Exploring sexual and reproductive health: women experiencing homelessness in England and Australia

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A thesis jointly submitted in partial fulfilment of the requirements of Sheffield Hallam University for the degree of Doctor of Philosophy

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Exploring Sexual and Reproductive Health: Women Experiencing Homelessness in England and Australia

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Statement of Authorship

Except where reference is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis accepted for the award of any other degree or diploma. No other person's work has been used without due acknowledgement in the main text of the thesis. The thesis has not been submitted for the award of any other degree or diploma in any other tertiary institution.

All research procedures reported in the thesis were approved by La Trobe (HEC22254) and Sheffield Hallam (ER45548696) Human Research Ethics Committees.

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Abstract

This thesis explores the sexual and reproductive health (SRH) decision-making of women experiencing homelessness, an area of research neglected in homelessness scholarship. It uncovers the barriers to their decision-making and asks how it is possible to understand bodily autonomy in the context of survival. This research was conducted in England and Australia, two countries with mounting housing crises and characterised by neoliberal strategies that fail to address the structural factors forcing women into homelessness.

Findings are based on unstructured, qualitative interviews with 12 women in England and 11 women in Australia who self-identified as having experienced homelessness. Group collaging sessions were also conducted with four women in England and five women in Australia. A feminist ethics of care guided every stage of the research process. A theoretical lens combining concepts of reproductive justice, structural stigma and structural violence informs the research. This framework re-politicises stigma and delivers a new lens for interrogating the structural processes that inform women's decision-making.

This research produced a series of important and novel theoretical and empirical contributions to what is known about the SRH of women experiencing homelessness. From these, four of the most significant findings have been identified. First, good/bad womanhood discourses are an injurious force that devalue women experiencing homelessness and limit their reproductive autonomy. Second, women's capacity for SRH decision-making must be understood as integrally connected to housing deprivation. Third, violence permeates the lives of women experiencing homelessness and is a significant repressive force on their SRH decision-making. Fourth, the barriers these women face mean their SRH decision-making is highly complex and resourceful, and requires constant, often invisible, forms of labour. By examining SRH rights not in isolation, but rather as inextricably linked to the structures that shape the lives of women experiencing homelessness, this research offers a novel and nuanced understanding to guide policy, practice and future research.

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List of Abbreviations

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
DHS	Department of Human Services (Australia context)
HMRC	His Majesty's Revenue and Customs
MHCLG	The Ministry of Housing, Communities and Local Government (English context)
NHS	National Health Service (English context)
NDIS	National Disability Insurance Scheme (Australian context)
LARC	Long-acting reversible contraception
SRH	Sexual and reproductive health
SRSS	Status Resolution Support Services
VCAT	The Victorian Civil and Administrative Tribunal
WRSC	Women's Rough Sleeping Census (English context)

Chapter 1: Introduction

This thesis explores how women experiencing homelessness in England and Australia make decisions about their sexual and reproduction health (SRH). This focus emerged in response to a gap within a gap that was identified in existing homelessness research: a scarcity of research on women's homelessness (which has increased in the past two decades but remains relatively under-explored) and within that, a lack of research on this population's SRH experiences. Much of the existing research on the SRH of women experiencing homelessness is quantitative and has come out of the United States (U.S.), a country with unique political, economic, and healthcare systems, meaning the current literature is unlikely to reflect the barriers that women experiencing homelessness face in other contexts (Murray et al., 2020). The literature that does exists paints a stark picture of the SRH outcomes of women experiencing homelessness, highlighting significant unmet needs and challenges throughout their reproductive lives (Corey et al., 2020; Gordon et al., 2019). In response, this thesis set out to delve deeper into why this picture exists, and the lived experiences behind these poor outcomes, to address this critical knowledge gap.

This research was carried out within the geopolitical landscapes of England and Australia. These are two countries characterised by a neoliberal rationality that has led to a reduction of the welfare state, a withdrawal of investment in social housing, and the introduction of state policies that fail to address the structural factors that force women into homelessness. In both contexts, this research took place against a backdrop of increasingly unaffordable rents, a shortage of social housing, and a rising number of people recorded as homeless. These conditions reflect a broader housing crisis that continues to impact low-income and marginalised populations most severely.

There are some important differences to note between the health systems of these two contexts. Fundamentally, the UK has a universal healthcare system, the National Health Service (NHS), which provides comprehensive care and is free for all UK residents (with some services, such as accident and emergency care, available to anyone). Some may opt to pay for private healthcare which offers shorter wait times and greater choice. Contrastingly, Australia has a mixed public and private healthcare system. Medicare is the universal healthcare scheme, providing essential care to all Australian citizens and permanent residents at low or no cost. However, to lessen pressure on public healthcare, the government incentivises those who earn above a certain threshold to get private health insurance. Private health insurance offers services, such as dentists, opticians, and ambulance, that are not available on the public system.

This chapter provides the introductory context to this thesis by giving an overview of the current state of women's homelessness and defining key terms; articulating the research's aim and the questions used to guide the research; outlining the approach taken to carrying out the research; and mapping the structure of the thesis.

1.1. The challenges of quantifying women's homelessness

Determining the exact number of women experiencing homelessness in England and Australia is challenging, as both countries have multiple ways of defining and counting who is considered homeless. In England and Australia, women are obscured by measurement tools that are geared towards capturing more visible forms of homelessness that are experienced by lone adult men (Bretherton & Mayock, 2021). Despite this, it is possible to gauge a rough picture of the state of women's homelessness from the statistical data that is available in both contexts.

In England, homelessness data is collected in two ways: through rough sleeping counts and local authority statutory data. Since 2016, the government have collected demographic data, including gender, in the rough sleeping count. Women have consistently been shown to make up a small proportion of rough sleepers, and in the years 2022-2024 constituted 15% of all rough sleepers (MHCLG, 2025). However, this count is widely considered to under-record women and not attend the spaces where women are more likely to sleep rough. In response, since 2022 the Women's Rough Sleeping Census (WRSC) has been conducted across 33 London Boroughs and 55 local authorities across England. The WRSC applies a gendered- lens to the issue of rough sleeping and in doing so offers a more comprehensive understanding of the experiences of women who are sleeping rough, who are underrepresented in data and policy. The Census found 'women's homelessness is compounded by systemic neglect, with policies, funding, data collection methods and services failing to adequately recognise and respond to women's experiences' (Wright et al., 2025: 4). Staggeringly, it reports over ten times as many women rough sleeping than the official government count, suggesting women are more likely to experience rough sleeping than has traditionally been thought.

Statutory homelessness statistics in England are collected by counting anyone approaching their local authority and assessed as homeless. However, demographic information on gender is not reported. The closest statistic that can be drawn is from the number of homeless households in temporary accommodation. Between 2023 and 2024, the number of lone parent female households made up 33% of the total number of homeless households, representing a third of all households in temporary accommodation. Lone mother families make up 22% of families in the general population, but 58% of families in temporary accommodation (Garvie, 2025).

In Australia, official homelessness data is collected through a combination of Australian Bureau of Statistics (ABS) census data and through Australian Institute of Health and Welfare (AIHW) data collected from specialist homelessness services. The most recent ABS data is from 2021, where women made up 44.1% of those experiencing homelessness. This figure includes six groups considered homeless: people living in supported accommodation, living in improvised dwellings (e.g. tents or rough sleeping), staying temporarily with family or friends, or living in boarding houses, other temporary lodgings or 'severely' crowded dwellings. This data suggests that women's homelessness is significantly on the rise, with women accounting for 81.7% of the 6,097 increase in people experiencing homelessness in 2021 (ABS, 2021). AIHW data on specialist homelessness services shows that between 2023 and 2024, six in ten clients were women. This data also tells us that out of 280,000 clients using specialist services, around 109,000 had experienced family and domestic violence at some point during the reporting period (AIHW, 2025).

As has been mentioned, women are much less likely to be captured in current tools used to collect data on the numbers of people experiencing homelessness, rendering them less visible. Bretherton and Mayock (2021) suggest there are three types of errors that contribute to why this occurs: spatial, administrative, and methodological. Spatial errors refer to narrow definitions of homelessness that centre rough sleeping and mirror the stereotypical image of homelessness as 'the bearded, dirty male' (Austerberry & Watson, 1983). Administrative errors include the ways that homelessness data is recorded. In the United Kingdom (UK), women accessing domestic violence services such as refuges are not always recorded in systems as experiencing homelessness, despite experiencing both domestic abuse *and* homelessness. This is troubling, as it is well established that domestic violence is one of the lead causes of homelessness for women in both countries (AIHW, 2025; McMordie et al., 2025). However, this issue does not occur in Australia, where women living in refuges *are* counted in homelessness statistics. Methodological errors refer to the methods used to capture homelessness. For example, in the UK, using rough sleeping statistics as a way of counting homelessness is problematic as this is based on a visible population, which we know is predominantly male, as women are more likely to occupy forms of 'hidden homelessness' such as sofa surfing (Bretherton, 2020). In both countries, it is known that women are more likely to avoid professional homelessness services and only access them once all informal sources of support are exhausted, so using specialist service and local authority data can only offer a partial picture of who is experiencing homelessness (Johnsen, 2025). This is important because the methods which are deployed to record homelessness have significant consequences and are argued to 'shape how we research and respond to homelessness' (O'Sullivan, 2015: 17).

