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A Qualitative Study of Pregnancy Intention and the Use of Contraception among Homeless Women with Children

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Abstract

We undertook a qualitative analysis informed by grounded theory to explore pregnancy intention and the barriers to contraceptive use as perceived by homeless women with children. Semi-structured interviews (n = 22) were performed in English and in Spanish. The dominant theme emerging from the interviews was a strong desire to avoid pregnancy while homeless. However, few women in our sample used contraception or accessed reproductive health care consistently. There were multiple barriers to using contraception and to accessing reproductive health care services that homeless women reported: (1) inability to prioritize health due to competing demands, (2) shelter-related obstacles and restrictive provider practices that impede access to reproductive health care services and the use of contraception, and (3) change in the power dynamics of sexual relationships while homeless, making women more vulnerable to sexual exploitation. Findings suggest a multifactorial approach is needed to help homeless women use contraception and access reproductive health services.

Keywords

Homeless people; women's health; contraception; health care access; reproductive health

Homelessness is a significant problem in the United States (U.S.), with families representing the fastest growing segment of the U.S. homeless population. While recent reports indicate that the number of long-term, chronically homeless individuals has slightly decreased in recent years, there has been a 20% increase in the number of homeless families in shelters from 2007 to 2010, with homeless families now constituting 35% of people using shelters or transitional housing.[1] While the majority of homeless individuals are unaccompanied adult men, the majority of homeless families are composed of a single woman with one or more children. Women currently make up approximately one-third of the sheltered homeless population, but these trends indicate that women, particularly women with children, will be

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increasingly represented among the U.S. homeless population. Compared with single homeless women, women with custody of minor children are generally considered to be 'higher functioning' than single homeless women, with lower prevalence and less severe drug and alcohol abuse and mental illness.[2,3]

While it is well established that homeless adults have decreased access to health care resources and an increased risk of chronic illness and higher mortality rates, little is known about the reproductive health, including the family planning needs, of homeless women.[4,5,6] Previous studies have demonstrated that homeless women are less likely than others to have regular Pap smears, more likely to have abnormal Pap smears, and more likely to have a history of sexually transmitted infections and pelvic inflammatory disease.[7,8] In addition, limited data suggest that homeless women have a high risk of unintended pregnancy and inadequate use of contraception compared with the general population. One cross-sectional survey of 974 homeless women in Los Angeles in 1997 found that 28% of homeless study participants had been pregnant within the previous year, with 73% of the pregnancies reported as being unintended.[9] Among the homeless women using contraception, 92% relied primarily on condoms and only 32% of those reported using condoms with every sexual encounter.[10] In contrast, approximately 50% of all pregnancies in the United States are unintended and only 10% of women in the general population practicing contraception used condoms as their most effective method of birth control.[11,12]

Although limited previous research has suggested that homeless women are at higher risk of unintended pregnancy than the general population, we do not have a concrete understanding of the causes. One prior qualitative study interviewed 47 homeless women in Los Angeles about their perceived barriers to using contraception and accessing women's health services; this study found a variety of obstacles, including transportation and scheduling difficulties, competing survival needs, and feeling stigmatized by health care providers.[13] However, the population of this study was heterogeneous with respect to age (with many participants being older than 45 years) and less than half having minor children in their custody.

No prior research has investigated pregnancy intention and barriers to contraceptive use and other reproductive health care services specific to homeless women with children, the fastest growing sub-segment of the homeless population. Given that these women already have children they are responsible for, and existing research has demonstrated that homeless women are at high risk for unintended pregnancy and adverse birth outcomes,[14,15] it is especially important to understand potential barriers to using contraception and accessing reproductive health care. In order to describe the experiences of homeless women with children around pregnancy intention, sexuality, and contraceptive use, as well as to identify barriers to reproductive health care, we designed a qualitative study that targeted women heading homeless families in San Francisco. Ultimately, this study is designed to inform future interventions to assist homeless women to achieve better reproductive health.

