al., 2001); lack of insurance (Dasari et al., 2016; Ensign & Panke, 2002), provider stigma (Begun et al., 2019; Ensign & Panke, 2002; Gelberg et al., 2004; Kennedy et al., 2014; Killion, 1995); and geographic location (Ensign et al., 2001). Among those in need of prenatal care, transportation difficulties (Ake et al., 2018; Bloom et al., 2005; Fleming et al., 2017) and healthcare system-related barriers (Fleming et al., 2017; Gelberg et al., 2004) made receiving care more challenging.

## Chapter IV Overview: Fertility Management During Episodes of Unsheltered Homelessness

In light of recent policy changes impacting reproductive healthcare access and the disempowerment that inherently occurs during episodes of homelessness, current research efforts should prioritize deepening our collective understanding of unhoused women's experiences with fertility management (i.e., contraception). Study Three responds to calls made for additional research examining the experiences of unsheltered women (Speedlin et al., 2020) by focusing exclusively on the contraceptive experiences of unhoused individuals capable of pregnancy living in encampments and other unsheltered locations. Specifically, this study consisted of a qualitative examination of the contraceptive experiences of unhoused individuals capable of pregnancy to better understand experiences with reproductive care during episodes of homelessness. Semi-structured qualitative interviews were utilized to document the meaning that individuals assign to contraceptive practices during episodes of homelessness, barriers to obtaining desired contraceptive services, and whether these experiences contributed to feelings of empowerment.

Findings from this research have implications for both research and service delivery. This study was one of the first to examine whether contraceptive behaviors contribute to feelings of empowerment during episodes of homelessness. Additionally, previous research examining unhoused individuals' contraceptive experiences has, for the most part, historically documented the needs and experiences of individuals within shelter contexts. The present research expands on previous work by centering the experiences of unhoused individuals who are not residing in shelters. Findings from this work have implications for future research with unsheltered populations and recommendations for service provision.

## Summary

This dissertation is comprised of three studies that examine individual and contextual factors in relation to the programmatic and service needs of unhoused women and other individuals capable of childbirth. The first manuscript is a mixed-methods study that identifies factors that support unhoused mothers in successfully completing transitional housing programming across rural and urban environments. It also identified key differences in supportive factors across geographic contexts. The second manuscript is an integrative review of the literature documenting barriers to reproductive justice (i.e., contraception, prenatal care, and abortion) experienced by unhoused women at the individual, relational, and contextual levels of analysis. The third manuscript consisted of a qualitative exploration of the contraceptive needs and experiences of unhoused individuals living in encampments to develop a better understanding of the role of contraception towards feelings of empowerment during episodes of unsheltered homelessness. Collectively, the three manuscripts aim to expand our understanding of unhoused women’s service needs in order to improve service delivery for unhoused women and others capable of pregnancy.

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# Chapter II: Leveraging research to inform prevention and intervention efforts: Identifying risk and protective factors for rural and urban homeless families within transitional housing programs

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*Holly Brott, MA; Mariah Kornbluh, PhD; Jamie Banfield; AnnaMaria Boullion, MA; Gary Incaudo, MD*

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## Abstract

This mixed method study spotlights hardships and supportive factors for unhoused families led by single mothers who have successfully graduated from two transitional housing programs, one rural and one urban. Data collection consisted of entry and exit surveys (n = 241) as well as qualitative interviews (n = 11) with rural and urban residents. Binary logistic regression results indicated education and social support as significant predictors of successful program completion. Qualitative findings further illustrate narratives surrounding supportive factors and program supports (i.e., assistance securing employment, education courses, sense of community), as well as policy implications. Implications stress the need for enhancing supportive factors (i.e., education and social capital) in early prevention efforts (e.g., schools and community centers), as well as an intentional integration of addressing socio-emotional needs and resources within housing programs and services unique to rural and urban communities.

*Key Words* (7): Housing Insecurity, Poverty, Rural Populations, Mixed Methods

## Introduction

Currently one-third of the homeless population consists of families with children (U.S. Department of Housing and Urban Development, 2018) which are typically parented by a single mother (Swick & Williams, 2010). In California, single-headed households (typically led by mothers) with 2 to 3 children have seen a modest increase in family homelessness over the past decade (Institute for Social Research, 2017). Most research on family homelessness and interventions focus on concentrated urban areas (Biel et al., 2014; Shinn et al., 2015, see exceptions Authors, 2019; MacDonald & Gaulin, 2019). Comparing experiences across rural and urban transitional housing settings provides a deeper understanding of the differences and similarities in needs, resources, services and support for homeless families residing in rural areas compared to urban communities. Employing a sequential mixed-method design, this study aims to explore: 1) What factors support homeless mothers in successfully graduating from a transitional housing program within a rural and urban community located in Northern California?, 2) What do homeless mothers perceive to be key factors in facilitating successful graduation from a transitional housing program?, and 3) How do facilitators differ based on the geographic context of the shelter (i.e. rural versus urban settings)? Findings have implications for shelter design, services, and programmatic supports specific to rural and urban populations.

In this study, we are interested in what supportive life factors (i.e., educational status, and social support) and hardships (i.e., interaction with the criminal justice system, mental illness, substance abuse history, and experiences of domestic violence) influence residential success in a transition housing program? We begin by exploring the literature on family homelessness and specifically homelessness amongst mothers. Next, we employ data from mothers (female identified) shelter residents (in both urban and rural contexts) and perform inferential analyses and a binary logistic regression to examine associations between geographic context, demographics, and resident life history in relation to successful program completion. Then, findings from 11 key in-depth informant interviews (i.e., residents of the shelter) are utilized to highlight facilitators of successful program completion along with barriers and areas for improvement. We conclude by discussing implications for practice (e.g., program design, supports, and services) for transitional housing programs across diverse geographic contexts.

## Literature Review

Family homelessness was spotlighted as a public health phenomenon in the 1980s (Bassuk et al., 2011). Originally, this issue garnered much attention from the media, researchers, and policymakers but attention has declined in recent years despite increasing numbers of homeless families (Grant et al., 2013). Homeless mothers experience high rates of chronic stress and trauma as compared to housed populations (Swick & Williams, 2010). These mothers often feel ashamed of their housing status, triggering feelings of self-blame, anxiety and, at times, depression (Paquette & Bassuk, 2009). Research indicates that homeless mothers are more likely to report higher rates of mental health challenges, exposure to violence, coping with substance use, as well as encountering economic challenges (Rog et al., 2007; Swick & Williams, 2010). Progress has been made in housing programs, services, and interventions (Bassuk et al., 2014).

Bassuk and colleagues (2014) found that housing subsidies or affordable housing programs had a promising effect on recipients' ability to secure long-term housing stability. Several programs, policies, and interventions have been utilized to address family homelessness including Housing First, rapid-rehousing, shelters, emergency shelters, and transitional housing facilities (Brown et al., 2017; Chaviano, 2016; Gerwitz, et al., 2015; Henwood et al., 2013). Programming for homeless families often focuses on shelter provision or rental assistance (U.S. Department of Housing and Urban Development [HUD], 2020). Transitional housing services differ from other programming by providing a range of programs and supports (e.g., childcare, case management, classes on parenting, financial literacy, etc.) for up to 24 months in addition to shelter (U.S. Department of Housing and Urban Development [HUD], 2020).

Unhoused communities vary in their needs with geographic areas facing unique barriers in service delivery (Argent & Rolley, 2006). Baker and colleagues (2009) found that transitional housing facilities in the West were more likely to offer transportation, substance abuse programs, parenting classes, medical services, and legal services. Transitional housing services in the Northeast offered support in signing up for public assistance programs as well as legal services. Belanger and Stone (2008) identified significant discrepancies in service delivery between urban and rural counties including fewer substance abuse treatment programs for adults, afterschool programs, family preservation programs, domestic violence services, and financial assistance services in rural areas. Lewis et al. (2013) reports the unique ways in which rural communities have attempted to address these discrepancies by utilizing collaborations between churches and schools to provide showers, laundry services, meals, access to internet, and a mailing addresses while utilizing social workers and volunteers to provide childcare, transportation, family activities, tutoring, and assistance signing up for support programs. Discrepancies in service delivery are concerning because unhoused communities share similar characteristics (e.g., mental health, substance abuse, criminal history, and difficulties with employment; Bassuk et al., 2014, First et al., 1994) that highlight a need for similar services.

Although similar service needs exist among unhoused populations, the degree to which services are needed varies by geographic context (Cummins et al., 1998). For instance, obtaining employment is a common difficulty among unhoused communities (First et al., 1994). Rural communities struggle to maintain employment despite a moderate percentage of rural samples having a high school education or above (See Authors, 2019, Herner et al., 2018). The prevalence of substance abuse issues and mental health challenges are more common in urban communities than rural communities (Cummins et al., 1998). Demographics of rural and urban communities also differ as rural communities often have more non-Hispanic and white members than other ethnicities (McClellan et al., 2010). These differences suggest that some transitional housing programs may need a stronger emphasis in employment, substance abuse, and mental health support depending on their geographical location. Understanding whether transitional housing programs are meeting the needs of unhoused communities can provide important information for adjusting service delivery.

This study explicitly explores two transitional housing facilities. Such programs aim to support families by providing time-restricted housing and social support resources (e.g., counseling, group sessions, caseworkers, etc.) to help address the socio-emotional needs of families and their children (Portwood et al., 2015). Research has been promising for families who remain in transitional housing programs for at least 6 months (Fischer, 2000). In contrast with those that leave before 6 months, families that stay longer exhibit high rates of finding employment, permanent housing, and are less dependent on public assistance over time (Fischer, 2000; Farrell et al., 2010). While transitional housing is not the only housing approach utilized to support homeless families, research suggests that the act of successful graduation from the program may be a key step for families in securing long-term housing contributing to financial, emotional, and social security (Bassuk et al., 2014; Authors, 2019).

## Supportive Factors for Homeless Mothers within the Literature

In the next section, we describe potential supportive factors associated with homelessness from the empirical literature (i.e., education, and social supports). Informed by the literature, we identify how these supportive factors may help facilitate successful graduation from a transitional housing program for homeless mothers.

*Education.* Research indicates that educational attainment can serve as a buffer against homelessness and has been linked to higher employment and stable wages (Bassuk, 2010; Cheng, 2010). Education may play an especially important role for homeless mothers. Rivera (2003) conducted a prolonged ethnographic study tracking the impact of an educational intervention program for homeless mothers. Participants reported an increase in self-esteem, personal advocacy and an investment in their child's education. Prior research conducted by the authors found education to be a significant predictor of successful graduation from a rural housing transitional shelter for previously homeless men and women (Authors, 2019). Specifically, residents with high levels of education (e.g., high school diploma, GED, some college) were more likely to successfully complete the program (Authors, 2019).

*Social Support.* Social support has been found to provide housing insecure individuals with access to needed resources (i.e., childcare, transportation, emotional support, etc.) (Fitzpatrick, 2015; Malden et al., 2018; Townley, 2015). Alternatively, a lack of social support can place one at increased risk of experiencing homelessness (e.g., not having a place to stay or someone to lend money, Chambers et al., 2014). In a review of eighteen qualitative studies on homeless mothers, Meadows-Oliver (2003) found that social support was described as a survival strategy in which shelter mothers often drew strength from shelter staff, case managers and other shelter residents. In a prior research, we found that social support was a significant predictor of program completion for both previously homeless men and women residing in a rural transitional housing shelter. Residents with two or more contacts (i.e., friends, family, co-workers, and community members) were more likely to complete the program (Authors, 2019).

## Hardships Experienced by Homeless Mothers within the Literature

In the section below, we describe additional hardships associated with homelessness from the empirical literature (i.e., substance abuse, mental illness, and interaction with the criminal justice system). Informed by these hardships, we identify how such challenges may create additional barriers to graduation from a transitional housing program for homeless mothers.

*Substance Abuse.* Substance abuse is a pattern of substance use in which the amount or method used can cause harm to an individual and their surroundings (World Health Organization, 2018). The relationship between homelessness and substance abuse is non-directional, while one condition may not cause the other, both can exacerbate one another (Zerger, 2002). Boyd and colleagues (2003) found a 45% prevalence of alcohol or substance abuse within a sample of mothers experiencing homelessness. In an in-depth qualitative study Padgett and colleagues (2006) found that homeless women described developing substance abuse issues early in their adulthood and attributed this abuse to psychological distress, trauma and loss, the cumulative effect of housing insecurity, and poverty. Alternatively, others have utilized substances as a way to self-medicate with increased feelings of anxiety, uncertainty, and instability in reaction to housing insecurity (Teesson et al., 2003). The act of recovering from an addiction may yield additional barriers for residents in successfully graduating from a transitional housing program as they may also encounter challenges with sobriety as well as shelter rules.

*Mental Illness.* Mental illness consists of variations in behavior, perception, and social relations that can yield undue distress and/or impair adaptive functioning (Commission on Mental Health, 2002). Twenty to thirty percent of the homeless population suffer from mental illness, yet it remains unclear how social class, poverty, and mental illness intersect (Johnson & Chamberlain, 2011; National Coalition for the Homeless, 2009). Homeless mothers tended to be at higher risk of psychiatric disorders, in particular maternal depression (Weinreb et al., 2006). Mental health challenges can be brought on by poverty, housing insecurity, and a lack of adequate health care coverage (Kilmer et al., 2012; Suglia et al., 2011). Navigating a mental illness may put mothers at risk for not successfully completing transitional housing programming, especially if their mental health needs are not being adequately addressed.

*Criminal Justice System.* Homeless individuals are often charged with minor offenses (e.g., petty theft, or entry into vacant buildings) (Benda et al., 2003; Zarikson et al., 2004) with enhanced interactions with law enforcement occurring due to city bans or ordinances against camping, loitering, or panhandling (Wilking et al., 2018). Recent reviews indicate that 10% of homeless individuals report having experienced a period of incarceration (Metraux et al., 2007). In a sample of 951 homeless females, 13% reported being charged with a misdemeanor (Thompson et al., 2008). Entry into the prison system can place an individual at higher risk for housing insecurity. Metraux and Culhane (2004) found that 11.4% of individuals leaving the New York State prison system utilized a homeless shelter within two years of their release. The culmination of court fines, probation, and a criminal history can hinder a homeless individual from securing housing and employment (Herring & Yarbrough, 2015; Murphy et al., 2011) and may be an additional roadblock to successfully completing a transitional housing program.

## Hypothesis

Based on the literature, we put forth the following hypotheses. First, we believe that those with a higher education level will be significantly more likely to successfully complete the transitional housing program (*Hypothesis* 1). Second, participants with high levels of social support (i.e., number of social contacts) will be significantly more likely to successfully complete the transitional housing program than participants indicating lower levels of social supports (*Hypothesis 2*). Third, participants with a history of substance abuse may be significantly less likely to complete the transitional housing program than participants with no history of substance abuse (*Hypothesis 3*). Fourth, participants with a history of a diagnosed mental illness may be significantly less likely to complete the transitional housing program than participants with no known history of mental illness (*Hypothesis 4*). Participants with a history of interaction with the criminal justice system may be significantly less likely to complete the transitional housing program as compared to participants with no known criminal history (*Hypothesis 5*). Following our preliminary quantitative analysis, we take an exploratory in-depth qualitative approach, exploring additional shelter supports and barriers as well as examining differences in narratives across geographic contexts.

## Methods

### Sample and Setting

Data was gathered at one rural and one urban transitional housing programs located in Northern California. The rural transitional housing program resided in a rural county with a population of approximately 220,000 residents (U.S. Census Bureau, 2020). In contrast, the urban transitional housing program resided in a county with a population of 1.5 million residents (U.S. Census Bureau, 2020). Both programs provide housing and support (e.g., childcare, case management, classes on parenting, financial literacy, etc.)  with the goal of helping families experiencing homelessness become selfsufficient. Clients are referred by Child Protective Services, Department of Human Assistance, drug court, local substance use disorder treatment programs or former clients. Due to the nature of the referral systems (i.e., being composed of organizations focused on substance abuse) and needs within the community, both transitional shelters served a high proportion of clients with a history of substance abuse challenges.

The rural transitional housing program, established in 1991 to serve families experiencing homelessness and housing insecurity, consists of an apartment complex surrounding an administrative building, classrooms, and a childcare center. Participants progress through two phases. During phase 1, participants meet with a case manager and attend on site skill development classes. In phase 2, participants are employed or enrolled in higher education, pay rent and utilities, and develop a savings account. The program offers the following services over an 18 to 24-month period: individual apartment housing with kitchen, case management, programmatic resources (i.e., parenting classes, financial literacy courses, substance abuse counseling, mental health services, GED-related services and job readiness training) and a cooperative childcare system with direction from child protective service's supervisor for children 6-36 months and a referral system for preschoolers (3-5 years) with local community-based childcare services. School aged children receive homework assistance and tutoring after school hours from volunteers. Mothers ranged in age from 18 to 44 years (M= 30.34, SD= 5.81). The sample was predominately white (68.7%) and commensurate with county-level homeless population data (72.1% white) (*Retracted*[1] County-Wide Continuum of Care, 2017). The average education level was high school diploma or equivalent, with over half (57%) of the participants having completed some college/trade school.

The urban transitional housing program was established in 1985 and serves single women and women with children experiencing homelessness or housing insecurity. The program provides the following services over an 18-month period: communal housing and meals, case management, substance abuse counseling, mental health services, childcare for all ages, and GED related services. Participants navigate through five program stages: stabilization (i.e., individualized plans consisting of life skills courses, case management, and therapy), employment training and self-development (i.e., job-readiness courses and hands-on paid employment training), advanced employment training (i.e., career exploration and preparation), job acquisition (i.e., full time employment and subsidized individual apartments), and family sustainability and community involvement (i.e., support for up to three years after obtaining full time employment).. Participants ranged in age from 21 to 59 years old (M= 35.26, SD=7.35). Most of the sample identified as Black/African American (38.1%), White (31.7%), or Hispanic (20.1%). Black/African American families were slightly overrepresented in the urban shelter population when compared to county-level homeless population demographics (23% Black/African American; Institute for Social Research, 2017). The

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[1] *Retracted information to preserve anonymity of the county and location of data collection.*

average education level was less than a high school diploma, with only 42.4% having successfully completed high school prior to program entry.

## Design

This study employs a sequential mixed-method design consisting of 1) survey data (n = 241, shelter residents), and 2) in-depth qualitative study (n = 11, shelter residents who have graduated or are about to). In a sequential exploratory mixed-method design, data is collected at different time points, often consisting of an initial quantitative phase followed by a qualitative phase, implemented with the purpose of exploring the results in more depth as well as yielding opportunity for corroboration and triangulation across sources (Levitt et al., 2018).

## Quantitative Analysis

Pre-existing data from both programs (urban N= 141, rural N= 100) were utilized. Rural data was collected from 2013-2017, while urban data was gathered from 2016-2018. Data from both sites consisted of a program entry and exit survey as well as a self-report questionnaire including demographic information—both filled out by program staff. Researchers created a single database consisting of females with children residing in either shelter. The merged database contained demographic information, comparable life history variables (i.e., substance abuse history, and diagnosed mental illness) and clients program status (i.e., successfully versus unsuccessfully graduated from the program). All data collection was approved by the university’s institutional review board (Protocol #’s 3941 and 18221).

## Qualitative Interviews

Semi-structured interviews were conducted with current and former residents of the housing shelter (n = 11, n = 6 urban shelter, n = 5 rural shelter) recruited from the quantitative survey sample. Interview protocols were co-developed, piloted, and reviewed by shelter staff as well as students and community members that had experienced housing insecurity. Interviews lasted between 30 minutes to 1 hour. Participants were asked about their experiences with housing insecurity (i.e., "*What factors contributed to you needing housing services?"*), within the shelter (i.e., "*What services did you find most helpful?"*), as well as recommendations for programming, policy, and community outreach (i.e., "*Are there any services/and or resources that you are not receiving that you think would have been helpful?"*, and *"If you were talking to a policy maker, what would you tell them is the key to reducing homelessness?"*).

## Quantitative Measures

*Education*. Educational achievement for rural participants was measured using a 16-point scale (0=8th grade or below to 15= Postgraduate). Educational achievement for urban participants was measured using an 11-point scale (1= no school completed to 11= Post-secondary school). Education was recoded into a 3-point scale (1= some high school or less; 2= high school diploma/GED; 3= some college/college/trade school).

*Social support.* Participants were asked how many social supports they had (i.e., *How many family members and friends do you rely on for support?*). Responses ranged from 0-12.

*Substance Abuse*. Participants were asked whether they had a history of substance abuse. The variable was coded as a binary (yes/no).

*Diagnosed Mental Illness*. Participants were asked whether they had a mental illness that had been diagnosed by a professional. The variable was also coded as binary (yes/no).

*Criminal justice history*. Next, we assessed whether the client had a history of interaction with the criminal justice system. This variable was also coded as binary (yes/no). Responses for this variable were determined based on the following survey questions: history of arrests (rural data: yes/no), misdemeanor convictions (rural data: yes/no), felony convictions (rural data: yes/no) and having been to prison and/or jail (urban data: yes/no).

*Successful versus unsuccessful*. Participants were classified as either successful or unsuccessful at program exit. Success criteria was developed by rural program staff. Program staff rated participants as successful or unsuccessful at exit based on the following criterion: maintaining sobriety (both drugs and alcohol), programmatic completion, parenting their children within the home, and relocating to stable housing. Participants who met some, but not all success criteria were classified as unsuccessful. This classification was replicated by the first author retroactively using exit data collected at the urban shelter after being reviewed and agreed upon by urban shelter staff.

## Quantitative Analysis

First, chi-squares were utilized to examine demographic differences between the programs (rural versus urban). Second, a binary logistic regression was utilized to predict successful completion of the program (i.e., dependent variable) from seven variables: shelter type (urban vs. rural), age, race (dummy coded white vs. minority due to the small cell sizes), education, substance abuse history, diagnosed mental illness, criminal justice interaction, and social support.

### Qualitative Analysis

Employing an inductive approach, the authors identified significant ideas and experiences employing an open-ended content coding approach (see Krippendorff, 2004). Authors 1 and 2 analyzed transcripts to identify meaningful concepts within the text and developed a codebook. Next, the researchers applied a deductive theoretical framework to further tease out unanticipated themes surrounding perceptions of poverty (Creswell, 2003; see AUTHOR, 2019). Gowan's (2010) theoretical framework was utilized examining how homeless individuals perceived poverty from: 1) sickness mindset (i.e., poverty due to a deficit within the individual), 2) sin mindset (i.e., poverty due to individual choices and/or lack of motivation), and 3) system mindset (i.e., poverty due to systemic inequities). Qualitative codes were refined, tested, and applied to transcripts by three researchers (authors 1, 2, and 3). Coders achieved an alpha of .80 in inter-rater reliability and consensus coding was utilized to verify any areas of discrepancy. Qualitative themes were determined based on their salience within the data and divergence surrounding geographic location.

## Results

### Quantitative Results

*Descriptives.* The two programs differed significantly in terms of racial make-up, $X^2$ (1,233) = 32.32, p. = .000. The urban site had a higher proportion of minority clients (68.3%) compared to the rural site (31.3%).

In regard to education, on average participants (combined sample) did not graduate from high school or obtain their GED (M= 1.89, SD= .79). Significant differences in education were found between rural and urban populations, $X^2$ (2, N= 239) = 90.75, p. = .000. More rural participants had completed some college or trade school (57%; M= 2.26, SD= .91) compared to their urban peers (4.3%) who were more likely to have not graduated high school (M= 1.62, SD= .57).

In the context of social support, combined participants reported having three supportive relationships with family members and/or friends (M= 3.00, SD= 2.32). Alternatively, urban populations reported lower levels of social support $X^2$ (2, N= 226) = 72.27, p. = .000, with urban participants averaging two supports (M= 2.54, SD= 2.70), in contrast to rural participants who reported having three supports on average (M= 3.53, SD= 1.54).

Regarding substance abuse, most participants (combined) reported a history of substance abuse (77.1%), whereas 22.9% answered no. Significant differences in substance abuse history were found between the two groups, $X^2$ (1, N=231) = 7.22, p. = .007. A greater proportion of rural clients reported a history of substance abuse (85.7%), as compared to their urban peers (70.7%).

Concerning mental health, slightly more than one-half (53.5%) of all (rural and urban) participants had a mental illness diagnosis. Exploring the two samples separately, 56.7% of urban participants and 49% of rural participants reported having been diagnosed with a mental illness.

Nearly two-thirds (56.3%) of all participants reported a history of interaction with the criminal justice system, whereas 43.7% reported no history. Rural and urban participants also significantly differed in interaction with the criminal justice system, $X^2$ (1, 238) =4.15, p=.042. Rural clients reported higher rates of interaction with the criminal justice system (64%) as compared to their urban peers (50.7%).

In regard to program completion, over half of the combined sample (57.9%) were successful. Fifty-five percent (55.2%) of urban participants were successful, while 60.9% of rural participants were successful.

[*Insert table 1 here*]

Nearly two-thirds (59%) of participants with a history of substance abuse had a diagnosed mental illness, while 34% of those without a history of substance abuse had a diagnosed mental illness, $X^2(1)$= 10.28, p= .001. Significant differences in substance abuse history were found between white and minority participants, $X^2(1)$= 12.88, p= .000. Proportionally more participants who identified as white (87.7%) had a history of substance abuse compared to participants who did not identify as white (67.5%). Results also indicated that 62.7% of participants with a history of substance abuse had a history of interaction with the criminal justice system, whereas 36.5% of participants without histories of substance abuse had experienced interactions with the criminal justice system, $X^2(1)$= 11.22, p= .001. The proportion of participants with histories of interaction with the criminal justice system differed significantly by education level, $X^2(2)$= 7.95, p= .01. Two-thirds (60.2%) of participants with less than a high school diploma had a criminal justice interaction history, compared to 44.7% of percent of participants with a high school diploma/GED and 66.7% of participants who had completed some college or trade school.

*Successful versus Unsuccessful Completion.* Chi-squares were utilized to examine demographic differences between participants that were successful and unsuccessful in completing the program. No significant differences were identified. Regression results indicated that education was significantly related to successful program completion (p = .025; *supporting Hypothesis 1*). Odds ratios indicated that individuals with higher levels of education were nearly twice as likely (1.66) to graduate than their peers with lower levels of education. Social support was moderately significant (p = .085). Clients with higher indices of social support were more likely to graduate as compared to their peers who reported fewer social support networks (*partially supporting Hypothesis 2*). Notably, substance abuse history (*Hypothesis 3*), diagnosed mental illness (*Hypothesis 4*), and history of interaction with the criminal justice system (*Hypothesis 5*) did not significantly predict successful program completion.

[*Insert table 2 here*]

## Qualitative Results

Shelter residents identified key facilitators to their success within the transitional housing program. As highlighted below, programmatic support and shelter climate notably differed regarding geographic location. Recommendations surrounding policy and supports for housing insecure populations narratives varied in identifying the source of the problem and targeted agents of change.

## Programmatic Support: Job Training and Higher Education

Across all eleven interviews, participants described an acquisition of various skills and resources during their time within the transitional housing shelter. Skills included personal advocacy, financial literacy, parenting children who have been exposed to trauma, and recovery. In the narrative below, the interviewee describes the value of transitional housing programming in providing them with needed tools and supports from a holistic perspective:

> *You know because when I went to the rehab, it was all about how to live life sober, and then so once you have, so once you're sober and everything, it's like then what? This place [Housing Facility] gave me different tools, and helped me…to be able to be a good mom and a you know, a productive, uh member of society, to do what people do, or supposed to do you know.* (Urban Interviewee)

This quote highlights the value of the transitional housing program in providing women with diverse skills not solely focused on relapse prevention but rather a strength-based approach supporting their ability to flourish surrounding multiple aspects of their identity and personhood.

When exploring differences between participants' identified life skills within urban and rural settings, five out of six participants from the urban transitional housing shelter identified job readiness and employment as key benefits and notable outcomes with regards to their participation in the program. In the quote below, the interviewee discusses the novelty of obtaining employment: "*I didn't know what it was like to have a job. I ran the streets. That's all I did, you know what I mean? So, basically, they showed me what stability was. They showed me what a job was*." (Urban Interviewee). This quote highlights the importance of stable employment in regard to having a psychological sense of security. Similar narratives were not evident across interviews from participants engaged in the rural transitional housing program.

In contrast, three out of five participants engaged in the rural transitional housing program identified higher education and GED completion as key benefits of their participation within the transitional housing program. In this interview, the interviewee discusses their exploration of higher education during their time at the shelter and gaining internship experience, which was notably confined to the shelter: "*This is my 3rd semester back at the community college. I'm going for office administration. I have an internship here on Tuesdays and Thursdays. I want a degree to better my family, my life.*" (Rural Interviewee). In this quote, the interviewee stresses the value of an educational degree in association with the opportunity to improve their life circumstances. Notably, higher education and GED completion were absent in interviews from participants residing within the urban transitional housing program.

