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Reproductive justice for unhoused women: An integrative review of the literature

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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. Twenty-one articles were identified through keyword searches in Google Scholar, Ebscohost Academic Search Premier, and PsycINFO. In included articles, barriers were identified at the individual, relational, and contextual levels. Findings from this scoping 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 documenting 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, homelessness, prenatal care, unhoused women

1 | BACKGROUND AND SIGNIFICANCE

In addition to the stressors of homelessness, those who are of reproductive age (teens to mid-40s; 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 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 (Dasari et al., 2016; Gelberg et al., 2002, 2008; Killion, 1995). 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 abortion 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 (Dasari et al., 2016; Fleming et al., 2017; Smid et al., 2010). On the flip side, some individuals experiencing homelessness are not 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 has 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 toward pregnancy. Some individuals experiencing homelessness desire pregnancy, while others do not wish to become pregnant or have ambivalent attitudes (Begun, Combs, et al., 2019; Dasari et al., 2016; S. 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 (Ruttan et al., 2012; Killion, 1995). Antipregnancy 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 examines 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 documenting 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.

1.1 | Reproductive autonomy and well-being

The ability to determine when and whether one would like to reproduce is known as reproductive autonomy (University of California, San Francisco [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).

1.2 | Sociopolitical and historical context

In the mid-60s, 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 health care (Bailey, 2012).

While funding expanded access to reproductive health care 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, 2021a).

1.3 | 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 Human Rights Office of the High Commissioner, 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 health care and found that cost, political context, racism, and classism impacted reproductive care access and experiences. More recently, Liddell and 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).

2 | THEORETICAL GROUNDING

2.1 | Ecological systems theory

The ecological systems theory examines the systems, environments, and immediate contexts that individuals are nested within (Bronfenbrenner, 1979). 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 toward sex outside of marriage may impact accessibility and use of reproductive services at the chronosystem level.

2.2 | Significance

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). Before 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 toward 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 health care. 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 is in line with this goal, as it moves beyond the individual to examine the larger contexts that hinder autonomy in reproductive matters (Ross, 2017).

This scoping 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. This paper is guided by community psychology values, offering an examination of both individual and system-level barriers. Findings are presented and discussed in relation to context (i.e., the ecological level of analysis at which they occur).

3 | METHOD

3.1 | 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.

3.2 | 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., dissertations, policy papers, evaluation reports, etc.) utilizing original data to examine 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 (i.e., individuals lacking regular housing) 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, Combs et al. (2019).

Smid et al. (2010) qualitatively explored the experiences of pregnant youth experiencing homelessness. The sample contained 13 women and 8 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 documented 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, Combs et al. (2019) consisted of 16 women, 10 men, and 4 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), 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.

4 | INTEGRATIVE LITERATURE REVIEW

Search terms were entered in Google Scholar, Ebscohost Academic Search Premier, and PSYinfo between April and July 2021. Ninety-five abstracts were located. Seventeen were excluded because they discussed contraceptive use (e.g., decision-making practices toward "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 sexually transmitted disease 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 health care (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 include papers discussing contraceptive nonuse originally excluded due to terminology (i.e., "use"). Keyword searches 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" vs. currently homeless when surveyed). Nineteen articles were excluded because they did not meet the inclusion criteria (e.g., examined other

aspects of reproductive health care, 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 1 and 2). Included articles were published from 1995 to 2020. Located papers utilized qualitative (n = 11), quantitative (n = 9), and mixed (n = 1) methods (see Table 1). 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 14 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.

4.1 | Data extraction and analysis

Key details (i.e., reference, research question/hypotheses, method, sample, findings) were extracted from the included articles. Thematic analysis of included qualitative studies consisted of multiple read-throughs of the findings and memoing initial codes. Themes generated from initial readings were applied to the findings using a line-by-line coding approach.