Methods

Participants

Between September 2010 and April 2011, homeless women in families in San Francisco were recruited for individual, semi-structured interviews. Women were eligible if they were between the ages of 18 and 45, either English- or Spanish-speaking, were currently housed or seeking housing in a family shelter, had custody of at least one minor child, and were sexually active with at least one man in the past year. Women were excluded from the study if they were pregnant, deaf, unable to consent for any reason (including psychosis or current intoxication from drugs or alcohol), or had a hysterectomy or tubal ligation or a primary partner with a vasectomy. Study subjects were recruited using a consecutive, convenience sampling method from a family shelter placement agency. Women interested in completing the study contacted the research staff either in person during recruitment hours or by telephone. A trained research staff member then provided a brief introduction to the study and screened for eligibility. If the person was eligible and agreed to participate, the terms of the study were explained, a written information sheet describing the study was provided, and oral consent was obtained. Participants were paid one $15 gift card to a pharmacy at the conclusion of the interview. Ethics approval was granted by the University of California at San Francisco Committee for Human Research.

Data collection

The interview questions were designed by a panel of experts with research experience in the areas of family planning and homelessness. Participants completed a basic demographic information sheet at the time of recruitment. No names or personally identifiable information were collected. Topics covered in the interview included pregnancy intention, experiences with contraception and abortion, barriers to reproductive health care, and preferences for contraception use (Box 1). The interview tool was used only as a prompt, to encourage elaboration and to elicit themes. The interviews were audio-recorded and transcribed *verbatim*.

Data analysis

We conducted an analysis informed by grounded theory, with iterative and collaborative identification of themes. We had frequent group meetings where the research team discussed new themes and integrated them into the coding structure used for analysis. Discrepancies in coding were resolved by consensus. Two research team members examined the content of coded statements to ensure consistency, and repeated themes were distinguished from infrequent themes. Those repeated themes then formed the basis of theories that offered explanatory value to the challenges homeless women face in controlling their reproductive health. Thematic saturation determined the number of interviews we conducted.

Results

A total of 22 semi-structured interviews were completed (Table 1). Forty-four (44) women were approached and 26 (56.1%) were eligible for participation. Twenty-two (22) women (84.6%) agreed to participate. Of the four women who did not complete the study, three

identified lack of time to participate and one had no reason recorded. Eighteen (18) women screened for the study were found to be ineligible. The most common reason for ineligibility was being currently pregnant (Table 2). There were no prominent differences in the themes identified between the English and Spanish interviews.

Strong desire to avoid pregnancy while homeless

No women in our sample desired pregnancy while homeless. Although most women desired future children or were ambivalent about future pregnancies, none wanted to be pregnant or to have more children while they were homeless. Many women felt that having stable housing and finances was critical before getting pregnant again:

> I've got to wait [to get pregnant] 'til I get settled, more settled, where I can have a stable income and stable housing. 'Cause I mean, having a baby at a shelter right now is really, that's tough … I can't imagine having a baby in a shelter right now.

Many women were also concerned about the effect that being homeless has on children. Women heading homeless families stated that being homeless was distressing for their children, and this was cited as one of the main reasons for wanting to avoid pregnancy while homeless.

> It's [pregnancy] not something that I want and I'm taking measures to prevent it because I am homeless and wouldn't want to bring a child into this situation … Because I think it's traumatic for a child to experience homelessness … 'Cause it's unstable and it's a stressful situation and it's just not healthy, I don't think, for a child moving place to place. I believe children have a way of detecting tension and stress and I think it can affect them developmentally, mentally, it can affect their mental development …

Inconsistent use of contraception

Despite the universal desire to avoid pregnancy while homeless, few women in our sample were using contraception, and women who were using contraception often were doing so erratically. Instead of using a reliable contraceptive method, many women reported they tried to abstain from sexual intercourse in order to avoid pregnancy. However, most of the women who reported using abstinence as their main contraceptive method also admitted to recent sexual intercourse with a man within hours or days of the interview, oftentimes unprotected.