The difficulties laid out regarding collecting statistical data on homelessness contribute to women being left out of the public imagination of who is considered homeless and vulnerable to homelessness. This is reflected in policy design, which often fails to address the needs of women because their experiences are repeatedly masked and rendered invisible (Savage, 2016). As asserted by Watson (2023), 'This excludes experiences and social processes of oppression that differ due to gender and further serves to marginalise women in all their diversity' (p173). A failure to give attention to gendered issues in service responses to homelessness means there is often no provision or resources allocated for the issues that women face, including matters related to SRH, and so women's needs remain unmet.

1.2. Research aim and questions

The broad aim of this thesis is to explore the SRH decision-making of women experiencing homelessness in England and Australia. As noted, there is currently very little literature that qualitatively documents these experiences: the broadness of the research aim reflects this dearth of knowledge. Through investigating these experiences, this research seeks to understand and develop a picture of how women experiencing homelessness engage in decision-making processes about their SRH.

In order to address this research aim and guide the fieldwork, three research questions are posed. These are as follows:

1. How are women experiencing homelessness engaging in SRH decision-making processes?
2. How are their choices constrained or enabled? By what/ whom?
3. How can we understand bodily autonomy in the context of survival?

1.3. Definitions of key terms

1.3.1. Defining homelessness

This research adopts the European Typology of Homelessness and Housing Exclusion, the standard typology used by the majority of European countries to record and report on homelessness (Edgar et al., 2007). ETHOS defines homelessness as existing in four main categories: rooflessness, houselessness, insecure housing and inadequate housing. This definition has been chosen because it is the widest reaching definition of homelessness, encompassing the legal, physical and social elements of homelessness. Because of this broadness, it accounts for forms of 'hidden homelessness' which women are known to more typically occupy (Bretherton, 2020).

The term 'housing precarity' is also used throughout this thesis. I use Clair et al's (2019) definition of housing precarity as a 'state of uncertainty which increases a person's real or perceived likelihood of experiencing an adverse event, caused (at least in part) by their relationship with their housing provider, the physical qualities, affordability, security of their home, and access to essential services' (p16). Precariousness is understood as a social position which informs a person's exposure to adverse events, and the knock-on effects of such events. All four categories of homelessness under the ETHOS definition of homelessness are forms of housing precarity.

1.3.2. Defining SRH

In this thesis, I use the World Health Organisation’s definition of SRH as ‘a state of physical, emotional, mental and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction or infirmity’ (World Health Organisation, 2017: 3). This definition is used because it offers a holistic understanding of SRH beyond medicalised approaches and encompasses the tapestry of decisions that women will make across their reproductive lives. This includes decisions about having and raising children, which were important areas of this research. It also acknowledges that decision-making is not static, and that women are often navigating SRH decisions simultaneously.

1.3.3. A note on the language of ‘decision-making’

Throughout this thesis, I use the language of decision-making to refer to the cognitive processes that women engaged in when making a choice. However, I do not offer a set, pre-defined explanation of what 'choice' or ‘decision-making’ mean, because exploring these processes is a central concern of this thesis, and these terms are challenged as part of broader questions about what it means to exercise agency and free-will when engaging in decision-making.

1.3.4. A note on gender

Homelessness has been demonstrated to be a highly gendered experience, yet this is often missed by gender-blind research and neglected by policy and practice design. Failing to account for the gendered dimensions of homelessness means that important elements of women’s experiences are missed (Reeve, 2018; Theobald et al., 2023). Consequently, it has been essential to adopt a gendered lens to this research. Whilst I recognise the tricky terrain of talking about gender without being reductive or essentialist, and want to avoid reproducing dichotomies of 'male' and 'female', it is also necessary to recognise the patriarchal structures that govern society in order to reveal how these disadvantage women, make them more vulnerable to homelessness, and shape their experiences through and out of homelessness.

The SRH of trans women and gender-nonconforming individuals experiencing homelessness remain a largely unexplored area of research. Yet, in the current political climate of increasingly anti- trans rhetoric (and in the UK, retrenched legal rights) these experiences urgently need to be centred. McCarthy et al (2021) point out that studies looking at queer experiences of homelessness often combine trans people's experiences with those of lesbian, gay and bisexual people, and that even when trans individuals are included in research, rarely are experiences of trans males and trans females made distinct. However, for qualitative literature on trans experiences of homelessness in the UK and Australia, see Hail-Jares et al., 2021; England, 2021; 2025). This current research focuses on the SRH experiences of cisgender women, as it was decided that it would not be possible to do justice to the experiences of non- cisgender women within the time and resource constraints of a PhD. Despite this decision, one trans woman did partake in the research. This decision is discussed further in Chapter Three, section 3.3.1.

1.4. Research approach

As outlined in this chapter, homelessness scholarship rarely centres the lived experiences of women, and so women's homelessness remains concealed. With this in mind, I decided it was essential to approach this research from a feminist position, with the intention of centring the women's narratives and positioning them as experts of their own experiences. Additionally, reproductive justice is the cornerstone of this research, and so embedding social justice principles of equity, access, and participation into every step of the fieldwork process was crucial. Consequently, this research interprets women's perspectives as valid and crucial forms of knowledge, and recognises emotion, memories, and other more slippery and hard to verbalise experiences as essential parts of their stories.

It is also important to note that while this research spotlights the limitations on the women's agency in the context of their SRH, this does not mean decision-making was not taking place or that the women were without agency. Rather, it shows that the conditions in which the women were making decisions were extremely limited. Indeed, this thesis draws attention to the reality that the women were in fact engaged in complex, multi-layered decision-making *all the time* in the face of these barriers- significant, yet invisible, forms of labour.

1.6. Contributions to Knowledge

This thesis makes a series of important and novel theoretical and empirical contributions to what is known about the SRH of women experiencing homelessness, an area of scholarship that has been neglected. It provides an original theoretical contribution by applying a reproductive justice framework to how these women experience their SRH, a lens that has not been used before in existing homelessness literature. Interpreting the women's experiences through this framework demonstrates the centrality of having stable and secure housing to being able to enact autonomous decisions about one's SRH. It shows that it is impossible to understand decision-making processes in isolation from the context of housing deprivation: that housing is essential to having bodily autonomy.

This thesis offers new contributions to our existing knowledge on the relationship between women's homelessness and violence. It contributes further evidence to the body of literature which details the interpersonal and systemic violence that women experiencing homelessness face across their lives, but also advances knowledge by revealing how violence informed the women's SRH choices. Specifically, it shows how violence acted as a significant constraining force on the women's ability to enact reproductive autonomy.

Finally, despite the reproductive injustices that will be evidenced throughout this thesis, women were still engaged in highly complex and resourceful decision-making about their SRH. Although intensive forms of labour were evident in how the women approached their SRH, this did not result in meaningful or positive outcomes for them, and in fact often led to greater harm. This finding disrupts stigmatising portrayals of women experiencing homelessness as irresponsible, uncaring, or unable to manage their SRH, and instead reveals a picture of systems creating conditions under which the women were left with no good decisions to make.

1.7. Structure of thesis

This thesis is comprised of seven chapters. Following this introductory chapter, there are six more chapters as outlined below.

Chapter Two firstly offers a discussion of the existing literature on the gendered dimensions of women's homelessness, and what is already known about their SRH. It then sets out the theoretical framework applied to this research. It firstly outlines the key components of a reproductive justice framework, before moving on to discuss the concept of structural stigma and show how engaging in these theories reveals the ways in which intersecting systems of oppression impact possibilities for bodily autonomy in the context of SRH.

Chapter Three provides an overview of the methodological approach used to undertake this research. This includes: the epistemological underpinnings of the research; my positionality in relation to the research; the methods adopted to investigate the research questions; and the analytical process taken to interpret the data. It also details the ethical procedures implemented when carrying out the research to take care of the women and myself as a researcher, the ethical challenges that arose during the fieldwork process, and how I navigated these.