### Social Support: Sense of Community

Beyond programmatic support, participants also described social support as a key contributor to their success and overall well-being within the program. Nine of the interviews (six from the urban shelter, and three from the rural shelter) described a feeling of emotional intimacy, trust, and sense of support amongst shelter residents that contributed to their success within the program. *Sense of community* has been defined within the field of community psychology as an emotional bond and feeling of connection amongst members (Townley et al., 2011). Across interviews, participants described community building activities within the shelter such as celebrating birthdays and holidays, seeking advice from peers, and providing childcare and support in times of crises. These events fostered feelings of belonging, connection, and accountability. In the interview below, the interviewee describes the value of having peers who have endured similar lived experiences (i.e., housing instability and addiction):

> *I made a lot of friends that I'm still friends with that I'll be friends with for life ...when you're in an addiction… the only thing you know is the addiction ...we all identify with each other in one way or another... and make each other accountable...We listen to each other because it's people coming from our walks of life. It's not just somebody trying to tell us how they think that we should be if that makes sense.* (Urban Interviewee)

This interviewee notes the lifelong friendships they have made within the center and the value of getting explicit support from peers who have encountered similar experiences.

Interviewees from the urban shelter discussed an evolution in their perceptions around the importance of social support and relationships during their time in the program. Interviewees' initial focus included staying sober, reconnecting with family, obtaining a job, acquiring stable housing, and self-improvement. These interviewees noted that spending time within the shelter fostered a desire to build personal connections, as well as a gradual recognition surrounding the importance of community in relation to their health and well-being. In the quote below, the interviewee describes the change in climate within the shelter as residents began to develop relationships and identify areas of commonality in collective struggle:

> *It didn't feel like anybody there was a community... it was... kinda like you were on the streets... at first, nobody was friends with anybody... but it started changing after I was there for a couple months... we just all clicked...we were all on the same path in the same way, you know just a different kinda journey...I think that, that's super important to be a community and to be you know all there for a goal*

> *and not stray away and worry about the petty stuff, so I think that, that’s important.* (Urban Interviewee)

In contrast, only one interviewee from the rural shelter indicated that community was important for her upon entering the program:

> *It was a lot more in the beginning, ‘cause I really needed the support. And then towards... the last year or so, I focused more on, like, my family and, like, getting ready to be out of there. You know? But, yeah, in the beginning it was very important, like, just to build a relationship with people... and have the community to help... make me feel comfortable.* (Rural Interviewee)

A *sense of community* was predominantly described as a positive aspect of the program. However, this narrative was neither universal nor monolithic. For instance, one interviewee from the urban shelter noted that she often felt pressure and a strong sense of anxiety while reaching out to her peers for support:

> *There was a lot of times where I was just extremely overwhelmed and I can't always depend on the other-- clients here to... help me with my kids and that was kind of the thing that was always kind of pressed on me, 'well, go ask one of your sisters to help you with the children'. And that always kind of frustrated me because it's like, that's not their job. They're not here to help me take care of my kids or...no one ever came to me and said '[name] you look like you're going through a lot, let me take your kids for about an hour’.* (Urban Interviewee)

While social support was predominantly identified as a supportive factor for participants within the shelter. The quote above warns against making assumptions surrounding homogeneity in lived experience, comfort, and personality regarding community building efforts.

## Mindsets and Advocacy

Differences in belief systems surrounding the causes and solutions to homelessness were also found between rural and urban groups. For instance, the belief that the best solution for addressing homelessness is providing treatment and support to individuals was discussed substantially more among participants from the urban shelter compared to their rural counterparts. Gowan (2010) describes this as a “sickness mindset”, in which the problem is viewed to be due to a deficit of the individual as compared to conditions that foster social inequities. Five participants from the urban shelter emphasized that assistance from others was needed in order to no longer be homeless. For example, when asked what the key to reducing homelessness was, an interviewee shared the following:

> *P: Getting them into some type of shelter, some type of support... get them to try to help them get onto their feet.*
> *I: And when you say help get someone back on their feet, what might that entail?*
> *P: Umm, probably involve financially, emotionally, mentally, uh, you know, pretty much everything [laughs].*
> (Urban Interviewee)

This response highlights a belief that people experiencing homelessness need treatment (e.g., mental, emotional, etc.) and support (e.g., financial help). This narrative was only discussed by only one interviewee from the rural shelter:

> *I think they need to help more people and get funding and stuff like that so then they can help them and then they can get on their way...but then there’s also the people that don’t want help or don’t, that like being homeless... I don’t know what, what to do with them ...And a lot of times they need meds or something, maybe.* (Rural Interviewee)

Echoing narratives shared amongst interviewees from the urban shelter, this interviewee noted that individuals who are homeless need help and assistance. Yet, also implicit in this statement is the embedded assumption that those who do not seek out assistance are responsible for their circumstances.

In contrast, participants from the rural shelter referred to individuals experiencing homelessness as in need of additional support far less often than those from the urban shelter. Instead, narratives tended to focus on echoing meritocratic beliefs that individuals are responsible for their own success. "*They don't want it. For some of these families they are just getting a roof over their head. They aren't taking it seriously."* (Rural Interviewee). Gowan (2011) describes these narratives as a "sin-mindset" in which conceptualizations of poverty are attributed to an individual's life choices and/or lack of self-determination. Participants from the rural shelter also discussed the importance of developing skills to navigate the system, learn the "system talk", and self-advocate a skill set not mentioned amongst participants from the urban shelter. Self-advocacy consisted of learning how to ask for help, searching for support and resources, and navigating systems.

Participants from the rural shelter described learning how to identify their needs and advocate for resources. As one interviewee shared, "*If I need something, I ask. That's something I learned too*" (Rural Interviewee). An interviewee also described the importance of learning how to navigate systems when asked about skills and resources gained from the transitional housing facility:

> *I would just be, like, angry and want to call, and you don't do that. I know how to fight more legally. And respectfully. Instead of calling and flipping out on somebody. I know how to put it down on paper and ... I know how to better reach out in my own community than before... they've helped me learn how to do that.* (Rural Interviewee)

This participant emphasized the importance of learning how to advocate for themselves and their children in a manner that yielded results.

## Discussion

This study sought to highlight potential facilitators that influence the chances for homeless mothers to successfully graduate from transitional housing programs in both rural and urban settings. Findings offer a novel preliminary contribution to the literature, in that previous research has focused on urban samples limiting the opportunity to compare differences and resulting in services that may not reflect the needs of rural homeless families.

In our study, women with higher levels of education were significantly more likely to complete the transitional housing program (*Hypothesis 1 confirmed*). This finding was consistent with prior literature (see Authors, 2019; Cheng, 2010), indicating the potential importance of educational support within transitional housing programs. Notably treatment from shelter staff may be influenced by a class-based bias towards women without a higher education (Kim & Cardemil, 2012). Alternatively, individuals with a higher education may have more resources available to them than those without a higher education. More research is needed to identify the underlying mechanisms of this relationship. Qualitative findings revealed that the theme of obtaining a higher education was more prominent in interviews with participants from rural shelters, suggesting that educational success could potentially be a key value expressed within the shelter organization or larger community.

Education was not discussed by any interviewees from the urban shelter. Instead, these participants emphasized the value of job training and securing employment. In the rural setting, the job security and employment were much more limited, with the unemployment rate higher than the state average (California Bureau of Labor Statistics, 2019). Thus, rural shelter staff may have had notable limitations in connecting women to job opportunities. This finding mirrors prior reviews on the challenges of service delivery systems for homeless populations (Beer et al., 2003; Skott-Myhre et al., 2008), and yet provides a novel comparison with an urban sample. In practice, rural shelters could overcome limitations to connecting women to employment through partnerships with organizations and restaurants to provide job placements to program participants.

Conversely, the urban shelter may benefit from greater access to employment opportunities due to being located in an urban area and the shelter's emphasis on employment skill development. Notably, on average participants from the urban shelter had less than a high school diploma. Whereas linkages are becoming less robust, post-secondary education is still associated with trickle effects for an individual and larger community including: long-term job security, employment, community vitality, and civic outcomes (Doyle & Skinner, 2017; McMahon, 2009; Perna, 2005). While participants from the urban transitional housing shelter may have greater access to immediate resources in securing employment and the stable income necessary for housing, they may also encounter limitations in opportunities for long-term job advancement. In an effort to address inequities, it may be advantageous for transitional housing programs to provide residents with the autonomy to choose between educational and job advancement opportunities dependent upon individual needs and preferences. For instance, in practice urban shelters could partner with local universities to expand programming to include educational services (e.g., classes, certification, reduced tuition costs). Future research is necessary to explore whether distinct trends in skill development differ universally across rural and urban shelter programs.

Larger social support networks were associated with successful graduation (*Hypothesis 2 confirmed*) consistent with previous research that highlighted social support as a protective factor against homelessness (Authors, 2019; Fitzpatrick, 2015; Malden et al., 2018; Townley, 2015). Both rural and urban interviewees discussed the importance of social support and community however, differences were found between the two groups. For instance, a sense of community was more prominent in interviews conducted at the urban shelter. While further research is needed the physically unique aspects of the shelters may have contributed to these differing narratives. For instance, participants at the rural shelter lived in individual apartments, while participants at the urban shelter lived in dormitory-style housing with shared public spaces (e.g., living rooms, cafeteria, restrooms, etc.). Previous research has highlighted the role of public spaces in the development of a sense of community (Cattell et al., 2008; Francis et al., 2012). Thus, residents of the urban shelter were perhaps provided with more geographic spaces and opportunities to connect and create bonds than their counterparts at the rural shelter. In the context of practice, implementation of shared spaces (e.g., communal rooms or common areas) and opportunities (e.g., networking or social support programming) to connect socially with other residents may foster a greater sense of community for rural participants.

Additionally, a larger proportion of African American/Black residents were located at the urban shelter. Among this group, community building has historically been emphasized as a protective factor against structural racism and as a way to enhance well-being (Saegert, 1989; Edwards, 2000). Thus, such historic and cultural considerations may have also played a role. In sum, given the important role of social support in predicting successful program completion, programs ought to include shared physical spaces and opportunities for social support through programming to support homeless mothers. Future research ought to explore shelter practices in community building for unique populations both through programming as well as shelter design structures.

Mindsets that attribute homelessness to individualistic causes can contribute to internalized oppression and stigma, which in turn impacts how individuals’ utilize and experience services (Major et al., 2018; Weisz & Quinn, 2018). More specifically, these internal processes can contribute to underutilization and withdrawal from services (Milligan et al., 2002; Weisz & Quinn, 2018; Lin et al., 2017). Differences in ideas, strategies, and solutions surrounding addressing homelessness highlight the ways in which values may have varied across the two contexts. The individualistic rhetoric expressed by participants from the rural shelter could be related to the larger locality. Predominantly, white rural areas tend to be more conservative, fostering sentiments of individualism and distrust surrounding government supports (Cech, 2017; Parker et al., 2018). Such values potentially impacted residents’ perceptions of individualistic factors contributing to homelessness as well as guidance from shelter staff surrounding the importance of developing skills in personal advocacy. In contrast, interviewees from the urban shelter discussed that individuals experiencing homelessness need help and additional support. The rejection of meritocracy expressed in responses from residents of the urban shelter could be rooted in participants’ lived experience and understanding of structural racism in relation to class inequity. Previous research has found that participants who identified as Black/African American were significantly more likely to view the U.S. as inequitable and are less likely to believe hard work alone will get someone ahead (Brott et al., 2019; Jones et al., 2014). In the future, shelters staff might consider including educational programming on the effects of structural racism and multi-generational poverty in service-delivery, as consciousness raising discussions can identify inequities and initiate collective action (Adams et al., 2012). Additionally, internalized stigma interventions could be implemented to challenge stigmatized thinking patterns (Mittal et al., 2012). For instance, coping skills development and narrative enhancement and cognitive therapy (NECT) have been shown to change thinking patterns and reduce internalized stigma (Lucksted et al., 2011; Hansson et al., 2017).

In sum, history of substance abuse, diagnosis of mental illness, or interaction with the criminal justice system did not hamper participants’ successful completion of the program in both rural and urban contexts (*disconfirming hypothesis 3, 4, and 5*). Our findings highlight promising results in transitional housing facilities supporting vulnerable populations in addressing mental health needs and challenges. Due to the large sample of participants struggling with substance abuse upon entering the facility, key programmatic structures and community-oriented social support mechanisms may have been particularly beneficial in facilitating participants’ recovery processes. Furthermore, social support and education were key predictors of successful program completion for both rural and urban participants, highlighting the value of educational and support services within transitional shelters in helping disrupt ongoing cycles of housing insecurity and intergenerational trauma. Qualitative findings corroborate quantitative findings surrounding the value of social support and community-building amongst participants within both shelters, and further elucidate that educational and employment opportunities differed based on shelter and community contexts. Our preliminary findings suggest that both employment and educational opportunities may play an important role in participants' successful graduation from the transitional housing programming and their long-term housing security. Providing an array of programmatic services may even further bolster programmatic success across distinct contexts. Lastly, qualitative results highlight that further research is needed on the role of mindsets surrounding poverty and how these macro-level beliefs (i.e., individual beliefs versus root causes analysis) influence individual behaviors and actions.

### *Limitations*

Both programs were located in Northern California, thus differences found between the rural and urban shelter samples may not generalize to other regions. Data from both shelters was collected over a five-year period with only two years of overlap; it is possible that differences found were due to time. Additionally, because transitional housing programs often have strict entry requirements, findings may not translate well to homeless families who are not in transitional housing. Interviews were only conducted with program residents who were successfully navigating the program. Obtaining the perspectives of individuals who dropped out of the program would shed additional light on barriers experienced by homeless families.

## Conclusion

This study begins to address a gap in the current literature examining areas of divergence and convergence regarding homeless mothers in rural and urban communities. In practice, findings suggest the importance of both employment training and educational programming for rural and urban populations, opportunities and physical spaces for community building, and programming that encourages consciousness raising discussions surrounding economic and social inequities. Findings highlight the potential of education and social support as key facilitating factors contributing to successful graduation from transitional housing programs in both rural and urban areas. Future research ought to explore the long-term outcomes of transitional programs (i.e., longitudinal studies), as well as within unique rural and urban regions in the U.S. Finally, future inquiry ought to explore whether earlier preventative needs differ for families at risk of homelessness across rural and urban contexts.

*Table 1. Demographics rural versus urban*

| | Rural<br>(n= 100) | Urban<br>(n= 141) | Unsuccessful<br>(n = 83) | Successful<br>(n = 114) |
|---|---|---|---|---|
| **Race** | | | | |
| White | 68 (68.7%) | 44 (31.7%) | 38 (45.8%) | 55 (48.2%) |
| Asian | 3 (3 %) | 1 (0.7%) | 1 (1.2%) | 3 (2.6%) |
| Black | 7 (7.1%) | 53 (38.1%) | 23 (27.7%) | 25 (21.9%) |
| Hawaiian | 0 (0%) | 2 (1.4%) | 0 (0%) | 2 (1.7%) |
| Hispanic | 8 (8.1%) | 28 (20.1%) | 14 (16.8%) | 12 (10.5%) |
| Indian | 4 (4%) | 6 (4.3%) | 2 (2.4%) | 7 (6.1%) |
| Other | 3 (3%) | 3 (2.2%) | 0 (0%) | 6 (5.2%) |
| Multiple Races Reported | 6 (6.1%) | 2 (1.4%) | 3 (2.6%) | 3 (2.6%) |
| Missing | 1 (0%) | 2 (0%) | 2 (2.4%) | 1 (.8%) |
| **Education** | | | | |
| Less than HS | 31 (31%) | 59 (42.4%) | 38 (45.8%) | 36 (31.6%) |
| HS/GED | 12 (12%) | 74 (53.2%) | 27 (32.5%) | 39 (34.2%) |
| College/Some College/Trade | 57 (57%) | 6 (4.3%) | 17 (20.5%) | 39 (34.2%) |
| Missing | 0 (0%) | 2 (0%) | 1 (1.2%) | 0 (0%) |
| **Substance abuse history** | | | | |
| Yes | 84 (85.7%) | 94 (70.7%) | 59 (71.1%) | 88 (77.2%) |
| No | 14 (14.3%) | 39 (29.3%) | 20 (24.1%) | 26 (22.8%) |
| Missing | 2 (0%) | 8 (0%) | 4 (4.8%) | 0 (0%) |
| **Diagnosed mental illness** | | | | |
| Yes | 49 (49%) | 80 (56.7%) | 48 (57.8%) | 55 (48.2%) |
| No | 51 (51%) | 61 (43.3%) | 35 (30.7%) | 59 (51.8%) |
| Missing | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |
| **Criminal justice interaction** | | | | |

| | | | | |
|---|---|---|---|---|
| Yes | 64 (64%) | 70 (50.7%) | 44 (53%) | 68 (59.6%) |
| No | 36 (36%) | 68 (49.3%) | 38 (45.8%) | 46 (40.4%) |
| Missing | 0 (0%) | 3 (0%) | 2 (2.4%) | 0 (0%) |

*Table 2. Logistic regression of successful program completion*

| | b | se | z-ratio | prob. |
|---|---|---|---|---|
| Shelter Type | 0.31 | 0.41 | 0.56 | 1.36 |
| Age | 0.02 | 0.023 | 0.61 | 1.02 |
| Race | -0.07 | 0.36 | 0.03 | 0.94 |
| Education level | 0.51 | 0.23 | 5.03 | 1.66** |
| Substance abuse history | 0.22 | 0.41 | 0.29 | 1.25 |
| Diagnosed mental illness | -0.51 | 0.33 | 2.34 | 0.6 |
| Criminal justice interaction | -0.11 | 0.35 | 0.10 | 0.89 |
| Social support | 0.14 | 0.09 | 2.97 | 1.15* |
| Model $X^2$ =12.536 | | | | |
| Pseudo $R^2$ =.07 | | | | |
| N= 174 | | | | |

$p < .05$**, $p < .10$*

*Table 3. Qualitative themes*

| Code | Frequency | | Definition |
|---|---|---|---|
| | Urban (n= 6) | Rural (n= 5) | |
| Resources | | | |
| Job readiness | 5 | 1 | **Job Readiness** refers to classes, training, and support in finding employment. Examples include the following: developing a resume, skill set, and professional network to secure employment. |
| Education | 0 | 3 | **Education:** Furthering one's level of education. Examples include obtaining GED, Cosmetology, or Associates Degree. Additionally, there may also be an underlying assumption that education is needed to propel change. |
| Social Support | | | |
| Sense of Community | 6 | 3 | **Sense of Community** refers to feelings of belonging and that one's needs will be met. Examples include group therapy, advice from peers, providing childcare, and celebration/events over the holidays. |
| Mindsets & advocacy | | | |
| Sickness mindset | 5 | 1 | **Sickness:** The individual needs treatment and support. Examples include attributing one's housing status to underlying mental health issues and/or substance abuse disorder. |
| Sin mindset | 5 | 4 | **Sin:** The individual committed a crime, or poor behavior. The individual describes themselves or others as making poor choices, or not being committed to recovery. Examples of a sin mindset include describing themselves or others as "lacking motivation to be successful" and not fulfilling program expectations. **On the flip side,** individuals describe themselves or others as "taking ownership" and "being willing to get help". |

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# Chapter III : Reproductive Justice for Unhoused Women: An Integrative Review of the Literature

Brott, H., & Townley, G. (2022). Reproductive justice for unhoused women: An integrative review of the literature. *Journal of Community Psychology*.

*Holly Brott, M.A.; Greg Townley, Ph.D.*

**Author contribution statement**: H.B. conceptualized the review with guidance provided by G.T. H.B. wrote the manuscript. G.T. edited the manuscript and provided guidance throughout the revision process.

## Abstract

This review examines the reproductive health experiences of unhoused women and youth. Guided by the reproductive justice framework, this review examines barriers to accessing contraception, medical abortion, and prenatal care while homeless. Review of 21 articles identified barriers at the individual, relational, and contextual levels. Findings from this review illustrate the need to examine multiple levels of analysis when seeking to improve access to family planning services for individuals experiencing homelessness. Included literature suggests an overabundance of research capturing barriers to contraceptive care relative to the literature examining abortion and prenatal care experiences and a scarcity of research examining barriers to reproductive justice among unhoused individuals who do not identify as women.

*Keywords:* contraception, prenatal care, homelessness, unhoused women

## Background and Significance

In addition to the stressors of homelessness, those who are of reproductive age (teens to mid-40’s; American College of Obstetricians and Gynecologists [ACOG], 2021) are tasked with managing their fertility. Individuals who do not wish to become pregnant or continue a pregnancy may utilize contraceptive methods or abortion services, while accessible prenatal services support desired pregnancies. Compared to higher socioeconomic status (SES) women, individuals in poverty experience several challenges when accessing family planning health care including cost, transportation, and lack of insurance (Zimmerman, 2017). Lack of housing creates additional barriers for individuals seeking care.

Literature examining the reproductive care experiences among individuals experiencing homelessness has primarily focused on contraceptive access. Lack of contraceptive knowledge, financial concerns, and transportation are well-documented barriers to accessing contraception experienced by unhoused women and youth (Gelberg et al., 2009; Dasari et al., 2016; Killion, 1995; Gelberg et al., 2002). Less is known about the abortion care experiences of individuals experiencing homelessness. Limited research focusing on unhoused youth’s abortion experiences suggests that self-induced methods are common due to the perceived cost of services (Ensign, 2001). For example, some youth experiencing homelessness engage in high rates of substance use as a means of terminating unwanted pregnancies (Smid et al., 2010). Among those in need of prenatal care, provider wait times, lack of insurance, and Child Protective Services (CPS) concerns are commonly reported barriers (Fleming et al., 2017; Dasari et al., 2016; Smid et al., 2010). On the flip side, some individuals experiencing homelessness aren't in need of contraceptive, prenatal, or abortion services because they abstain from intercourse as a means of protection against unwanted pregnancy (Ensign, 2001). Youth experiencing homelessness using abstinence as a method of birth control have taken issue with assumptions that typecast unhoused women as sexually active and promiscuous (Ensign, 2001).

Pregnancy has been identified by unhoused youth as a key health concern (Ensign, 2001). Women and youth experiencing homelessness hold diverse attitudes towards pregnancy. Some individuals experiencing homelessness desire pregnancy, while others do not wish to become pregnant or have ambivalent attitudes (Begun et al., 2019; Dasari et al., 2016; Kennedy et al., 2014). Among youth and women experiencing homelessness, having a baby has been described as a catalyst for life changes and offered increased access to housing (Rutten et al., 2012; Killion, 1995). Anti-pregnancy attitudes include concerns about the cost of raising children and the responsibilities associated with parenthood (Tucker et al., 2012).

This review examines the reproductive experiences of unhoused individuals who have the ability to become pregnant. Most literature captures the experiences of cisgender women, referring to them as "women". Thus, the word "woman" will be used throughout this paper, even though many women lack what the medical community refers to as "female reproductive systems" (i.e., pituitary gland, ovaries, uterus, cervix, vagina; Clarke & Khosla, 2010). Contraception, pregnancy, and abortion are also needed services for unhoused individuals who do not identify as women, yet their perspectives are noticeably absent from the literature capturing barriers to accessing the aforementioned services. Additionally, unhoused individuals under the age of 25 are commonly referred to as “youth” in the literature examining homelessness. In this review, “youth” is employed to refer to women under the age of 25, unless otherwise noted.

## Reproductive Autonomy and Wellbeing

The ability to determine when and whether one would like to reproduce is known as reproductive autonomy (UCSF, 2021). Research has shown that having reproductive autonomy contributes to well-being. For instance, women who were able to obtain an abortion for an unwanted pregnancy reported decreased depression symptoms and increased self-esteem afterward (Major et al., 2000). Women who gave birth after an unplanned pregnancy had lower self-esteem compared to women who had had an abortion (Russo & Zierk, 1992). Among youth who lacked pregnancy intention, significant differences were found in education completion; individuals who terminated an unplanned pregnancy completed schooling at higher rates compared to youth who opted to give birth (Zabin et al., 1989).

## Sociopolitical and Historical Context

In the mid-sixties, the Office of Economic Opportunity (1964) and Medicaid (Title XIX of the Social Security Act, 1965) were established after a war on poverty was declared in the United States. This legislation contributed to the development of government-funded family planning services (Bailey, 2012). Before government intervention, the cost of contraception served as a barrier to its widespread use. New legislation (e.g., Title X: Family Planning and Population Research Act, 1970; the Family

Planning Act, 1975) resulted in a network of health centers across the United States designed to increase access and affordability of reproductive healthcare (Bailey, 2012).

While funding expanded access to reproductive healthcare for women living in poverty, Black Indigenous People of Color (BIPOC) women, and individuals living with serious mental illness, among others, were sterilized without consent (Stern, 2005). For example, in 1978 a class action lawsuit (Madrigal v. Quilligan) was filed against Los Angeles County General after a group of Latinx women were coerced into signing consent forms for sterilization without a full explanation of the procedure or its consequences within hours of having given birth (Library of Congress, n.d.). Thus, while access to reproductive care was expanded, it coincided with a period of forced and coerced sterilization practices in the United States which impacted who was allowed to become a parent (Stern, 2005).

Meanwhile, individuals living in poverty continued to lack access to abortion services to prevent unwanted parenthood due to a lack of federal funding. The Hyde Amendment prohibited (and continues to prohibit) the use of federal dollars for abortion services (American Civil Liberties Union [ACLU], 2021). Consequentially, individuals who relied on Medicaid for health care were unable to have an abortion without paying for it out of pocket or traveling to a state with state-level legislation in place expanding Medicaid services to cover abortion costs, which is an access barrier that continues to exist today (Planned Parenthood, 2021).

## Reproductive Justice

In response to unequal access to care, feminist scholars and activists developed the reproductive justice framework (Ross, 2017). Reproductive justice asserts “the right not to have children, the right to have children under chosen conditions, and the right to parent one’s children in safe and healthy environments” (Ross, 2017, p. 171). The framework was built out of grassroots efforts to holistically capture and advocate for the reproductive needs of Black women, whose reproductive rights have historically, and continue to be impacted by racism and inequality (Ross, 2017).

Reproductive justice moves beyond reproductive rights, which have been declared a human right by both the World Health Organization (WHO) and the United Nations (Temmerman et al., 2014; United Nations, 2018), and calls for an examination of the systems that influence reproductive autonomy (Ross, 2017). Recent research examining the larger systems that influence reproductive autonomy identified power imbalances and environmental threats as factors that influence reproductive justice. For instance, Smith et al. (2020) examined the power dynamics influencing women’s healthcare and found that cost, political context, racism, and classism impacted reproductive care access and experiences. More recently, Liddell & Kington (2021) examined environmental threats to reproductive justice among indigenous women. Participants discussed a heightened incidence of fertility problems in tandem with increased pollution and exploitation of natural resources within their communities (Liddell & Kington, 2021).

## Significance

Increases in research examining feminist concerns is a relatively new (within the last 25 years) phenomenon within the field of community psychology. Only one woman

(Dr. Luleen S. Anderson) attended the Swampscott conference (Bond & Mulvey, 2000). Prior to 1997, only 9.8% of articles published in the *American Journal of Community Psychology* and the *Journal of Community Psychology* focused on “women relevant” issues; of those, only 3% could be classified as feminist (Angelique & Culley, 2000, p 793).

Community psychologists are uniquely positioned to examine barriers to reproductive justice given our values of social justice and diversity and orientation towards appraisal of systemic factors that impact the individual. Indeed, reproductive justice fits well within the community psychology value of social justice, which encompasses the right to equal access to healthcare. It has been previously suggested that “to move closer to the mission of community psychology, a more focused attention to collective wellness and social justice is needed” (Prilleltensky, 2001, p 757). Reproductive justice moves beyond the individual to examine the larger contexts that hinder autonomy in reproductive matters (Ross, 2017). Advocating for reproductive freedom is also aligned with community psychology’s values of diversity and empowerment, in which individuals from all backgrounds are supported in their choices regarding parenthood.

This review synthesizes the literature on barriers to reproductive care experienced by unhoused women and youth. Following the reproductive justice framework, this review examines literature focusing on barriers to accessing contraception, barriers to abortion, and barriers to prenatal care among unhoused youth and women. Given the role that power dynamics play in equal access to care, an examination of both individual and system-level barriers is needed. This paper is guided by community psychology values, and findings are discussed in relation to context (i.e., the level of analysis at which they occur). In the following section, an overview of foundational theories in community psychology are described in relation to reproductive justice. Collectively, these theories further situate reproductive justice within the scope of community psychology and will guide this review of the literature examining barriers to contraceptive, abortion, and prenatal care experienced by unhoused women and youth in the United States.