- I go to the clinics and they do the shots and the pills and so I've done all that. But right now I try not to even engage in sexual activities because of that, of preventing pregnancy.
- I'm using the patch and when I run out of patches or I don't have patches, I'm using a sponge and I'm being, majority abstinence, just not even trying to engage or indulge in sex right now, because it's not going in hand in hand with my situation … .

Barriers to contraceptive use and reproductive health care

Many reasons given for not using contraception consistently by the homeless women in our sample mirror the barriers to using contraception reported by the general population, such as fear of side effects, fear of health problems, and partner dislike of condoms. However, several obstacles mentioned were more specific to the context of being homeless.

General health, including reproductive health, is a low priority—One barrier to contra-ceptive use and reproductive health care reported by homeless women was an inability to prioritize health due to competing demands. Women described feeling overwhelmed by the stresses caused by being homeless, resulting in a decreased priority placed on their own personal health. Women reported their time was consumed by trying to secure housing, food, employment, and health care for their children. Personal health care appointments were frequently not made or skipped.

- It's just heavy. Say like you don't know where you're going to be living in the next month, day, year, you know. You can't focus on too much other things. And so if I have to just eliminate a couple of things just to keep my mind focused—children got to school, okay, I might have to go to work, I'm trying to get this housing … you can't stop to take care of your health sometimes. So it's very, very, very hard.
- However it went down, they had to leave their home where they cook their meals for their children, you know, bathe and slept, made love to their husbands. That was taken away from them so the last thing on their mind is thinking about contraception. So their minds are so shattered and their lives are so destroyed that that's the last thing on their mind. It's the last thing they're thinking about is contraception.

Shelter-related obstacles—Many women reported they did not have a reliable place to store contraceptive methods, with little to no secure space in the shelters. Most shelters have a lock-out period during the day, when women must take their children and all of their personal belongings out of the shelter for a length of time, varying from several hours to most of the day. When women are able to leave personal belongings in the shelter, they reported that personal belongings, including contraceptive equipment, are frequently stolen.

> … because if I had a place to stay, then usually like the condoms would be in a place where they're easy to get to, like on the stand next to the bed or something like that. But when you're homeless and sometimes it's just so spontaneous sex, you might just say, "Let's check into this hotel," right? And then if I just don't happen to have a condom in my purse, then I might just say, "Hey, you know what, I'll just risk it this time."

Another barrier to maintaining reproductive health among homeless women was a lack of privacy and hygiene in the shelters. Many women were concerned about the shelters being dirty and the possibility of acquiring infectious diseases, such as tuber-culosis and HIV. Concerns for their own health and the health of their children in the setting of unhygienic shelters were significant. Related to the lack of hygiene in the shelters is the absence of privacy; women frequently commented on the lack of feminine hygiene products resulting in

women using toilet paper during their menstrual periods and absence of doors in bathrooms. This influenced women's use of contraception; some women reported they declined certain methods because of the risk of increased or unpredictable bleeding in a context of being unable to afford feminine hygiene products, dirty bathrooms, and lack of privacy.

One additional shelter-specific issue reported by the women was that reproductive health care was rarely offered on-site in the shelters. Many women praised the social services offered by family shelters, including case management, assistance obtaining housing, employment, food, and other resources, and money management. These same women frequently lamented that the services offered by the shelters did not include health care. Most shelters provided little to no information about where or how to obtain health care, particularly reproductive health care. When asked, women reported that it would be helpful to receive a list of clinics that provide health care to homeless women and informational fliers on basic women's health information, including contraception.

> In the case management, they basically, they talk about housing, they talk about making sure your kids are in school and money management. And I think maybe making sure that the women are getting health care and the kids are getting dental care and health care, I think that should be mandatory along with case management.

Provider practices—Women frequently reported feeling that they were treated differently when their provider learned they were homeless. Some women stated that they never disclose to their provider that they are homeless, for fear of substandard care or judgment.

> I think it changes how my doctor or nurse talk to me. I think once they know you're homeless they don't really have that much care or concern about you 'cause you're homeless … You get really treated just really not cool … And it seems like the doctors, once they find out that you're living in a shelter or homeless, you know, along with that they make their own conclusions that oh, you're in a shelter. You must be a drug addict, you must be this, you must be that.