5 | 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

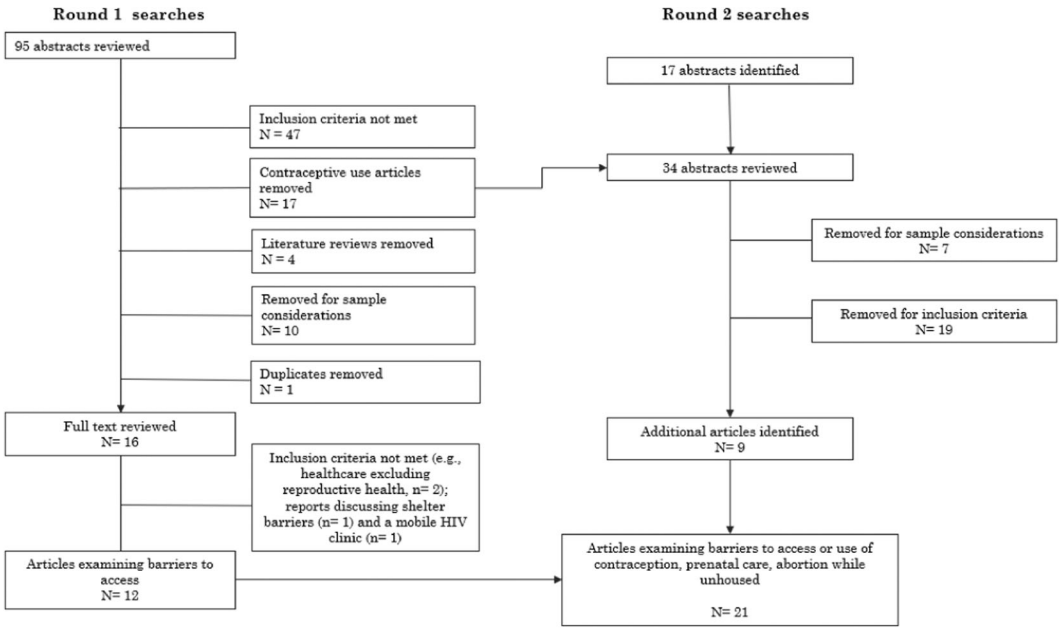

FIGURE 1 Article inclusion/exclusion

TABLE 1 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 18–21	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 18–24 experiencing homelessness	Pittsburgh, PA	Qualitative & Quantitative
Ensign	2001	20 women engaged with clinic ages 15–23	Seattle, WA	Qualitative
Ensign & Panke	2002	20 women ages 14–23	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 18–39	Southern CA	Qualitative
Killion	1998	15 homeless women from 5 shelter locations	Southern CA	Qualitative

(Continues)

TABLE 1 (Continued)

Author	Year	Sample	Location	Method
MacKellar, Valleroy, Hoffmann, Glebatis, LaLota, McFarland, Westerholm, & Janssen	2000	478 homeless women aged 18–26	San Francisco, CA; New York City, NY; Ft. Lauderdale, FL; Houston, TX	Quantitative
Smid, Bourgois, & Auerswald	2010	13 homeless women aged 18–26 & 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 2 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.

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 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 toward 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.

5.1 | 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 CPS, 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.

TABLE 3 Findings

References	Individual factors	Relational factors	Contextual factors
Ake et al. (2018)	Lack of childcare		Transportation
Barman-Adhikari et al. (2017)		Reproductive coercion Transactional sex	
Begun, Combs, et al. (2019)	Misconceptions about contraception/ reproductive system Fear of side effects Birth control challenges Lack of contraceptive knowledge Financial barriers	Reproductive coercion Transactional sex Monogamy	Transportation Stigma
Bloom et al. (2004)			Transportation Stigma
Cederbaum et al. (2013)		Monogamy Reproductive coercion Transactional sex	
Corey et al. (2020)	Fear of side effects Cost		Healthcare system
Dasari et al. (2016)	Misconceptions about contraception/ reproductive system Fear of side effects Time/competing demands Cost	Reproductive coercion	Healthcare system
Ensign (2001)	Fear of side effects Healthcare system misconceptions Birth control challenges Financial barriers	Monogamy	Geographic context
Ensign and Panke (2002)		Social support	Transportation Healthcare system Stigma
Fleming et al. (2017)			Transportation Healthcare system
Gelberg et al. (2004)	Misconceptions about contraception/ reproductive system Time/competing demands	Reproductive coercion	Transportation Healthcare system Stigma Living arrangement
Gelberg et al. (2002)	Fear of side effects Substance use history Financial barriers Age Race	Reproductive coercion	Living arrangement
Gelberg et al. (2008)	Misconceptions about contraception/ reproductive system Substance use history Age Time/competing demands Race	Social support Monogamy Tra	Living arrangement

TABLE 3 (Continued)

References	Individual factors	Relational factors	Contextual factors
D. P. Kennedy et al. (2010)	Misconceptions about contraception/ reproductive system	Monogamy Reproductive coercion	
S. Kennedy et al. (2014)	Fear of side effects Birth control challenges Time/competing demands	Reproductive coercion	Living arrangement Stigma
Killion (1995)	Financial barriers		Living arrangement Stigma
Killion (1998)	Time/competing demands Financial barriers		
MacKellar et al. (2000)		Social support Reproductive coercion	
Smid et al. (2010)	Fear of CPS		
Tucker et al. (2006)		Reproductive coercion	
Wenzel et al. (2001)	Healthcare system misconceptions Birth control challenges Substance use history		Healthcare system

Abbreviation: CPS, Child Protective Services.