## Theoretical Grounding

### Ecological Systems Theory (Bronfenbrenner, 1977)

Within one's immediate context, relationships with others such as a spouse, partner, or paying client could impact whether contraception is accessible or used. At the mesosystem level, the ability to access care hinges on congruence between appointment availability and shelter programming schedules. State mandates that require doctors performing an abortion to have privileges at the local hospital are an exosystem factor that could create a barrier to abortion access. Belief systems that stipulate who should and should not become a parent are an example of a macrosystem factor that could impact one's experiences when attempting to access family planning services while unhoused. Changes in legislation that increase or decrease access to abortion and societal changes in attitudes towards sex outside of marriage may impact accessibility and use of reproductive services at the chronosystem level.

### Empowerment

Empowerment has been defined as “the mechanism by which people, organizations, and communities gain mastery over their lives” (Rappaport, 1984, p. 3). Reproductive autonomy is a form of empowerment. The ability to access and utilize contraception allows individuals to determine if and when they become a parent. Preventing unwanted parenthood through access to medical abortion services allows individuals to maintain control of their lives. In regard to pregnancy, previous research examining empowerment during pregnancy identified access to care as a defining systemic factor (Nieuwenhuijze & Leahy-Warren, 2019). Supporting desired parenthood among unhoused individuals through accessible prenatal services indicates a belief in their parenting competencies and capabilities. Furthermore, accessible prenatal care promotes maternal and infant health (Yan, 2017).

## Method

### Search Strategy

Ebscohost Academic Search Premier, Google Scholar, and PsyINFO were utilized to locate articles. Search terms included combinations of the following terms: variations of pregnant (pregnancy, prenatal, etc.), unhoused (homeless, homeless youth, homeless women, etc.), contraception (family planning, birth control, reproductive care), abortion, prenatal care, and barriers.

### Inclusion and Exclusion Criteria

This review synthesizes the literature on barriers to access and use of contraception, prenatal services, and abortion among women and youth experiencing homelessness in the United States. It was conceptualized that “access” papers would highlight the barriers to wanted care, whereas “use” papers would describe attitudes as to why women choose not to use contraception. The original inclusion criteria excluded papers discussing “use”. Access and use, however, were used interchangeably in the literature. Furthermore, some barriers to contraception use discussed were beyond the individual’s control (e.g., partner preferences, abuse, etc.). An iterative approach was taken, and an additional round of searches was conducted to include papers that discussed barriers to reproductive care (i.e., contraception, prenatal care, abortion) use. Peer-reviewed and unpublished works (e.g., book chapters, dissertations, policy papers, evaluation reports, etc.) examining barriers to contraception, prenatal care, and abortion experienced by unhoused women and youth were included.

Articles focusing on samples consisting of women and/or youth currently experiencing homelessness were included. Articles with mixed-gender samples were included if the analyses and findings were examined by participant gender. Papers reporting mixed-gender findings were for the most part excluded. An exception was made for the following qualitative studies: Smid et al. (2010) and Begun et al. (2010).

Smid et al. (2010) qualitatively captured the experiences of pregnant youth experiencing homelessness. The sample contained thirteen women and eight men experiencing homelessness. Male participants were recruited to participate in the study through their partners. Findings were discussed in relation to the gender of the participant, and captured the challenges of being partnered, but not legally married when attempting to access services. Additionally, this was the only article located that examined the prenatal experiences of unhoused youth.

The sample in Begun et al. (2010) consisted of sixteen women, ten men, and four individuals who identified as transgender. This article was included because it captured the reproductive needs and experiences of transgender men (i.e., assigned female at birth [AFAB]), whose experiences accessing care were for the most part absent in the literature. While qualitative theme generation was developed based on the full sample, text descriptions of the themes indicated the gender identity of participants endorsing and providing evidence for each theme. Findings discussed in this review are those that were endorsed by women and transgender men.

In the United States, the ability to access and utilize reproductive health care has been directly influenced by structural factors (e.g., lack of universal health insurance) and policy (e.g., Title X). An examination of barriers to accessing abortion, contraception, and prenatal care within this specific context has implications for future inquiry, service provision, and policy. Therefore, articles focused on populations outside of the United States were excluded from this review. Additionally, regarding housing status, samples that included individuals that were "ever-homeless" (i.e., any history of homelessness, but not currently homeless) were excluded.

## Integrative Literature Review

Search terms were entered in Google Scholar, Ebscohost Academic Search Premier, and PSYinfo. Ninety-five abstracts were located. Sevente.en were excluded because they discussed contraceptive use (e.g., decision-making practices towards "risky sexual behaviors", condom use and nonuse, and factors that contribute to contraceptive usage) rather than barriers to access. Fifty-seven articles were removed because they did not meet inclusion criteria (e.g., examined other aspects of reproductive health, such as menstruation and STD testing, but did not examine barriers to prenatal, abortion, or contraceptive services; contained samples that did not meet inclusion criteria). Four literature reviews were excluded. One duplicate paper was excluded. Two reports, which discussed barriers to sheltering homeless women and the efforts of a mobile HIV and reproductive service outreach, were removed when additional review indicated that they did not report barriers to accessing care. Two papers that discussed the healthcare (excluding reproductive health) needs of homeless women were removed. Twelve articles capturing barriers accessing contraception, prenatal care, and abortion experienced by unhoused women and youth were identified.

An additional round of searches was conducted to capture papers discussing contraceptive nonuse originally excluded due to terminology (i.e., “use”). Keyword searches in Google Scholar, Ebscohost Academic Search Premier, and PSYinfo identified 17 abstracts, in addition to the 17 abstracts that were previously excluded due to terminology, for a total of 34 abstracts. Seven papers were excluded due to sample considerations (e.g., mixed-gender samples/findings; use of “ever-homeless” versus currently homeless when surveyed). Nineteen articles were excluded because they did not meet the inclusion criteria (e.g., examined other aspects of reproductive healthcare, such as access to HIV testing, but did not explore contraceptive, prenatal, or abortion service access), resulting in nine additional articles.

In total, 21 articles examining barriers to accessing and using contraception, prenatal care, and abortion services experienced by unhoused women and youth were located (see Figure 1 and Tables 4 and 5). Included articles were published from 1995 to 2020. Located papers utilized qualitative (n=11), quantitative (n=9), and mixed (n=1) methods.

## Summary of Findings

This review examines barriers experienced by unhoused individuals when accessing contraception, abortion, and prenatal care. In the included literature, barriers were identified at the microsystem and macrosystem levels of analysis. In this review, barriers have been grouped at the individual or contextual level based on how they were discussed in the literature (see Table 3). For example, while misconceptions about contraception and the reproductive system may be the result of inadequate reproductive education (e.g., a contextual factor), they were framed as individual attitudes and perceptions hindering access in the majority of examined literature. Therefore, they are discussed as individual-level barriers in this review.

While relationships fall within the microsystem level of analysis, relational dynamics preventing use and access to contraception in the included literature suggest that unhoused women are not the sole decision-makers in their choices concerning contraceptive utilization. Rather, contraceptive choices are influenced by other key individuals in their lives. Regarding contraception access and use, relationships can serve as a source of empowerment or oppression. Barriers created through relationships with others have been categorized as “relational” in this review to capture the distinct role that friends, partners, and clients have in determining one’s access and use of contraception.

### Individual Level Barriers

At the individual level, barriers to accessing contraception, prenatal, and abortion care included the following: misconceptions about contraception and reproduction, fear of Child Protective Services, fear of side effects, healthcare system misconceptions, challenges with birth control, history of substance use, time constraints, lack of contraceptive knowledge, lack of childcare, financial barriers, age, and race.

### ***Misconceptions About Contraception and Reproductive Systems***

Several articles discussed misconceptions and false information participants believed about birth control and their reproductive systems. Lack of reproductive education from parents and school systems resulted in contraceptive knowledge obtained through peer networks (Begun et al., 2019). This sometimes resulted in misconceptions about the mechanisms of the reproductive system. For instance, Gelberg et al. (2004) reported that a participant believed they could not get pregnant if they did not orgasm. Others believed that taking birth control was the equivalent of having an abortion (Gelberg et al., 2004).

Lack of contraceptive knowledge was identified as a barrier by both women and youth experiencing homelessness. Gelberg et al. (2008) found that women who were unsure of which method to use were three times less likely to use birth control. Not understanding how intrauterine devices (IUD) worked was also identified as a barrier to use. For example, unhoused youth were under the impression that obtaining an IUD would involve surgery and could not be removed early, which served as a barrier (Dasari et al., 2016). Youth interviewed in one study believed that condoms did not work, and therefore were not worth spending money on (Begun et al., 2019). Kennedy et al. (2010)

found that negative attitudes towards condoms increased the likelihood of unprotected sex.

### *Fear of Child Protective Services*

Smid et al. (2010) identified fear of Child Protective Services (CPS) as a barrier to accessing prenatal care among youth experiencing homelessness. Participants reported putting off prenatal health care appointments out of fear of losing custody of their unborn children as a consequence of their housing status being discovered by their provider. These fears were rooted in their own experiences in the foster care system as children, combined with witnessing their peers lose custody during episodes of housing insecurity. Smid et al. (2010) reported that the area where their research was conducted lacked affordable subsidized housing units for pregnant couples; available housing resources were limited to single women. Moreover, affordable housing was mentioned as a needed resource by all of the participants interviewed when discussing prenatal care.

### *Fear of Side Effects*

Several articles discussed fear of side effects as a barrier to using contraception. Perceived side effects were identified as a barrier by 27% of participants, resulting in less frequent contraceptive use (Gelberg et al., 2002). Similarly, Corey et al. (2020) found that side effects were a barrier to contraceptive use among women who did not desire pregnancy. Nearly half (47%) of individuals surveyed reported concerns about side effects and 40% reported concerns that birth control was unhealthy (Corey et al., 2020). In another study, women perceived birth control to be “harmful to one’s health” (Gelberg et al., 2002, p. 281). Concerns about Long-Acting Reversible Contraceptive (LARC) methods included pain, bleeding, infertility, weight gain, and uterine perforation (Dasari et al., 2016). Others reported that methods known to cause irregular bleeding were not desirable due to lack of accessible hygiene products and restrooms (Kennedy et al., 2014).

Fear of side effects also deterred youth from using birth control. Youth reported concerns about weight gain and future fertility that were far greater than their concerns about unplanned pregnancy (Begun et al., 2019). Youth reported hesitancy over Depo-Provera (i.e., a contraceptive injection) due to fears of weight gain and irregular periods, which were especially challenging to manage while unhoused (Ensign, 2001).

### ***Misconceptions About Healthcare System***

Two articles discussed misconceptions about the healthcare system as barriers to care. Youth were under the impression that parental consent was needed to access an abortion (Ensign, 2001). Additionally, they believed that underage homeless women would be reported runaways, which prevented many from accessing care (Ensign, 2001). Women who perceived barriers to care were significantly less likely to visit a doctor for birth control (Wenzel et al., 2001).

### ***Birth Control Pill Challenges***

Contraceptive use was challenging to maintain while unhoused. Taking birth control pills every day was a challenge for unhoused youth interviewed in Seattle (Ensign, 2001). Participants shared they were unsure of what to do in the event of a “missed pill”, which was a common occurrence (Ensign, 2001, p. 143). A separate study found that women who used contraception inconsistently were found to be three times less likely to access birth control services (Wenzel et al., 2001). Storage needs were an additional barrier to use. Kennedy et al. (2014) reported that women lacked personal space in shelters to store contraception, while contraception that was able to be stored at the shelter was frequently stolen. Carrying birth control was also challenging; youth reported it being a nuisance to carry around while highly mobile (Begun et al., 2019). Youth also reported that taking birth control pills at the same time every day was challenging while experiencing homelessness (Begun et al., 2019). Some youth shared their dislike of birth control methods that altered hormones, which also prevented use (Ensign, 2001).

### *History of Substance Use*

Several articles discussed having a history of substance use as a barrier to contraceptive use. Wenzel et al. (2001) found that, among a sample of unhoused women who wanted birth control, women who reported a history of alcohol use disorder were seven times less likely to access reproductive care. Others found that women who reported a history of alcohol use disorder identified health risks and concerns over where to store birth control as major deterrents to contraceptive utilization (Gelberg et al., 2002). Among a sample of women staying in shelters, substance use was significantly related to unprotected sex (Tucker et al., 2006). Similarly, Gelberg et al. (2008) found a relationship between substance use and contraception; women who had used substances were more likely to not use contraception compared to participants who did not have a history of substance use. One exception to this narrative was MacKeller et al. (2000), which found that using less marijuana significantly predicted condom nonuse.

### *Time and Competing Demands*

Time constraints and competing demands were commonly discussed barriers to accessing contraceptive care. Killion (1998) found that survival-related tasks left little room for other pursuits. Unhoused women reported knowing where they could receive services for free but stated that doing so would take away time from finding basic needs (Gelberg et al., 2004). Additionally, shelter requirements, such as mandatory programming, took up time that could be otherwise used to access care (Gelberg et al., 2004). Kennedy et al. (2014) found that women experiencing homelessness were so consumed with tasks related to survival that reproductive healthcare needs were often neglected. Unhoused women who reported difficulties meeting basic survival needs (e.g., food, shelter, sanitation, and bathrooms) were significantly less likely to use contraception (Gelberg et al., 2008). Conversely, homelessness was only identified as a barrier to birth control access by two participants in Dasari et al. (2016). The majority of participants felt that homelessness did not impose additional barriers to accessing contraceptive care (Dasari et al., 2016).

### *Lack of Knowledge on Where to Obtain Contraception*

One article discussed lack of knowledge on where to obtain contraception as a barrier to access. Unhoused youth participating in focus groups at a shelter in Colorado reported not knowing where to go to receive contraceptive care (Begun et al., 2019). While some youth reported knowing where to get condoms, others shared not knowing where to go for family planning services. Information about contraception and where to obtain it had never been explained to the majority of participants. Youth disclosed a desire for education about contraception, sharing that “it seem[ed] like a different language” (Begun et al., 2019, p. 13).

### *Lack of Childcare*

One article discussed childcare as a barrier to reproductive healthcare access and utilization. Ake et al. (2018) conducted focus groups with women living in an urban shelter to determine participants’ unmet prenatal healthcare needs. Lack of childcare during appointments was identified as a barrier to accessing care. Specifically, participants discussed the difficulty of bringing children with them to appointments when using public transportation.

### *Financial Barriers*

Several articles identified financial constraints to reproductive care access and utilization. The cost of treatment served as a major deterrent to women seeking contraception and abortion services. Misperceptions about the cost of treatment (i.e., assuming that treatments would not be covered by insurance or cost more than their actual cost) served as an additional barrier.

**Contraception.** Killion (1995) found that participants lacked the money needed to purchase contraceptives and the knowledge on where to obtain contraceptives at no cost. Participants described having to make choices between purchasing contraceptives and other needs, such as food. Killion (1998) found similar results in subsequent research; the cost of contraceptives was again identified as a barrier to usage among a group of women residing in shelters. Interestingly, free condoms were available at the shelter, but the embarrassment of asking shelter staff for protection deterred participants from obtaining them. Cost was identified as a barrier to using LARC methods by unhoused women and youth in two studies (Corey et al., 2020; Dasari et al., 2016). In a separate study, 20% of a sample of 229 chronically homeless women responded that cost was a major barrier to contraceptive use, which contributed to rare use of contraceptives (Gelberg et al., 2002). Misperceptions about the cost of birth control were also identified as a barrier. Qualitative research examining unhoused youths' contraceptive experiences found that participants grossly overestimated the cost of obtaining contraceptives, with one participant sharing that "one that lasts a long time is like $10k or something crazy" (Begun et al., 2019, p. 12). Furthermore, youth were not aware that contraceptive care was covered by Medicaid (Begun et al., 2019).

**Abortion.** One article discussed perceived cost as a deterrent to abortion access and utilization. Ensign (2001) conducted focus groups with youth experiencing homelessness in Seattle. Youth shared several strategies that they had used themselves or heard of other youth using to end an unwanted pregnancy. Self-induced strategies to end unwanted pregnancies included herbal remedies, heavy drug use, physical harm, and ingesting toxic chemicals (Ensign, 2001). Participants shared that self-induced abortions were commonly utilized by youth experiencing homelessness in part due to the cost of medical abortions. Unhoused youth surveyed elsewhere reported no barriers to accessing medical abortion (Smid et al., 2010).

### ***Age as a Moderator of Barriers***

Two articles discussed age-related differences in barriers to contraceptive use. Among unhoused youth (ages 15 to 24), uncertainty about which contraceptive method to use was the largest barrier to contraceptive use while women between the ages of 35 to 44 most reported contraceptive discomfort as a deterrent to use (Gelberg et al., 2002). Youth (ages 15 to 24) were five times more likely to not know how to use contraception compared to women between the ages of 35 to 44 (Gelberg et al., 2002). While this finding was not significant, Gelberg et al. (2002) speculated that significant differences would exist in a larger sample, given the significant differences identified between age groups in preliminary bivariate analyses. Differences in usage also existed between the two groups: women over the age of 25 were twice as likely to not use contraception compared to youth (Gelberg et al., 2008).

### ***Race***

Articles examining the role of race in contraceptive access and use among unhoused women found racial differences in experienced barriers. For instance, Gelberg et al., (2002) found that not having proper storage for birth control was most common among Black participants. They were significantly more likely than members of other racial or ethnic groups to lack access to spaces to store birth control (Gelberg et al., 2002). Additionally, Black participants had more concerns about contraceptive health risks relative to others surveyed.

Compared to other racial and ethnic groups, Hispanic women reported a lack of contraceptive knowledge and partner dislike as barriers to contraceptive use but were least likely to report that contraceptives were not natural (Gelberg et al., 2002). An article examining contraceptive nonuse across ethnic groups found that Hispanic women were twice as likely to not use contraception compared to Black women (Gelberg et al., 2008).

## Relational Barriers

Reproductive care use was influenced by relationships with other individuals. Relational barriers to contraceptive use included the following: social support, monogamy, reproductive coercion, and transactional sex.

### *Social Support*

Social support influenced access and use of reproductive care. Lack of social support significantly predicted nonuse of protection during intercourse; unhoused youth who reported fewer social support contacts were significantly less likely to use condoms (Mackeller et al., 2000). Qualitative research involving youth experiencing homelessness in Seattle also identified a lack of social support as a barrier to seeking care (Ensign & Panke, 2002). Youth reported that having a friend in the room during the appointment provided them with the “moral support” needed to access care (Ensign & Panke, 2002, p. 169). Similarly, Gelberg et al. (2008) found that women who lacked encouragement from peers to use birth control were three times more likely to not use it, compared to women who had been encouraged by others to use birth control.

### *Monogamy*

Being in a committed relationship and having one steady sex partner served as barriers to contraceptive use and access. Women’s relationship commitment was significantly related to unprotected sex; women who were committed to their partners were less likely to use condoms (Kennedy et al., 2010). Others found that women who reported one consistent sex partner were 2.5 times less likely to use contraception compared to women who reported having more than one partner (Gelberg et al., 2008).

Mackeller et al. (2000) found similar results; condom nonuse was significantly predicted by having one sex partner. Qualitative research uncovered a possible explanation for these findings. Women interviewed shared that condom nonuse was a symbol of trust and asking to use a condom with a committed partner could be misconstrued as a symbol of infidelity (Cedarbaum et al., 2012). Unhoused youth made similar decisions about condom use based on level of partner trust (Ensign, 2001; Begun et al., 2019). Youth reported that condom use was generally inconsistent, but condoms were more likely to be used during intercourse with acquaintances versus committed partners (Begun et al., 2019). Requiring condom use during intercourse signified a lack of trust (Ensign, 2001).

### *Reproductive Coercion*

Reproductive coercion occurs when an individual's reproductive choices are controlled by their partner (American College of Obstetricians and Gynecologists [ACOG], 2013). Several articles identified reproductive coercion as a barrier to contraceptive access and utilization. This was exhibited in a variety of partner behaviors including voicing one's dislike of condoms, sabotaging birth control methods, and abuse.

Episodes of homelessness can reduce the amount of power that unhoused women have in sexual interactions (Kennedy et al., 2014). Gelberg et al. (2004) found that relationship partners influenced unhoused women's reproductive health choices. For instance, partner dislike of birth control was reported as a barrier to using contraception, resulting in rare use (Gelberg et al, 2008). Women and youth reported feeling coerced by their partner to not use a condom (Begun et al, 2019; Dasari et al., 2016). Unhoused youth who had conversations with their partner about safe sex were four times less likely to use condoms during intercourse (Barman-Adhikari, 2017). Others found talking about safe sex and condom use with partners challenging, particularly in circumstances where the relationship dynamic had changed, such as instances of newfound sobriety (Cedarbaum et al., 2012). Specifically, women who had previously engaged in condomless sex during periods of drug use who wished to start using condoms found it difficult to advocate for that choice with their partner (Cedarbaum et al., 2012).

Birth control sabotage was mentioned by two studies. In Kennedy et al. (2014), participants reported instances where relationship partners intentionally damaged condoms to prevent use. Women also shared experiences of having birth control hidden from them by their partner and experiences of hiding their birth control to prevent conflict (Dasari et al., 2016).

Abuse was identified as a barrier to contraception by three studies. Women with partners who had been physically abusive were nearly six times as likely to not use protection (Kennedy et al., 2010). History of rape was also identified as a significant predictor of not using a condom (MacKeller et al, 2000). Additionally, an increased likelihood of unprotected sex was significantly predicted by having an abusive partner that heavily consumed alcohol (Tucker et al., 2006). Psychological abuse also significantly predicted unprotected sex (Tucker et al., 2006).

### *Transactional Sex*

Engaging in sex for resources, such as food, a place to stay, or money, otherwise known as transactional sex, impacted women’s condom use choices. In some instances, transactional sex was a barrier to contraceptive use. For instance, Begun et al. (2019)

found that condomless sex was more lucrative; participants reported making more money if they did not require their client to wear a condom. Homeless youth engaged in transactional sex practices were nearly four times more likely to report condom nonuse (Barman-Adhikari, 2017). However, Cedarbaum et al. (2012) provided a counternarrative; participants reported greater contraceptive use during sexual interactions with acquaintances to fulfill basic needs (e.g., money, a place to stay, drugs), except when under the influence of drugs. Similarly, Gelberg et al. (2008) found that women engaged in transactional sex were four times more likely to use contraception compared to women not engaging in transactional sex.

## Contextual Barriers

Contextual barriers to contraceptive and prenatal care included living arrangements, transportation, the healthcare system, stigma, and geographic context.

### *Living Arrangement*

The use and accessibility of contraception differed by living arrangement. For instance, relative to individuals who were staying in shelters, individuals living outdoors were less likely to report that contraceptive side effects or health risks were a barrier to using contraception (Gelberg et al., 2002). Additionally, another study found that individuals who slept outside were closer in proximity to reproductive healthcare services compared to individuals staying in shelters, which impacted service accessibility (Gelberg et al., 2004). Women in shelters were twice as likely to use contraception compared to women living doubled up, in hotels, or other temporary housing arrangements (Gelberg et al., 2008). Others found that shelter requirements that prevented married couples from staying together resulted in fewer opportunities for sex, which contributed to a lack of contraceptive planning when couples were able to find the time and space to be intimate (Killion, 1995). Additional unmet family planning needs within shelter spaces included lack of on-site reproductive health services, contraceptive education, and information on where to access reproductive care while without housing (Kennedy et al., 2014).

### ***Transportation***

Transportation difficulties were a barrier to contraceptive and prenatal care for both homeless women and youth. For instance, public transportation was not a viable option for youth seeking reproductive care because they lacked money for bus fare. Money for bus fare was also identified by unhoused women as a transportation-related barrier to accessing care (Gelberg et al., 2004). Youth who were able to utilize public transportation to get to contraceptive appointments claimed that doing so was difficult (Begun et al., 2019). Women staying in shelters with check-in times faced additional transportation difficulty when attempting to access appointments that were located far from where they were staying (Gelberg et al., 2004).

Lack of transportation made accessing prenatal care more challenging. Transportation, parking, and distance to the clinic were identified as significant barriers to prenatal care by two-thirds of unhoused pregnant women surveyed (Bloom et al., 2005). Transportation, parking, and clinic distance serving as barriers to care was significantly related to how many children the individual was parenting (Bloom et al., 2005). Similarly, Ake et al. (2018) found that women residing in an urban shelter desired additional transportation options besides the bus. Fleming et al. (2017) found that shelter entry caused some women to switch prenatal providers due to difficulties getting to appointments.

### ***Healthcare System***

Several barriers to care were products of the healthcare system. Check-in processes, dissatisfaction with contraceptive counseling, and difficulties scheduling appointments prevented women from accessing the contraceptive, abortion, and prenatal care that they desired. Notably, women who had regular access to care were five times more likely to receive contraceptive services (Wenzel et al., 2001).

Lack of insurance and dissatisfaction with clinic check-in practices were identified as barriers to service utilization. While lack of insurance was reported as a barrier to care by unhoused women, participants also reported knowledge of free clinics where they could access care (Dasari et al., 2016). Lack of identification and insurance was a barrier experienced by unhoused youth when attempting to access reproductive care (Ensign & Panke, 2002). Furthermore, youth interviewed expressed a desire to attend a clinic that specifically treated unhoused individuals due to previous experiences navigating the check-in process without an address or form of payment (Ensign & Panke, 2002). Additionally, participants disliked filling out paperwork and preferred to be verbally asked information (Ensign & Panke, 2002).

Women and youth interviewed also expressed dissatisfaction with contraceptive counseling offered by their provider. For example, Corey et al. (2020) found that most women (70%) relied on their doctor to provide contraceptive information, yet they had not been educated about LARC methods. In another study, youth shared that while their providers had educated them about LARC methods, they felt as though the provider had intentionally excluded information to encourage them to use a LARC method of contraception (Dasari et al, 2016). Participants felt coerced to try certain methods of birth control and desired additional dialogue and transparency regarding potential side effects associated with the contraceptive methods being suggested to them by medical providers (Dasari et al., 2016).

Care was often delayed due to scheduling difficulties. Participants reported long wait times for new patients seeking prenatal care (Fleming et al., 2017). Gelberg et al. (2004) found that participants waited up to two months to see a provider. Participants also expressed difficulty in finding a provider that accepted Medicaid. For instance, one participant reported needing to get insurance that would be accepted by the nearby hospital, which resulted in a gap in care while pregnant (Fleming et al., 2017). Once at the clinic, participants waited multiple hours to see a provider (Gelberg et al., 2004).

Contraceptive services did not meet the needs of consumers in two studies. Clinic guidelines that required two appointments to begin a birth control method were identified as a barrier (Kennedy et al., 2014). One clinic offered free condoms as part of an outreach program. However, the two free condoms available per day did not meet the contraceptive needs of participants, who then had to purchase condoms elsewhere (Gelberg et al, 2004).

### ***Internalized and Felt Stigma***

While stigma involves individual-level perceptions, the antecedent of these perceptions is societal judgment towards the individual based on group belonging (Major et al., 2018). In studies included in this review, stigma was discussed as an experience that occurred within the context of healthcare settings, which was subsequentially internalized by participants. Thus, stigma is discussed as a contextual factor in this review.

Stigma served as a barrier to seeking contraceptive and prenatal care and was experienced by both unhoused youth and women. Youth described feeling disrespected when asked questions about their sex lives, particularly in instances where their responses were doubted by providers (Ensign & Panke, 2002). Additionally, youth described being pushed towards contraception based on assumptions that they were behaving promiscuously (Ensign & Panke, 2002). Concerns about stigma caused some youth to not use healthcare at all (Begun et al., 2019). Experiences of stigma were also endorsed by a participant who identified as a transgender man; however, the participant described continued engagement with the clinic because the risk of becoming pregnant far outweighed the stigma he experienced when accessing contraception (Begun et al., 2019).

Women experienced similar stigma when accessing contraception and care. Women who were able to access condoms through the shelter they were staying at declined to do so out of fear of judgment from providers (Killion, 1995). Women seeking contraceptive healthcare hid their housing status to avoid stigmatization from their provider (Kennedy et al, 2014). Others reported a difference in treatment once their housing status was disclosed (Kennedy et al., 2014). Gelberg et al. (2004) found that providers were a barrier to contraception access. Participants reported feeling disrespected and mistreated. However, others blamed lack of care access on the individuals themselves (Gelberg et al., 2004). Among women in need of prenatal care, survey results indicated that provider relationships were a “slight barrier” to care (Bloom et al., 2005, p. 431).

### ***Geographic Context***

One article highlighted the influence of geographic context on availability of services. Unhoused youth reported that condoms were more readily available on the west coast relative to other regions in the United States (Ensign, 2001). We will return to a discussion of the possible role of geographic context in the next section.