Restrictive prescribing practices by health care providers was another barrier to using contraception reported by the homeless women in our sample, including lack of quick-start methods and not providing adequate numbers of refills. In addition, women reported barriers to obtaining birth control in one visit, including a lack of trained individuals to insert an intrauterine device (IUD) or implant and requirement of two visits prior to starting a method for reasons such as obtaining sexually transmitted infection (STI) or Pap smear results.

> I can't just walk up and say, "Hey, I need this [contraceptive method], I need that." They want you to go through a process … but at times I be needing it at that moment.

Positive provider practices reported by our participants that facilitated contraceptive use included being given samples of contraception to start immediately.

> On one occasion she had the birth control pills right then and there and she was able to start me on birth control pills. That's one of the things I really, really liked.

> Even though it might have not been the one that I absolutely wanted, but I needed it at that time, and they had them on hand.

Change in power dynamics of sexual relationships—Women generally reported feeling less in control of their sexual choices when homeless. Many women reported a change in their sexual relationships during periods of homelessness, including with whom they have sex, where and how often they have sex, and why they have sex. For example, women commented on how the logistics of having sex while staying in a shelter are complicated; sexual activity is strictly forbidden in most shelters, and there is little privacy. In order to engage in sexual activity, most women reported either using a hotel or relying on their sexual partner to provide the location.

> It does change because you can't, technically, you can't have sex in a shelter anyway. So that changes everything, it really does … basically you have to go out so they have to provide a place, area, house or motel room to, you know, have sex …

Another important effect of homelessness on women's sexual relationships was the tendency to use sex as a resource to secure housing, food, or other material benefits. Several women reported having traded sex for shelter or other resources for their family, such as food or money, multiple times while homeless. One woman reported that the wellbeing of her children was the major motivating factor for exchanging sex for shelter.

> A couple of times while I had kids, when I was homeless there would be times where a male friend would say I could come spend a night at his house. But it would be, it would stipulating the fact that I have sex with him. It was like an unwritten rule, you know what I mean? … I mean, it's just the same as prostitution. Prostitutes sell themselves so they can have money for whatever they need, including a roof over their head. It's like a sex exchange thing, you know what I mean, sex for a roof. When you have two small kids and it's cold outside and you really don't have anywhere to go and you know that if you keep showing up in the hospital lobby they're going to call CPS [Child Protective Services] eventually, because obviously I'm not able to take care of my kids, then you have to do what you have to do.

Reproductive coercion was another prominent theme among homeless women, limiting women's ability to use contraception. Several women shared experiences when their sexual partners intentionally sabotaged their attempt to use contraception.

> I have very little sex. I am in a relationship with the father of this baby, but I'm very cautious. I just won't be with him sexually because a) I'm focused and I'm trying to get out of my homeless situation, and b) he's been known to take condoms off, break them, tear holes in them.

Discussion

While women in our study expressed a clear desire to avoid pregnancy while homeless, they identified barriers to use of contraception and access to reproductive health care that were

related to their lack of secure housing. Notably, the women in this study were not ambivalent about pregnancy; no women in our sample wanted to become pregnant while being homeless. However, few women were using reliable contraception. This conflict between pregnancy intention and inadequate contraception use is not unique to women who are homeless; many previous studies have elucidated social determinants that affect a woman's use of contraception even when pregnancy is not desired.[16,17] This study demonstrates that homelessness is another clear social determinant that influences a woman's reproductive health choices and behaviors, including use of contraception. Our data have uncovered a variety of barriers specific to homelessness that limits use of contraception and maintaining reproductive health care. These findings identify critical changes that could be implemented by homeless agencies, health clinics, and clinicians that could positively affect homeless women's reproductive health.