Chapters Four, Five and Six present the empirical findings of this research and provide an analysis of the research findings through the conceptual lens outlined in Chapter two. Chapter four introduces a good/ bad womanhood dichotomy and outlines how the stigma that fuels, and is generated by, this binary was an injurious and constraining force on the women's SRH. It discusses the 'stickiness' of the labels attached to women, the moral judgements associated with these labels, and how these served to devalue them (Ahmed, 2004a; 2004b). In doing so, it reveals how stigma had significant implications for the women's decision-making processes. Chapter five builds on this analysis of stigma by exploring how the women navigated complex health, welfare and justice systems associated with homelessness. It shows that women very often had little or no professional supports available to them, and discusses the direct and indirect effects this had on their SRH. Chapter six builds on the previous two findings chapters to explore the tension between women being held responsible for their SRH, yet at the same time systematically denied the resources to do so. It focuses directly on decision-making processes and reveals the choices that women had to engage in were often paradoxical or illusionary in nature.

Chapter Seven draws together the research findings in a series of overarching conclusions. It spotlights the most important and original theoretical and empirical contributions for how we understand the SRH of women experiencing homelessness. This chapter also suggests avenues for future research and offers policy and practice recommendations based on what the women themselves identified as good practice within professional services.

Chapter 2: Literature Review and Theoretical Framework

This chapter provides a critical appraisal of the existing literature on women's homelessness and offers an account of the theoretical framework developed and applied to explore the thesis' aim and questions.

Firstly, this chapter explores literature that has been identified as most pertinent in relation to the focus of this thesis. It delves into gendered experiences of homelessness, focusing on the gendered elements that are specific to women's pathways into, through, and out of homelessness. It then moves on to review the small body of literature on the state of SRH of women experiencing homelessness, in order to offer insight into existing knowledge and to identify gaps.

The second part of this chapter lays out the theoretical lens adopted in this thesis. The concept of reproductive justice is firstly explored and shown to call into question how intersecting systems of oppression inform how women make decisions about their SRH. Next, the concept of structural stigma, characterised as a violent structural force, is introduced and then discussed in the context of women's homelessness to demonstrate stigma's compounding effects on their lives. I offer justification for why this framework has been chosen as the most effective way to examine the SRH of women experiencing homelessness, by illustrating how it provides a holistic approach that illuminates the structural barriers they face throughout their reproductive lives.

2.1. Legal definitions of homelessness in England and Australia

While for the purpose of this research I adopted the ETHOS definition of homelessness, it is important to set out how both England and Australia legally define homelessness, as this provides context for understanding how women's homelessness is captured in these contexts. As has been outlined in the introductory chapter, obtaining a clear picture of who is currently experiencing homelessness is a complex task, and in England and Australia, statistics are murky. This is partially due to the ways that homelessness is defined in each context, with definitions varying between and within each country. In Australia, the ABS (2012) define homelessness, for the purposes of collecting statistical data for the census, as:

> When a person does not have suitable accommodation alternatives they are considered homeless if their current living arrangement:
>
> - is in a dwelling that is inadequate; or
> - has no tenure, or if their initial tenure is short and not extendable;
> - or does not allow them to have control of, and access to space for social relations.

In the UK, homelessness is recorded differently in each nation. In England, the legal definition of homelessness, according to part seven of the Housing Act 1996 (UK), is:

> A person is homeless if they have no accommodation in the UK or elsewhere which is available for their occupation and which that person has a legal right to occupy. A person is also homeless if they have accommodation but cannot secure entry to it, or the accommodation is a moveable structure, vehicle or vessel designed or adapted for human habitation and there is nowhere it can lawfully be placed in order to provide accommodation. A person who has accommodation is to be treated as homeless where it would not be reasonable for them to continue to occupy that accommodation.

Both definitions are informed by understandings of homelessness as more than just rooflessness, and incorporate essential elements of ‘home’, such as safety, privacy, control of space and security. Under each definition, a lack of at least one of these elements could constitute homelessness. However, the inclusion of subjective criteria (such as overcrowding, which is not measured consistently) emphasises that individuals can have different expectations about what constitutes a safe and secure home.

Although these definitions go beyond 'rooflessness’ and do account for some kinds of hidden homelessness that women are more likely to experience, we know that women are still likely to be underestimated in homelessness statistics (for the reasons set out in section 1.1) (Bretherton & Mayock, 2021). Additionally, there are critiques of the applicability of these definitions, which are not all encompassing and mean that certain experiences of homelessness remain unseen (Noongar Mia Mia, 2022). For example, the ABS definition was developed for the general population in Australia. This means that it fails to capture aspects of homelessness experienced by First Nations peoples, such as the experience of ‘spiritual homelessness’, where one is disconnected from their homeland, family, or kinship networks, and so is not ‘on country’. Conversely, someone living in a house in an extended family network may not consider themselves as living in an overcrowded dwelling and facing homelessness, despite the legal definition (AIHW, 2014). This shows that definitions may reproduce and entrench particular racialised understandings of what constitutes ‘home’ in official statistics.

2.2. The gendered nature of women’s homelessness

Historically, there has been a scarcity of research on the distinctiveness of women’s homelessness (Bretherton, 2020). Watson and Austerberry (1983) were amongst the first scholars to focus on the specifics of women’s housing exclusion and homelessness. Their pioneering study explored the topic through a Marxist feminist lens and named patriarchy as a core driver of women's homelessness. In doing so, it shifted the perspective to examine the structural causes of homelessness. A focus of research documenting the uniqueness of women's homelessness was reinvigorated in the 2010s, and resultingly this issue has begun to receive more attention both academically and in policy and practice contexts (see, for examples, Biederman & Nichols, 2014; Mayock et al., 2012; McCarthy, 2019; Reeve, 2018; Savage, 2016). This section explores two areas of research that have helped to contour the nature of women's homelessness: women's pathways through homelessness, and their experiences of accessing professional services.

The literature that is reviewed in this section comes out of the UK, Ireland, and Australia. My starting point for reviewing the literature was to look at research from the UK and Australia, because these are the two countries in which this current research was conducted. However as previously noted, there is limited literature on the specific gendered dimensions of women's homelessness, and so I decided to look to relevant bodies of literature beyond these two contexts as needed. Consequently, Irish scholarship is included in this section, because there is a significant body of research from Ireland, particularly research that is directly relevant to motherhood and the experiences of women who are mothering while homeless.

2.2.1. Women's pathways into, through, and out of homelessness

As has started to be unpacked in section 1.1, homelessness is a highly gendered experience, and women's pathways through homelessness are distinct. Consequently, this section reviews the literature on the gendered nature of women's movements into, through, and out of homelessness. Existing evidence suggests there are a specific set of vulnerabilities women face that put them at a greater risk of becoming homeless, and impact upon their experiences of homelessness. These factors reflect a range of gendered systemic disadvantages— including poverty, adverse childhood experiences, domestic violence, maternal trauma and single parenthood— all of which influence women's pathways into, and experiences through, homelessness (Mayock et al, 2015; Löfstand and Quiglars, 2016; Fahmy et al., 2016; Bretherton & Pleace, 2024). As noted by Grammatikopolou et al. (2021), poverty is not gender-neutral, and women are more likely to be living in poverty than men. Bretherton and Mayock (2021: 21) echo this, arguing 'it is women who are in positions of socioeconomic disadvantage who are at greatest risk', naming poverty as a major driver of women's homelessness. Edgar (2001) demonstrates how women are more in danger of becoming homeless due to their marginalisation in the labour market, housing insecurity, experiences of domestic violence, and the disproportionate burden of being single parents. These risks are further compounded for women who occupy multiple marginalised identities, for example migrant women, LGBTQ+ women and disabled women (Saunders, 2021).

Domestic violence is consistently shown to be a major causal factor for becoming homeless, and to be a high-risk factor for women while homeless (Bretherton & Pleace, 2024; Johnsen, 2025). As argued by Bretherton and Mayock (2021), 'There is strong, consistent evidence of a mutually reinforcing relationship between women's homelessness and experience of domestic abuse' (p5). In the latest WRSC report (2024), domestic violence was identified as the primary causal factor for women sleeping rough. Women in situations of hidden homelessness are particularly vulnerable to abuse (Bretherton & Mayock, 2021). For example, in Northern Ireland, McMordie et al (2025) found that for women experiencing homelessness, violence was cyclical and involved overlapping and continuous abuse from multiple perpetrators across their lifetimes. Systemic failures to protect women from ongoing violence meant that women remained trapped in abusive relationships or faced homelessness after leaving their abusive homes. Temporary accommodation, particularly mix-gendered arrangements, was shown to expose women to further violence and re-traumatise women, in turn creating heightened vulnerability to substance use. The authors characterised this as a 'vicious cycle of violence-related trauma, trauma-related substance use, and substance-use related homelessness' (McMordie et al, 2025: 3).