## **Discussion**

Recent reviews examining the reproductive experiences of unhoused women have focused on American youth’s attitudes and experiences accessing abortion (Munro et al., 2021) and factors impacting the use of prenatal care among unhoused women in the U.S. and Europe (McGeough et al., 2020). Guided by the reproductive justice framework, this review is the first to examine barriers to reproductive choice through the inclusion of barriers to contraception, abortion, and prenatal care. Examination of barriers to services that prevent unwanted pregnancy (i.e., contraception and abortion services) and promote wanted pregnancy (i.e., prenatal care) within one review produces findings with research and practical implications that support the reproductive decision-making practices of unhoused individuals, which may contribute to feelings of empowerment. Framing of findings at the ecological level in which they occur has implications for future service provision and policy. Furthermore, it identifies both gaps in the literature and understudied phenomena.

## Overview of Results

The majority of gathered literature focused on barriers toward contraception. Individual-level barriers prevented access and optimal utilization of contraception, prenatal care, and abortion. Barriers created through interactions with social partners, (e.g., social support, monogamy, and reproductive coercion), influenced contraceptive access and use. Contraception and prenatal care access and use were also impacted by contextual barriers (see Table 6).

## Critique of the Literature Strengths and Limitations

### *Methodology*

This review contained quantitative (n=9), qualitative (n=11), and mixed-methods (n=1) literature (see table 4). Most of the included quantitative papers had large sample sizes ranging from 212 to 976 participants. Two of the included quantitative papers had small samples. Corey et al. (2020) and Bloom et al. (2004) had sample sizes of 54 and 47 women, thus limiting the generalizability of findings. Included qualitative findings provide rich contextual information about the unmet service needs of unhoused women and youth. Seven papers reported findings from youth samples, while fourteen included women samples. There was a mix of both quantitative and qualitative literature among both age groups. Based on findings from the included literature, it appears that unhoused youth and women share similar access barriers when attempting to get care.

### *Limitations*

**Time.** Articles included in this review were published across a twenty-five-year period. Chronosystem level factors, including policy changes and shifts in attitudes towards sexuality and reproductive health, are not accounted for in this review but may influence access barriers.

Several barriers identified seem to hold constant over time. Misconceptions and lack of contraceptive knowledge were identified as barriers to use in both Gelberg et al. (2004) and Begun et al. (2019). The finding that side effects deterred use was reported in Gelberg et al. (2002) and recently in Corey et al. (2020). Difficulties managing birth control while unhoused were reported both in 2001 (Ensign, 2001) and 2019 (Begun, 2019). Financial barriers were present in 1995 (Killion, 1995), and in 2018 perceptions that birth control was expensive served as a barrier to use (Begun et al, 2019).

At the relational level, reproductive coercion has continued to be a barrier to contraceptive access. Gelberg et al. (2002) found that partner dislike prevented use. Similarly, Begun et al. (2019) found that condom decisions were being made by partners; participants reported condom nonuse because their partners didn’t want to use them.

Several systemic barriers remained unchanged across the period examined. Transportation was identified as an access barrier in 2002 (Ensign & Panke, 2002) and 2019 (Begun et al., 2019). Lack of insurance has remained a barrier to access for unhoused youth (Ensign & Panke, 2002; Dasari et al., 2016). Delays in receiving care were present in both 2004 (Gelberg et al., 2004) and 2017 (Fleming et al., 2017). Provider stigma was identified as a barrier in 2002 (Ensign & Panke, 2002) and 2018 (Begun et al., 2019).

While several barriers identified seem to hold constant over time, it is unclear the extent to which attitude shifts and policy changes influence the ways in which they transpire at each ecological level. Similarities identified between findings across time suggest a need to shift beyond research documenting barriers and instead focus on participant identified solutions and policy change.

**Access Versus Use.** Access and use were used interchangeably in the literature. Some of the included literature describing “barriers” to use reported predictors of nonuse without measuring whether contraception was something that the participants wanted. It is unclear in some articles whether they included a screening question that inquired whether contraception was desired, which could potentially influence findings. Differentiating whether nonuse is related to disinclination or accessibility is needed in future research.

**Levels of Analysis.** While this review was guided by community psychology theories and values, none of the included articles were published in community psychology journals. Included literature was primarily published in journals geared towards the public health and nursing disciplines. The abundance of individual-level factors (n= 10) relative to relational (n= 4) and contextual barriers (n= 5) identified in this review may reflect the values (e.g., the medical model, model of prevention science) guiding the aforementioned disciplines rather than an indication that service barriers are primarily individual-level factors.

## Implications For Research

### *Gender*

Individuals with female reproductive systems were the focus of this review. Most papers included in this review contained cisgender women-only samples. The perspectives of unhoused non-binary and transgender individuals living with female reproductive systems are underrepresented in the literature on contraceptive, prenatal, and abortion access and utilization. This is particularly problematic considering that transgender individuals face additional safety threats while unhoused and oftentimes become unhoused due to lack of safety in their home environments (Shelton, 2016). Cipres et al. (2017) found that 85% of unhoused trans men were trying to avoid pregnancy yet failed to use contraception regularly. Further efforts to document barriers to contraception access among unhoused trans men are needed. Future research ought to expand beyond the perspectives of cisgender women experiencing homelessness to include the experiences of others with female reproductive systems, such as individuals who identify as nonbinary or transgender.

### ***Race***

Race was examined in tandem with commonly reported barriers in two studies. An understanding of racial discrepancies in barriers to access and use highlights ways in which the current system is not meeting the needs of specific groups. However, articles in this review that examined race in relation to access explored it as an individual-level factor, which fails to tease apart the reasons why marginalized groups may not be accessing care, such as experiences of racial discrimination within healthcare settings. In addition to identifying racial differences in access, racism ought to be examined as a macrosystem factor in relation to barriers to care among unhoused individuals.

### *Location and Geopolitical Context*

One paper discussed how family planning care access and use were impacted by location (Ensign, 2001). Unhoused youth reported that condoms were easier to obtain on the west coast relative to other regions of the U.S. (Ensign, 2001). Included studies had samples from thirteen metropolitan areas located in nine states (CA, CO, WA, PA, IL, FL, WI, TX, NY). Notably, four of these states (CA, IL, NY, WA) utilize state funding to expand access to abortion services for Medicaid recipients (ACLU, 2021). Additional barriers are likely present in geographic areas that are politically conservative. For instance, among the states that the samples in this review are from, one (TX) has legislation requiring parental consent and two (CO, FL) mandate parental notification when seeking abortion services, whereas three states (CA, WA, NY) have state-level legislation that protects access to abortion (Center for Reproductive Rights, 2021). Future research efforts documenting how restrictive and progressive policies impact unhoused individuals' access and use of family planning services are needed.

The samples in this review were recruited from urban areas and likely do not reflect the needs and experiences of individuals who are without housing in rural contexts. Reproductive care can be less accessible in rural areas. For example, a recent review found that rural areas offered fewer after-hours appointments compared to urban areas (Martin et al., 2016). Furthermore, providers were in the office far less frequently (once a month, compared to four times per week) in rural areas (Martin et al., 2016). Given these discrepancies, it seems likely that individuals with fewer resources, such as those experiencing homelessness, could experience greater difficulty accessing care.

Future research ought to explore the role of geographic context when examining barriers to reproductive care among individuals experiencing homelessness.

### ***Sheltered Versus Unsheltered Homelessness***

Shelter-related barriers included lack of storage, contraceptive theft, and mandatory programming that interfered with seeking reproductive care (Kennedy et al., 2014; Begun et al., 2019; Gelberg et al., 2002; Gelberg et al., 2004). Additionally, entering the shelter system sometimes resulted in increased distance to reproductive care sites (Gelberg et al, 2004; Fleming et al., 2017). When shelters offered contraception, it was underutilized due to embarrassment and fear of judgment (Killion, 1998). Shelter requirements that prevented couples from staying together resulted in spontaneous intercourse, which often didn’t allow for contraceptive planning (Killion, 1995).

Notably, most articles recruited samples from shelter (i.e., both drop-in and overnight) settings. Five articles did not specify where samples were recruited from. Only two articles reported samples that consisted of individuals “on the streets” and in shelter settings. Findings indicated that individuals who lived outdoors were less likely to have issues with contraceptive side effects or health risks yet were also less likely to use contraception compared to women residing in shelters or transitional housing (Gelberg et al., 2002; Gelberg et al., 2007). The perspectives of individuals who are not engaged in homeless services systems are needed. Additionally, future research ought to examine whether shelter engagement impacts access and use of reproductive healthcare.

### ***Cost***

It is curious that cost was identified as a barrier to accessing contraception, given that Title X has historically provided funding for contraception (Planned Parenthood, 2021). Recent legislation put forth by the Trump administration in 2019 restricted funding from service centers that provide abortion services (including referrals to other clinics for the procedure), which resulted in a mass withdrawal from Title X funding by family planning centers (Planned Parenthood, 2021). In some of the included articles, cost barriers described were explicitly specified by the researchers to be a perceived barrier versus an actual barrier. In included articles published before 2019, it is possible that some of the cost barriers could be perceived- not actual- barriers. This distinction should be elucidated in further research documenting barriers to contraception to determine whether additional funding or additional public health education is needed.

### *Gaps in the Literature*

Literature on prenatal care and abortion access among unhoused individuals was scant. It remains unclear whether the lack of literature on these topics reflects individuals' reproductive needs being met.

Two articles discussed abortion experiences. Smid et al. (2010) reported that participants (unhoused youth in Berkeley) didn't experience barriers when accessing medical abortion. Only one article documented barriers to abortion. Perceived cost and concerns about obtaining parental consent led many youth to use self-induced abortion methods, which could contribute to the lack of research in this area (Ensign, 2001). Misperceptions about abortion laws have been previously identified as a barrier to medical abortion access among low-income women (Lara et al., 2015). It is possible that some individuals experiencing homelessness hold similar misperceptions about abortion laws, akin to the misperceptions about contraceptives described in this review. Future research might explore whether misperceptions about abortion laws serve as a barrier to medical abortions among individuals experiencing homelessness. Reported findings may also be influenced by stigma; despite its recognition as “safe, effective, and acceptable care” by the World Health Organization, medical abortion remains a stigmatized procedure in the United States (WHO, 2018; Miller, 2020). Nonetheless, additional research examining barriers to accessing medical abortions while unhoused is needed.

Barriers to prenatal care were discussed in four of the included studies. Barriers were identified at both the individual and system levels. Individual-level barriers included fear of CPS and difficulty bringing children to appointments (Smid et al., 2010; Ake et al., 2018), whereas systemic barriers included transportation difficulties (Fleming et al. 2017; Bloom et al., 2005). Researchers examining maternal health outcomes during episodes of housing instability found that unhoused women were at risk for poorer birth outcomes and have advocated for prenatal care within shelter settings (Clark et al., 2019). Prenatal care within shelter settings could potentially eliminate the transportation difficulties examined in this review.

### Practical Implications

Access to family planning services allows individuals to maintain control over their reproductive lives and fosters empowerment during pregnancy (Nieuwenhuijze & Leahy-Warren, 2019). This review identified several barriers that prevent optimal service utilization among youth and women experiencing homelessness. Relative to the literature examining barriers to abortion and prenatal services, there is an overabundance of literature examining barriers to contraceptive use. It is unclear whether the attention being given to preventing pregnancy reflects its importance to researchers or those who are being researched. Future projects ought to include questioning around which components (if any) of reproductive justice are most important to unhoused individuals. Collaborations with community family planning clinics and community-based participatory action research projects with unhoused individuals are needed to identify which issues are most important to the community. While future research is needed, implications for programming and policy based on review findings include the following: increased reproductive education, implementation of storage spaces for birth control in shelter spaces, and implementation of on-site reproductive services.

### ***Increased Reproductive Education***

The prevalence of misperceptions regarding contraception and reproduction suggests a need for additional reproductive health education. Shelters might consider implementing onsite reproductive education programming that discusses contraceptive options and information about reproductive processes as a means of health promotion. In Dasari et al. (2016), participants responded positively when shown a diagram of birth control options created by the Centers for Disease Control (CDC). Research examining reproductive education interventions for unhoused women found that participants had more contraceptive knowledge after participation and increased self-efficacy in reproductive autonomy (Meurice et al., 2019; Aparicio et al., 2020). However, prior research indicates that lack of contraceptive knowledge is not limited to individuals experiencing homelessness and has been found among individuals in poverty (Zimmerman, 2017), which suggests a potential need for programming that promotes increased reproductive health education at a broader societal level, such as the K-12 education system. Expanding policies that mandate reproductive education that is medically accurate, and participant-driven could promote reproductive autonomy and enhance both individual and collective empowerment.

### ***Storage Spaces for Birth Control in Shelters***

Shelter spaces might consider implementing secure storage for personal belongings, given this review's finding which indicated that lack of adequate storage for contraceptive methods created a barrier to use. Recent findings suggest that access to adequate storage while unhoused can enhance feelings of safety and freedom (Peattie, 2021). While it remains unclear whether contraceptive storage needs exist for individuals who are not connected to shelter services; this solution has the potential to promote increased wellbeing in addition to ameliorating a reported barrier to contraception among individuals who utilize shelter spaces.

### ***Implementation of On-Site Reproductive Services***

Implementation of on-site contraceptive and prenatal care within the shelter system has the potential to eliminate several barriers to care, including transportation issues and difficulty managing appointments with the demands of shelter living. Furthermore, it is a solution that has been advocated for by the individuals who would be the recipients of such services (Kennedy et al., 2014). Individuals surveyed expressed a desire for onsite services and information from case management about community clinics where they could obtain care (Kennedy et al., 2014). Among pregnant women experiencing homelessness, increased onsite resources, such as mutual support groups and prenatal education classes were desired additions to current shelter programming (Ake et al., 2018; Fleming et al., 2017).

## Conclusion

This review sought to synthesize literature capturing access barriers to contraception, prenatal care, and abortion experienced by unhoused individuals. Barriers to accessing contraception, prenatal, and abortion services were identified at the individual level. Relational barriers prevented the utilization of contraception. Contextual barriers prevented the utilization of contraception and prenatal care. Findings from this review demonstrate that multiple levels of analysis must be considered when designing and seeking to improve access to family planning services for unhoused individuals. In addition to providing an overview of barriers to contraception, prenatal care, and abortion among unhoused women and youth, this review highlighted several gaps that warrant further study. Findings indicate a paucity of research examining abortion and prenatal care barriers experienced by unhoused individuals, which need to be studied further. Additionally, the perspectives of unhoused individuals who do not identify as women, but have similar service needs, are needed. While additional research is needed, findings suggest that increased reproductive education, storage spaces for contraception within shelter settings, and onsite reproductive services could increase access and utilization of contraceptive, abortion, and prenatal care among unhoused individuals.

*Table 4. Article characteristics*

| Author | Year | Sample | Location | Method |
|---|---|---|---|---|
| Ake, Diehr, Ruffalo, Farias, Fitzgerald, Good, Howard, Kostelyna, & Meurer, | 2018 | 26 women residing in shelter settings | Milwaukee, WI | Qualitative |
| Barman-Adhikari, Hsu, Begun, Portillo, & Rice | 2017 | Subsample of women identifying youth from a total sample of 869 homeless youth | Hollywood, CA; Venice, CA | Quantitative |
| Begun, Combs, Torrie, & Bender | 2019 | 30 women ages 18 to 21 | Denver, CO | Qualitative |
| Bloom, Bednarzyk, Devitt, Renault, Teaman, & Van Loock | 2004 | 183 pregnant homeless women | Northeast Florida | Quantitative |
| Cederbaum, Wenzel, Gilbert, & Chereji | 2013 | 45 women experiencing homelessness | Los Angeles County, CA | Qualitative |
| Corey, Frazin, Heywood, & Haider | 2020 | 54 homeless women | Chicago, IL | Quantitative |
| Dasari, Borrero, Akers, Sucato, Dick, Hicks, & Miller | 2016 | 15 women ages of 18 to 24 experiencing homelessness | Pittsburgh, PA | Qualitative & Quantitative |
| Ensign | 2001 | 20 women engaged with | Seattle, WA | Qualitative |

| | | | | |
|---|---|---|---|---|
| | | clinic ages 15 to 23 | | |
| Ensign & Panke | 2002 | 20 women ages 14 to 23 | Seattle, WA | Qualitative |
| Fleming, Callaghan, Strauss, Brawer, & Plumb | 2017 | 9 pregnant women residing in shelter settings | Philadelphia, PA | Qualitative |
| Gelberg, Browner, Lejano, & Arangua, | 2004 | 47 homeless women | Skid Row- Los Angeles, CA | Qualitative |
| Gelberg, Leake, Lu, Andersen, Nyamathi, Morgenstern & Browner | 2002 | 229 chronically homeless women | Los Angeles County, CA | Quantitative |
| Gelberg, Lu, Leake, Andersen, Morgenstern, & Nyamathi | 2008 | 457 homeless women | Los Angeles County, CA | Quantitative |
| Kennedy, Wenzel, Tucker, Green, Golinelli, Ryan, Beckman, & Zhou | 2010 | 445 women in shelter settings | Los Angeles County, CA | Quantitative |
| Kennedy, Grewal, Roberts, Steinauer, & Dehlendorf | 2014 | 22 women experiencing homelessness | San Francisco, CA | Qualitative |
| Killion | 1995 | 15 homeless pregnant women ages 18 to 39 | Southern CA | Qualitative |
| Killion | 1998 | 15 homeless women from 5 shelter locations | Southern CA | Qualitative |

| | | | | |
|---|---|---|---|---|
| MacKellar, Valleroy, Hoffmann, Glebatis, LaLota, McFarland, Westerholm, & Janssen | 2000 | 478 homeless women aged 18 to 26 | San Francisco, CA; New York City, NY; Ft. Lauderdale, FL; Houston, TX | Quantitative |
| Smid, Bourgois, & Auerswald | 2010 | 13 homeless women aged 18 to 26 & their partners (8 homeless men) | Berkeley, CA | Qualitative |
| Tucker, Wenzel, Elliott, & Hambarsoomian | 2006 | 133 women residing in shelters | Los Angeles County, CA | Quantitative |
| Wenzel, Leake, Andersen, & Gelberg, | 2001 | 974 homeless women residing in shelters | Los Angeles County, CA | Quantitative |

*Table 5. Included Journals*

| |
|---|
| **Advances in Nursing Science** |
| **AIDS and Behavior (2)** |
| **AIDS Education and Prevention** |
| **American Behavioral Scientist** |
| **Contraception and Reproductive Medicine** |
| **Free Clinic Research Collective** |
| **Journal of Advanced Nursing** |
| **Journal of Health Care for the Poor and Underserved (2)** |
| **Journal of Health Psychology** |
| **Journal of Nurse-Midwifery** |
| **Journal of Obstetric, Gynecologic, & Neonatal Nursing** |
| **Journal of Patient-Centered Research and Reviews** |
| **Journal of Pediatric and Adolescent Gynecology** |
| **Maternal and Child Health Journal** |
| **Perspectives on Sexual and Reproductive Health** |
| **Social Work in Health Care** |
| **Women & Health (2)** |
| **Women's Health Issues** |

*Note: Journals with more than one article included in the review are indicated in parentheses*

*Table 6. Findings*

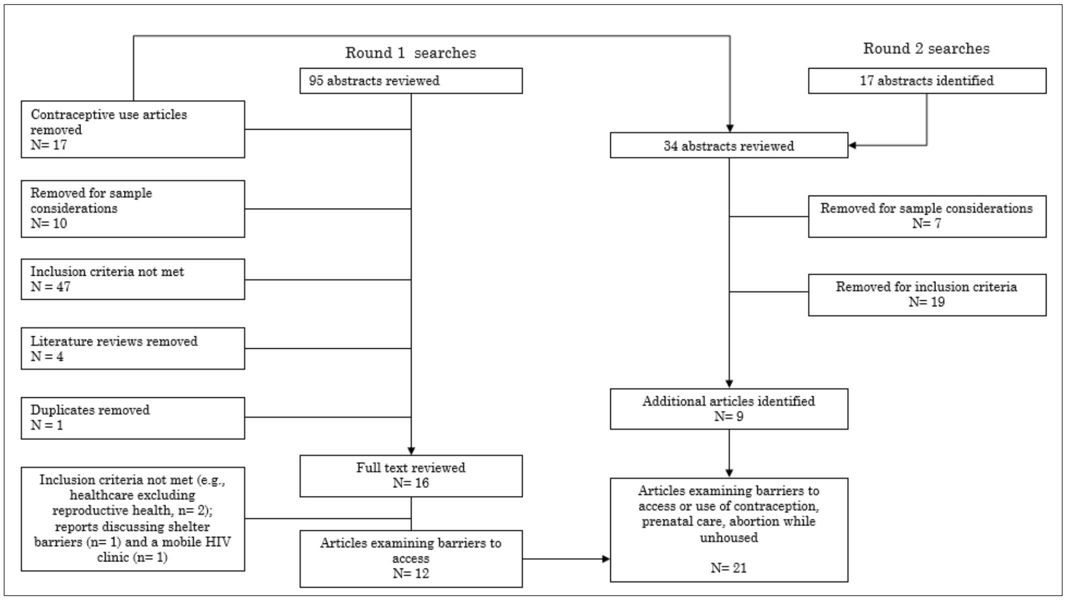
| Article | Individual Factors | Relational Factors | Contextual Factors |
|---|---|---|---|
| Ake, Diehr, Ruffalo, Farias, Fitzgerald, Good, ... & Meurer (2018) | • Lack of childcare | | • Transportation |
| Barman-Adhikari, Hsu, Begun, Portillo, & Rice (2017) | | • Reproductive coercion<br>• Transactional sex | |
| Begun, Combs, Torrie, & Bender (2019) | • Misconceptions about contraception /reproductive system<br>• Fear of side effects<br>• Birth control challenges<br>• Lack of contraceptive knowledge<br>• Financial barriers | • Reproductive coercion<br>• Transactional sex<br>• Monogamy | • Transportation<br>• Stigma |
| Bloom, Bednarzyk, Devitt, Renault, Teaman, & Van Loock (2004) | | | • Transportation<br>• Stigma |
| Cederbaum, J. A., Wenzel, S. L., Gilbert & Chereji (2013) | | • Monogamy<br>• Reproductive coercion<br>• Transactional sex | |
| Corey, Frazin, Heywood, & Haider (2020) | • Fear of side effects<br>• Cost | | • Healthcare system |
| Dasari, Borrero, Akers, Sucato, Dick, Hicks, & Miller (2016) | • Misconceptions about contraception /reproductive system<br>• Fear of side effects<br>• Time/competing demands<br>• Cost | • Reproductive coercion | • Healthcare system |

| | | | |
|---|---|---|---|
| Ensign (2001) | • Fear of side effects<br>• Healthcare system misconceptions<br>• Birth control challenges<br>• Financial barriers | • Monogamy | • Geographic context |
| Ensign & Panke (2002) | | • Social support | • Transportation<br>• Healthcare system<br>• Stigma |
| Fleming, Callaghan, Strauss, Brawer, & Plumb (2017) | | | • Transportation<br>• Healthcare system |
| Gelberg, Browner, Lejano, & Arangua (2004) | • Misconceptions about contraception /reproductive system<br>• Time/competing demands | • Reproductive coercion | • Transportation<br>• Healthcare system<br>• Stigma<br>• Living arrangement |
| Gelberg, Leake, Lu, Andersen, Nyamathi, Morgenstern, & Browner (2002) | • Fear of side effects<br>• Substance use history<br>• Financial barriers<br>• Age<br>• Race | • Reproductive coercion | • Living arrangement |
| Gelberg, Lu, Leake, Andersen, Morgenstern, & Nyamathi (2008) | • Misconceptions about contraception /reproductive system<br>• Substance use history<br>• Age<br>• Time/competing demands<br>• Race | • Social support<br>• Monogamy<br>• Transactional sex | • Living arrangement |
| Kennedy, Wenzel, Tucker, Green, Golinelli, Ryan, ... & Zhou (2010) | • Misconceptions about contraception /reproductive system | • Monogamy<br>• Reproductive coercion | |

| | | | |
|---|---|---|---|
| Kennedy, Grewal, Roberts, Steinauer, & Dehlendorf (2014) | • Fear of side effects<br>• Birth control challenges<br>• Time/competing demands | • Reproductive coercion | • Living arrangement<br>• Stigma |
| Killion, (1995) | • Financial barriers | | • Living arrangement<br>• Stigma |
| Killion, (1998) | • Time/competing demands<br>• Financial barriers | | |
| MacKellar, Valleroy, Hoffmann, Glebatis, LaLota, McFarland, ... & Janssen (2000). | | • Social support<br>• Reproductive coercion | |
| Smid, Bourgois, & Auerswald (2010) | • Fear of CPS | | |
| Tucker, Wenzel, Elliott, & Hambarsoomian (2006) | | • Reproductive coercion | |
| Wenzel, Leake, Andersen, & Gelberg (2001) | • Healthcare system misconceptions<br>• Birth control challenges<br>• Substance use history | | • Healthcare system |

Figure 1

*Article inclusion/exclusion*



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# Chapter IV: Fertility Management During Episodes of Unsheltered Homelessness

## Abstract

Women account for over one-third of the unhoused population in the U.S. (United States Department of Housing and Urban Development, 2019) and oftentimes experience barriers when seeking to manage their fertility while unhoused (Begun et al., 2019; Kennedy et al., 2014). Previous research examining contraceptive experiences while homeless has, for the most part, failed to account for the experiences of individuals who report less engagement with homeless services, such as those living in encampments and other unsheltered environments. Therefore, the present study seeks to document the contraceptive experiences of unsheltered individuals capable of pregnancy. Qualitative interviews were conducted with 15 individuals capable of pregnancy residing in unsheltered locations to identify barriers to reproductive services, meaning ascribed to contraception and use, and potential linkages between reproductive health behaviors and feelings of empowerment. Findings highlight reproductive health services utilized, unmet reproductive healthcare needs, barriers to care, meaning assigned to access and use, contribute to our understanding of the meaning placed on contraception, linkages between reproductive behaviors and empowerment, and depowering experiences. Findings offer novel contributions to the literature and have implications for future research and service delivery with individuals experiencing unsheltered homelessness.

## Introduction

Homelessness among women is growing in the United States. Between 2016 and 2019, there was a 17% increase in homelessness among women[2] overall, and a 35% increase in unsheltered homelessness (United States Department of Housing and Urban Development, 2019). The increased prevalence of homelessness among individuals able to become pregnant calls for a renewed focus on their reproductive experiences and fertility needs. Roughly half (45%) of pregnancies in the United States are unplanned (Guttmacher Institute, 2019). Unhoused individuals experience unplanned pregnancies at greater rates relative to their housed counterparts (Gelberg et al., 2008).

Several contraceptive methods exist for individuals seeking to avoid pregnancy. Hormonal contraceptive methods effectively reduce the chance of pregnancy by up to 99% through mechanisms that block ovulation, while barrier methods, such as condoms or diaphragms, are 79- 87% effective at preventing pregnancy (CDC, 2022). Other methods of pregnancy prevention that rely on fertility tracking (e.g., standard days method [SDM], basal body temperature [BBT] method) reduce the likelihood of pregnancy through avoidance of intercourse during ovulation; however, they have been associated with a higher chance of unplanned pregnancy, with at least 13 per 100 women who utilize them becoming pregnant in a single year (Trussell et al., 2018). Decisions

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[2] The word “woman” is used throughout this manuscript when describing previous research findings which contained cisgender woman-identifying samples. The present study seeks to examine the experiences of individuals who can become pregnant, which includes, but is not limited to individuals who identify as women. Non-gendered language (e.g., individuals who can become pregnant) has been used where possible to describe this study’s focal population.

regarding whether to use contraception and which method to utilize are shaped by both individual-level (e.g., contraceptive knowledge, preference, financial strain) and contextual factors (e.g., policies pertaining to reproductive health, provider interactions; Harper et al., 2010; Lyons et al., 2019).

Within the United States, contraceptive access has historically been influenced by both restrictive and progressive policy decisions. In 1873, congress passed one of the first pieces of legislation credited with deterring contraceptive access and utilization—the Comstock Law, which made it illegal to mail, sell, or possess “obscene” materials, which explicitly included contraception (e.g., condoms, abortifacients) and educational materials on how to avoid pregnancy (Tone, 2001). This law remained in effect for nearly 100 years until it was determined to violate privacy rights among married, and later unmarried, women (Griswold v. Connecticut, 1965 [381 U.S. 479]; Eisenstadt v. Baird, 1972 [405 U.S. 438]). This reversal occurred shortly after hormonal contraception methods became available (i.e., “the pill”; Baird & Glasier, 1993); and policy soon shifted toward making contraception accessible for all women, particularly women in poverty, through the passage of Title X which designated funding for family planning clinics, which in turn increased access to reproductive care (Bailey, 2012). Subsequently, policies shaping contraceptive availability have been implemented in a pendular fashion; both progressive (e.g., Affordable Care Act) and restrictive (e.g., domestic gag rule restrictions to Title X) reproductive health policies continue to influence contraceptive accessibility and service provision.