5.1.1 | Misconceptions about contraception and reproductive systems

Several articles discussed misconceptions and false information participants believed about birth control and their reproductive systems. Notably, these barriers have continued to persist (Begun, Combs, et al., 2019) despite being noted in the literature nearly 20 years ago (Gelberg et al., 2004). Lack of reproductive education from parents and school systems resulted in contraceptive knowledge obtained through peer networks (Begun, Combs, 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, Combs, et al., 2019). D. P. Kennedy et al. (2010) found that negative attitudes toward condoms increased the likelihood of unprotected sex.

5.1.2 | Fear of CPS

Smid et al. (2010) identified fear of CPS as a barrier to accessing prenatal care among youth experiencing homelessness. Participants reported putting off prenatal healthcare 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.

5.1.3 | 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). Nearly 20 years later, Corey et al. (2020) found similar results; side effects were a barrier to contraceptive use among women who did not desire pregnancy. Roughly half (47%) of the 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 a lack of accessible hygiene products and restrooms (S. 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, Combs, 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).

5.1.4 | 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).

5.1.5 | 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. D. P. 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, Combs, et al., 2019). Youth also reported that taking birth control pills at the same time every day was challenging while experiencing homelessness (Begun, Combs, et al., 2019). Some youth shared their dislike of birth control methods that altered hormones, which also prevented use (Ensign, 2001).

5.1.6 | 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 MacKellar et al. (2000), which found that using less marijuana significantly predicted condom nonuse.

5.1.7 | 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). S. 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).

5.1.8 | Lack of knowledge of where to obtain contraception

One article discussed the lack of knowledge of 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, Combs, 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, Combs, et al., 2019, p. 13).

5.1.9 | 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.

5.1.10 | 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. Financial barriers were first identified in 1995 (Killion, 1995) and have remained a deterrent to contraceptive care (Begun, Combs, et al., 2019; Corey et al., 2020).

Killion (1995) found that participants lacked the money needed to purchase contraceptives and the knowledge of 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, Combs, et al., 2019, p. 12). Furthermore, youth were not aware that contraceptive care was covered by Medicaid (Begun, Combs, et al., 2019).

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).

5.1.11 | Age as a moderator of barriers

Two articles discussed age-related differences in barriers to contraceptive use. Among unhoused youth (ages 15–24), uncertainty about which contraceptive method to use was the largest barrier to contraceptive use while women between the ages of 35 and 44 most reported contraceptive discomfort as a deterrent to use (Gelberg et al., 2002). Youth (ages 15–24) were five times more likely to not know how to use contraception compared to women between the ages of 35 and 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).

5.1.12 | 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).

5.2 | 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.

5.2.1 | 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 (Mackellar 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.

5.2.2 | 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 (D. P. 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). Mackellar 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 (Cederbaum et al., 2013). Unhoused youth made similar decisions about condom use based on level of partner trust (Begun, Combs, et al., 2019; Ensign, 2001). Youth reported that condom use was generally inconsistent, but condoms were more likely to be used during intercourse with acquaintances versus committed partners (Begun, Combs, et al., 2019). Requiring condom use during intercourse signified a lack of trust (Ensign, 2001).

5.2.3 | Reproductive coercion

Reproductive coercion occurs when an individual's reproductive choices are controlled by their partner (American College of Obstetricians and Gynecologists [ACOG], 2021). 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 (S. 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, Frey, 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 et al., 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 (Cederbaum et al., 2013). 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 (Cederbaum et al., 2013).

Birth control sabotage was mentioned in two studies. In S. 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 (D. P. Kennedy et al., 2010). History of rape was also identified as a significant predictor of not using a condom (MacKellar 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).

5.2.4 | 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, Combs, 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 et al., 2017). However, Cederbaum et al. (2013) 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.

5.3 | Contextual barriers

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

5.3.1 | 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 a lack of on-site reproductive health services, contraceptive education, and information on where to access reproductive care while without housing (S. Kennedy et al., 2014).

5.3.2 | Transportation

Transportation issues were first noted in 2004 (Gelberg et al., 2004) and have remained a barrier to contraceptive and prenatal care (Begun, Combs, et al., 2019; Fleming et al., 2017). Transportation difficulties were a barrier to 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, Combs, 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 twothirds of unhoused pregnant women surveyed (Bloom et al., 2004). Transportation, parking, and clinic distance serving as barriers to care was significantly related to how many children the individual was parenting (Bloom et al., 2004). 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.

