CLINICAL COMMENTARY

Unhoused and Pregnant: Challenges of Prenatal Care for Women Experiencing Homelessness

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Introduction

Women and families are the homeless population's fastest-growing segment in the United States.[1] Unhoused women lack access to necessary healthcare, including basic prenatal care. This vignette presents the startling and dire situation of an unhoused pregnant woman in Los Angeles. Her circumstances starkly contrast the prenatal care received by housed women. We discuss reasons homelessness puts women at greater risk of pregnancy complications, the barriers to prenatal care, consequences of inadequate prenatal care, and the ways we should adjust our approach to improve care for this vulnerable population.

Case Presentation

"Medical team. Does anyone need any help?" the nurse called out as we walked on our street medicine rounds. A 28-year-old woman emerged from a makeshift tent. She was visibly pregnant and asked if we could see her. The woman reported mild nausea, lower abdominal discomfort, and fatigue without vaginal bleeding. She reported no prenatal care. Her last menstrual period was around twenty months ago. She had six prior pregnancies, with the first four resulting in live births. These pregnancies were complicated by gestational diabetes, pre-eclampsia with possible seizure, and congenital syphilis. Her most recent pregnancy ten months earlier resulted in a stillbirth. She had had no return of menses after this last delivery and was unsure of the duration of current pregnancy. She had been taking prenatal vitamins for a few months and wanted prenatal care. She had been unable to come to the insurance covered clinic because of transportation as she had to take three trains. She did not want to leave her tent in case it "wasn't there when she return[ed]." She had history of methamphetamine use and intimate partner violence but denied either currently. She was living in the tent with a male partner.

On exam, her heart rate was regular but tachycardic to 118 with a blood pressure of 144/80. The rest of her exam was unremarkable other than trace bilateral ankle edema. Her point of care hemoglobin was 8.1. We started iron supplementation and gave her an additional supply of prenatal vitamins as well as referrals to a nearby clinic for prenatal care.

The next week, she accessed obstetrical care and had an ultrasound and blood work. She was found to be around eight months pregnant. Her pregnancy ultimately resulted in a stillbirth. Seven months later our outreach medical teams saw her and she was again pregnant. She again requested assistance with obstetrical care and expressed difficulties obtaining housing. She was later lost to follow-up.

Discussion

This 28-year-old woman's history and circumstances are unfortunately typical and demonstrate the complex relationship between pregnancy and homelessness. Unhoused women have higher overall rates of pregnancy and unintended pregnancy than the general population. These higher rates result from lack of access to contraceptives, particularly more effective long-acting reversible contraceptives, as well as the need for intimacy, survival sex (meaning trading sex for food, a place to sleep, drugs, or other basic needs), and forced sex.[2,3] Many women have experienced or fled situations of domestic violence, and they have high rates of sexual trauma, increasing the complexity of these cases.

Not only do unhoused women have higher rates of pregnancy, they face many challenges to their prenatal care. Women who are both pregnant and homeless have more acute and chronic health problems than other women, including hypertension, diabetes, asthma, and mental illness.[4] They are also typically younger with increased risk of sexually transmitted infections, and higher rates of stress, depression, anxiety, and substance use, with an increased likelihood of preterm and low birth-weight babies.[2,5,6]

The socioeconomic challenges these women face and the effects on their health cannot be overstated. Pregnant unhoused women have increased risk of food insecurity, inadequate nutrition, and nutrient deficiencies, particularly iron deficiency anemia which correlates with low birth weight.[5] Another major concern is violence. One study of pregnant homeless women had 91.5% report someone had hit them or tried to hurt them in the past year; 57% said they had changed residences three or more times in the past year; 32% said they often go to bed hungry, and 19% said they feel unsafe where they live. Of those surveyed, 56% were receiving prenatal care, and 75% perceived barriers to accessing prenatal care. These included site-related

barriers like distance, transportation, wait time, provider-client relationship, and inconvenience.[2]

For many women experiencing homelessness, competing priorities like the need for food, clothing, shelter, and personal safety take precedence over prenatal care. For some, it is challenging just to make an appointment and keep it. They fear consequences for substance use, and they may distrust the healthcare system. Problems of abuse and fear of being reported to Child Protective Services or having children taken away also contribute to decreased care.[2,6]

Systemic barriers contribute, too. These include fragmented care among different health care teams and clinics that do not share medical records, questions about eligibility for services, lack of insurance or underinsurance, and negative attitudes from health care providers.[6] Lower health literacy among unhoused women compounds these problems and makes the healthcare system even harder for them to navigate.

As a result of delayed and inadequate prenatal care, homelessness in pregnancy has been linked to adverse perinatal outcomes, including increased risk of preterm delivery, low birth weight, delivery complications, and neonatal intensive care unit admission.[4,5,7] These can have important long-term health and economic implications because premature babies experience increased risk of other developmental problems, such as deficits in academic achievement and attention disorders.[6]

Despite these barriers, many unhoused women perceive pregnancy as an opportunity for change and are motivated to have healthy pregnancies. Because we know prenatal care is essential to early detection of complications, we must develop systems that help support change.

Three possibilities come to mind. First, we should adjust our attitudes by improving provider communication. We should remain respectful, minimize judgement, and focus on reducing barriers to access care. We should treat mental health and substance use during pregnancy as priorities and do so in a nonjudgmental way. Finally, we should ensure unhoused women feel supported, not condemned if they have delayed seeking care.

Next, because lack of transportation is a common barrier to care as with this patient, we should consider transportation assistance programs. Although street medicine provides care to women where they are, it presents challenges. Typically, street teams do not have obstetric providers and cannot offer the full testing of a standard prenatal visit.[8] Referrals to obstetricians therefore remain critical. Street teams can assist with access and transportation and can encourage prenatal visits.

Finally, we should consider ways to help even before pregnancy. We can make long-acting reversible contraception more readily available. We can also assist with nutritional, medical, and substance use counseling in women of childbearing age.[5]

Health care providers alone cannot solve the conditions that lead to the dire situation of unhoused pregnant women. The solutions are sociopolitical rather than medical. Policy changes at the governmental level will be necessary to address the problems of housing, evictions, the cost of living, and domestic violence.[9] Programs to help with rapid re-housing of pregnant women should be considered. But the healthcare system can do its part by changing attitudes toward homeless women, decreasing fragmented care, providing transportation assistance, increasing access to contraception, and offering counseling.

Conclusion

Our patient demonstrates major barriers to prenatal care faced by unhoused women. These include higher rates of medical comorbidities, mental illness, substance use, inadequate nutrition, lack of transportation, and intimate partner violence. Given the potential long-term health consequences for children born to unhoused women, we must work harder to reduce these disparities.

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