Experiences with Prenatal Care Among Women in a Philadelphia Homeless Shelter

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Abstract

Prenatal care for the underserved is a national concern, especially among homeless women likely to experience barriers to care during pregnancy. Inadequate prenatal care confers increased risk for gestational complications and unfavorable postnatal outcomes, including prematurity and low birth weight. Yet while many studies delineate the prevalence and health consequences of inconsistent prenatal care in the homeless and underserved, few explore the women's experiences or identify perceived needs within this population.

This study explored both positive and negative experiences with prenatal care and pregnancy among Philadelphia's pregnant homeless women with the intention of designing effective interventions to increase the consistency and to improve the quality of care. Study participants were recruited from Philadelphia's primary intake shelter for women and children, and were individually interviewed about their pregnancies and prenatal care experiences. Interviews were digitally recorded, transcribed, and reviewed for thematic elements. Nine women were interviewed in total.

Self-identified barriers undermining consistent prenatal care included issues with insurance, lack of transportation to appointments, and negative experiences with prenatal care during previous pregnancies. While some women reported rewarding relationships with their prenatal care providers, many expressed a need for education regarding exercise, diet, and stress-reducing practices for both expecting and breastfeeding mothers. Women also expressed interest in support groups, parenting classes, and therapy sessions as venues to share their stories and to learn from others. These insights inspired several initiatives at Eliza Shirley House for Women through JeffHOPE, Jefferson's medical student-run free clinic, including designing educational materials and classes, and providing family therapy sessions.

Background

In 2007 it was estimated that 3.5 million people experienced homelessness, of which 17% were single women and 30% were families with children[1]. Additionally, many women are part of a hidden homeless population who live with family or friends, and who are constantly at risk of being forced to leave the household. This risk can increase when a woman becomes pregnant by adding stress and financial burden. It is estimated that 1 in 5 homeless women are pregnant, almost twice that of the general population[2]. In a study that assessed the prevalence of homelessness and pregnancy in several cities nationally, Cutt D.B. et al. found that in Philadelphia 17.2% were homeless prenatally and 15.8% were homeless postnatally[3]. Consistent and comprehensive prenatal care is an essential part of maintaining a healthy pregnancy. For women who are pregnant and homeless, later presentation to prenatal care and inconsistent prenatal care can be common occurrences due to inherent and perceived barriers to care. A retrospective study conducted in Canada in 2005 found that pregnant women who were homeless had a threefold increase

in risk for preterm delivery, a seven-fold increase in risk for infant birth weight under 2000 grams, and a threefold increase in risk for delivery of a newborn small for gestational age[4].

Legislation has been enacted to eradicate financial barriers to prenatal care among homeless women. Despite this, access to care within this patient population remains less than ideal due to barriers rooted in the social determinants of health. These barriers include transportation, long wait times for appointments, a lack of trust in the healthcare system, being unaware of the importance of prenatal care, having an unplanned pregnancy with a delay in presentation, and not having a regular healthcare provider. Bloom, et al. interviewed pregnant homeless women and found that 43.9% were not receiving prenatal care. Even with women receiving care, only 50% were receiving consistent care appropriate to their gestational age. 57.4% of women reported barriers to care with 66% specifying a lack of transportation[2].

While the sources of barriers to prenatal care and its consequences in pregnancy outcomes have been elucidated by these and other studies, few explore the women's experiences with pregnancy and prenatal care while homeless, both positive and negative, or identify perceived needs within this population. This study explored experiences with pregnancy and prenatal care received by Philadelphia's pregnant homeless women, as well as conducted a needs assessment with the intention of designing effective interventions to increase the consistency of care.

Methods

Participants were recruited during clinic hours of JeffHOPE, the Sidney Kimmel Medical College's student-run free clinic, at the Eliza Shirley House for Women, the primary intake shelter for newly homeless women and children in Philadelphia. No incentives were utilized in the recruitment for this

Participant	Age	Race	Education Level	Total Pregnancies	# of Prior Children	Living Situation during Pregnancy
1	20	W	11th Grade	2	0	Transient housing (with family)
2	22	M - B&L	12th - high school graduate	2	0	Transient housing (with father of baby's family)
3	25	W	12th - high school graduate	7	3	Homeless, living at Eliza Shirley
4	33	O	Associate's Degree (fashion)	2	1	Transient housing (with family)
5	27	B	11th Grade	3	2	Homeless, living at Eliza Shirley
6	23	L	Certified Nursing Assistant	2	1	homeless, living at Eliza Shirley
7	24	B	12th Grade	3	2	homeless, living at Eliza Shirley
8	25	B	GED	2	1	homeless, living at Eliza Shirley
9	29	B	9th Grade	4	3	homeless, living at Eliza Shirley