5.3.3 | 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, the 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 for 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 dialog 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 2 months to see a provider. Participants also expressed difficulty in finding a provider that accepted Medicaid. For instance, one participant reported needing to get the 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). Notably, this barrier to service receipt was first identified in 2004 (Gelberg et al., 2004) and remains an issue presently (Fleming et al., 2017).

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 (S. 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).

5.3.4 | Internalized and felt stigma

While stigma involves individual-level perceptions, the antecedent of these perceptions is societal judgment toward 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. Findings in this review indicate that stigma within service settings has persisted across time (Begun, Combs, et al., 2019; Killion, 1995).

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 toward contraception based on assumptions that they were behaving promiscuously (Ensign & Panke, 2002). Concerns about stigma caused some youth to not use health care at all (Begun, Combs, 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, Combs, 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 health care hid their housing status to avoid stigmatization from their provider (S. Kennedy et al., 2014). Others reported a difference in treatment once their housing status was disclosed (S. 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., 2004, p. 431).

5.3.5 | Geographic context

One article highlighted the influence of geographic context on the 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.

6 | 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 United States 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.

6.1 | Overview of results

The majority of the 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 3).

6.2 | Critique of the literature strengths and limitations

6.2.1 | Limitations

Time

Articles included in this review were published across a 25-year period. Chronosystem-level factors, including policy changes and shifts in attitudes toward sexuality and reproductive health, are not accounted for in this review but may influence access barriers.

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.

6.3 | Implications for research

6.3.1 | 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 nonbinary 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 a 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.

6.3.2 | 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.

6.3.3 | 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 United States (Ensign, 2001). Included studies had samples from 13 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, in 2021, Texas implemented legislation that prohibits abortion procedures after the detection of a fetal heartbeat (S.B. 8) and penalizes assistance to individuals terminating pregnancies (Center for Reproductive Rights, 2022). More recently, the US Supreme Court reversed Roe v. Wade, which protected the right to abortion and may influence other aspects of reproductive health care in the near future. 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 (Martins et al., 2016). Furthermore, providers were in the office far less frequently (once a month, compared to four times per week) in rural areas (Martins 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.

6.3.4 | 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, 2021b). 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, 2021b). 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.

6.3.5 | 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) did not 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 WHO, medical abortion remains a stigmatized procedure in the United States (Millar, 2020; WHO, 2018). 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 (Ake et al., 2018; Smid et al., 2010), whereas systemic barriers included transportation difficulties (Bloom et al., 2004; Fleming et al., 2017). 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.

6.4 | 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, stigma-reduction

interventions, increased resources for unhoused women in coercive relationships, and implementation of on-site reproductive services.

6.4.1 | 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). Elsewhere, research examining reproductive education interventions for unhoused women found that participants had more contraceptive knowledge after participation and increased self-efficacy in reproductive autonomy (Aparicio et al., 2019; Meurice et al., 2019). 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.

6.4.2 | 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 well-being in addition to ameliorating a reported barrier to contraception among individuals who utilize shelter spaces.

6.4.3 | Stigma-reduction

Findings indicated that stigmatizing interactions with health service providers served as a barrier to contraceptive service utilization. The potential threat of being stigmatized by health providers prevented engagement in service use (Begun, Combs, et al., 2019). Coalition building between shelters and reproductive care clinics could support referral processes, re-engagement with services and decreased internalized stigma. Additionally, healthcare organizations serving unhoused individuals might consider focusing intervention efforts, such as staff training, to reduce stigma toward unhoused individuals' regarding their sex lives. For instance, education on the value of sexual intimacy for well-being among individuals experiencing homelessness could be provided to healthcare workers (Ecker et al., 2018). Establishing universal guidelines for interactions with patients, rather than letting biases influence which contraceptive methods are discussed (Dasari et al., 2016) might contribute to less experiences of felt stigma.

6.4.4 | Resources for women experiencing reproductive coercion

Shelter spaces and other service centers might consider implementing supports for unhoused women in exploitative relationships, given the widespread experiences of reproductive coercion identified in this review. Education on

healthy relationships could be included in efforts to provide reproductive education to individuals experiencing homelessness. This strategy has been identified as effective and acceptable among housed samples. For instance, Miller et al. (2017) found that receiving educational brochures about reproductive coercion during health appointments made participants feel cared for. Moreover, Intimate Partner Violence (IPV) programming developed specifically for individuals experiencing homelessness is also needed (Petering et al., 2014).

6.4.5 | 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 (S. 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 (S. 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).

7 | 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, stigma-reduction interventions, increased resources for unhoused women in coercive relationships, and implementation of on-site reproductive services could increase access and utilization of contraceptive, abortion, and prenatal care among unhoused individuals.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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