Interventions aimed at improving reproductive health may be highly effective in this specific population, as homeless women with children are generally higher functioning than single homeless women or men; simply by maintaining custody of minor children, these women demonstrate a relative capacity to care for themselves and their children and experience lower prevalence and less debilitating substance use and mental illness.[2,18,19] In addition, compared with the chronically homeless population, homeless women with children are more likely to experience housing instability with transient homelessness, staying in a shelter for two months or less over the course of one year, with most of their nights spent in their own temporary housing or with family or friends.[20] Accordingly, simple interventions to better the reproductive health of homeless women in families may be feasible. Understanding the issues faced by homeless women with children will allow for the design and implementation of such interventions.

One potential intervention suggested by our findings is provision of basic reproductive health care and contraceptive services within the shelters. The women in this study clearly reported great difficulty in securing time, transportation, and childcare that would allow them to attend appointments for health care. Most shelters in San Francisco offer a primary care clinic one or more days per week in association with local hospitals and public health organizations. Health care providers and public health agencies specializing in women's health could work with primary care providers to expand services to women, including basic gynecologic exams, Pap smears, STI screening, and contraceptive services. Gynecology mobile clinics may be one cost-efficient option, providing mobile specialized equipment for focused women's health services, such as exam tables with stirrups and contraceptive supplies. Indeed, one study of homeless women found that receiving care at mobile health centers and outreach clinics was associated with patient satisfaction.[21] Mobile clinics have been shown to be both feasible and cost-effective in providing other types of specialized care to underserved populations, such as counseling for breast cancer risk-reduction strategies, hypertension diagnosis and management, mammography, HIV and tuberculosis diagnosis and treatment, and cervical cancer screening.[22,23,24,25,26]

The design of shelters for homeless women and their children could also be modified to help women to improve their reproductive health. Providing each woman with a secure locker or area where they have ready access to store personal belongings, including contraceptive

methods, may enable women to use contraception more easily. Healthcare for the Homeless Clinicians' (HCH) Network recommends specifically addressing the issue of storage of contraceptive methods by shelters and physicians, acknowledging the importance of this issue to homeless individuals and other displaced populations, such as refugees.[27] Despite this recommendation from the HCH, the women sampled in our study reported a lack of safe storage space for personal belongings, including contraceptive methods.

Additionally, there are several ways health care providers can better care for homeless women. It is clear that homeless women internalize the stigma of homelessness, causing a heightened sensitivity to the way that health care providers and others in authority positions treat them. Understanding this, and being sure to care for homeless women with respect and dignity, may help homeless women to feel more comfortable in disclosing their homeless status and health issues. Directly asking women where they stay at night, rather than whether or not they are homeless, may help the provider to better understand the context of their needs. Furthermore, contraceptive prescriptive practices can be tailored to help homeless women to access and to use contraception more easily. Recent research has demonstrated that requiring multiple visits to start a contraceptive method, such as requiring two visits to insert an IUD in order to obtain STI screening results, is both unnecessary and prohibitive for most women.[28,29,30] Requiring two visits to start any method may be an even greater impediment for homeless women, who have difficulty making or attending health care appointments. Same-day STI screening and quick start of the contraceptive method, including same day IUD insertion, is strongly preferred for homeless women. Similarly, providing women with one year of refills of their contraception is imperative to increase contraceptive use for all women,[31] particularly homeless women. Being aware that homeless women may be especially averse to side effects such as heavy or irregular vaginal bleeding, given the context of limited access to feminine hygiene supplies and privacy in shelters, can assist health care providers in helping women to choose an appropriate contraceptive method.

Finally, homeless women clearly experience a change in the power dynamics of sexual relationships, which places them in a vulnerable position when negotiating safe sexual practices. Women confirmed that being homeless can change every aspect of a sexual relationship, including whom women have sex with, why they have sex, and when and where they have sex. Relying on a sexual partner to provide a location for sexual activity or childcare may place homeless women in a weaker position to negotiate use of contraception and safe sexual conditions. Furthermore, when a woman's situation becomes so desperate that she must use sex as a resource for survival or for shelter for herself or her children, she is naturally placing herself, and possibly her children, at great risk of exploitation. Indeed, women who trade sex for goods are at significant risk of sexual violence, with women who trade sex for goods, including shelter, being three times more likely than their homeless counterparts who do not trade sex for goods to experience sexual violence.[32]