Table 1. Demographics. Race Key: W= White/Caucasian, B= Black/African American, L= Latina/Hispanic, O=Other, M=mixed

study. All women invited to participate in the study met the inclusion criteria consisting of being a current resident of the Eliza Shirley House for Women and being currently pregnant OR pregnant within the last 6 months while identifying as homeless, in temporary housing, or in transient housing. Individual interviews were conducted. Discussion guides including demographic as well as open-ended questions were utilized. Interviews were audio recorded and transcribed with subject identifiers omitted. Researchers included on the study each individually reviewed and coded the interview transcriptions for common themes. Meetings were held to discuss themes and to develop initiatives to improve consistency of prenatal care.

Results

Women frequently discussed difficulties with access to providers and insurance. Transportation caused delays in care for two women and was a determining factor for four women when choosing a provider. Thus, moving to a shelter caused several women to change prenatal providers regardless of their current level of satisfaction. In changing prenatal providers, many complained of long wait times for new patients, causing further delays and gaps in prenatal care. Due to insurance barriers, Participant 3 was unable to receive prenatal care for four months of a high-risk pregnancy. The hospital had terminated its contract with her Medicaid company, so she attempted to change her insurance to one that was accepted by the hospital. In the interim, she was unable to receive any prenatal care and utilized the Emergency room. Another participant did not realize her insurance had been cut off until she tried to pick up medications, stating, "when I went to go get my medicine they said my insurance was cut off in April. I don't know how." Four participants noted the difficulty of adhering to the rigidity of the shelter's dining schedule and menu given increased nutritional needs during pregnancy. These shared experiences fit into an overarching theme of a loss of control and autonomy expressed by five women within the shelter system. Regarding this issue, participant 5 stated, "you eat breakfast at 7:30, lunch is at 12, and dinner's at 4. So from 4 until curfew which is 10:30, you have nothing to eat unless you have money." In addition to the timing of meals, the content of meals was incompatible with pregnancy for some of the participants as well. as participant 3 described, "I get sick from certain foods and I can't eat it [but] they can't compromise on too much things because they have to go by what is on the menu."

Homelessness and the associated environmental stress was a large theme mentioned by all nine participants. It was evident that these stressors were felt particularly strongly by those who had children living in the shelter with them. Participant 3 illustrated by asking, "Why can't they [my kids] have their toys that they used to have? Why we have fire drills at 1 o'clock in the morning? And why we can't have our own room? Things like that … those are definitely struggles … and it's just difficult." Regarding noise and privacy issues within the shelter, participant 5 described her living in the shelter as, "you know it's not a fit environment for a newborn. It's barely fit for a pregnant woman or kids…winding down it's kinda hard with the noise. It's a lot of noise, so pretty much it's not that much sleep. And then I'm not good at hearing people snoring, so it's not really a favorite place for a pregnant woman."

For several women, the shelter was a last resort and a reprieve utilized out of safety concerns for domestic violence or other unhealthy living situations. Four of the participants experienced domestic violence during their pregnancy. Participant 1 experienced an altercation with her newborn's paternal grandmother prior to arriving at the shelter, stating, "she tried to choke me and then her boyfriend got involved. He got in my face and everything. My daughter was still in the chair, I was trying to pick up my daughter and get out…then there was a shootout. There's always shooting and fighting." Participant 6 describes her relationship with the father of the baby prior to

coming to the shelter, saying that after she became pregnant, "he really started getting abusive because he could really control me now that I'm having his kid." Participant 2 described her experience, stating that "with the father … he can go from 0 to 100. So if I would argue back with him when I was pregnant, I would probably have lost my baby." This participant explained that she felt the need to take to protect herself and her family from this individual, remaining in the shelter as much as possible and limiting contact with friends and family.

Feelings of isolation and little support was another theme that emerged among many women. Participant 4, who was living with her mother at the beginning of her pregnancy, reported, "I thought that since I was living with family I would get my support, and I didn't. I didn't feel like I was supported at all. It was like once I told my mom I was pregnant, she like distanced herself from me … [when I told her I was pregnant] she was like, where y'all gonna move?" In the same vein, a few participants were hesitant to share that they were pregnant with their family members. Participant 7 admitted, "I haven't told my mom yet 'cause I already have two now, and she's probably going to be mad that I had another one and I'm in this predicament. She's going to be pissed. She's going to be upset." Often, the women turned to the support of the shelter staff, such as participant 3 whose family did not approve of her children's father. During her interview she stated, "it's actually really crazy that the staff here is more supportive than family members."