Contraceptive methods have been praised as a catalyst for gender parity since they afford women the ability to plan their reproductive lives (i.e., pregnancy and subsequent childbirth) thereby increasing opportunities for individual empowerment, such as education and career advancement (United Nations, n.d.). Yet, the majority of research examining unhoused individuals' experiences with reproductive care and contraception has failed to document linkages between reproductive behaviors and feelings of empowerment. Previous research has largely been conducted by disciplines guided by the medical model and prevention science. Contraceptive access and use tend to be used interchangeably in the literature, and previous inquiry has for the most part focused on individual-level factors contributing to contraceptive nonuse. This approach fails to capture the significance ascribed to contraceptive choice. Therefore, this study seeks to expand our current understanding of unhoused individuals' experiences with birth control through solicitation of narratives that capture the meaning they assign to their contraceptive behaviors, as well as documenting barriers to optimal contraceptive engagement.

## Unhoused Women's Contraceptive Preferences and Experiences

Reproductive healthcare has been identified as a central health concern among unhoused individuals who do not wish to become pregnant (Begun et al., 2019; Ensign, 2001; Tucker et al., 2012). Research examining medical concerns among unhoused health clinic users found that women predominantly utilized the clinic for reproductive healthcare-related services (e.g.., STI testing, and contraception; Ensign & Panke, 2002; Evans et al., 2014). Once in the clinic, positive interactions with providers contribute to feelings of support and autonomy when making birth-control decisions, while negative interactions, such as perceived stigma and feeling pushed towards certain methods, dissuade future engagement in care (Dasari et al., 2015; Gelberg et al., 2004; Kachingwe et al., 2019). Unhoused youth, in particular, reported that feeling their contraceptive choices were supported and respected impacted their desire to access reproductive healthcare (Kachingwe et al., 2019).

Similar to their housed counterparts, unhoused women have diverse contraceptive preferences. For instance, condoms have been described as “literally the worst” (Begun et al., 2018, p. 9), while others have found condoms to be the most utilized contraceptive method due to accessibility (Corey et al., 2020; Gelberg et al., 2008). Relationship type also influences whether condoms are used; condoms are more likely to be utilized when interacting with casual partners, while those in monogamous relationships report greater condom nonuse (Begun et al., 2019; Gelberg et al., 2008; Kennedy et al., 2010; Semborski et al., 2021). Condom use decisions are often made based on trust (Ensign, 2001). Shelter status (i.e., sheltered versus unsheltered) can also impact condom utilization. Unhoused couples within shelter settings reported greater non-use of condoms due to the inability to plan when intercourse might occur (Killion, 1995). Recent research found that unhoused youth most commonly reported condom use as their preferred method, while youth living in supportive housing reported using no contraception or the withdrawal method (Semborski et al., 2021).

Examining hormonal contraceptive methods, which have been identified as most effective at preventing unwanted pregnancy, researchers found that long-acting reversible contraception (LARC) methods were unhoused participants' preferred birth control choice, yet nearly two-thirds of the sample (59%) reported not using their preferred method due to access barriers (Kozlowski et al., 2022). Among women staying in shelters, nearly half (43%) of those surveyed expressed interest in IUD education and potential use (Corey et al., 2020). Elsewhere, participants reported feeling coerced into choosing a LARC method by their healthcare provider despite their concerns about side effects and future fertility (Dasari et al., 2016). Participants reported receiving inadequate and biased counseling which did not fully address potential side effects and provider encouragement to begin birth control despite them having expressed disinclination (Dasari et al., 2016). The aforementioned findings highlight the importance of considering contraceptive preference when examining the reproductive needs of unhoused individuals capable of pregnancy.

## Barriers to Contraception Access During Episodes of Homelessness

During episodes of housing insecurity, unhoused women may experience difficulty meeting their family planning needs. Barriers to contraception have been identified at the individual, relational, and contextual levels of analysis (Brott & Townley, 2022). At the individual level, misconceptions about service availability and cost, concerns about side effects, and time constraints serve as barriers (Begun et al., 2019; Corey et al., 2020; Dasari et al., 2016). Relationships also impact contraceptive use and access. Unhoused women and youth desire peer support when attending family planning appointments and are more likely to use contraception when encouraged by peers to do so (Ensign & Panke, 2002; Gelberg et al., 2008). Relational factors that hinder autonomy over fertility management practices include partner dislike of birth control, reproductive coercion, and birth control sabotage (e.g., damaging condoms, hiding contraception to prevent use; Begun et al., 2019; Gelberg et al., 2008; Kennedy et al., 2014). Contextual factors that serve as barriers to contraceptive access and use include transportation difficulties, healthcare system-related barriers, and stigmatizing interactions with providers (Begun et al., 2019; Corey et al., 2020; Dasari et al., 2016; Ensign & Panke, 2002; Gelberg et al., 2004; Kennedy et al., 2014).

## Healthcare Service Utilization Across Contexts

Notably, research outlining barriers to contraceptive access has primarily occurred within urban shelter and clinic settings, which restricts our understanding of the impact of contextual affordances and barriers on contraceptive experiences. Differences in health-related service utilization and experiences have been found across types of living situations (i.e.., sheltered versus unsheltered homelessness) and context (i.e., rural versus urban) when examining healthcare more broadly. For instance, researchers examining healthcare utilization among sheltered and unsheltered women experiencing homelessness found that women residing in shelter environments were more likely to have received a Pap smear, tuberculosis test, and utilized dental care in the previous year compared to women who resided outdoors (Nyamathi et al., 2000). Women residing in shelters who had histories of intimate partner violence reported using the emergency department for healthcare needs instead of seeing a primary care physician (Vijayaraghavan et al., 2011).

Most of the research examining the healthcare experiences of unhoused individuals has occurred within urban contexts. Findings suggest that emergency departments are commonly utilized among unhoused people, and at higher rates relative to housed individuals, which has been attributed to difficulties accessing routine healthcare (Abramson et al., 2020). Unhoused youth interviewed in a health clinic setting reported that they typically attempted to self-treat conditions prior to engaging with the healthcare system (Ensign & Panke, 2002).

The healthcare experiences of rural Americans who lack housing have been less commonly examined. Unhoused individuals in rural Nebraska identified lack of insurance and healthcare costs as barriers to receiving care (Easterday et al., 2019). Research examining the healthcare experiences of unhoused men in rural New England found that despite reporting numerous health concerns, including mental health needs, chronic conditions, and infections, participants reported preferring to self-treat rather than see a doctor due to previous negative experiences and concerns that doctors could not be trusted (Whitley et al., 2013). Instead of engaging with the medical system, participants reported regular participation in self-directed health promotion activities such as physical activity and time in nature to stay healthy (Whitley et al., 2013).

Differences identified across type of living situation and geographic context highlight the importance of examining experiences with managing one’s health during episodes of homelessness as events embedded within contexts and a continued need to explore the impact of contextual factors on engagement with care systems. Previous research examining reproductive healthcare engagement, in particular, has primarily documented the experiences of individuals within urban shelter and clinic settings. Limited research involving unsheltered individuals found that women who resided primarily outdoors were less likely to use contraception compared to those within shelter settings (Gelberg et al., 2002; Gelberg et al., 2007). Additional research documenting the experiences of individuals residing in encampments and other unsheltered locations is still needed.

## Autonomy and Empowerment During Contraceptive Decision-Making

Most research documenting unhoused individuals' reproductive experiences and contraceptive needs has been conducted within public health and nursing disciplines and has historically emphasized individual-level factors contributing to contraceptive nonuse. When structural issues are raised, solutions are typically identified within the systems level (e.g., clinics, hospitals, etc.) versus broader change at the policy level. Moreover, contraception is typically framed as an assumed need rather than something that an unhoused person could choose if desired. This framing further reduces the autonomy of unhoused individuals by implying that they are incapable of making family planning decisions.

In order to affirm the autonomous contraceptive decision-making practices of unhoused people, it is important for research to shift toward examining the meaning that they assign to contraceptive access and use during episodes of housing instability. The field of community psychology is well-equipped to contribute to this work, particularly given its focus on empowerment and social justice. In community psychology, empowerment is commonly conceptualized as a process in which individuals and communities develop a sense of “mastery over one’s life” (Rappaport, 1984, p. 3). Empowerment encompasses both processes and outcomes which may occur at multiple levels of analysis (Rappaport, 1984; Zimmerman, 1995). Empowering processes are opportunities and events that afford individuals increased autonomy, capital, and critical consciousness (Zimmerman, 1995).

Researchers have not yet examined whether contraceptive decision-making (i.e., the choice to use or not use contraceptives) and use (i.e., fertility control) serve as sources of empowerment during episodes of homelessness. However, previous research examining empowerment processes during episodes of homelessness suggests that choices can serve as a source of empowerment for unhoused individuals (Lambdin-Pattavina et al., 2020; Oudshoorn et al., 2020). Specifically, the ability to choose which services to engage in and voice opinions contributed to feelings of agency (Lambdin-Pattavina et al., 2020; Oudshoorn et al., 2020). Empowerment also emerged as a theme during interviews with unhoused women about their reproductive needs. Participants discussed the importance of teaching young women to “fulfill [themselves] and getting to know [themselves] before we even start trying to put birth in [their] head” (Kozlowski et al., 2022, p. 116).

Research examining the linkages between empowerment and contraception has primarily been conducted in lower-income countries, solicited the perspectives of married women, and has historically framed contraceptive use as an outcome of feeling empowered, rather than a source of empowerment (Mahmud et al., 2012; Prata et al., 2017). Limited research examining how contraceptive use contributes to empowerment found that contraceptive uptake contributed to economic and educational growth among married women in Ethiopia (Alano & Hanson, 2018). The ability to control fertility also contributed to psychological well-being; avoiding undesired pregnancies allowed women to focus their energy that would otherwise be spent on children elsewhere (Alano & Hanson, 2018). It is unclear whether the benefits derived from contraceptive engagement would translate to unhoused women within a western context and outside the context of marriage, but these initial findings provide a foundation on which this study intends to build.

## Present Study

The present study sought to document the contraceptive needs and experiences of unhoused individuals who are able to become pregnant in the Portland metro area and examine the role of contraception in their sense of empowerment. Previous research examining the relationship between contraception and empowerment has mostly failed to examine empowerment as an outcome of contraceptive decision-making. Moreover, it is unclear the extent to which contraceptive access and engagement (or disengagement) in family planning practices impact unhoused individuals' feelings of empowerment. True empowerment requires change across multiple levels of analysis (Rappaport, 1984). Examination of the meaning that unhoused individuals place on their experiences with contraception and barriers to care during episodes of homelessness may yield findings that could be leveraged to strengthen service delivery (e.g., removal of access barriers, expansions to current programming) and inform public policy (abolishment of policies that restrict access).

In order to better understand the contraceptive needs and experiences of unhoused women, and how this might relate to their empowerment, this study examined the following questions: 1) What barriers prevent people from getting the best reproductive health services (such as birth control) in the Portland metro area? 2) What meaning do individuals assign to contraceptive practices (both access and use) during episodes of homelessness? 3) In what ways are reproductive choices empowering? Further, previous research has primarily focused on cisgender samples recruited from within shelter and service environments. Thus, the perspectives of unhoused individuals who do not identify as women, but may have similar service needs, or who are not actively engaged in homeless services, are still needed. This study addressed these gaps by focusing on contraceptive behaviors among unsheltered individuals and by using a more inclusive approach to sampling that includes transgender and nonbinary people who can become pregnant.

## Method

This study utilized semi-structured interviews to better understand the unmet needs and meaning assigned to reproductive health behaviors during episodes of unsheltered homelessness.

### Study Context

In 2019, approximately 4,015 individuals were experiencing homelessness in the Portland Metro area (City of Portland et al., 2019). Among those counted, half (50.7%) were classified as unsheltered. In regard to gender, 34.7% identified as women, and 1% identified as transgender. Women-identifying and transgender individuals accounted for one-third (female, 29.3%; transgender, 1.1%) of the unsheltered homeless population counted (City of Portland et al., 2019).

The political context in which this study occurred should also be noted. Data collection occurred in the first quarter of 2023, a mere six months after Roe v. Wade was overturned by the US Supreme Court. Subsequently, several states passed legislation restricting abortion, and popular media discussed potential threats to contraceptive access in the aftermath. The state of Oregon codified abortion in 2017 and is one of the top five states in the US for women's rights (Institute for Women's Policy Research, 2022). While individuals capable of pregnancy in the state of Oregon were less impacted by recent legislative changes, it is possible that the current attacks on reproductive health access experienced elsewhere influenced motivations to participate and responses provided in the present study.

## Participants

Fifteen (14 women-identifying, 1 non-binary) individuals experiencing unsheltered homelessness participated in semi-structured interviews (see Table 7). Participants were 36 years old on average (M= 36.6, SD= 7.81), and roughly half (46.6%) reported actively using a contraceptive method available over the counter (e.g., condoms) or available by prescription (e.g., Depo-Provera, Mirena, etc.). Racial/ethnic identity was collected as a write-in option to allow participants to fully convey their identities, and they were welcomed to list multiple racial/ethnic identities. Participants identified as Black (n = 3), Middle Eastern (n = 1), Native American (n = 5), and White (n = 12), and 5 participants reported a bi-racial or multi-racial identity. Participant sleeping locations included tents (n = 10), RV’s (n= 4), crashing with friends when possible (n = 2), and public transit (n = 1). Most (93.3%) participants reported having their living location swept (i.e., forcibly removed from the location they were currently staying in by city workers) in the past year, with several participants sharing they had experienced multiple sweeps, or had been swept recently. Length of time unhoused ranged from 10 months to 20 years. Roughly half (46.6%) of participants identified themselves as parents to a child under the age of 18. Other identities represented in the data include: English as a second language (6.6%), LGBTQIA (20%), survivor of intimate partner violence (73.3%), person with a mental disability or mental illness (53.3%), and person with a physical disability or chronic illness (60%).

## Sampling and Recruitment

Interviews occurred between January and March of 2023 on seven separate outings. An outreach worker with lived experience of homelessness accompanied me in the field on two occasions. I was introduced to the outreach worker by my advisor, who had partnered with her on other research projects. On the first outing, the outreach worker suggested we survey individuals in the neighborhood they used to camp in, stating that it is less commonly visited by researchers and individuals doing outreach with this population. On the second outing, I met the outreach worker outside of a nonprofit located in a neighborhood commonly frequented by unhoused community members due to a high concentration of nearby service locations. The outreach worker provided introductions to their friends interested in participating who fit the study criteria. During the remaining five outings I was accompanied by an undergraduate or graduate student research assistant. Locations surveyed were determined based on recommendations from individuals experiencing unsheltered homelessness, recommendations from another researcher engaged in field-based research with unsheltered homeless populations, and previous Point-in-Time (PIT) unsheltered count data (see Figure 2).

Eighteen individuals in total were interviewed. Two interviews have been excluded from this analysis because information shared midway through their interviews suggested they did not meet study inclusion criteria (i.e., experiencing unsheltered homelessness, capable of pregnancy; one participant reported living in a tiny homes village during the demographics, another disclosed that she had a hysterectomy procedure prior to becoming unhoused). A third individual stopped the interview mid-way after disclosing they did not feel well. Their incomplete interview was also excluded from analysis because I was unable to confirm permission to use the information I had collected, and the collected information did not add anything novel to the data.

The research team approached individuals near encampments and explained the purpose of the study. Approached individuals were asked whether they were currently experiencing homelessness in an unsheltered location, over the age of 18, and capable of experiencing pregnancy to the best of their knowledge. We approached individuals who appeared feminine and masculine to ensure that individuals who do not identify or present as women but are capable of pregnancy were given the opportunity to participate. Individuals who did not qualify due to pregnancy ability were asked whether they knew anyone who might be interested. Business cards containing researcher contact information were provided to individuals who reported knowing individuals who might be interested in participating. Additional information regarding who was approached and who participated can be found in Table 8.

During recruitment, participants were offered the opportunity to be interviewed at the moment or schedule a time for me to return. Participants were also offered the option to schedule a time to speak by telephone. Interview locations were determined by participants to ensure both privacy and comfort. All interviewees opted to be interviewed at the moment. Most interviewees elected to be interviewed near their camp or a short distance (e.g., 20 feet) away. Additional information about interview locations selected by participants is included below.

## Procedures

After identifying a location suitable for conversation, participants were provided a copy of the informed consent (see Appendix A). Key details were verbally shared, and participants were offered time to ask any questions prior to providing verbal consent. Upon completion of the interview, participants were provided a $25.00 Visa gift card and offered a copy of the Rose City Resource Guide, a booklet of available services and resources pertaining to homelessness in the Portland metropolitan area.

Semi-structured interviews occurred outdoors and lasted 18 minutes on average. After verbally consenting, participants were asked a series of questions about their current contraceptive and reproductive health behaviors, unmet service needs, meaning assigned to contraceptive practices, and ways that reproductive choices contribute to or detract from feelings of empowerment (see Appendix B). All interviews were audio-recorded. Upon interview completion, participants were debriefed, compensated, thanked for their time, and asked to share the researcher’s contact information with any of their peers who may be interested in participating.

**Conducting Interviews in Public Spaces**

Interviews occurred in public spaces. In many instances, participants reported that the location we were in was suitable for participation. Interviewees also opted to step a few feet away from encampments or bike paths, cross the street, and on one occasion suggested that we walk a block away to a location with a raised cement curb which allowed them to sit comfortably while being interviewed. The most publicly visible interview setting was a cement curb in front of a Plaid Pantry, which was selected by three interviewees. I asked each if they would rather sit on the side of the building, or perhaps walk across the street to ensure privacy and reiterated that I would be asking them about their reproductive health. Participants felt it was an appropriate and comfortable place to have those conversations, stating that we were sitting in their usual “hang out” spot and would rather not create additional distance from their peer group. Interviews were seldom interrupted by others (except for one instance) beyond occasionally momentarily pausing the conversation to allow an individual to pass by on the sidewalk prior to asking the next question to allow for privacy. Participants were also instructed ahead of the interview to communicate their feelings of comfort throughout the process (i.e., comfort with location, questions being asked). Two participants paused their interview experience midway to quickly communicate with friends; one saw a peer in the distance and took a brief pause to go ask for a cigarette, another shouted to a peer across the street that McDonalds was running a special for free six-piece chicken nuggets to celebrate a high scoring Trailblazer's game.

### Author Positionality and Reflexivity

I have worked with unhoused women primarily in shelter settings as a front office intern and researcher involved in evaluative projects. Through this work, I've had informal conversations with women about their kids as well as their experiences trying to have their health needs met in the context of homelessness. As someone who is capable of pregnancy, the topic of birth control and accessible reproductive health services is also of personal importance to me.

The information presented above was my informal script and way of introducing myself to potential participants beyond what was provided on my informed consent forms. This spiel aimed to establish connections and contribute to further rapport with participants throughout the interview process.

Both myself, and the individuals that accompanied me in the field all presented femininely, which I was told was a strength by one participant, as evidenced by the following quote: "I'm happy you're a woman. If a man was like, 'Yeah can I talk about your organs, I'm like mmm, no'". This participant further articulated that "Women understand. Men don't fully." Thus, even though I have never experienced homelessness in either a sheltered or unsheltered location, participants readily identified me as someone who would be able to inherently understand their experiences. Others reported feeling safe with me, and on one occasion I was told I was "cool as hell". These statements were shared at both the beginning of the process and peppered between stories of inaccessible reproductive health services, sexual assault, and lost children. This interview experience was not universal; during one interaction I perceived that my identity as a housed individual contributed to a sense of distrust from a participant who disclosed a lack of engagement with any services beyond Portland Street Medicine (a non-profit organization providing medical care in the field to individuals experiencing houselessness). The participant was brief in her responses regardless of how much I probed, and my typical approaches to building rapport failed to achieve my intended goal.

In the field, I was also perceived as someone who might be able to help based on my appearance and the interactions I was having with other individuals. On one instance, a man approached as I was interviewing one of his friends to ask if I would be able to help him find a place to stay. I offered to call Portland Street Response and asked if he would like a copy of the Rose City Resource guide (both of which were declined). All told, my appearance and mannerisms served to gain participant and community trust.

On another instance, I felt my feminine presentation was a liability. My undergraduate research assistant and I followed a lead to see if any younger women were camping in a location recommended by an older participant. When we arrived, we saw one male individual outside of his tent, who promptly asked if we were the police. Both my RA and I perceived a strong sense of distrust in that moment. After we introduced ourselves and explained why we were there, he offered to introduce us to women camping nearby, which I perceived as a diffusion of any concern about my presence near his home. The individuals he had in mind were not interested, but as we turned to leave the area, we saw a woman exiting her tent. When we introduced ourselves and explained the study, she shared that she had experienced four abortions and was very interested in participating. Moments later, a male presenting individual approached our interview location (determined by the participant) and told her she was not allowed to participate. She told him to leave because she had “an appointment with these ladies”. She again asked him to remove himself from the location, stating that if he “was going to live in her house, he had to abide by her rules.” He refused to leave the location that the participant had selected as a suitable space for her interview. At that moment, it became clear that the interview would not be able to be conducted at that time in that location. I asked the participant if she would like to take my card and give me a call or text to find a better time and location that worked for her. She responded yes and reiterated her beliefs in women’s rights to abortion. I left the scene promptly afterwards due to researcher safety concerns and engaged in a debriefing process with my RA. The potential participant never called.

Both my prior experience working in settings that support unhoused women and my identity as a woman informed my interactions with participants during interviews. My own lived experiences attempting to access desired reproductive healthcare in a rural, conservative context have unequivocally informed my beliefs about this topic. While they remained bracketed and undisclosed to best center my participants’ perspectives, during interviews it’s likely that participants were able to perceive the sincerity of my compassion during our interactions, which in turn may have influenced the stories that they chose to share and the depth at which they were told. However, it’s also possible that other aspects of my identity (e.g., perceptions of competence/professionalism, stated level of education and experience working with unhoused women) influenced how much participants were willing to disclose. During interviews, I approached sensitive topics in a nonjudgmental way and asked follow-up probes with curiosity and an eagerness to learn about their experience. When participants shared stories about lost children, I acknowledged their grief and encouraged them to share their children's names with me if they'd like. I also respected participants who did not want to get into the finer details of the losses and trauma that they had endured. I incorporated phrasing such as "I'd like to ask a few follow-up questions about that, if that's okay?" to remind participants of their control over the interview process and what they chose to disclose. I left interactions certain that I had "witnessed" (Stein & Mankowski, 2004) my participants' realities, which at times was made more evident by my own emotional response experienced while engaging in reflexive journaling upon returning home.

## Data Analysis

Recorded audio interviews were transcribed verbatim (including utterances, such as "um" and pauses in conversation). Analysis for all three research questions followed the six-step process for thematic analysis outlined by Braun and Clarke (2006). During Phase 1, the researcher is tasked with "familiarizing themselves" with the data. My "familiarizing" process began during transcription. Recordings were transcribed by me and one research assistant with support from Express Scribe transcription software. After the initial transcriptions were produced, I engaged in an editing process in which I re-listened to each interview and confirmed the accuracy of transcriptions. Next, I read through transcripts multiple times and jotted down key ideas, which I compared to memos produced during data collection. During Phase 2, the researcher is tasked with creating initial codes. Key ideas noted during the reading and re-reading process were included in my initial codebook. It also included salient ideas and concepts identified through open coding in the first four transcripts, which included two individuals presently utilizing contraception and two individuals who reported non-use. I organized and defined initial codes, then applied them to the rest of the transcripts. Additional codes were added to the codebook and modified as needed throughout the coding process. I read through transcripts multiple times during the coding process to ensure that all data extracts were appropriately tagged in a consistent manner. Next, codes were clustered into larger categories (Phase 3). These larger categories, or themes, were reviewed, compared to the data, and modified as needed (Phase 4), described in detail, and defined (Phase 5). The coding process was supported through the use of ATLAS.ti qualitative software.

I engaged in several strategies to establish credibility and trustworthiness (i.e., rigor) throughout the research process (Lincoln & Guba, 1986). During data collection, my research assistant and I had quick check-ins between interviews whenever possible to discuss how the research interviews were going. Additionally, on the car ride home I compared my observations and reflections with her perceptions of the interactions she was witnessing. I also engaged in peer debriefing with my research advisor throughout the data collection process. We engaged in conversation regularly about my experiences in the field, which afforded me space to critically examine my own assumptions. He also made space for me to process the emotionally intense narratives I heard in the field, which contributed to my ability to view my data in a more holistic way. I also engaged in reflexive journaling throughout data collection. I took field notes between interviews about contextual factors (e.g., weather, location, individuals approached, potential areas for future data collection mentioned by participants) and the recruitment process (e.g., contacts versus interviews, appearance of individuals who said no, any information provided regarding their decision to not participate). Upon returning home, I entered these notes into a larger excel document tracking the interview process throughout data collection. I also jotted bullet note summaries about my experience interviewing individuals. I kept track of things that surprised me, key ideas expressed, strategies that seemed to support rapport building, and any points that I wanted to check in with my research advisor about. I also noted my own emotional response to what I was hearing in the field. I returned to these reflections throughout the analysis process, and they directly informed theme generation. For instance, extreme cases and traumatic experiences have been included as findings despite these experiences being unique to a few participants in the sample.

During the transcription phase, I incorporated as much detail as possible from the audio recording. This included noting pauses, phrases said with emotion, and the occasional quick segue into talking about the weather or a participant’s pet. Preserving these smaller details supported my ability to fully engage with the data once the coding phase began. For example, several participants laughed nervously when recounting experiences of sexual assault. Both the experience itself, and the emotions expressed during the interview led me to code these events as traumatic. Additionally, expressed emotions signaled the importance of specific topics to my participants, which informed theme generation.

When coding, I preserved a bit of the text before and after the content to be coded to preserve the context in which the statement was made. When faced with uncertainty about a text segment, I discussed my coding decisions with my research assistant. Moreover, I kept a paper trail of my coding process. This included memo-ing coding decisions and areas of uncertainty and tracking how codes were being applied to the dataset. This was supported by the use of a code book, which was expanded and modified throughout the analytic process. I also sought consultation on emerging themes from my research advisor.

When writing the report (Phase 6), I supported the transferability of my findings by including rich descriptions of the study context, recruitment, procedure, and identified themes. I selected participant quotes representative of themes and counternarratives when applicable. Additionally, I preserved the language and inflection of my participants in included quotes through punctuation and a lack of censorship of the language they used to describe their experiences (i.e., inclusion of swear words). I also included statements made by me where relevant to provide the reader with the context needed to make sense of my participant’s responses.

## Results

Participants were asked about their current engagement with contraceptive and other reproductive healthcare services, unmet reproductive healthcare needs, questions surrounding the meaning assigned to their contraceptive experiences (both access and use), and the ways in which their reproductive choices were empowering (see Table 9). The following sections discuss a subset of the major themes and subthemes identified in this study that address the primary research questions. Themes were identified based on frequency and felt emotion (both my own and participants'). Additionally, extreme cases have also been included as themes. Major themes and subthemes beyond the scope of the present research questions (e.g., subjective factors contributing to method used, thoughts about pregnancy, judgement towards reproductive behaviors) have been excluded. Illustrative quotes presented throughout the findings include the participant number (e.g., P01). Additionally, statements made by the interviewer have been identified with initials (i.e., HB).

## Reproductive Health Experiences

Participants discussed their current utilization of gynecological care. Participants also reported unmet reproductive healthcare needs and barriers to receiving desired care.

### *Reproductive Health Services Utilized*

Participants were asked about their current contraceptive behaviors and engagement in reproductive services that involve going to a doctor or a clinic. Eight participants reported receiving a variety of reproductive services, including annual breast exams (n= 1); Pap smears (n= 3); birth control related care (n=4); care for ovarian cysts (n= 1) and UTI's (n= 1); Plan B (n= 1); screening for sexually transmitted diseases (n= 1); and pregnancy tests provided at a clinic (n= 1). For example, one participant reporting using condoms and receiving recommended annual services: *"Um, condoms, um, and my pap smear stuff is, that's up to date… and oh yeah, the Plan B"* (P18).

Seven participants shared that they did not use any reproductive services that involve going to a doctor or a clinic on a regular basis. Of those, three participants who reported not using contraception shared that there were not any reproductive services that they wanted to use. Others expressed that they "*hadn't really thought about it*" (P12). Another shared that they had no unmet needs despite not currently engaging in reproductive healthcare services because if one were to arise, they could "*go to the street doctors. They help you with anything"* (P13).