Homeless women may also be at increased risk of reproductive coercion (coercion by male partners to become pregnant) or birth control sabotage (partner interference with contraception), further limiting their use of contraception. The prevalence of intimate partner violence (IPV) is inversely correlated with income level, suggesting that poverty may be a

risk factor for IPV.[33] Prior research has verified a high incidence of IPV among homeless and low-income mothers, with almost two-thirds reporting a lifetime experience of IPV and one-third a violent incident with a current partner.[34] In a separate large cross-sectional study of women aged 16–29 years, one-third of women reporting IPV also reported reproductive coercion or birth control sabotage, and these were both associated with unintended pregnancy.[35] It is therefore reasonable to suspect that reproductive coercion is also increased among homeless women in families. All women experiencing homelessness or housing instability should be screened for IPV and reproductive coercion at every health care visit, with resources for help readily available.

If a homeless woman discloses reproductive coercion, health care practitioners should be mindful of the potential value of long-acting reversible contraceptive (LARC) methods, such as the IUD and implant. Indeed, some researchers have suggested specifically using LARC as a method to combat reproductive coercion as it provides effective contraception without requiring the acquiescence of, or even awareness by, male partners.[36] Homeless women using LARC methods also experience the substantial advantages of not needing storage or privacy for effective use, as well as not needing routine medical maintenance required for other methods of contraception.

The findings from this qualitative study may not be generalizable to all homeless women with children. For example, women in our study may be different from home-less women with children who are not seeking services, and the women who chose to be in the study may be significantly different from those who declined participation. Furthermore, San Francisco provides relatively generous social and housing services to its homeless population compared with other urban areas in the United States, possibly limiting generalizability.

The findings from this study add novel and significant information about the reproductive experiences, including pregnancy intention and barriers to contraceptive use, of homeless women with children. Women in our study described many barriers to using contraception and to accessing general reproductive health care services, and identified several problematic areas of health care and homeless service provision that could be improved upon. Future quantitative studies could further elucidate these barriers. We hope that by better understanding the challenges homeless women face in maintaining their reproductive health, feasible interventions can be designed to care better for this underserved and growing population.

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SAMPLE INTERVIEW QUESTIONS

1. What would it be like if you got pregnant right now?
2. Tell me about a situation when you used contraception.
3. Tell me about a situation when you did not use contraception.
4. How has being homeless affected how you feel about getting pregnant and having more children?
5. How do you feel being homeless has affected your use of contraception?

Table 1

INTERVIEW PARTICIPANTS

Interview ID (N = 22)	Primary Language	Age (Mean = 32)	Race
Engl	English	33	Black
Eng2	English	42	White
Eng3	English	4l	Black, Native American
Eng4	English	43	Black, Native American
Eng5	English	3O	Black
Eng6	English	27	Black, Native American, White
Eng7	English	4l	Black
Eng8	English	28	Black
Eng9	English	34	White
EnglO	English	2O	Asian
Engll	English	44	White
Eng12	English	26	Black
Cogl	English	24	Not recorded
Cog2	English	34	Not recorded
Cog3	English	3O	Not recorded
Cog4	English	27	Not recorded
Cog5	English	4l	Not recorded
Spal	Spanish	27	Hispanic
Spa2	Spanish	28	Hispanic
Spa3	Spanish	25	Hispanic
Spa4	Spanish	26	Hispanic
Spa5	Spanish	23	Hispanic

Table 2
REASONS FOR INELIGIBILITY TO PARTICIPATE IN INTERVIEW

Recorded Reason	N (Total N = 18)	%
Currently pregnant	8	44.4
Spanish speaking only and no Spanish proficient research assistant available	3	16.7
Not sexually active within the last 12 months	2	8.7
Over age limit	2	8.7
Housed	1	5.6
Primary language other than English or Spanish	1	5.6
Malfunction of audio recording	1	5.6