It is important to note that domestic violence is not the only cause of women's homelessness, and that a singular focus on violence can eclipse the systematic failures that contribute to women's homelessness, such as gendered experiences of poverty or a lack of specialist women's services (Bretherton & Mayock, 2021). As Reeve (2018) reminds us, it is rarely questioned *why* leaving a violent partner leads to homelessness beyond the violence itself. Exploring this reveals the other gendered disadvantages women face that make them more vulnerable to homelessness, such as being more likely to be primary caregivers and less likely to own their own homes.

In Australia, older women are the fastest-growing group experiencing homelessness. The 2021 ABS Census estimated that 7,325 women aged 55 years and over were experiencing homelessness; this is a 6.6% increase from the 2016 Census (ABS, 2021). This group have been identified as particularly vulnerable to financial and housing insecurity due to taking on an unequal share of unpaid caring and domestic roles, not having participated in the workforce, not accumulating superannuation or other savings over the life course, and having reduced opportunities for home ownership (Australian Human Rights Commission, 2019; Hastings & Craig, 2023). For all of these reasons, women who go through divorce later in life, or those leaving violent relationships, face a higher risk of homelessness (Shao, 2024).

Watson (2018) argues survival sex—the exchange of sex or intimate relationships for material resources and support— is one strategy women might engage in when experiencing homelessness. This is a way in which women can use their limited feminine capital to navigate their instability and dangers experienced in homelessness spaces, particularly on the streets. This finding is echoed by Reeve (2018), who found engaging in survival sex manifested in different ways beyond commercial sex work, including entering ongoing sexual relationships with housed men to avoid homelessness or re-uniting with ex-partners (who in some cases were violent).

As has been demonstrated in this section, women have distinct trajectories into and through homelessness. However, much less is known about how women exit homelessness, and the barriers or enablers they face to doing so. An exception to this is Mayock and Sheridan's (2020) study of sixty women's homelessness histories found over half of the women had experienced long-term homelessness (more than two years), suggesting this phenomenon may be more common than recognised in the literature. In order to begin to unpack how women navigate their homelessness and their possible avenues for exiting homelessness, the following section examines the literature on how they engage with professional support services.

2.2.2. Experiences of accessing professional support services

This section explores the enablers and barriers to women experiencing homelessness accessing professional support services. It is established that in England, there are fewer women-only homelessness services than there are services for men, and resources are generally concentrated on those with dependent children (Bretherton & Pleace, 2018). In Australia, whilst there are specialist service provisions for women, there are still vast gaps in service delivery that caters to particular women's needs, including for older women

(Hastings & Craig, 2023), and pregnant women (Murray et al., 2020). In both countries, women, in theory, experience greater protections for resolving homelessness than men. However, even within homelessness policy that appears to advantage women, accessing support is often contingent upon women presenting in ways that align with conventional gender roles, and which require women to perform acts of femininity (Bretherton et al., 2021).

Failure to conform to traditional gender expectations has been found to result in women being disciplined and the refusal of access to service supports (Mayock & Sheridan, 2020). This suggests that notions of femininity and respectability are embedded in homelessness policies and service design, which in turn create environments of conditionality and shore up notions of worthiness which have real implications for the care that women receive. As argued by Bretherton (2020), women's homelessness is most commonly understood through the lens of normative, traditional gender expectations that locate women firmly as mothers and carers within the home. This is particularly stark for women who are mothers and do not have children in their care. These women are labelled 'single' and face considerable barriers to accessing services, as their maternal identity becomes invisible once separation occurs: invisibility that is enshrined in homelessness and child protection systems (Bimpson et al., 2020).

Research suggests that women are far less likely to use designated homelessness services and more commonly draw upon informal support networks of family, friends and acquaintances (Bretherton et al., 2015; Bretherton, 2020). Commonly, women will only access professional services once all of their other options have been exhausted (Bretherton & Mayock, 2021). This means, at times, women will go to significant lengths to conceal their circumstances, such as staying in violent relationships, in order to maintain access to housing (Johnsen, 2025). Women drawing on their resources to exit homelessness disrupts dominant, stigmatising portrayals of women as powerless victims.

There are multiple reasons that women are less likely to access support services than men. Research demonstrates that some women will avoid using homelessness services because they are mixed-gender, spaces where their bodies are associated with heightened vulnerability and diminished social status (Watson, 2018). This may be in part because of previous experiences of domestic violence which induce fear about being in unpredictable environments with men (Bretherton & Pleace, 2018). Research found that women may also feel that services are 'male-oriented' and therefore do not sufficiently understand the issues they face or cater to their needs; this was shown to be particularly challenging for women who had experiences of abuse. Women also spoke of the issue of a lack of childcare provision available in recovery services as being a significant hinderance (Groundswell, 2022).

Service avoidance can also stem from women having previous negative experiences with professionals, leading to anticipating stigmatising interactions (Johnsen, 2025; Gordon et al., 2019). This sometimes manifests in infantilising encounters with services, which generates feelings of powerlessness and shame. For example, Mayock and Sheridan (2020) found women cited disciplinary practices in hostels making them feel they were being monitored and watched, through modes of surveillance including TV cameras, routine room checks, and bag searches. Similarly, Bretherton (2020) reports that women found utilising services a stressful experience and faced difficulty even finding information on what kinds of services were available to them. Additionally, Bretherton and Mayock (2021) demonstrate that when women do present to services, many are dealing with the compounding effects of trauma, and frequently have high, intersecting levels of need. Women also express difficulties when adjusting to life after hostels, and the lasting impacts of living in environments where their actions were 'policed' (Mayock & Sheridan, 2020).

Studies point to the specific barriers women face in the context of healthcare services. Gordon et al (2019) found a mistrust of health providers and fear of losing their child to social services characterised women's interactions with professional services. Both contributed to women concealing their needs from healthcare providers, particularly regarding their substance use. In these instances, situations arose where proper support was not provided to women and their needs remained unmet. Constant monitoring from services was also reported as stressful by women. Conversely, in situations where women were able to establish rapport with a healthcare provider, they were more likely to comply with care provision (Gordon et al, 2019). Similarly, Biederman and Nichols' (2014) research explored how women facing homelessness experienced healthcare provider encounters along a dehumanising/ humanising continuum. Dehumanising themes ranged from expectations being unmet and feeling judged and negatively stereotyped, to feeling alienated, and at the worst end of the spectrum, completely powerless. In contrast, humanising encounters were described as feeling cared for, trusted, and at best empowered, in which women felt increased independence and self- esteem through these interactions. The influence of these interactions cannot be overstated; good rapport, empathy, understanding and trust in relationships have been shown to be a significant influence on people seeking healthcare, and said to be a 'decider between life and death' for some patients experiencing homelessness (Gunner et al., 2019: 532). This literature demonstrates the relationship between trust levels with services and health outcomes for women experiencing homelessness.

It is difficult to get a broad picture of how women interact with professional services as the limited studies that do exist on women's experiences are primarily qualitative and small-scale in nature. However, the existing research does uniformly show that women feel marginalised and infantilised within services, and as a result will often exclude themselves and seek solutions that do not involve accessing formal supports (Bretherton & Mayock, 2021). The literature can be characterised by this quote from Johnsen (2025), who argues women experiencing homelessness are 'caught in a pernicious cycle of exclusion and exploitation' that is fuelled by 'abject institutional and societal neglect' (p13). This chapter now moves on to review the existing literature on how women experience SRH in the context of their homelessness.

2.3. The state of the SRH of women experiencing homelessness

When considering the existing literature on the SRH of women who face homelessness, it is essential to adopt a gender lens to spotlight the nuances in how homelessness is differentially experienced by women. Riley et al (2007) argue that women-specific studies indicate that gender is one of the strongest predictors of poor health among people experiencing homelessness. This includes reproductive health: existing research delineates the multitude of challenges that women experiencing homelessness face across the spectrum of reproductive health, and their adverse reproductive and maternal health outcomes (Corey et al., 2020). This section presents what is currently known about SRH in the context of homelessness and critically discusses this literature.

As set out in section 2.2, where the literature from the UK and Australia is restricted, I have looked further afield and drawn on bodies of scholarship from other countries. Consequently, this section about SRH also draws upon literature from the U.S., as this is primarily where the evidence base on SRH emerges from. This is particularly relevant regarding the literature on contraception and unintended pregnancy, where much of the evidence comes out of the U.S.