### *Unmet Reproductive Healthcare Needs*

Unmet reproductive healthcare needs were discussed by twelve participants and included a lack of patient centered healthcare (n= 9), a need for additional mental and physical healthcare services in relation to their reproductive health (n= 7), and a desire for additional reproductive health education (n= 2). Participants also discussed how their pregnancy experiences were impacted by homelessness (n=2).

**Lack of Patient Centered Healthcare**. Nine participants expressed a need for patient centered reproductive healthcare, which was currently lacking from their interactions with providers. Participants who discussed a lack of patient centered reproductive healthcare described being "*lumped into boxes*" (P01) versus treated like an individual. One participant described healthcare providers as "*really judgmental on us homeless people"* (P12). Participants expressed a desire for providers to "*get to know* *their client, patient more better*" (P14), before prescribing contraception instead of simply offering the "high profile" method. This is further illustrated in the quote below:

> *Everybody's experience with birth control is their own, and um, a lot of providers um, in a certain area, they lump, um, they lump a group of people into like, a box, you know what I mean? Like, they have blanket diagnoses, they have um, they have um, blanket medications that they use, and it- everybody's just an individual, you know? … Like I wish that they would take into consideration more um, me and my personal health issues, and where I've been with birth control and where I want to go* (P01).

Participants also described impersonal interactions with providers that failed to account for, or in other instances were dismissive of the participant's experience with certain contraceptive methods. Participants reported not feeling listened to, resulting in feelings of frustration. For example, one participant described telling her provider about unpleasant side effects, only to be told to "*just give it a couple more days*" (HB06). The participant shared that they ultimately stopped seeing the provider due to repeated instances of feeling unheard.

Two participants provided counternarratives to the information presented above. One participant described her process of selecting a birth control method as supportive. Providers *"gave [her] all kinds of options of the birth control they have in stock"* (P04). She described them providing her with a personalized recommendation for a specific method based on the information she shared with them. Another participant shared that her doctor *"tells [her] everything [she] needs to know"* (P10).

**Desired Mental Health Supports**. Two participants discussed a need for additional mental health support for individuals experiencing homelessness. One participant shared that she was "*still working on getting into therapy*" (P07) to receive support in processing and healing from a traumatic sexual assault experience. Another shared that her doctor recommended that she see a therapist for the "*mental and emotional damage*" (P04) she experienced after miscarrying while unhoused.

**Desired Physical Health Supports**. Participants reported wanting mammograms (n=1), Pap smears (n=3), *"women's check-ups"* (P03; n=3), female sided contraception (n=1), and tubal ligation procedures (n=1). Participants described needing check-ups to "*make sure that everything's okay down there*" (P14). Some discussed their reproductive health needs with this lack of specificity. Instead, they spoke about their reproductive care needs more broadly. For example, one participant shared that she'd "*love to have a gynecologist that [she] could see*" (P17) and reported accessing reproductive care on an as-needed basis from the emergency room instead.

***Desire to Switch Contraceptive Method*.** Three participants currently using contraception (both prescribed options and condoms) expressed a desire to use a different method than they were currently using. Desired options included a longer acting method such as an IUD or Depo Provera, female dams and female condoms, and the NuvaRing. The participant who would rather use female condoms reported that they would make their life "*so much easier*" because they "*wouldn't have to worry about what sizes [they] need*" (P07). Participants who desired longer acting methods (i.e., IUD, Depo Provera, NuvaRing) praised their ability to determine whether or not they menstruate while using the NuvaRing, and the convenience of using methods “*that last a long time*” (P18).

### *Additional Reproductive Health Education and Outreach is Desired*

Two participants discussed a desire for additional reproductive health outreach and education. One participant shared that unhoused individuals do not have the same ability to access new health information as individuals who are living inside. She shared the following statement when asked what she wished reproductive healthcare providers knew:

> *[I wish they] knew to provide new information. Like I think they probably assume that most people see the new stuff on commercials, or something. But if something new comes out, maybe people like us wouldn’t know* (P11).

Another participant also described a need for additional basic reproductive health resources and care outreach. Having dropped out of school in sixth grade, she missed out on sex ed classes. This resulted in her being “*detached from having like, the knowledge*” (P17). She shared that she didn’t know what sexually transmitted diseases (STD) were until she had one. She shared that when she first experienced STD-related pain during intercourse, she thought *“it was just how it was supposed to feel at that point”* (laughs). This participant expressed a desire for additional reproductive health outreach and knowledge about how and where to receive care.

**Pregnancy Outside**. Two participants discussed their experiences navigating pregnancy while living outside. Pregnancies experienced during homelessness were described as stressful and challenging. One participant described the additional stress that homelessness put on her body while pregnant:

> *So I’d be walking a mile and a half during my first trimester, one way to the MAX coming out, selling all day [referring to newspapers], in the freezing cold or hot heat. And then walking back home in that. HB: Mhm. P07: Well, to the tent* (P07).

Another participant compared her pregnancy outside to pregnancies she had experienced while living inside and described the pregnancy she experienced while homeless as more “*stressful*” (P18). Both her immediate environment and *“almost getting them [her babies] taken away from the state and everything”* (P18) impacted the amount of stress that this participant experienced while pregnant outside. She explained how this stress continued until her child was born:

> *And then praying that the baby come out okay. And I guess when you first have the baby, and then you hear them cry for the first time, and then like, there’s like stuff in their lungs or something, you think, “Oh it’s your fault. So, is it okay? You know, like what’s wrong with it?” Cause I knew what I was doing out here, you know, so it was a lot different* (P18).

While these experiences were described as stressful, participants who discussed the stressors of pregnancy in the context of homelessness did not suggest additional supports to reduce increased stress during this time.

## Barriers to Optimal Reproductive Healthcare

Barriers to reproductive healthcare were discussed by 12 participants. Participants discussed accessibility barriers, difficulties with time, challenges navigating systems, financial barriers, patriarchal influences, and hygiene-related concerns. Each of these factors impacted their ability to engage with desired reproductive healthcare services.

### ***Location Accessibility***

Nine participants discussed location accessibility as a factor that contributed to their reproductive health behaviors and engagement in services. One participant shared, "*It's easier to have sex than it is to have birth control… so if they can be both convenient as each other, probably save a couple, save a baby from being born (laughs)*" (P18). Factors that impacted accessibility of care included service location, an unmet need for healthcare outreach with unhoused populations, and transportation-related issues.

Participants expressed a need for services beyond the downtown area and "*into the greater Portland Metro area*" (P07). One participant shared that her mental health prevents her from leaving her neighborhood, even when care is desired:

> *I have real bad anxiety, I can't, if I leave I just eh, I can't stay too, can't stay too far, too much, I can't stay anywhere long enough to handle all that. HB: Yeah. P14: You know. If it comes to St. John's, yes. I would be happy to* (P14).

Another participant proposed targeted outreach and services for individuals with reproductive healthcare needs as a potential solution. Other participants described these as already accessible, stating, "*They provide condoms out here for the girls… and they come out with the medical van. They're out here all the time"* (P16). Others described their reliance on condoms for birth control solely because they are the most convenient.

Two participants named transportation as an accessibility barrier to receiving desired reproductive healthcare services. One participant shared that *"it's really hard to get around from place to place sometimes"* (P04), particularly when they lacked money for bus fare. Another participant discussed losing their car in the process of becoming homeless, which impacts their current ability to get to appointments.

### ***Time***

Five participants discussed time as a barrier to desired reproductive healthcare services. Being homeless was described as "*a twenty-four-seven job*" (P01) that makes it difficult to make it to appointments. Participants described difficulties finding the time in the day to receive care. One participant explained that part of the experience of being homeless is being removed from the calendar world:

> *Um, just not having like, a schedule. Like not being able to wake up or remember the date, you know? HB: Yeah. Makes it hard to plan for that type of appointment? P03: Yeah. Like if I know what time of day it is and on the date of the day, or the day of the week. HB: Yeah. That makes a lot of sense. Are there any other barriers that prevent you from accessing these services? P03: Not usually. It's just not being inside. Not being able to keep a schedule* (P03).

Participants also described lacking the time to "*wait hours and hours*" (P14) to receive desired reproductive health care at clinics or get connected with a doctor. Another participant discussed the need to deprioritize reproductive health in the context of homelessness. She shared that *"there's a lot going on, day to day, trying to get through each day"* (P02), which impacts her ability to engage in desired reproductive health care behaviors.

### ***Navigating Systems and Jumping Through Hoops***

Participants described difficulties navigating various systems in order to have their reproductive healthcare needs met. Two participants shared that they needed to find a new primary care doctor, which impacted their ability to access reproductive health care. Participants also discussed sudden changes in medical coverage and being denied medical benefits, both of which impacted their service utilization. One participant described a three-year gap in coverage due to issues with the state health insurance program:

> *Now you know what the medical do to women out here, they'll let us on for awhile, then*
>
> *cut us off and then it takes three years to reapply cause they deny ya two different times. (whispered) Yeah, it was great* (P06).

This participant also shared the story of a friend who was denied benefits during the first trimester of her pregnancy. As a result, this individual was only able to get three check-ups during her entire pregnancy.

The process of accessing desired care was described as a series of jumping through hoops. As one participant explained, *"You have to jump through so many hoops to get services that a lot of us don't even want to jump through the hoops because they're so stupid and ridiculous"* (P04). At its most extreme, a participant described being unable to find a gynecologist to provide follow up care after she was sexually assaulted. Upon being discharged from the hospital, she was instructed to follow up with her gynecologist. She told the provider that she did not have one, and they gave her a list of people to call. The difficulties she faced when trying to navigate the system resulted in her returning to the hospital for care.

> *And I go to make that appointment, and that's why I ended up just going to the hospital. Because I was like, well, I need to see them again. And I tried to explain to them. And at the hospital they were like, why didn't you just make an appointment? And I told them they told me I had to do this first, and like they want you to go online and do something. And I don't even have a phone (laughs)* (P17).

While this patient was eventually able to receive care, others shared that jumping through hoops did not always result in having care needs met. Participants who experienced difficulty navigating systems in order to receive care described the process as *"more stress than it's worth"* (P04). Difficulties accessing desired services contributed to hospital overutilization. Hospitals were described as the place to go when accessible reproductive healthcare was needed.

### *Financial Barriers*

Five participants discussed financial barriers that impacted their ability to engage desired reproductive healthcare. Participants described being unable to afford birth control or regular trips to the doctor. An example of this can be seen in the following quote: *"HB: And what are some of the reasons that you are currently not using birth control? P13: I just don't have the money for it"* (P13). This participant shared that they used to use condoms, but they became too expensive to continue using. One participant described the unaffordability of healthcare more broadly, stating, *"All your money goes toward your bills and you don't have a way to get medication, you don't have a way to pay our hospital bills*" (P04).

### ***Patriarchy***

Two participants described how contraceptive needs and accessibility are informed by living in a patriarchal society. For instance, one participant described the need for *"birth control for every woman in America"* (P06) as required to safeguard against the sexual assault perpetrated by men towards unhoused women. Another participant described a need to *"study the female body more"*, because *"the more options that are available, the better off it will be for females"* (P07). This participant felt that men were prioritized in contraceptive options and expressed a desire to see female condoms as readily available as male condoms.

### ***Hygiene***

One participant disclosed that hygiene impacts her desire to engage in services. This participant shared that she was wearing the only clean clothes that she had and reported a lack of spaces to do laundry. Inability to engage in hygiene practices, such as showering or brushing her teeth led this participant to avoid others. She shared the following about her experience: *"It actually kind of makes me not really want to be around people because I feel like I stink all the time because I can't take a shower"* (P04).

## Meaning Assigned to Contraceptive Practices

After discussing reproductive health practices more generally, participants were asked what access to birth control meant to them. They were also asked what meaning they assign to their contraceptive behaviors (either use or non-use of contraception). Responses indicated that access and use of contraception hold similar, yet distinct meaning to participants. Participants discussed pregnancy prevention when discussing both access and use.

### *Access*

Birth control access was described as having the ability to prevent pregnancy (n= 8), lifesaving (n= 2), and having methods be accessible (n =4). One participant described the ability to access birth control as "*independence*" (P02).

**Preventing Pregnancy**. Eight participants described access to birth control as a means to prevent pregnancy. One participant referred to this as *"not bringing innocent lives in a world of nothing but drugs and violence"* (P04). Others shared similar statements, sharing that birth control access means *"no babies out here on the streets"* (P13). One participant discussed the importance of preventative rather than tertiary contraceptive methods, sharing that access means she wouldn't have to consider abortion, which she'd never had, but thought could be *"detrimental, to like a person's sanity"*

(P17). Notably, she was not currently engaged in contraceptive behaviors due to a lack of accessibility.

**Life Saving**. Birth control access was described as *"lifesaving"* by two participants. One participant shared that accessible birth control allowed her to better provide for herself.

> *I can't afford to keep a kid in an RV. I can't afford to keep my RV as is. Let alone afford another mouth to feed. I can barely feed my own. Birth control means that, it's just one less lost child* (P07).

Another participant who spoke about birth control as lifesaving described it as *"life or death"* (P17), while others shared that accessible birth control is a *"huge stress reducer"* (P11).

**Access to Birth Control Means It Should be Accessible**. Four participants shared that access to birth control should mean that it is easily accessible. One participant described desiring to *"[be] able to go somewhere, to a doctor's office, even if you don't have an appointment to just be able to um, get over the counter something"* (P15). Participants also spoke of the importance of being able to have one's contraceptive choices enabled. One participant who reported not using contraception expressed, *"It's nice to have, but then again, I really, I really never liked using it"* (P12).

### ***Use***

Participants were asked what meaning, if any, they assigned to their contraceptive behaviors (both use and non-use of birth control). Responses (n=8) included the ability to prevent pregnancy (n= 5), feelings of responsibility and independence (n= 2), and avoidance of sex when not using (n= 1).

Five participants attributed their ability to prevent pregnancy as a result of contraceptive use behaviors and described the use of birth control as taking advantage of available resources to prevent pregnancy. Birth control was also discussed as a tool to delay pregnancy until additional stability was achieved. Another participant described her use of birth control to prevent pregnancy as *"a big priority"* (P06). One participant who reported using the withdrawal method shared that non-use of birth control meant *"not doing a damn thing"* (P15) and not being concerned with pregnancy risk. Abortion was discussed as *"an after (pause) procedure to deal with a lack of birth control"* (P03).

When asked what meaning, if any, was assigned to their current contraceptive behaviors, one participant shared that her use of birth control made her feel responsible because she was able to avoid unwanted pregnancies. Another expressed that it contributed to *"more freedom, ease of, peace of mind"* (P11).

Participants also expressed that not using birth control meant that you should avoid sex and vice versa. One participant said that her non-use of birth control meant *"no sex"* (P13). Another explained that birth control was not something that she needed to use because she was not engaging in intercourse, so she didn't really assign any meaning to it. She shared that *"it would be different if [she] were having sex and wasn't using birth control"* (P02) but shared that it just wasn't something she needed.

## Linkages Between Reproductive Behaviors and Empowerment

Reproductive behaviors and choices regarding pregnancy decisions and birth control decisions contributed to feelings of agency and control among participants. They also allowed participants to feel a sense of ownership over their feelings of safety and sexual gratification. For some participants, these feelings spilled over to other areas of their lives. While feelings of empowerment were experienced with reproductive behaviors, participants also articulated other sources of empowerment in their lives. They also shared depowering experiences including birth control failure and side effects, coerced birth control decisions, and reproductive trauma.

### ***Agency***

Agency occurs when an individual feels they are able to take control in situations when limited control is possible. Participants who demonstrated agency expressed feelings of control over their actions and told stories about times they took actions in which minimal control was possible. Three participants shared examples of exercising agency in order to maintain control over their reproductive lives. For example, a participant expressed expertise in navigating busy healthcare systems to acquire a different type of birth control than they were currently using and expressed an ability to obtain an appointment if they wanted to, despite it potentially being *"hard"* to obtain an appointment.

Another participant described using celibacy as her primary form of birth control after having other methods disagree with her body. Using celibacy allowed this participant to avoid the *"ups and downs"* (P14) she had experienced when trying prescribed birth control methods and avoid undesired pregnancy.

Agency was also demonstrated by a participant who found herself pregnant with her abuser's baby after her birth control method failed:

> *I lied to my ex-partner because he was abusive, and I didn't want him in mine or the baby's life. So like three weeks after I found out I was pregnant with [child's name], I decided to message him and tell him I had aborted the baby, and that he didn't need to worry about me anymore, and there was never any reason to contact me again. I was called quite a few names. I was called a baby killer, a bitch, a whore, a prostitute, a bicycle, a doorknob. But oh well, it was worth it because now she has a, now she's gonna live a good life without the abuse of her fucking sperm donor around, and he doesn't even know about it* (P06).

Faced with a situation in which her housing status and relationship impacted her day-to-day life, this participant took a series of risks in order to achieve the outcome that she desired.

Participants who expressed agency successfully navigated a variety of hardships in efficacious ways. While this is to be applauded, it is also important to acknowledge that stories showcasing individuals acting with agency during circumstances in which a variety of factors make it difficult to do so could potentially be weaponized and contribute to further blame on unhoused individuals for experiencing difficulty navigating situations beyond their control.

### ***Control of Body***

Eleven participants described the relationship between their contraceptive behaviors and feelings of control over their bodies. This was discussed in a few different ways, including using over the counter and prescribed contraceptive methods to avoid pregnancy while sexually active; using the withdrawal method; and maintaining control over one's body and pregnancy risk by abstaining from sex.

Participants discussed the importance of using prescribed contraception to control whether or not they became pregnant, which in turn allowed them to have worry-free sex. This was described by one participant as *"taking control of my body and my sexuality with birth control"* (P03). Conversely, a participant who stated they were not currently using contraception shared that their birth control behaviors did not contribute to any sense of power because they were unable to control whether or not they became pregnant if they were to engage in intercourse.

One participant who reported using the withdrawal method shared that she felt very much in control of the situation because it was ultimately up to her whether or not she was going to have sex. Others discussed control over their bodies regarding decisions to abstain from sex as a form of birth control. When asked whether and how birth control decisions contribute to feelings of power, a participant shared the following:

> *Oh yes, heck yeah. Cause I can, me being celibate, and stuff, cause I don't let anybody just enter my temple. HB: Yeah. P14: You know? You gotta be the right one or, you know, you have to honor, to be somebody special for you to do that, you know. And that makes me powerful over my own body* (P14).

Abstinence also allowed participants to avoid the risk of pregnancy without needing medical intervention. Participants discussed the importance of being able to control their fertility without having their reproductive system "*cut up*" (P10) or needing to put objects in their bodies.

> *Just being able to control if I have my child or not. You know, without having to go in and have to get tubes tied, and you know all that other surgical stuff. Like, I don't want to go and get cut open just to have, you know my reproductive system cut up* (P10).

Participants who discussed the importance of maintaining a sense of control over their bodies through their contraceptive behaviors utilized a variety of strategies to exercise control over their fertility. Participants felt very in control regardless of their chosen method. This highlights the importance of supporting contraceptive decisions in order to promote feelings of bodily autonomy.

**Control of Birth Control.** In addition to feeling control over their bodies, four participants also discussed feelings of control over the contraceptive method they were using. Examples of this included purchasing and supplying condoms during intercourse and describing their ability to have longer-term options (e.g., IUD) removed if they were to decide they no longer wanted to use it. This can be seen in the following quote: *"I know that I can get it out at any point in time as long as I go to the clinic to make that appointment, so that's easy, so that makes me feel very in control"* (P04). This participant also shared that if she were to have her birth control removed, the time needed for her hormones to *“go back to the normal way”* would be within a year, which also contributed to feeling in control.

### ***Protection***

Two participants described the importance of contraception as a form of protection. Condoms protect individuals from unwanted pregnancy and sexually transmitted diseases, which in turn fosters feelings of power, agency, and control. A participant who reported engaging in sex work shared the following about her experience:

> *Knowing um, I keep my germs and my stuff with me, and they keep theirs with them (laughs). HB: Yeah. P18: And it’s gonna be the same thing tomorrow as far as no, nothing new you know? As far as scaring, pregnancy, or disease. So yeah, the condoms do make me feel a little bit of empowerment. A lot* (P18).

Another participant likened the protection provided by contraception to pepper spray and compared carrying condoms to carrying a knife or gun. Having condoms readily available helped them feel a sense of safety while navigating life on the streets.

Notably, the participant who likened carrying condoms to carrying a weapon reported receiving unwanted attention from sex traffickers while trying to engage in employment opportunities. They reported feeling less control during these events, which was further reduced when they did not have access to their preferred contraceptive method. They shared the following about their experience: *“But when I started being able to carry female condoms, I was a lot more safe, I felt, because I’d always have one in case someone wanted to take me off the street”* (P07).

Analogies formed by this participant between condoms and other types of protection indicate the role of contraception in supporting feelings of control over one's safety during episodes of homelessness. Regardless of whether they would actually be able to use condoms in the event of an attack, having them on hand made this participant feel more capable of protecting themselves.

### ***Sexual Gratification***

One participant discussed how their preferred method of contraception allows them to freely engage in sex for pleasure. Access to their preferred method would allow them to attend a BDSM club *"without any worry of am I going to get pregnant having fun today."* This participant often found themselves without access to their preferred method and shared that *"it's gotten to the point that I've been thinking about going out and saying, 'Fuck it. If I get pregnant, I get pregnant'"* (P07).

This narrative highlights the role of contraception in promoting sexual gratification. Notably, this was expressed by a participant who identified as non-binary. Findings from previous studies suggest that sexual gratification can be particularly beneficial for individuals who are transgender or non-binary because it can contribute to feeling affirmed in one's gender identity (Lindley et al., 2020).

### ***Reproductive Choices***

Six participants discussed the importance of autonomy over reproductive choices. This was discussed in relation to pregnancy and decisions surrounding their use of prescribed and over the counter contraceptive methods. These choices contributed to feelings of power and control.

**Rights to Choose**. Two participants highlighted the importance of continued autonomy over their right to choose whether or not they wanted to become or continue a pregnancy. This choice was described by one participant as *"my right- as a woman to choose. Whether I have a baby or not"* (P16).

**Not Using Contraception is an Active Choice**. Three participants articulated that not using contraception can be an active choice. While some participants who were not using contraception cited access barriers that prevented use, others were clear that their nonuse of prescribed and over the counter contraceptive methods was an intentional choice that they had actively made for themselves. Participants not using birth control appreciated that it was available if they *"decided to choose to do that again"* (P02).

### ***Lack of Accessible Methods Results in a Forced Choice***

Two participants highlighted the role that accessibility plays on one's ability to make a choice. Accessible contraception allows participants to make a choice to use it, while a lack of accessible contraception results in a forced choice. For instance, one participant shared that unhoused women *"need to be able to have those choices and we don't have that. It's one of the big things out here that's gonna help women"* (P06). Another participant shared, *"When you're homeless, it's not as accessible to have that choice. It's more like forced on you that you don't get the choice that often"* (P17).

### ***Spillover to Other Areas of Life.***

Six participants connected their reproductive behaviors to other areas of their life. Contraceptive behaviors impacted employment, contributed to feeling responsible, and created room in their lives for other concerns. One participant shared that remaining celibate keeps her *"focused"* on her goals, which included "*getting off the streets*" and reuniting with her existing children (P14). Another described having *"more freedom"* and *"one less thing to constantly worry about"* as a result of her long-acting method (P11). She credited her birth control for creating *"mental space to worry about other things, like trying to find a job, or whatever you have to do to be able to do that. HB: Mhm. P11: and like, more stable food situations, stuff like that"* (P11). Another individual engaged in sex work shared that she felt like less of a *"dirtbag"* as a result of her contraceptive engagement, which contributed to a *"little sense of ownership"* when she was able to see her kids.

Others did not draw connections between feelings derived from their reproductive behaviors and other areas of their life. One participant shared that *"it's not the birth control itself, it's me recognizing, as a woman in a society full of arrogant egotistical men- HB: Yeah. P04: That us women need to stand up for ourselves and each other"* (P04).

### ***Other Sources of Power***

Other behaviors contributing to feelings of empowerment included being able to take care of oneself and others in their lives (n= 6), being respected (n=2), having a support network (n= 2), and maintaining a sense of self (n=1). Six participants also shared that they were not sure what made them feel powerful or expressed that nothing in their life contributed to feelings of empowerment. For example, one participant shared that they "*are still working on that one*" (P07) after having recently left an abusive relationship. Others responded that they were “*not really sure how to answer that*” (P11), or “*right now, nothing really*” (P10).

## Depowering Experiences

Depowering experiences consisted of experiences where the individual experienced a lack of control related to their birth control practices. Depowering experiences were discussed by 13 participants and included events where their birth control methods failed, were rejected by the body, or caused adverse effects; when birth control decisions were made by others; and reproductive trauma.

### *When Birth Control Methods Fail, are Rejected by the Body, or Cause Adverse Side Effects*

Eight participants discussed depowering experiences that occurred as a result of the contraceptive method they were using. These events included when birth control methods failed, were rejected by the body, or caused adverse effects. These experiences dissuaded participants from continued use of the method they were using prior. For example, one participant described feeling as though she no longer was in control after her IUD slipped during intercourse, resulting in an unwanted pregnancy. Another shared that she got pregnant while using three different types of prescribed contraception on four separate occasions.

Participants also described disagreement between their bodies and the prescribed contraceptive method they were attempting to use. This presented as methods being rejected by the body or undesirable side effects, which prompted them to discontinue use of their prescribed method. For example, one participant shared that her body rejected the first IUD that she tried. She described this experience as "*kind of chaotic*" and stated that "*it didn't make [her] feel in control"* (HB03). Another participant who was not using contraception at the time of interview described trying several different methods and being unable to find one that worked for her:

> *"Um, I don't respond well to certain birth controls, like Implanon doesn't work for me.. HB: Mhm. P01: It starts growing out of my arm. And then the Mirena, um, it swells my uterus up. HB: Oh gosh. P01: So I'm just, not- a lot of things that affect the hormones in my body don't really (pause) um, they don't really work for me"* (P01).

Inability to find an agreeable method left this participant with fewer options to choose from. Notably, the methods named by this participant are methods commonly recommended to individuals experiencing homelessness due to their efficacy, suitability for long term use, and low level of maintenance (Health Care for the Homeless Clinicians' Network, 2008).

Other side effects discussed by participants included prolonged infertility, feeling out of control of one's body due to hormone shifts, and pain. Participants felt a lack of control when their birth control methods failed to prevent pregnancy, were rejected by their bodies, and caused adverse side effects, which in turn impacted their future utilization of contraception. For some participants, this meant finding a new method. Others stopped using birth control altogether.

### ***When Others Make Birth Control Choices for You***

Four participants discussed circumstances in which their birth control decisions were coerced or influenced by others. Three out of four participants experienced this as depowering. This included events where participants experienced "*some instances when [they] didn't feel like it was all up to [them]"* (P02), partners poking holes in condoms, and being coerced into getting on birth control by their parents. One parent recalled that her father put her on birth control the day after she started her period at eleven years old, despite not being sexually active yet:

> *Honestly, I was on the Depo Vera when I was- from ages of 11 to 21. I was on the Depo Provera for years because my dad thought I was sexually active once I started my period. HB: Mmhm [affirmative]. P04: And I didn't actually lose my virginity until I was like 17* (P04).

On the flipside, another participant described early birth control decisions influenced by her mother in a positive way. She described her mother as *"smart"* and having *"good communication"* (P16) for engaging in conversations about contraception after others around her became pregnant at 15.

### ***Reproductive Trauma***

Nine participants voluntarily disclosed traumatic reproductive events unprompted by the researcher when discussing their prior experiences and unmet reproductive healthcare needs. Events presented as reproductive trauma were described by the participant as traumatic or challenging, or elicited an emotional response (e.g., nervous laughter, tears) when shared. While participants themselves did not state that they found these events depowering, they are presented as such because each incident involved a loss of control. Traumatic reproductive events included stillbirths, ectopic pregnancies, and miscarriages; abortion; infant mortality; and sexual assault.

**Stillbirths, Ectopic Pregnancies, and Miscarriages.** Participants discussed stillbirths (n=1), ectopic pregnancies (n=1), and miscarriages (n=6) as emotionally painful and traumatic experiences. For the most part, participants did not draw connections between the context of homelessness and their inability to carry a pregnancy to term. However, two participants shared that they miscarried after being beat up while living outside. One participant provided no additional details beyond sharing that it occurred when she was seven months pregnant, while the other reported that she was physically assaulted by her partner after being put on bedrest, which impacted her ability to work and contribute financially to their partnership.