Many of the women facing their pregnancy and homelessness without support systems emphasized the principle of self-reliance. Participant 6 proudly stated, "I think I do a hell of a job as a mother and father." And for many women, their motivation was to ensure that their children would have the best possible lives in the future. This sentiment was expressed by participant 9 who stated, "as far as helping myself and my children...there is no one that they can rely on but me right now, and I just want the best for them."

Beyond learning from women's experiences with pregnancy and prenatal care while homeless, a needs assessment of the population was performed with a goal to develop future interventions. During interviews, participants were asked to identify ways to support pregnant homeless women specifically at Eliza Shirley House Shelter as well as within the community. The ideas included providing support groups for women in similar situations to identify and find solidarity, as well as therapy sessions to help women learn tools to cope individually. One participant thought providing fun activities would help with stress reduction. Some of the women advocated for more resources for housing, employment and healthcare that were more tailored toward pregnant women. Additionally, there was interest in educational

Theme	Frequency (n=9)
Concern for personal safety	4/9
Lack of social support	8/9
Transportation/location affecting access to care	4/9
Insurance concerns affecting access to care	3/9
Lack of control in the shelter system	5/9

Table 2. Common themes of interviews.

programming to address pregnancy misconceptions, pregnancy expectations, and parenting classes.

Discussion

Five main themes that heavily factored into the women's experiences were identified during this study - access to care, insurance coverage, lack of control in the shelter environment, environmental stressors and personal safety, and a lack of social support. These are shown in Figure 2. Despite these issues, it was also found that the women displayed a tremendous amount of resilience in the face of adversity and were acting according to what they thought would be best for the future of their children.

Regarding the issue of transportation, a program that would reliably transport pregnant homeless women from their shelter to the clinic could negate the transportation issues that have caused women to miss a prenatal appointment or to change providers. Insurance difficulties, including misconceptions about coverage, can prevent women from receiving optimal care during their pregnancies. A policy intervention allowing pregnant women to receive prenatal care and associated medications even while their insurance is not active could be appropriate.

Common themes also discovered involved a lack of control in the shelter and environmental stressors. Pregnant women at this shelter are placed on the floor with women who have young children, an environment with more noise and is difficult to access as evidenced by the many complaints about excessive flights of stairs. One of the participants thought that a worthwhile solution would be to create a shelter exclusively for pregnant women. A shelter like this could potentially address other pregnancy-specific issues identified in the study, such as mealtime practices. Despite these conditions, many women displayed their strength during discussions about fleeing unsafe conditions and instead, choosing homelessness to protect the wellbeing of their unborn child.

To address the identified need of support systems, a new approach to prenatal care has been recently implemented in clinics. As Julia Phillippi, CNM, MSN, explains, "the current prenatal visit structure and format is not research-based and may not resonate with the needs of women. The newer group model, called Centering Pregnancy, combines prenatal care with a group format and has shown excellent health and satisfaction outcomes."[5] This group format allows pregnant women to receive integrated care, where education, peer support and psychosocial issues are included in the prenatal care delivery system. One research group conducted a randomized control study comparing women receiving group model care compared to traditional prenatal care. This study found a 33% risk reduction in preterm births for women in group care compared to women in standard care. The women receiving group care were also significantly more likely to know more about their prenatal care, be prepared for labor and delivery and feel more satisfied with their care.[6] This group model of care has the potential to help to overcome many of the barriers to prenatal care that the pregnant homeless women in this study identified, while also addressing their psychosocial needs.

Regarding a few participants' desire for educational resources, The Homeless Prenatal Program, an organization originating in San Francisco, CA has shown evidence for the value in prenatal and parenting educational programs. By providing these educational services, their program has increased healthy outcomes for both mother and child within their patient population. Thirty-five hundred babies have been born through the Homeless Prenatal Program since 1992, and of those, 90.1% were of normal birth weight, and 98.5% were drug free.[7] The success of the Homeless Prenatal Program shows that education can go a long way in improving prenatal care, pregnancy experiences, and pregnancy outcomes.

Conclusion

Based on the discovered themes and insights, several ideas for initiatives at the researchers' home institution and student-run clinic at Eliza Shirley were developed. One such program would address the nutritional concerns expressed by many participants. This nutritional program would entail personalized meal plans developed using local affordable food establishments. The researchers hope to develop nutrition, pregnancy, and parenting educational programming including group classes to be held on clinic days and pamphlets to hand out. To date, the researchers have developed a partnership with Jefferson's Couples and Family Therapy program and students trained in mental health care now provide individual and group counseling to pregnant homeless women at the Eliza Shirley House for Women, with the option for regular outpatient follow-up. Studies to determine the efficacy of these interventions would be useful, however given the transient nature of this particular shelter, with most women staying only one week to one month in duration, such a study would prove difficult.

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