2.3.1 Managing SRH in the context of homelessness

As has been stated, there is a lack of research on women's homelessness: this is particularly stark in the marked knowledge gap on their SRH experiences.

Whilst little research has been conducted on the reproductive decision-making of women in general, the experiences of women experiencing homelessness have been particularly neglected. However, the small body of literature that does exist points to the obstacle's women experiencing homelessness face across their reproductive lives. Sutherns and Bourgeault (2008) argue that healthcare take up is shaped by a variety of factors, outlining three key determinants of 'effective access' to healthcare: the availability of health services, the resources people have available to make use of these services, and the appropriateness of services (such as continuity of care, perceptions of quality, etc). In the research available on how women experiencing homelessness manage their SRH, all three of these determinants are shown to be denied.

Firstly, research demonstrates that women experiencing homelessness face significant unmet needs regarding accessing SRH services. In the UK, women experiencing homelessness are twice as likely to become pregnant compared with women in the general population but less likely to receive antenatal care (Gordon et al., 2019). Structural barriers to accessing antenatal care include financial constraints and negative stereotyping from healthcare professionals, which hinders care-seeking due to fears of stigmatising interactions (McGeough et al., 2020). Women also face barriers to their contraceptive preferences, due to factors such as distance to health clinics and long waiting times (Shah et al, 2019). In the US, female youth who experience homelessness have been found to face barriers to accessing abortion care, even in states with liberal abortion policies that offer services for free. Barriers identified include negative experiences with healthcare providers, a lack of official identification and health documents, fear of legal repercussions, and associated costs (Munro et al., 2021).

Stigma has been consistently identified as a barrier to accessing SRH services: this is amplified in contexts of homelessness, where women have been shown to feel reluctant to engage with services out of fear of stigmatisation after revealing their housing status (Munro et al., 2021). Competing basic unmet needs have also been cited as a reason why women did not access reproductive health services, which could not be a priority when women were seeking food, safety and shelter (Kennedy et al., 2014). For many women, low self-esteem or chronic exhaustion are also cited as barriers to addressing their health needs. In the first study conducted in the UK on the health needs of women experiencing homelessness, carried out and led by women with lived experience, 65% of women reported 'that they struggled to find the motivation and confidence to deal with their health issues' (Groundswell, 2020: 5). These studies highlight that service availability and affordability do not always equate to access. This raises important questions about the barriers that women face that go beyond the issue of service availability and shows the importance of locating decision-making within intersecting power structures.

A worldwide systematic review by Orsini et al (2024) of qualitative research on how women experiencing homelessness manage their menstrual health found that this was not only logistically challenging but accompanied by feelings of shame and a lack of dignity. These feelings stemmed from embarrassing interactions with, primarily male, staff when asking for sanitary products, and feeling judged by others for being unable to manage their menstruation, which compounded feelings of isolation. In Australia, Watson (2023) reinforces that women face difficulties in maintaining personal hygiene due to a lack of access to facilities. She stresses that menstruation and other bodily experiences- including childbirth, menopause, and hormone treatment- remain unaccounted for in gender-blind responses to homelessness.

Primarily, the literature is narrowly concentrated on a couple of discrete SRH experiences and fails to consider the full spectrum of women's SRH lives. Brott and Townley's (2023) scoping review of research from the U.S. identified a combination of individual, relational and contextual barriers to receiving abortion, contraception, and prenatal care. However, it revealed the majority of articles centred on exclusively contraceptive care, and focused on individual-level barriers, such as time constraints and financial barriers, compared to relational and contextual ones. This points to a gap in the existing literature on structural barriers to access and wider SRH experiences beyond contraceptive decision-making.

2.3.2. Pregnancy and birth

It is well established that women experiencing homelessness face higher rates of unintended pregnancy than women in the general population (Galvin et al., 2023a). In fact, Corey et al (2020) found that, in the U.S., 75% of pregnancies among women experiencing homelessness are unintended compared to 45% nationally. In England and Australia, there are no statistics available on the number of pregnant women experiencing homelessness. However, in Australia, evidence from small-scale surveys carried out by two housing support agencies in Victoria suggests the rate of pregnancy for women who are homeless is at least equivalent to that of their housed counterparts (Murray et al., 2018). Research in the UK by Gordon et al (2019) suggests the primary sources of vulnerability leading to pregnancy were unstable family backgrounds and experiences of childhood trauma. These experiences were said to have 'left women with inadequate health knowledge and unhelpful perceived societal norms surrounding personal safety, health care, and support' (p763). Further, Gordon et al (2019) found women experiencing homelessness received no postnatal support. This is a particularly important finding in the context of the substantial number of women who have lost children to social services (Bimpson et al., 2020; Parr, 2024). Women in these situations may turn to survival strategies which push them deeper into homelessness and increase their vulnerability to adverse SRH outcomes (Broadhurst and Mason, 2013; 2020).

Significantly, while some pregnancies are welcomed, in many cases women want to prevent pregnancy but face difficulties obtaining effective contraception due to their cost, storage, a lack of education on the available options and fears of side effects (Thompson et al., 2023). Similarly, qualitative studies in the U.S. have found women expressed a strong desire to prevent pregnancy while homeless, yet few consistently used contraception, citing competing basic needs, restrictive provider practices, and vulnerability to sexual exploitation as barriers (Kennedy et al., 2014; Eapen et al., 2023). In the U.S., women aged 13-25 experiencing homelessness are particularly at risk, and five to eight times more likely to become pregnant than their housed peers. Young women are also less likely to access prenatal and other kinds of reproductive health care (Dworsky et al., 2018).

This body of evidence suggests that homelessness creates conditions under which there are considerable barriers to women enacting their reproductive preferences. This is important in the context of housing insecurity, as unintended pregnancy can lead to adverse health outcomes and prolong periods of homelessness (Galvin et al, 2023a). Women experiencing homelessness are also more likely to experience premature labour and stillbirth than women in the general population. For example, large-scale, quantitative research from Yamamoto et al (2021) examining statewide databases of hospital admissions in three U.S. states reveals large disparities in birthing outcomes between women experiencing homelessness and housed women. However, it has also been suggested that some women view pregnancy as an opportunity for new possibilities and a catalyst for change (Watson, 2018).

While it appears that there is a large body of literature on contraceptive choices and unintended pregnancy, most of the extant research comes out of the U.S. Findings from U.S.-based studies should be understood within the context of a residual healthcare system, characterised by the absence of universal entitlement and under-resourced public provision for those unable to obtain coverage. Additionally, much of the literature on unintended pregnancy and homelessness is predominantly quantitative in nature, meaning the lived experiences behind these numbers remains shrouded. Researching in the U.S., Cronley et al's (2018) study is an exception to this and provides qualitative insight into how women's reproductive health rights are hindered in contexts of homelessness, finding a 'loss of reproductive health rights seem to be catalysed by an unexpected pregnancy at a young age' (p329).

In the Australian context, Murray et al (2020) show that without their basic needs met, women experiencing homelessness faced significant barriers to preparing for motherhood. This included vulnerability to physical and sexual violence, nutritional needs, and poor mental health, all of which had consequences for the woman and her baby. Furthermore, because of their homelessness, several women considered terminating their pregnancies. Commonly, only women who are in the late stages of pregnancy, or already had children, were prioritised for housing. Additionally, some women living in single accommodation have been known to avoid disclosing pregnancy out of fear of being asked to leave (Theobald et al., 2023).

As has been outlined in section 2.2.1, the interrelationship between women's homelessness and violence is well established in research. Sexual violence is one form of violence that women face that denies their reproductive autonomy. Women are at high risk of experiencing sexual victimisation, particularly those who sleep rough (Bretherton & Pleace, 2018; Wright et al., 2025). Sexual violence is a risk factor for unintended pregnancy. Not only this, but violence has been demonstrated to be mirrored in healthcare settings, where pregnant women are vulnerable to coercion and abuse, and can face infantilising and minimising attitudes from providers (Murray et al., 2020). Reproductive health trauma, including a loss of control over one's birthing experience, is suggested to have long-term impacts on their lives (Cronley et al., 2018).

The following section examines the literature on women's experiences of mothering while homeless. Whilst it stands separately from this current section on the SRH of women experiencing homelessness, it is important to note that I understand experiences of motherhood as part of the broader constellation of SRH experiences. However, the body of literature on motherhood and mothering while experiencing homelessness is distinct and so is explored separately for the purpose of this literature review. Literature examined in the following section is drawn from the UK, Australia and Ireland.