Another participant recounted the challenges of recovering both physically and mentally while living outside after miscarrying in the beginning of her second trimester. She left the hospital with bed rest orders six hours after she began bleeding and experiencing pain while on public transit and returned to her tent. Early in her recovery, she *"couldn't stand, could barely roll over, and had to have people help* [her] *walk"* (P04). She recounted being so pale that friends asked why she was outside. In addition to navigating physical recovery, the participant also had to navigate the emotional grief of losing a wanted child. She shared the following:

> *After I lost my baby, I went into a deep depression. I seriously just wanted to lock myself away from the world because I didn't, I didn't feel like I was part of the world. I felt like I had lost a part of my soul when I lost my daughter* (P04).

Others found themselves short for words to describe the emotional impact of their experiences. For example, another participant disclosed that she had miscarried a couple of times but did not volunteer more information beyond stating that they were *"all bad"* (P12). Other participants who disclosed miscarriages engaged in strategies to reduce the emotional intensity of the moment (e.g., laughter, utterances to indicate the end of a desire to share such as *"but yeah. It's okay"* [P17]). While participants readily volunteered information about the losses they had endured, their responses and mannerisms were reflective of a need for continued healing surrounding these experiences.

**Abortion.** Three participants discussed the mental toll that having an abortion put on them or their friends. Participants who spoke about abortion in this way articulated a need for follow-up care services in the aftermath, as well as increased preventative options. The abortion procedure itself was described as *"real cold"* (P15). Interactions with providers during abortions were described similarly; participants shared that providers *"do the process and get it over with"* (P14). Participants discussing abortion experiences shared a need for increased emotional support and understanding from providers.

One participant shared the need for supportive services in the aftermath of an abortion, stating, *"You go through different steps, and you feel different things afterwards. And I think that they should follow up to make sure people don't have those situations, cause you know, it can save a lot of suicidal, you know, people suicidal and* *stuff like that"* (P14). She described navigating her feelings alone because she did not want to tell others about her abortion, and shared that it still impacted her.

Another participant expressed a need for increased prevention efforts to reduce the need for abortion services. One of her friends had been pregnant five times in the past year alone, resulting in four abortion procedures, which were described as *"a lot to handle in a year"* (P17). Inability to access birth control was reported as a topic discussed frequently among her friend group and viewed as something that would reduce the need to utilize abortion services if alleviated. Notably, others interviewed in nearby locations did not describe the same barriers to access relayed by this participant; however, she was younger relative to others interviewed.

**Infant Mortality.** One participant attributed the recent loss of her newborn to inadequate medical attention she had received while pregnant, which she attributed to her status as an unhoused individual. During pregnancy, she sought care for sores in her vaginal area, which were misdiagnosed. Below is her description of her experience accessing care at the hospital:

> *They didn't even hardly barely touch me at all. Didn't run no tests, nothing. Told me I had—I don't remember what they said I had, but they gave me some medicine, said, "Take it for a week. You'll be fine"* (P12).

Three and a half months later, her child died of syphilis at sixteen days old. The participant felt strongly that her daughter would still be here if she had received an accurate diagnosis when she sought healthcare during pregnancy. On top of grieving the death of her wanted child, the participant shared that this event has resulted in a reluctance to utilize healthcare services in the future unless she is *"absolutely dying"*. This narrative highlights a worst-case scenario in which reproductive trauma experienced while unhoused has lasting impacts on future engagement in care.

**Sexual Assault.** Three participants disclosed experiences of sexual assault while unhoused. Younger participants described rape as a common occurrence — *"something that happens like, every other week"* (P17). Participants expressed that the lack of control experienced during rape was compounded by an inability to maintain control over one's fertility in these instances. They shared the following about their experience: *"I got raped in an alleyway. I asked him, 'Please, I don't care if you use my body. Just please let me put my condom on.' HB: Mhm. P07: He wouldn't"* (P07).

Another participant spoke about the lack of control over her ability to prevent sexually transmitted diseases during assault. Specifically, she shared that she only recently began going to the hospital following an assault after learning that a friend contracted AIDs from her attacker. She shared the following: *"It never even occurred to me like, that could be the worst, you know? You think the worst thing that happened is what just happened (nervous laughter)"* (P17).

All three participants who discussed sexual assault described the importance of birth control during these interactions. Birth control reduces the likelihood of pregnancy, which allows the individual to maintain a semblance of control during forced sexual interactions. An example of this can be seen in a participant's response when asked about a time her current form of contraception made her feel in control; she responded with an anecdote about her IUD protecting her from becoming pregnant when her ex-partner raped her: *"He was drunk one night and forceful, forcefully - basically raped me — forcefully had sex with me. I am so thankful that night that the birth control was in place and in control"* (P06).

On the other hand, participants who were not using contraception while attacked expressed it as something that would have made the situation less stressful:

> *If I was on birth control, let's say, and I was already getting the pill or the IUD or something and then I did get raped, cause you get raped a lot being homeless… Um, I wouldn't have to had the added worry of, okay well now I'm, not only did this happen, but now I'm not on the pill, so now I have to wait and take a test"*

(P17).

Participants who disclosed sexual assault described a lack of control experienced both during and after being assaulted. Contraception was identified as a way of maintaining some control in an otherwise horribly disempowering situation.

## Discussion

This study sought to expand our current understanding of the reproductive experiences and needs of unhoused individuals through semi-structured interviews with individuals residing in encampments and other unsheltered locations. These perspectives have been historically underrepresented in research examining the contraceptive experiences of unhoused individuals and offer a novel contribution to the literature. Additionally, the present findings demonstrate the importance of including individuals experiencing unsheltered houselessness in research efforts seeking to improve reproductive health equity for individuals without housing. The following section provides recommendations for future research and applied implications for service delivery and policy based on the current study's findings.

## Summary of Findings and Recommendations for Research and Practice

### *Unmet Service Needs*

While some participants reported having all of their reproductive needs met, a large proportion of participants reported unmet reproductive health needs, including patient-centered care, therapy to support healing from reproductive trauma, and additional reproductive health education and outreach. While additional research is needed, the present findings suggest considerable overlap in physical reproductive health service needs among individuals experiencing unsheltered houselessness and individuals experiencing houselessness within shelter settings. For example, in the present study participants reported financial barriers to obtaining desired contraceptive methods, which has previously been identified as a barrier among sheltered samples (Gelberg et al., 2002). However, also present within this study's findings were unmet service needs that may be unique to individuals experiencing houselessness in unsheltered locations, which will be explained below.

A large proportion of participants who had unmet reproductive healthcare needs reported a lack of patient-centered care. The individualized treatment that participants yearned for included personalized recommendations based on their past experiences, as well as family planning goals rather than being pressured to try the latest, newest method available. One participant experienced being "lumped into categories" (i.e., categorized as a "homeless person") as negative judgement from providers, which has previously been identified as a barrier to engagement in reproductive care services among unhoused women (Begun et al., 2019; Bloom et al., 2004). When providing reproductive healthcare services to unsheltered individuals, taking a person-centered approach could be leveraged to build better rapport with individuals seeking care. Person-centered approaches center the lived experience of the individual seeking care and approach reproductive health from a justice lens rather than a risk prevention lens (Julian et al., 2020). In practice, person-centered approaches require support across multiple ecological levels of analysis and require that we dismantle current oppressive systems that impact accessibility of care (Holt et al., 2020). This relies on funding to expand provider training to incorporate structural racism, stigma, and class biases and policies that expand access to contraceptive care (Holt et al., 2020).

Participants expressed a need for therapeutic services to help them process traumatic reproductive health events. This is noteworthy for two reasons. First, this study is one of the first to identify mental health services as a reproductive healthcare need for unhoused individuals capable of pregnancy. Additional research is necessary to determine whether this need is specific to unsheltered populations, who tend to be less connected to services relative to their peers residing in shelters (Nyamathi et al., 2000). Second, this finding highlights a practical implication for reproductive healthcare centers and organizations doing health outreach with individuals experiencing homelessness in unsheltered contexts. There is ample research highlighting the benefit of engaging in therapeutic services in the aftermath of traumatic experiences (Lewis et al., 2020). These benefits could be of particular importance for individuals who are living outdoors who are likely facing additional stressors.

Friendship benches—which have recently emerged as a solution to bridge gaps in mental health service delivery in lower income countries—may be a beneficial approach within unsheltered contexts (Chibanda, 2016). The Friendship Bench approach involves providing basic mental health and counseling training to individuals already embedded within a community, who then conduct targeted outreach and provide support to individuals in need. In the context of unsheltered homelessness, this could involve providing basic mental health and trauma counseling skills, and funding individuals with lived experience to provide peer support.

Another possible approach could involve dispatching trained mental health outreach workers to encampment areas on an ongoing basis to support individuals in processing traumatic experiences. Recent research tested clinical ethnographic narrative interventions (CENI-TF) as a potential tool to support healing from trauma among mothers in shelter settings and found that the process of developing a narrative supported mothers in making sense of their traumatic experiences (Gultekin et al., 2023). This approach could potentially be adapted to unsheltered contexts, during which trained outreach workers guide participants through prompted questions that support the construction of one's narrative and allow for deeper reflection. While additional research is needed to test the feasibility of such an approach, participant's willingness to disclose traumatic events without prompting in the course of the present study suggest that such an intervention may be viable in outdoor settings.

Two participants described experiences navigating pregnancy while unhoused. Being unhoused and pregnant was described as physically taxing and particularly stressful. Previous research has identified maternal stress during pregnancy as detrimental to development in-utero (Huizink et al., 2003). Additional research is necessary to identify potential support services for individuals who are pregnant during episodes of unsheltered homelessness to better promote both maternal and infant health outcomes. One potential solution includes mindfulness-based interventions (e.g., yoga, meditation, breathing exercises) which have been shown to significantly reduce stress and pregnancy anxiety among low-income women during pregnancy (Abatemarco et al., 2021). Additionally, unhoused mothers within shelter contexts reported increased emotional capacity to deal with life stressors and new tools to regulate their emotions after completing a mindfulness intervention (Alhusen et al., 2017).

### *Barriers to Desired Services*

A high degree of overlap exists between barriers identified in the present study and previous findings with unhoused individuals connected to shelter services (Brott & Townley, 2022). This was somewhat surprising in light of findings that individuals in shelter settings were more likely to use contraception relative to those staying in unsheltered settings (Gelberg et al., 2002; Gelberg et al., 2007). Nonetheless, barriers identified in the present study suggest there may be subtle differences in how barriers are experienced depending on shelter status.

**Location Accessibility**. Previous research tends to discuss location accessibility barriers as the distance between shelter spaces and spaces to access reproductive care, which is often framed as a transportation issue (Gelberg et al., 2004). In the present study, participants attributed inaccessibility to the concentration of services in the downtown area, which was particularly challenging for a participant who experienced adverse mental health symptomology whenever she left the neighborhood she grew up in for too long. Moreover, participants in the present study articulated a need for targeted outreach and services provided in their immediate context (i.e., encampment, neighborhood, etc.), while transportation issues were discussed minimally. Additional research could tease apart factors contributing to desires for "home" healthcare among individuals staying in encampments and other unsheltered locations. In practice, organizations engaged in health outreach with unsheltered populations could integrate additional reproductive health services during outings.

**Time**. While time has previously been identified as a barrier to reproductive care, findings elsewhere have, for the most part, not documented difficulties keeping track of the calendar world as a time-related barrier to care (Gelberg et al., 2004; Kennedy et al., 2014). Incidentally, limited research previously identified shifts in perceptions of time during episodes of homelessness (Van Doorn, 2010). While focusing on the present supports the fulfillment of survival related tasks (e.g., food, spaces to rest), lack of time organization and scheduled activities can also contribute to a breakdown in perceptions of time. This in turn may explain the lack of rootedness in the calendar world expressed by some participants that impacted their ability to schedule future appointments. This has implications for both service delivery and future research. First, reproductive healthcare centers serving unhoused community members could implement drop- in appointments in order to reduce the time barriers experienced by this group. Organizations such as Planned Parenthood currently offer this option via telehealth; however, this option is inaccessible to individuals without access to a telephone, suggesting a need for alternative modalities. Second, the breakdown of time described both in the present study and previous research suggest a potential need to foster the reintegration of timekeeping to support individuals transitioning out of unsheltered houselessness. However, additional research is needed to determine the appropriateness and effectiveness of such an approach.

**Difficulties Navigating Systems**. Similar to previous research with sheltered samples, participants in the present study experienced difficulties navigating various systems in order to have their reproductive healthcare needs met. In some instances, this contributed to using the hospital for services that could have been received elsewhere. Accessing reproductive healthcare— condoms in particular—was also made more difficult due to financial barriers, suggesting a need for continued public health efforts to disseminate condoms and other resources during outreach with individuals experiencing unsheltered homelessness. Participants also framed their experiences as embedded within the context of a patriarchal society, which they viewed as negatively impacting the availability of female condoms and the expenses associated with managing one’s fertility. Combined, these findings suggest a need for more streamlined healthcare services for individuals who are experiencing housing insecurity. Experts suggest that a streamlined approach would consider the individuals needs before (e.g., reproductive health education, outreach), during (e.g., free services, non-biased care), and after (e.g., accessible support) reproductive healthcare appointments (Holt et al., 2020). Given that healthcare systems are nested within larger society, this approach requires increased funding and policies expanding reproductive healthcare access (Holt et al., 2020).

**Hygiene.** One participant discussed hygiene as a barrier to engaging in reproductive services. Lack of clean laundry and inability to shower were described as factors that impacted her desire to engage with others and attend support groups for parents who have lost children. The present findings add to the body of literature representing the importance of spaces to engage in hygiene behaviors during episodes of homelessness. This is of particular importance for individuals experiencing homelessness in unsheltered locations who tend to have less access to spaces to engage in hygiene behaviors (Sommer et al., 2020). When spaces to engage in hygiene practices (e.g., showering, laundry) are available, safety concerns, time-related barriers (e.g., wait times, operating hours), and facility-related factors (e.g., water temperature, cleanliness, toiletries) can impact whether they are accessible and used (Buechler et al., 2020). This points to a need to develop research partnerships with service centers that provide hygiene-related services to unsheltered populations to evaluate the extent to which the services offered meet the needs of their target consumers.

### *Meaning Assigned to Access and Use*

Findings also suggest that participants ascribe different meanings to contraceptive access and use. Both access and use were associated with the ability to prevent pregnancy. However, when discussing access, participants spoke about the need for increased accessibility, which was described by some as lifesaving. When discussing meaning derived from use/non-use of birth control, participants relayed the importance of engaging in behaviors aligned with their reproductive goals. These behaviors included using contraception when sexually active to avoid undesired pregnancy and avoiding intercourse when not using contraception. This is noteworthy, as the two terms (i.e., access and use) have historically been used interchangeably in studies examining the contraceptive practices of individuals experiencing homelessness (Brott & Townley, 2022). As a result, previous research has at times failed to fully distinguish whether contraceptive behaviors were related to personal preferences or accessibility barriers (Dasari et al., 2015; Gelberg et al., 2002). This is of particular importance when considering participants who reported contraceptive non-use in the present study who reported avoiding sex to avoid pregnancy.  In the absence of accessible contraception, choosing to abstain from intercourse is one way in which participants were able to exercise control over their fertility, despite not labeling these practices as contraception. Differences in meaning assigned to contraceptive practices depending on the term used (i.e., access versus use) highlights the importance of differentiating the two terms in future research with this population. In quantitative and survey research, this could involve including questioning involving both accessibility of services and level of desire to engage in such services. In qualitative research, this could involve utilizing both terms and using follow up probes to allow participants to share both accessibility factors and factors impacting reproductive utilization behaviors.

### ***Linkages to Empowerment***

This study is one of the first to examine how contraceptive behaviors and reproductive experiences both contribute to and detract from empowerment. This is an important contribution to the literature connecting empowerment with reproductive health, which has historically excluded the perspectives of individuals experiencing houselessness.

The present study also offers a departure from existing literature examining the contraceptive experiences of unhoused individuals, which has primarily examined contraceptive behaviors and reproductive care experiences through a medical model lens. In the current study, participants expressed a variety of ways that their contraceptive behaviors contributed to feelings of agency, control, and choice. Of particular interest given the current political landscape of reproductive health rights are themes surrounding the importance of maintaining feelings of choice and control over reproductive health behaviors, such as pregnancy. Feelings of control and choice discussed by participants are particularly important in the context of unsheltered homelessness, which is often described as a disempowering experience (Farrugia et al., 2010). It is also noteworthy that participants sampled in one of the few states with expanded protections for reproductive rights discussed the importance of being able to choose whether or not they carry a pregnancy to term. Unsheltered individuals capable of pregnancy in contexts with more restrictive reproductive health policies in place may be experiencing less control over their reproductive lives, contributing to an even greater loss of autonomy experienced while unhoused. Future research examining how restrictive reproductive health policies are impacting their sense of empowerment is needed.

The present findings also demonstrate the role of accessible reproductive healthcare in supporting feelings of safety and bodily autonomy during episodes of unsheltered homelessness. These feelings are all the more important when considering the frequency of sexual assault described by participants in the current study. Participants described condoms as a form of protection that made them feel safer and described the importance of contraception during experiences of sexual assault. On the flipside, participants who were unable to access desired contraception described feeling a lack of control during these experiences. Participants also expressed that contraceptive inaccessibility contributes to a forced choice to not use birth control. Together, these narratives underscore the importance of increasing access to contraception during episodes of unsheltered homelessness.

Participants also shared a multitude of traumatic reproductive health experiences occurring in the midst of houselessness, which has been identified as a traumatic experience in and of itself (Goodman et al., 1991). The high degree of trauma disclosed indicates a need for trauma-informed reproductive health services for unhoused individuals. Trauma-informed health care begins with expressing an openness to learn about someone’s traumatic experience during intake and involves patient-centered interactions with providers in which individuals feel in control of their health (Reeves, 2015).

Unhoused women’s abortion experiences have historically been underreported in the literature. In the present study, participants expressed a desire for additional support in the aftermath of abortion procedures, which participants described as emotionally difficult and isolating events. Elsewhere, research with unhoused youth found that abortion experiences were navigated alone (i.e., without the support of a romantic partner; Begun et al., 2018). Research with housed individuals who received abortions found that while negative mental health outcomes in the aftermath were less common, individuals with poorer mental health ahead of their abortion procedure were more likely to report negative mental health outcomes afterwards (Major et al., 2000). It is possible that individuals experiencing unsheltered homelessness are uniquely predisposed to having a more difficult time in the aftermath of an abortion due to external factors contributing to poorer mental health while outside combined with a lack of social support to help navigate emotions afterward. Future research is needed to determine whether this is the case. In the present study, participants expressed a desire for service providers to support their emotional healing process postabortion.

## Limitations

While obtaining the perspective of individuals underrepresented in literature examining the experiences of unhoused individuals was a key strength of the present study, it is possible that the context in which participation occurred influenced recruitment and participation. Interview length ranged from 8-34 minutes. While short interviews contained rich information, it’s possible that interview lengths were impacted by the settings in which they occurred. Interviews occurred outside in the middle of winter. It is possible that weather conditions and the outdoor context influenced participation. For example, participants might have had more to say if we were sitting indoors versus standing outside in 40-degree weather. This is particularly relevant when considering participants who reported physical disabilities and chronic health conditions. For instance, two participants shared that their pain symptoms were aggravated by colder temperatures. Additionally, although participants were afforded the opportunity to select where and how the interview was conducted, the available options may have felt unsuitable or undesirable to some individuals approached. Future research should consider the effects of weather and interview location carefully to ensure that participants feel comfortable sharing openly and thoroughly their experiences. Two participants paused their interviews to obtain or share resources with peers who appeared nearby. While participants were engaged in the interview process, they also needed to engage in survival related behaviors, such as keeping track of peers in the area, which could explain the brevity of some interviews. Another factor that may have contributed to shorter than anticipated interviews was a need to pay attention to one's surroundings due to concerns about safety, which is something I also experienced as the interviewer.

Interviews also occurred during a period of high-volume sweep activity which made connecting with unsheltered individuals more challenging. On one occasion, the encampment I planned to survey (based on recommendations from an individual with lived experience) had been swept, so no one was available in the area to participate. Displacement and fears of future displacement were anecdotally described as adding extra stress to daily living. Moreover, on one occasion, my time in the field was cut short when the organization responsible for sweeps arrived to clear the campsite.

While the present study adds an important perspective to the literature, several participants expressed that I needed to connect with "young" girls experiencing houselessness in unsheltered locations who they perceived to have unique insights about reproductive health to share. Substantial efforts were made to locate and recruit younger individuals; however, in total I was only able to successfully interview two participants in their mid-twenties. Notably, both reported high instances of experiences of sexual assault relative to older participants interviewed. Additional research examining the perspectives of youth experiencing unsheltered homelessness are still needed.

Moreover, while efforts were made to recruit a gender diverse sample, the perspectives of non-binary and transmasculine individuals capable of pregnancy are underrepresented in the present findings. The approaches used in the present study (i.e., approaching individuals who look feminine and masculine, using inclusive language such as “people capable of pregnancy”, snowball sampling) were insufficient. In future studies, partnering with organizations serving non-binary and transmasculine unhoused individuals, as well as queer-serving organizations that do outreach with unsheltered communities could be beneficial.

## Conclusion

This study offers a novel perspective to the literature examining the reproductive health experiences of unhoused individuals. The present findings shed light on the unmet reproductive healthcare needs of individuals residing in unsheltered locations and underscore the contextual barriers influencing service accessibility. Findings offer several practical implications for service delivery. Moreover, findings highlighting key differences between meaning assigned to access and use of birth control showcase the importance of not using the two terms interchangeably during research with this group.

The present study was one of the first to examine potential connections between reproductive behaviors and feelings of empowerment. Participants articulated the importance of maintaining a sense of autonomy over their reproductive methods, choices, and bodies. Participants also identified depowering reproductive experiences, including a high prevalence of trauma experienced in the context of unsheltered homelessness. For these reasons, it is imperative that future research, practice, and policy work include the perspectives of individuals experiencing homelessness in unsheltered locations.

*Table 7. Demographics*

| **ID** | **Birth Control** | **Age** | **Race** | **Gender** | **Sleeping location (Past week)** | **Length unhoused** | **Sweep** | **Aspects of Identity** |
|---|---|---|---|---|---|---|---|---|
| 01 | None | 35 | Black<br>White | woman | “Staying at peoples spots”<br>Couch surfing | 1.5 years | Yes | |
| 02 | Not sexually active | 49 | White | woman | RV<br>“Different people's spots” | 10 months | Yes | • Physical disability/ chronic illness<br>• IPV survivor<br>• Parent to child under 18 |
| 03 | IUD | 34 | White | woman | Tent | 12 years | Yes | • IPV survivor<br>• Parent to child under 18 |
| 04 | IUD | 37 | Native American | woman | Tent | 1 year | Yes | • Mental disability/ mental illness<br>• Physical disability/ chronic illness |

| 11 | 10 | 07 | 06 |
|---|---|---|---|
| Injection | Not sexually active | Condoms | Injection |
| 32 | 38 | 25 | 41 |
| White | White | Native American<br>White | Native American<br>White |
| woman | woman | non-binary | woman |
| Tent | Tent | RV | RV |
| 5 years | Intermittent homelessness<br>9 years | Intermittent homelessness throughout childhood<br>Current episode 1 year | Intermittent homelessness<br>8.5 years |
| Yes | Yes | Yes | No |
| • LGBTQIA<br>• Mental disability or mental illness<br>• IPV survivor | • Mental disability/ mental illness<br>• Physical disability/ chronic illness<br>• IPV survivor<br>• Parent to child under 18 | • LGBTQIA<br>• Mental disability/ mental illness<br>• Physical disability/ chronic illness<br>• IPV survivor | • Physical disability/ chronic illness<br>• IPV survivor<br>• Parent to child under 18 |

| | | | | |
|---|---|---|---|---|
| 16 | 15 | 14 | 13 | 12 |
| Condoms | Withdrawal | Abstinence | None | None<br>Trying to conceive |
| 53 | 44 | 35 | 39 | 29 |
| White | White | Black<br>Native American | White | White |
| woman | woman | woman | woman | woman |
| Tent | Tent | Tent | Trailer | Tent |
| 4 years | Intermittent homelessness<br>6 years | Intermittent homelessness<br>Current episode 1 year | 20+ years | 7 years |
| Yes | Yes | Yes | Yes | Yes |
| | • Parent to a child under 18 | • Mental illness/ mental disability<br>• Physical disability/ chronic illness<br>• IPV survivor | • Mental disability/ mental illness<br>• Physical disability/chronic illness,<br>• IPV survivor | • IPV survivor<br>• Parent to child under 18 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 17 | None | 26 | Middle-Eastern<br>Native American | woman | Tent | Intermittent homelessness | 15 years | Yes | - LGBTQIA<br>- Mental disability/ mental illness<br>- Physical disability/ chronic illness |
| 18 | Condoms | 33 | Black | woman | Tent<br>On the max | | 7 years | Yes | - Mental disability/mental illness<br>- Physical disability/ chronic illness |

*Table 8. Recruitment Notes*

| **Date** | **Weather** | **Start Time** | **Location** | **Approached*** | **Interviews** | **Notes on Who Declined** |
|---|---|---|---|---|---|---|
| 1/16 | 40- 51°<br>Sunny | 11 am | A | 4 | 3 | • Mid-twenties, White woman, sitting with two men. |
| 1/23 | 38- 49°<br>Cold | 10 am | B | 5 | 4 | • White woman (40's) approached me as I was leaving the scene. I did not have an additional gift card. Provided my business card (said they had a phone) |
| 1/25 | 43- 48°<br>Cold | 12 pm | B | 5 | 2 | • Participant declined mid-way through (stated they did not feel well)<br>• Participant disclosed mid-interview that her "tubes were tied" (ineligible for study criteria)<br>• Left scene due to researcher safety<br>• 2 individuals inside tent were not interested in meeting me |
| 2/27 | 36- 42°<br>Cold, Some rain, Left over snow | 11 am | C | 1 | 1 | |
| 3/1 | 32- 46° Sunny | 12 pm | D | 4 | 3 | • Individual said no from inside their tent |
| 3/8 | 35- 45° | 1 pm | E | 4 | 3 | • White woman, mid-thirties. |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Sunny | | | | | Expressed disinterest- stated she didn't have much to say because she had been monogamous for many years |
| 3/15 | 40- 53°<br>Sunny | 11:30 am | E | 5 | 2 | • White woman said she was older, using condoms, and not interested in talking about it<br>• Two White women (30-40's) said no because they were preparing for a sweep (truck showed up as we were leaving) |

**Approached individuals who were otherwise eligible to participate (i.e., fit study criteria)*

*Table 9. Overview of findings*

| **Theme/Subtheme (frequency)** | **Description** |
|---|---|
| ***Utilized Reproductive Health Services*** | |
| Mammograms (1) | Participants reported seeing a provider for annual breast exam/ mammogram related care. |
| Pap Smears (3) | Participants reported seeing a provider for Pap Smears. |
| Birth Control (4) | Participants reported seeing a provider for birth control related care. This included care to start a new method and ongoing fertility management. Examples include attending the clinic every 3 months for an injection. |
| Care for Ovarian Cysts (1) | One participant reported ovarian cysts as an ongoing reproductive concern that contributes to care engagement. |
| UTI's (1) | One participant reported receiving care for urinary track infections as part of her reproductive health engagement. |
| Plan B (1) | One participant reported accessing services to receive emergency contraception as needed. This service was provided through her pharmacy. |
| STD screening (1) | One participant reported utilizing reproductive health clinics for sexually transmitted disease screenings on an as needed basis. |
| Pregnancy Tests (1) | One participant reported attending a crisis pregnancy center for free pregnancy tests whenever they think they might be pregnant. |
| ***Unmet Reproductive Healthcare Needs*** | |
| Lack of Patient-Centered Care (9) | Participants expressed a desire for patient-centered healthcare and reported that care currently lacked a patient-centered approach. Examples include feeling unheard by providers and contraceptive counseling that does not take into account individual factors. |
| Mental Health Services (2) | Participants expressed a desire for therapy to support healing after experiencing reproductive trauma. |
| *Physical Health Services* | |
| Mammograms (1) | One participant reported needing to be seen for a mammogram. |
| Pap smears (3) | Participants reported an unmet need for Pap smears. |
| "Women's check-ups" (3) | Participants discussed an unmet need for “women’s check-ups”. They expressed a knowledge that care was needed, but lacked the vocabulary to communicate more specifically what care was needed. |
| Female Sided Contraception (1) | One participant expressed a need for “female sided contraception”/female condoms. |
| Tubal Ligation (1) | One participant expressed an unmet need for a tubal ligation procedure. |
| Desire to Switch Method (3) | Some participants using birth control expressed a desire to switch to a different type of method and experiencing barriers to doing so. |
| Reproductive Health Education (2) | Participants expressed a need for additional reproductive health education and outreach with unsheltered individuals. |
| Pregnancy Outside (2) | Participants discussed experiences of pregnancy within the context of unsheltered homelessness. Pregnancy outside was described as stressful. |