2.4. Homelessness and motherhood

There is a growing body of literature on the lives of women who are mothers while experiencing homelessness. Many of these studies point to the relationship between motherhood, housing insecurity and child protection systems. The mothering capabilities of women experiencing homelessness have been shown to be under intense scrutiny within social policy landscapes that treat women with suspicion and subject them to heightened regulation (e.g. Bimpson et al., 2020; Savage, 2025; Watson et al., 2025). As stated by England and Henley (2024), 'Becoming homeless brings poor families, especially those headed by a lone female, into the full view of the state, and renders their once-private activities public and subject to scrutiny' (p4). They argue women are required to deploy certain performances that enable them to be legible as 'good' mothers and thus successfully navigate welfare systems and gain resources (and by extension, autonomy). The multi-layered stigmatisation attached to motherhood and homelessness is discussed in depth in Chapter 4.

Savage (2016), researching in Ireland, argues the importance of acknowledging 'affective systems' (systems of providing love and care), in addition to socio-economic, political and cultural spheres. Specifically in the context of mothers experiencing homelessness, she argues these women face deep affective injustices on multiple fronts. These injustices include care work going unrecognised as important; expectations placed on women to provide primary caring roles which fail to acknowledge the difficulties of caring in the context of homelessness; and the stigma attached to being perceived as 'failing' in these roles. She shows that rather than nurturing being a 'natural' feminine trait, as is often thought, it is in fact a mode of labour which requires extensive resources, which are not accessible for women experiencing homelessness. As such, these women are misrepresented as 'bad' mothers who are unable to properly care for their children (Savage, 2025).

As discussed in section 2.2.2, evidence suggests that mothers may choose not to engage with professional services out of fear of coming under scrutiny from child protection services, which may result in their children being removed from their care (Smid et al., 2010; Johnsen, 2025). Fear of child removal is not unfounded: women have repeatedly been found to be separated from their children because of their homelessness (Reeve, 2018; Parr, 2024; Theobald et al., 2024). Once children are removed, women are no longer seen as parents and thereafter classed as 'single' in legislative terms. This means they are no longer considered a priority group under homelessness legislation and only granted housing suitable for a 'single' person. The literature underscores the catch-22 of women being unable to secure the housing they need to have their children returned to their care, but because their children are not in their care, they cannot access the needed housing (Bimpson et al., 2020).

In addition to the literature on how the policies and procedures of homelessness and child protection policies constrain and, at times, deny women's motherhood, there is a small body of literature that evidences the impact of living in temporary accommodation on mothers, specifically the psychological and affective implications, and the disruption of maternal identity (Carey et al., 2022; England & Henley, 2024; Reeve & Turrell, 2025). This literature is significant as it demonstrates how spaces of homelessness are experienced differentially by women and can fundamentally alter their sense of self and contribute to lasting feelings of 'othering'.

As underscored so far in this chapter, experiences of homelessness are deeply informed by gender roles and power dynamics. Through applying a gendered lens, the ways in which gendered norms shape the design of policies and services, women's engagement and interactions with service providers, and the set of value laden assumptions that characterise these relationships, are revealed. In the second half of this chapter, I propose a theoretical framework to explore why these vast inequities exist in the SRH of women experiencing homelessness and to understand the structural constraints in which they negotiate their SRH.

2.5. Theoretical framework

As outlined in this chapter so far, existing research demonstrates women experiencing homelessness have overwhelmingly negative SRH outcomes and face many barriers to accessing reproductive care. The body of research reviewed begins to reveal the multifaceted, complex and interconnected nature of the challenges that these women face. However, this literature is predominantly quantitative in nature and theoretically under-developed. All three guiding research questions of this thesis are concerned with processes of decision-making, constraints and enablers to choice, and the exercising of bodily autonomy. These questions require a deep inquiry into the women's inner worlds and exploration of their lived experiences. This is in keeping with Bungay's (2013) assertion that it is essential to situate 'the complexity of women's health care...within ideological and structural relations of power that shape the organisation and delivery of health services, health provider practices, and women's engagement in the health care system' (p1017). To address this, it was essential to design a theoretical framework that allowed for a close examination of how women made decisions about their SRH in the context of their homelessness.

To move beyond an individualising framing of the women's SRH and instead spotlight how systemic inequalities shaped their experiences, a reproductive justice framework was applied and extended to examine the violent consequences of stigma. Reproductive justice is an underutilised framework in homelessness research (but cf. Brott & Townley, 2023; Turrell, 2025). I was drawn to this lens because of its attention to structural barriers, and its emphasis on understanding how these operate and intersect to constrain the choices the women had available to them, depending on their social location. For these reasons, this lens was the most appropriate and effective way to interrogate these systemic inequalities. The following section details the core features of a reproductive justice framework and outlines how this approach is a powerful tool to interpret the women's SRH experiences.

2.5.1. Reproductive justice

Reproductive justice is a movement that emerged from women- of- colour grassroots organisations situated in the U.S. in the 1990s in response to frustrations about white feminist organisations' primary focus on pro-choice activism and disregard of other reproductive issues that were pertinent to their communities. The most notable of these is the SisterSong Women of Colour Health Collective (known as SisterSong), formed in 1997 by and for Indigenous and women-of-colour by 16 women, including some who had originally coined the term reproductive justice. SisterSong is a network of organisations working in the field of reproductive justice across the US, originally created to spark a national advocacy and education movement (Price, 2010).

A reproductive justice framework applies principles of human rights and social justice to reproductive health. This movement rejects an oversimplified picture of reproductive rights and instead offers a more nuanced understanding of the full spectrum of women's reproductive lives. It expands debates beyond an exclusively women's right to access an abortion, the main concern of the predominantly white feminist- led reproductive rights movement, to consider overlapping reproductive health issues (Eaton & Stephens, 2020). In doing so, reproductive justice broadens conversations beyond an oversimplified and under-theorised choice rhetoric which masks that not all women have the same reproductive options to choose from (Roberts, 1997).

Dorothy Roberts (1997), a seminal figure in the reproductive justice movement, spotlighted how Black women's reproductive rights have been systematically violated and denied throughout history. For example, she traced how Black women in the US have been disproportionately subject to forced sterilisations, coercive contraception (such as Norplant, a contraceptive implant, being aggressively promoted to women-of-colour and low-income women without making them fully aware of the risks and side effects), and welfare reforms (including 'family caps' on benefits families are able to receive) that function to curtail the capacity for bodily autonomy. All of these techniques can be understood as part of a broader eugenics movement that functions to govern the bodies of women-of-colour designated as undesirable to reproduce (Price, 2010). This can also be thought of in terms of reproductive stratification: a concept developed by Colen (1986) to describe the processes through which certain bodies are encouraged to reproduce, whereas others are subject to control and are disempowered to reproduce, according to classed and racialised hierarchies. As noted by Brown (2025), a contemporary example of reproductive stratification in action is punitive welfare policies that discourage low-income families from having children, which can be understood as a continuation of the aims of the earlier eugenics movement.

Reproductive justice centres on three interconnected principles that provide the core pillars of the concept of reproductive autonomy:

> (1) the right to have a child under the conditions of one's choosing; (2) the right not to have a child using birth control, abortion, or abstinence; and (3) the right to parent children in safe and healthy environments free from violence by individuals or the state. (Ross, 2017: 290).

These three principles delineate the rights women need to have control over decisions regarding their bodies. They operate according to the notion of 'positive freedom', a concept coined by Sen (1999) which understands freedom as being more than simply the absence of constraints and involving genuine opportunities to enhance one's life that is contingent upon having particular conditions. This entails both the freedom to act and make decisions and the freedom from having to do or make particular decisions: in this context, the freedom to raise a child in a safe and healthy environment as well as the right to *not* have a child. The necessity of possessing resources in order to have legitimate freedom is therefore stressed in a reproductive justice approach, revealing an intrinsic link between choice and poverty (Solinger, 2001).

Articulated by one of the pioneers of the movement, Loretta Ross (2017), 'reproductive justice is rooted in the belief that systemic inequality has always shaped people's decision making around childbearing and parenting, particularly vulnerable women' (p291). Consequently, reproductive justice moves past individualising conceptualisations of choice and agency and foregrounds the structural conditions which limit the ability to exercise choice (Morison & Herbert, 2019). This standpoint allows for an examination of the web of social structures that influence reproductive decision-making. In this sense, it is a theory rooted in intersectionality, a concept created by Kimberlé Crenshaw (1989) that interrogates dynamics of power and the overlapping, simultaneous forms of oppression that women face to understand how these create unique experiences of disadvantage. Intersectionality recognises that decision-making occurs within the broader systems of oppression that shape women's lives. In the instance of this current research, this recognises that women experiencing homelessness are not a homogenous group and occupy a variety of multiple and intersecting marginalised identities. This is essential when exploring this topic, as failing to acknowledge the structural contexts in which decision-making occurs means overlooking how the choices that are available to women are located within power relations related to social positionings including gender, class and race (Bungay, 2013).