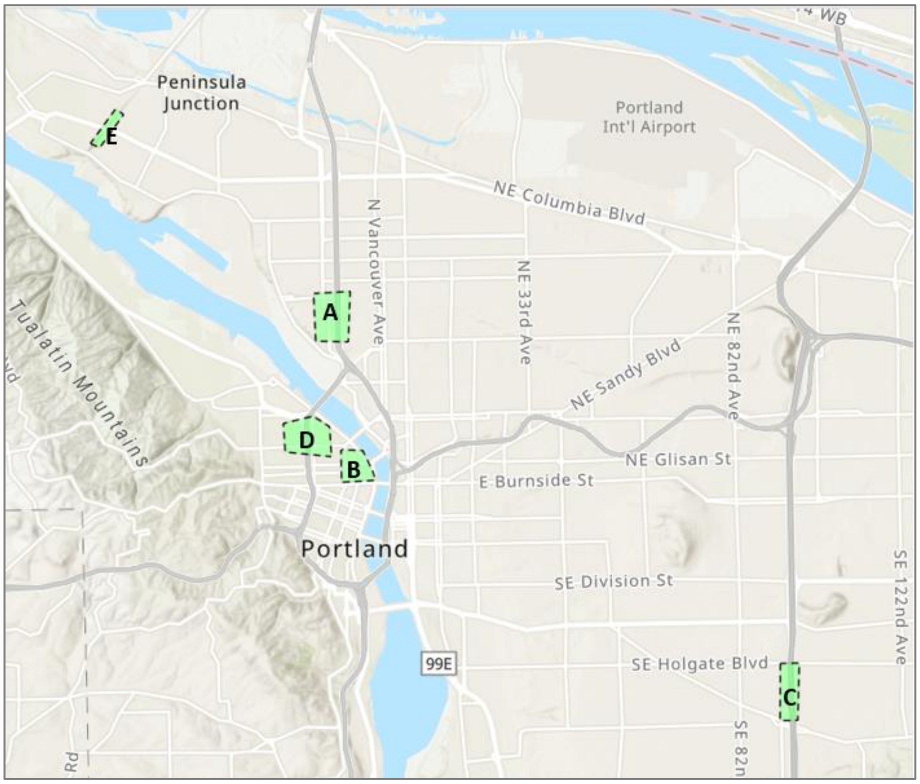
| | |
|---|---|
| ***Barriers to Optimal Reproductive Healthcare*** | |
| Location Accessibility (9) | Participants describe difficulties accessing service centers, which are centralized to certain areas of the city, or express a desire for services to meet them in their immediate context. |
| Time (5) | Time-related issues described as barriers to service engagement. Examples include discussing the competing demands of houselessness (which leave minimal room for other tasks), being unable to remember the date, and not having a schedule. |
| Navigating Systems (4) | Participants describe "jumping through hoops" in order to receive care and sudden shifts in medical coverage that impact service provision. |
| Financial Barriers (5) | Cost of reproductive care or lack of money to pay for birth control/ services described as barriers. |
| Patriarchy (2) | Participants situated their reproductive health experiences within the context of a patriarchal society. |
| Hygiene (1) | Inability to engage in hygiene behaviors can prevent individuals from engaging in services. |
| ***Access*** | |
| Preventing Pregnancy (8) | Participants attribute accessibility of contraception to their ability to avoid unwanted pregnancy. |
| Life Saving (2) | Accessible contraception was described as life-saving, since it would reduce unwanted pregnancies (and subsequent abortion services). |
| Accessible Methods (4) | Birth control access means having accessible methods. Examples include being able to receive same-day care without an appointment or obtain a method that is longer lasting. Accessible methods allow participants the ability to make desired contraceptive choices. |
| Independence (1) | Accessible contraception was described as contributing to feelings of independence. |
| ***Use*** | |
| Ability to Prevent Pregnancy (5) | Using methods to delay pregnancy. Birth control was discussed a tool to be utilized until additional stability was achieved. |
| Responsibility and Independence (2) | Using contraception to prevent unwanted pregnancy was described as a "responsible" behavior that contributed to feelings of freedom. |
| Influencing Sex Behaviors (2) | Contraceptive use influences sex behaviors. Individuals not using prescribed methods suggested that use means "no sex". Others suggested that meaning wasn't assigned to use because they were abstaining from sex. |
| ***Linkages Between Reproductive Behaviors and Empowerment*** | |
| Agency (3) | Participants described situations in which they took control in situations where little control was possible. Examples of this include navigating complex systems to have care needs met and navigating unplanned pregnancies. |
| Control of Body (11) | Birth control behaviors contributed to feelings of control over one's body. |
| Control of Birth Control (4) | Participants articulated feelings of control over the method of contraception they were using. |
| Protection (2) | Condoms were described as a form of protection against STD's and unwanted pregnancy. One participant likened this protection to the same feelings of safety derived from carrying a knife. |

| | |
|---|---|
| Sexual Gratification (1) | One participant explained how accessible contraception allows them to have a fulfilling sex life. |
| *Reproductive Choices* | |
| Rights to Choose (2) | Autonomy over rights to choose whether to become or continue a pregnancy. |
| Not Using Contraception is an Active Choice (3) | Not using prescribed/over the counter (OTC) methods can be an active choice. Participants described the intentionality behind their decisions to not use prescribed/OTC methods. |
| Lack of Accessible Methods Results in a Forced Choice (2) | When contraception is not accessible, individuals are subjected to a forced choice to not use it. Participants who spoke about contraception in this way described themselves or others not being able to make contraceptive choices due to a lack of accessibility. |
| Spillover to Other Areas of Life (6) | Contraceptive behaviors impacted employment, contributed to feeling responsible, and created room in participants' lives for other concerns. |
| *Other Sources of Power* | |
| Taking Care of Oneself and Others (6) | Being able to take care of oneself and others contributed to feelings of power. Examples include sharing resources with peers (e.g., hygiene supplies, information about resources) and not having to rely on others. |
| Being Respected (2) | Being respected, especially by healthcare providers, contributed to feelings of power. |
| Having a Support Network (2) | Social support/peers described as a source of power. Examples include family members, friends, pets, and romantic partners. |
| Maintaining a Sense of Self (1) | Maintaining morals and values while unhoused. |
| Uncertainty or Unable to Identify Source of Power (6) | Uncertainty, or unable to identify a source of power. |
| *Depowering Experiences* | |
| When Birth Control Methods Fail, are Rejected by the Body or Cause Adverse Side Effects (8) | Participants described experiences where their birth control methods didn't work or didn't agree with their bodies. These events made participants feel like they were not in control. |
| When Others Make Birth Control Choices for You (4) | Participants discussed other individuals who influenced their contraceptive decisions. Examples include parents and partners. |
| *Reproductive Trauma* | |
| Stillbirths, Ectopic Pregnancies, Miscarriages (8) | Participants discussed losses during pregnancy (i.e., stillbirths, ectopic pregnancies, miscarriages). These events were described as emotionally and physically painful. |
| Abortion (3) | Participants discussed emotional responses in the aftermath of abortion procedures. Participants who spoke about abortion in this way articulated a need for follow-up care services, as well as increased preventative options. |
| Infant Mortality (1) | One participant described the trauma of losing their newborn at sixteen days old to syphilis. Her interactions with the healthcare system related to this event have resulted in a distrust in hospitals. |

| | |
|---|---|
| Sexual Assault (3) | Descriptions of sexual assault experiences. Sexual assault was described as commonplace. Assaults were even more traumatic when contraception was not being used. |

Figure 2

*Map of Recruitment Locations*



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# Appendix A: Consent to Participate in Research

**Project Title:** **Experiences with contraception during episodes of unsheltered homelessness**

**Population:** Individuals capable of pregnancy staying in unsheltered locations

**Researcher:** Holly Brott, Department of Psychology, Portland State University

**Researcher Contact:** brott@pdx.edu | (458)240-3103

You are being asked to take part in a research study. The box below highlights the main information about this research for you to consider when deciding whether or not to join in the study. Please carefully look over the information given to you on this form. Please ask questions about any of the information you do not understand before you decide to agree to take part.

| Key Information for You to Consider |
|---|
| ● **Voluntary Consent**. You are being asked to volunteer for a research study. It is up to you whether you choose to take part or not. There is no penalty if you choose not to join in or decide to stop your involvement.<br>● **Why is the study being done?** The reason for this research is to understand your experiences with and barriers to birth control.<br>● **How long will it take?** Your participation should last between 30 minutes and 1 hour.<br>● **What will I be expected to do?** You will be asked to answer interview questions about your experiences with birth control.<br>● **Risks.** It is possible that some of the questions asked may cause emotional discomfort. You are welcome to skip any questions that you do not wish to answer.<br>● **Benefits:** Your insights and experiences with birth control can be used to improve services.<br>● **Compensation** Participants will receive a $25 gift card.<br>● **Participation is voluntary and the only alternative is to not participate**. |

## Why is this research being done?

We want to learn about your experiences with contraception, how making contraceptive choices make you feel, and document the barriers that individuals staying in unsheltered locations experience when trying to access and use birth control. You are being asked to participate because you have the ability to become pregnant and are currently staying in an unsheltered location. About 15 people will take part in this research.

**What will I do if I decide to take part?**
If you agree to be in this research, you will be asked questions about your use (or non-use) of contraception (birth control), your feelings towards contraceptive choices, and any barriers that you experience when trying to access or use birth control. Our conversation will be audio-recorded and will occur over the phone or in a location agreed upon by the participant (you) and the researcher.

**Confidentiality: How will my privacy and data be protected?**

Your interview is confidential and private. Audio-recorded interviews will be assigned a number and not include your name. Individuals and organizations that conduct or monitor this research at PSU may be permitted access to inspect research records. This may include private information.

**What if I want to stop my participation in this research?**
Your participation in this study is voluntary. You do not have to take part in this study, but if you do, you may stop at any time. You have the right to choose not to take part in any study activity or completely stop at any point without penalty or loss of benefits to which you are otherwise entitled. Your decision whether or not to join in will not affect your relationship with the researchers or Portland State University.

**Will I be paid for being in this research?**
Participants will receive a $25 dollar gift card.

**Who can answer my questions about this research?**
If you have questions or concerns, contact the lead researcher, Holly Brott at: brott@pdx.edu or (458)240-3103.

**Who can I speak to about my rights as a part of the research?**
The Portland State University Institutional Review Board (“IRB”) is overseeing this research. The IRB is a group of people who independently review research studies to ensure the rights and welfare of participants are protected. The Office of Research Integrity is the office at Portland State University that supports the IRB. If you have questions about your rights, or wish to speak with someone other than the research team, you may contact:

Office of Research Integrity
PO Box 751

Portland, OR 97207-0751
Phone:  (503) 725-5484
Toll Free:  1 (877) 480-4400
Email:  psuirb@pdx.edu

**Consent Statement**

I have had the chance to read and think about the information in this form. I have asked any questions I have, and I can make a decision about my participation. I understand that I can ask additional questions anytime while I take part in the research.

☐ I agree to take part in this study

☐ I do not agree to take part in this study

# Appendix B: Interview Protocol

*[warm up]*

Thanks so much for taking the time to chat with me today, especially about something so personal and private. My goal is to learn from you. I am interested in hearing more about your experiences and hope to share your views with other researchers and organizations that offer reproductive services, such as birth control, to unhoused community members.

I know that talking about birth control with others- like someone you just met- can be a bit uncomfortable, so I'd like to remind you that you are welcome to skip any questions that you do not wish to answer and let me know if you are feeling uncomfortable with any of the questions asked. Before we dive in, can you tell me a little bit about yourself?

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***[RQ 1) What barriers prevent people from getting the best reproductive health services (such as birth control) in the Portland metro area?]***

Before we start talking about birth control, I just wanted to be clear that by birth control I mean anything you might do to keep from getting pregnant or control your ability to become pregnant. This may include pills, an IUD or other device obtained from a doctor or clinic, condoms, withdrawal (e.g., having a male sexual partner withdraw their penis before ejaculating [or coming] inside you), or methods that rely on paying attention to your period or menstrual cycles.

Now, I am going to ask you some questions about your use birth control or reproductive services.

- Do you currently use birth control or contraception?
    - <u>*If yes:*</u>
        - What types of birth control do you use?

        What led you to use this type(s) of birth control? (or Why do you…)
- Are there other types of birth control that you want to be using?

  <u>*If yes:*</u>

        - What other types of birth control do you wish that you could use?
        - What are some of the reasons that you are not able to use these other types of birth control?
            - Probe for additional information
            - *Consider asking why they aren't able to use each type of birth control separately*

- <u>*If they are not using any form of birth control, ask the following questions*</u>

        - What are some of the reasons that you are not currently using birth control?
        - How long has it been since you last used birth control?
        - What led you to stop using birth control at that time?
        - Probe for more information depending on the response

- *(IF USING BIRTH CONTROL NOW ASK)* If you were to decide that you want to use a different type of birth control than you are currently using, where would you go?

- *(IF NOT USING BIRTH CONTROL NOW ASK)* If you were to decide that you want to start using birth control, where would you go?

I have a few more general questions about reproductive services. By reproductive services, I mean any health care, counseling, or referrals provided at a clinic, hospital, or by a doctor or an outreach worker related to reproductive health-related needs (including getting a birth control refill, PAP smears, pregnancy testing, etc.).

- What reproductive services do you currently use that involve going to a clinic or a hospital?
    - *(Alternative phrasing: family planning, birth control, contraceptive)*
- Are there any reproductive care services that you want to use, but haven't been able to?
    - If yes, what services?
    - What has kept you from being able to get these services?
- Finish the sentence: "When I think about birth control, I wish that providers knew that ___________________________"
    - *Probe for additional information*

---

***[RQ 2) What meaning do individuals assign to contraceptive practices (both access and use) during episodes of unsheltered homelessness]***

- What does access to birth control mean to you?
- What does using/not-using birth control mean to you?
- Outside of our current conversation, is birth control or pregnancy something that you find yourself thinking about?
    - *If yes:* How often?
    - When you do think about birth control and managing your ability to become pregnant, what are some of the thoughts that you have?

---

***[RQ3) In what ways are reproductive choices empowering?]***

- What makes you feel powerful?
        - Do your current birth control behaviors (i.e., use or non-use) make you feel powerful (i.e., empowered, in control, sense of agency)?
            - Why or why not?
- A) For those who use birth control methods:
    - In what ways does your use of birth control contribute to feelings of control, freedom, or choice?
- B) For those who don’t use birth control methods:
    - In what ways does not using birth control contribute to feelings of control, freedom, or choice?
- Do these feelings (e.g., control, freedom, choice) carry over to other areas of your life?
    - Which areas? In what ways?
    - Which came first, ___________ [*insert other area topic here*], or your use/non-use of birth control?
- Can you tell me about a time/experience when your current form of birth control made you feel in control?
    - Have there been times when you didn’t feel so in control or powerful when using the same method?
- What else is important for me to know about how using or not using birth control affects your life in positive or negative ways?

---

***Demographics***

*Thanks for answering all those questions! I just have a few more questions to ask. You are welcome to skip any that you do not wish to answer.*

What is your age?______________________

How do you describe your race/ ethnicity?____________________________

How do you describe your gender?_____________________________

In the last week, where have you slept most often?

- Follow-up prompts:
    - In an abandoned building
    - In a car or other motor vehicle
    - In a hotel/ motel
    - In an emergency shelter
    - Outside in a tent
    - Outside, not in a tent
- On transit or at a transit stop
- In a tiny home village/ pod

- House or apartment

How long have you been houseless? (Answer in months or years) ____________________

Have you experienced a sweep in the last year?

- Yes
- No

Do you identify as any of the following?

- Veteran
- LGBTQIA
- Person with a mental disability or mental illness
- Person with a physical disability or chronic illness
- Non-English speaker, or English as a second language
- Survivor of IPV
- Parent to a child under age 18
- Any other identity not listed here you wish to share? ________________________

# Chapter V: Conclusion

The demands unique to individuals capable of pregnancy, combined with raising rates of homelessness among this group, require continued research examining factors impacting their experiences (United States Department of Housing and Urban Development, 2019). Common pathways into houselessness among individuals capable of pregnancy experiences of childhood trauma, intimate partner violence (IPV), substance use behaviors, poverty, lack of educational and employment opportunities, unplanned parenthood, mental and physical health conditions, and histories of incarceration or institutionalization (Hilton & Trella, 2014; Hinton & Cassel, 2012; Phipps et al., 2018; Tutty et al., 2013). Factors contributing to episodes of homelessness in turn impact service needs, which may vary depending on context. Differences in service accessibility and experiences have been found across rural and urban contexts and among sheltered and unsheltered women (Brott et al., 2021; Nayamathi et al., 2000; Sommer et al., 2020). However, recent research examining the experiences of unhoused women has largely occurred in shelter and clinic environments located in urban settings. Additional contexts need to be examined to inform service delivery.

This dissertation sought to expand our understanding of how contexts impact the service needs of individuals capable of pregnancy. Collectively, the three studies included in this dissertation examined the role of geographic context on programmatic delivery and resident service needs, highlighted barriers to reproductive justice found across the individual, relational, and contextual levels of analysis, and documented the contraceptive experiences of unhoused individuals living in unsheltered locations. Combined, findings from the three studies contribute to a more nuanced understanding of the experiences and needs of unhoused women and others capable of pregnancy and offer recommendations for future research, service provision, and policy.

## Summary of Dissertation Studies

### *Study One*

Study One examined the role of geographic context on service delivery. Utilizing a sequential mixed method design consisting of survey data and in-depth qualitative interviews, my coauthors and I determined factors that predict successful completion of transitional housing within a rural and urban context and examined how service needs vary between contexts. Our findings indicated that level of education and social support both positively predicted successful program exit. Additionally, findings also highlighted differences in services depending on geographic context. Findings from this study showcase how service experiences and needs may vary depending on contextual factors, such as geographic context.

Across the two geographic contexts, key differences included programming needs, the importance of sense of community, and differences in mindsets surrounding individuals experiencing homelessness in transitional settings. Urban participants valued opportunities to gain employment related skills (i.e., job readiness programming), including resume workshops and training opportunities. Meanwhile, rural participants valued opportunities to engage in higher education learning opportunities. Opportunities to receive social support and develop a sense of community were described as important by both urban and rural participants; however, sense of community was mentioned more frequently by urban participants relative to rural participants. Both urban and rural participants alike attributed housing status to a “sin mindset”. They described themselves and others as exhibiting poor behaviors and being unmotivated to navigate programmatic requirements. However, urban participants also described themselves and others as in need of additional resources and support in order to improve (i.e., a “sickness mindset”).

Differences in support experiences across the two contexts suggest the importance of examining how experiences of homelessness are influenced by contextual factors. While the findings from this study offered a novel contribution to the literature, additional research should prioritize documenting experiences across a variety of environments and contexts (e.g., rural environments, unsheltered environments, relational and contextual factors) to better meet the service needs of unhoused individuals capable of pregnancy.

### ***Study Two***

Study Two consisted of a review of the literature examining barriers to reproductive justice during episodes of houselessness. Findings suggest that barriers to contraception, prenatal care, and abortion exist at the individual, relational, and contextual levels of analysis. For example, at the individual level, fear of contraceptive side effects and misconceptions about birth control impacted accessibility and use (Begun et al., 2019). Relational factors (e.g., monogamy, transactional sex, reproductive coercion) also impacted accessibility; reproductive decisions were often influenced by other individuals in their lives (Cedarbaum et al., 2013). Geographic context, transportation-related issues, and stigma are examples of contextual factors that impacted accessibility and use of care (Ensign, 2001; Gelberg et al., 2004).

This review of the literature highlighted several gaps in the literature that warranted future study. First, in the included literature, the majority of research utilized samples connected to service settings (e.g., shelters, health clinics), limiting our understanding of the experiences and needs of individuals in unsheltered contexts. These perspectives are of great importance because individuals in unsheltered locations tend to be less connected to services and therefore, may experience greater difficulty obtaining desired reproductive care services. Second, the perspectives of individuals who are transmasculine and nonbinary were noticeably missing in previous research examining barriers to reproductive justice during episodes of homelessness. Research examining reproductive care service utilization among housed samples has identified additional barriers specific to this group, which are likely also present, if not even more pronounced, during episodes of unsheltered homelessness (Hoffkling et al., 2017). Third, included studies tended to use the phrases “access” and “use” interchangeably, which impacts our interpretations of present findings. It was unclear in some instances whether non-use was related to access barriers or a lack of desire to engage in the specified reproductive health behavior. Fourth, existing literature approached this topic from a medical model lens, which views contraceptive non-use as risky among this group and failed to capture what meaning, if any, contraceptive practices held for participants themselves. For these reasons, additional research incorporating a more diverse sample, examining meaning attached to access and use, and identifying reproductive behaviors from a strengths-based lens was needed.

### *Study Three*

Building off of findings from Study One (i.e., the importance of examining various contexts) and gaps identified in Study Two (i.e., the need for additional research with more diverse samples, including unsheltered individuals and individuals capable of pregnancy who do not identify as women), Study Three examined contraceptive experiences during episodes of unsheltered homelessness. Findings highlighted both satisfaction with, and barriers to optimal reproductive care experienced by unsheltered individuals. This study also identified the meaning attached to reproductive care access and use, as well as connections between contraceptive behaviors and feelings of empowerment. This study expands our understanding of context specific barriers to optimal reproductive service delivery voiced by individuals experiencing unsheltered homelessness, which have direct implications for service delivery and policy.

The present findings also offer a novel contribution to reproductive empowerment literature, which has yet to examine how empowerment is experienced in conjunction with contraceptive behaviors during episodes of homelessness. Moreover, previous research examining the linkages between empowerment and reproductive health occurred in lower income countries with married women, which limited our understanding of how contraceptive behaviors relate to feelings of control, agency, and choice among other populations. In Study Three, participants exhibited agency through their reproductive behaviors. Examples of this included navigating systems to obtain new contraception, using celibacy as birth control when other methods weren't compatible with their bodies, and taking risks to prevent one's abuser from knowing their unborn child. Participants felt a sense of control over their bodies regardless of whether they were using prescribed (e.g., IUD, injections), over the counter (e.g., condoms), or natural (e.g., abstinence) methods of contraception. This underscores the importance of affirming the contraceptive decision-making practices of individuals experiencing houselessness in order to promote feelings of bodily autonomy. Feelings of autonomy expressed by participants are especially important within the context of unsheltered homelessness, which often involves a loss of control and power.

Findings presented in Study Three also illustrated that reproductive behaviors can be depowering. Specifically, participants experienced a lack of control when they were unable to make reproductive choices independently, when their desired contraceptive methods did not work, and experiences of trauma that involved a loss of power and autonomy. The depowering experiences described by participants showcase the importance of affirming ones' reproductive choices, implementing services specific to the needs of unsheltered populations, and advocating for policy that expands access to reproductive healthcare.

## Contributions to the Literature

Collectively, the three presented studies provide us with a better understanding of the role of context during episodes of homelessness and contribute to a greater understanding of service needs unique to unhoused individuals capable of pregnancy. Additionally, Studies One and Three utilized samples that have been less commonly included in research examining the experiences and service needs of unhoused individuals. In addition to informing the literature, the inclusion of these “hard to reach” groups provides us with information that can be utilized to develop and sustain contextually appropriate services.

A valuable contribution of Study One was the incorporation of rural perspectives. Opportunities to compare the experiences of unhoused women between geographic settings are rare. In Study One, rural participants differed from their urban counterparts in regard to education, level of social support, histories of substance use, and prior interactions with the criminal justice system. Rural participants also articulated a need for different types of resources relative to their urban counterparts. These findings contribute to a greater understanding of the service needs of unhoused mothers in rural transitional housing contexts.

Study Two examined barriers to reproductive justice during episodes of homelessness through the inclusion of services that support wanted pregnancies (i.e., prenatal care) and prevent unwanted pregnancies (i.e., contraception, abortion). Utilizing an ecological approach, this review was an important contribution to the community psychology literature as “feminist” issues have historically been less emphasized in our field, despite our stated commitments to diversity and social justice.

Study Three incorporated the perspectives of individuals experiencing unsheltered homelessness — which are also less commonly represented in the literature — in order to better understand their experiences with contraception and other reproductive health services. Key findings with direct implications for service delivery include recommendations for service provision through outreach workers nearby one’s home, an expressed desire for therapeutic supports to help navigate complex emotions in the aftermath of reproductive traumas such as miscarriages and sexual assault, and a strong desire for patient-centered care.

Study Three is also the first to examine how contraceptive behaviors relate to feelings of empowerment and depowerment during episodes of unsheltered homelessness. Participants derived feelings of agency, control, and choice through their reproductive behaviors, regardless of contraceptive type used. Depowering experiences included coerced contraceptive choices and reproductive trauma. Participants who were unable to access desired contraception expressed that it further compounded feelings of lacking control during episodes of sexual assault. These findings illustrate the importance of accessible contraception during episodes of unsheltered homelessness.

## Future Research Directions

The present collection of studies highlight contextual factors impacting service experiences and unmet reproductive healthcare needs. However, future research efforts are still needed to further identify how to best support individuals capable of pregnancy during episodes of homelessness.

Findings in Study One illustrated the importance of examining homeless service user experiences across contexts. Namely, the differences in service needs identified by rural participants—whose perspectives are less commonly reported in the literature—highlights the need for additional research with rural individuals experiencing houselessness. In Study One, participants who had obtained higher levels of education were significantly more likely to successfully complete transitional programming. Education also emerged as an important resource during interviews with women residing in the rural context. However, education was not mentioned by any of the urban participants. Instead, they stressed the importance of opportunities to develop career-related skills, including employment training and resume workshops. It’s unclear whether these differences are related to the larger geographic contexts or the transitional shelter contexts themselves. Future research is needed to explore whether the trends identified in the present study occur universally.

Differences in mindsets surrounding poverty were also found across the two shelter settings examined in Study One. Participants across both settings attributed houselessness to individualistic root causes (i.e., a sin mindset), which may be indicative of internalized stigma; however, urban participants also specified that individuals experiencing houselessness were also in need of additional treatment and support. It’s unclear whether differences in attributions were a result of the shelter contexts themselves or the geographic locations they were nested within, which should be explored further in future research.

Gaps identified in Study Two offer several avenues for future research. Most notably, gathered literature revealed an abundance of articles pertaining to contraception services relative to research examining prenatal and abortion care. It’s unclear whether this focus on contraception relative to other aspects of reproductive health is guided by researcher inquiry or in response to community need. Future research could utilize a participatory approach to ensure that research is being conducted for the unhoused community rather than on the unhoused community. Study Two also identified the underrepresentation of transmasculine and non-binary individuals experiencing homelessness in research examining barriers to reproductive justice. While Study Three aimed to rectify this by utilizing a more inclusive sampling approach, future research documenting their service experiences is still needed.

Future research is also needed to document how geographic and geopolitical context influence accessibility of reproductive healthcare during episodes of homelessness. Accessing healthcare in rural areas can be more challenging (Martins et al., 2016); and individuals experiencing houselessness in rural areas tend to experience greater difficulty obtaining services (Buck-McFadyen, 2022; Carpenter-Song et al., 2016; Hilton & Trella, 2014). Future research with rural unhoused individuals is needed. Included articles in Study Two were representative of areas with both restrictive and progressive reproductive health policies in place; however, it is unclear how these policies impacted user experiences and barriers to care. An examination of how both progressive and restrictive policies impact service accessibility for unhoused individuals is needed in future research.

Findings in Study Three suggest that while unsheltered and sheltered individuals face similar barriers to having reproductive needs met, there are subtle differences in how they are experienced. For example, previous studies with sheltered participants have discussed service location as a transportation barrier to care (Gelberg et al., 2004). In the present study, participants expressed a desire for services and outreach near encampment locations. However, similar to previous findings with sheltered samples, participants also reported difficulty navigating systems to access care (Dasari et al., 2016; Wenzel et al., 2001). Continued research with unsheltered samples is needed to develop a more nuanced understanding of their service needs and how they may differ compared to sheltered individuals.

While Study Three sought to recruit a diverse sample, the majority of participants identified as women. Future research is needed with individuals capable of pregnancy who do not identify as women. Additionally, multiple participants in Study Three articulated a need to interview younger women experiencing houselessness. These women were perceived to have a lot that needed to be shared about their reproductive health experiences. Future research efforts should include targeted outreach to connect with younger women.

In conclusion, the three studies included in the present dissertation underscore the importance of examining individual and contextual factors that influence interactions with services during episodes of homelessness. Studies One and Three incorporated the perspectives of individuals staying in contexts that have historically underrepresented, and Study Two highlighted barriers at multiple levels of analysis. While additional research is needed, the present dissertation contributes to a better understanding of how contexts impact experiences of homelessness and interactions with service systems which has implications for future research, service delivery, and policy.

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