Reproductive justice is also deeply concerned with the politics of knowledge production and emphasises the importance of avoiding essentialism and valuing the lived experiences of those traditionally relegated to the margins as crucial forms of knowledge (Price, 2010). It recognises that not all women have equal resources to be able to realise their rights and that the decision-making process is informed by location within systems of oppression.

A reproductive justice standpoint serves as a powerful tool for debunking the assertations of neoliberalism and post-feminism that free choices are universally accessible, because it illuminates the structural conditions which mean that this is unattainable for many women. It exposes the contradictions embedded within a neoliberal rationality which simultaneously encourages the rollback of the welfare state and individualising responsibility under the guise of 'freedom of choice', whilst also enacting greater control over women's bodies through increased regulation, restricted access to services and welfare conditionality (Morison & Herbert, 2019).

It is important to contextualise the choices that are available to women within a neoliberal political rationality which champions the right to choose in and of itself above all else (Brents & Sanders, 2010). Values of choice and personal responsibility have infiltrated public discourse, leading Rottenberg (2018) to contend that neoliberalism has expanded to an economic rationality that permeates all spheres of life. Neoliberalism presents everyone as having the ability to make choices freely, a rhetoric which positions poor women as solely culpable for their adverse circumstances due to their own poor judgement and decision-making. This is also true of post-feminist discourses, in which feminist ideals of choice, agency and authenticity are central to the postfeminist ethos, and women's decisions are positioned as no longer constrained by inequalities or oppression (Gill, 2011). These discourses have been critiqued and argued to rest on 'essentially individualistic, consumerist notions of 'free' choice that do not take into consideration all the social, economic and political conditions that frame the so-called choices that women are forced to make' (Smith, 2005: 127). Both ideologies mask the social structures which limit women's ability to choose and subsequently justify the demonisation of those living in poverty and the austerity policies which penalise them. Personal responsibility narratives are essential to both English and Australian governmental policies, evident in interventions that focus on individualised responses rather than targeting the structural drivers of homelessness (Stonehouse et al., 2022). These narratives individualise failure and further marginalise people experiencing homelessness in the process.

Furthermore, understanding housing insecurity through a reproductive justice lens illuminates how housing justice cannot be untangled from reproductive justice. Specifically, it demonstrates how housing insecurity limits the choices that a woman has over her reproductive health, and that secure, safe and affordable housing is a fundamental aspect of reproductive autonomy. Attending to the conditions under which women are compelled to make decisions does not negate their agency but offers an alternative explanation from the dominant, oversimplistic and marginalising discourses of blame and personal responsibility that characterise the actions of women experiencing homelessness. In doing so, housing insecurity and poverty are reinforced as reproductive justice issues.

By applying a reproductive justice lens to the SRH of women experiencing homelessness, the many intersecting identities that they occupy, and how these inform SRH experiences, can begin to be uncovered. As introduced in the literature review, these women are subjected to overlapping and compounding forms of stigma, related to their housing status, gender, poverty, and other intersecting factors. Consequently, I decided to focus on how stigmatisation impacted women's experiences in the context of SRH and build on a currently limited area of research. However, I did not want to exclusively focus on stigma at an interpersonal level, as conceptualised by Goffman (1963). In keeping with a reproductive justice framework, I wanted to attend to the ways that stigma operated on a structural level. The following section introduces theorisations of stigma as a violent and structural force and suggests how this theorisation holds the potential to advance knowledge of the SRH women experiencing homelessness.

2.5.2. A top-down theorisation of stigma

When reviewing the literature on women's homelessness, stigma was identified as a pervasive and cross-cutting structural influencer on women's lives. This was also evident in literature about the adverse health outcomes that homeless populations face, where stigma was frequently identified as a powerful hinderance to accessing care. Reviewing these two bodies of literature together, I decided that stigma was an important issue to explore as a critical component to understanding the women's decision-making processes. Additionally, by focusing on stigma as a structural form of injustice that women experiencing homelessness face, a reproductive justice approach is enacted. When referring to stigma, this thesis uses the definition of stigma as occurring 'when a person possesses (or is believed to possess) "some attribute or characteristic that conveys a social identity that is devalued in a particular social context"' (Crocker et al., 1998, cited in Major and O'Brien, 2005: 394-395).

In the West, the concept of stigma has most commonly and widely been used in the field of psychology and understood as operating on an interpersonal level. This understanding of stigma stems from the germinal work of Goffman (1963), who conceptualises stigma as creating ‘spoiled identities’: a process through which individuals are devalued and marginalised from fully participating in society. His theorisation has a predominantly micro-level focus and is concerned with how individuals employ techniques to manage their ‘spoiled identities’ in response to stigmatisation. However, in the past two decades Goffman’s conceptualisation of stigma has faced significant criticism for failing to attend to how stigma is generated and perpetuated at a macro- level (Tyler, 2020). While there is recognition in the literature that Goffman does theorise stigma as a form of social control, and a social process that takes place in the context of unequal power relations, his analysis has been suggested to be underdeveloped (Tyler & Slater, 2018). In particular, it has been critiqued for an excessive focus on responsibilising people to ‘accept’ social norms and manage their own stigma, paradoxically rendering his relational theory of stigma as largely individualistic (Browne, 2025).

These critiques have led to the development of top-down conceptualisations of stigma that centre on understanding stigma as a mode of power. This alternative theorisation began with the work of Link & Phelan (2001) who stated that ‘in response to these criticisms, we define stigma as the co-occurrence of its components- labelling, stereotyping, separation, status loss, and discrimination- and further indicate that for stigmatisation to occur, power must be exercised’ (p363). Writing in the context of mental health research, they developed this conceptualisation to tease out the ways that power is enacted, encapsulated in their concept of ‘stigma power’. Here, stigma is perceived as a resource that is exercised to enact the aims of stigmatisers by keeping those stigmatised ‘down, in, or away’ (Link & Phelan, 2014: 25). Their understanding was pioneering in acknowledging the structures that generate and reinforce stigma, and how stigma is used as a resource that has tangible consequences for the lives of those stigmatised.

This conceptualisation has been developed further by Imogen Tyler (2020) in her book *Stigma*, where she outlines how stigma is used as a 'machinery of inequality' through exposing how it is harnessed to legitimise austerity narratives that construct certain groups as undeserving. Her conceptualisation reveals how stigma both draws upon and reinforces structural inequalities. Tyler (2020) is critical of Link and Phelan's work for presenting an oversimplified and binarised understanding of power, where power is wielded by 'the stigmatisers' over the stigmatised. Instead, she overtly links stigma to neoliberal capitalism and understands it as 'conceptualised vis-a-vis the motives of institutions and states within a broader political economy of neoliberal capitalist accumulation' (Tyler, 2020: 15). Tyler re-politicises stigma by identifying it as a form of neoliberal governance and firmly denotes it as a tool used to serve exploitative capitalist regimes. Here, stigma is argued to be a force that is both actively produced and unintentionally (re)circulated through behaviours, practices, discourses. This operationalisation of stigma sits within the broader project of austerity, argued by Cooper and Whyte (2017) to be a political strategy that calls upon the global financial crisis to justify neoliberal policies that widen social inequalities, encourage the speed of capital accumulation, and redistribute wealth upwards.

Structural stigma theory has been used in public health research. It has been demonstrated to be a causal factor of health inequity in contexts including: the suicide rates of LGBTQ+ teen populations (Hatzenbeuhler, 2010); the experiences of mothers who have had multiple children removed from their care (Broadhurst & Mason, 2013); and the framing of emergency hormonal contraception use as a marker of irresponsibility (Murphy & Pooke, 2019). Stigma is understood to create obstacles for stigmatised groups and have significant implications for the health of these populations (Hussein &

Ferguson, 2019). In homelessness research, structural stigma has been demonstrated to play a significant role in contributing to unequal health outcomes, adversely affecting the health of individuals experiencing homelessness and acting as a barrier to engaging in health-seeking behaviours (Mercado et al., 2024). Additionally, Reilly et al (2022) conducted the first systematic review examining the impact of stigma on the health outcomes of individuals experiencing homelessness, which revealed stigma, particularly stigmatising interactions with healthcare providers, was a pervasive barrier to service access. Collectively this literature indicates that 'stigma thwarts, undermines, or exacerbates several processes (i.e., availability of resources, social relationships, psychological and behavioural responses, stress) that ultimately lead to adverse health outcomes' (Hatzenbeuhler et al., 2013: 814).

However, there is a pronounced lack of research regarding the effects of stigma on the SRH experiences of women who face homelessness. In the context of women's healthcare, Rose (2015) argues that 'by actively producing a discourse of women as irrational, illogical and incapable, practitioners at times justify control over and violation of women's rights and bodies' (p36). She points to the ways in which women's bodies are controlled by stigmatising narratives which justify policies that constrain reproductive choices. This raises questions about the implications of stigma on the health of women experiencing homelessness, who face stigmatisation on multiple levels. The following section begins to explore some of these implications through framing of stigma as a structural and violent force, and in doing so, spotlighting its violent effects.

2.5.3. Stigma as a mode of violence

Understanding stigma as structural, rather than relational, shifts the focus to exploring how power is generated through stigmatisation via institutions and, in doing so, devalues marginalised groups (Turrell, 2025). Structural understandings of stigma, as a mode of power that enshrines and reproduces structural inequalities, suggest that stigma can be understood as a mode of structural violence. Indeed, Tyler (2020) coined the concept ‘stigmacraft’ to refer to how stigma is produced through cultural mechanisms to inscribe identities onto certain bodies. In doing so, institutions legitimise and enact structural violence on marginalised groups. She contextualises stigma as a form of top-down violence and strategy of governmentality, against a backdrop of neoliberal mentalities, patriarchy, and capitalism. The notion of stigma operating as a form of structural violence is echoed by Finn and Murphy (2022), who argue that ‘contemporary stigma works to conceal the failings of neoliberal capitalism by shaming the perceived moral irresponsibility and failures of its losers’ (p9).

Structural violence was first conceptualised by Galtung (1969), who defined it as a form of violence that is systematically enacted through bureaucratic mechanisms which render it routine and mundane. Galtung’s theorisation emphasises that violence is not exceptional, but rather a feature of everyday life that is enacted slowly over time. The everyday-ness of structural violence generates a collective desensitisation to it, as its effects are often invisible. Structural violence expands beyond somatic experiences and encompasses the mental and emotional aspects of health, as well as the physical. This kind of violence leads to avoidable suffering— such as poverty and marginalisation— because, as Galtung notes, it is ‘built into the structure’ of society (Galtung, 1969: 171). Significantly, in the context of understanding stigma as a mode of structural violence, it does not necessitate having an individual perpetrator. Instead, agents of harm are embedded in social structures and institutions, such as governmental or legal systems, that generate and perpetuate harm.

Writing about structural violence in a health context, medical anthropologist Paul Farmer (1996; 2004) demonstrates how certain populations are systematically more vulnerable to ill-health than others. Farmer et al (2006) introduce the concept of 'analytic omission' to refer to the failure to acknowledge the structural and historical forces that influence health disparities and shape health outcomes. Their work spotlights the overarching effects of poverty and how this intersects with other social axes to shape the lived realities of health inequities. Understanding stigma as a mode of structural violence draws attention to how stigma is enacted within institutions through systematic practices that inflict harm and maintain social control. This understanding spotlights how stigma is embedded in everyday social structures, policies, and interactions.

Conceptualising stigma as a mode of structural violence has also been used by scholars researching the experiences of welfare claimants. Patrick (2016) demonstrates that using this conceptualisation in this context reveals stigma to be an internal and external process, whereby individuals experience stigma on a personal level whilst also responding to external forces of stigmatisation. Stigma has been shown to be generated through political discourse and media reporting by Okoroji et al (2020), who found a clear relationship between political discourse, media reporting and public attitudes towards welfare recipients, identifying how violence operates at multiple levels of the lives of its targets. Similarly, Burnett (2017: 217) describes the hatred directed at welfare claimants as a form of 'institutionally produced hatred', arguing that stigma is a key component of austerity narratives and serves the interests of the political elite. He makes the point that instances of individual violence mirror the violence that is embedded in government policy. Finn and Murphy (2022) found stigmatisation was intensified for single mothers claiming welfare, who 'identified a double and triple aspect of stigmatisation, discriminated against within the private rental sector for being single mothers, homeless and poor' (p683). Stigma was shown to interact with norms of femininity to produce a distinct set of judgements directed at these women concerning their parenting and caregiving capabilities.

Bringing together the literature on structural stigma and structural violence suggests that violent experiences of stigma are likely to shape the SRH of women experiencing homelessness, leading to adverse health outcomes and the denial of reproductive autonomy. It is, therefore, a useful lens to apply to this research topic, as it can reveal gendered dynamics that are often overlooked when understanding the distinctiveness of women's homelessness. In the following section, the literature on how structural stigma operates within the context of women's homelessness, focusing on the ways in which 'spoiled identities' are produced and reinforced by structural forces, is explored.

2.5.4. Stigma and women's homelessness: 'spoiled identities'

In order to understand how stigma functions in the context of women experiencing homelessness, this section explores literature that engages with the gendered dimensions of stigma and how these interact with stigmatisation related to homelessness to create 'spoiled identities'. Through doing so, it begins to unpack how stigma operates as an oppressive force in the lives of marginalised women.

Goffman (1963) defines a spoiled identity as 'the phenomenon whereby an individual with an attribute which is deeply discredited by his/her society is rejected as a result of the attribute. Stigma is a process by which the reaction of others spoils normal identity' (p3). To understand how women experiencing homelessness come to be ascribed spoiled identities, it is essential to examine the multiple levels at which stigma operates to reveal the underlying forces that ascribe such identities. In particular, attention must be given to the historical and cultural contexts of gendered oppression and how these intersect with contemporary discourses surrounding the 'problem woman' (O'Sullivan, 2015). Only through a gendered analysis can the figure of the 'homeless woman' be understood as a discursive category, shaped by a set of assumptions formulated by notions of legible femininity (Mayock & Sheridan, 2020).

The literature unequivocally tells us that women who do not conform to normative gendered expectations are stigmatised and marginalised (Löfstand & Quiglars, 2015; Savage, 2016; Mayock & Sheridan, 2020). Women experiencing homelessness, who exist outside of normative gender expectations on multiple fronts, face multi-layered stigma for transgressing these societal norms. As articulated by Bretherton and Pleace, (2018), homelessness 'places a woman at a great distance from the roles she is expected to fulfil; she is not raising children, she is not in a (domestic) role in a relationship with a male partner, she is not caring for an elderly relative that needs support, she is not nurturing or reinforcing a family' (p14). Discourses positioning women's value within the domestic sphere, as mothers, homemakers and caregivers, stem from historically entrenched gender norms that have long constructed those falling outside of these roles as 'victims' or 'fallen women' (O'Sullivan, 2015).

In a contemporary setting, these judgements can be understood through Tyler's (2013) theorisation of 'revolting subjects', individuals cast as socially abject through moralising judgements and rhetoric that questions their deservingness. These narratives invoke gendered ideas of respectability, and position those falling outside of this as morally deficient. As Tyler (2013) informs us, such judgements are also interwoven with class expectations. She analyses working-class tropes perpetuated by the tabloid media, such as the figure of the 'chav mum', portrayed most commonly a single mother who is burden on the state, sexually promiscuous, excessive, lacking in discipline, and negligent. Her analysis demonstrates how working-class women are more likely to be marked as abject and as representing failed femininity. This echoes the pioneering work of Beverly Skeggs (1997), who demonstrated how working-class women had to constantly prove their moral worth in a system where they were devalued for being unable to attain middle-class norms of ‘respectable’ femininity, highlighting that femininity is classed.

Class is not the only system of classification at play: Tyler (2008; 2013) explains how class abjection is inextricably linked to racial difference. Specifically that, rather than an invisible, taken-for-granted whiteness, working-class whiteness is hypervisible, “a whiteness contaminated with poverty” (Tyler, 2008: 25). White working-class women are cast as abject figures and excluded from receiving the benefits of white privilege. This is encapsulated in the figure of the ‘chav mum’, where certain women are deemed undesirable to reproduce, and seen as being sexually irresponsible and overly fertile. Here, motherhood becomes a site of surveillance where, as Tyler (2013) describes, lives are ‘saturated with state power’ (p68).

Henley and England (2024) provide an example of how this discourse manifests in neoliberal welfare environments by discussing how mothers experiencing homelessness face unique experiences of welfare governance, with their reliance on the welfare state seen as a personal choice rather than the result of structural failings. They show how these women strategically performed what they term ‘maternal activation’, a constant navigation between two opposing disciplinary discourses: the responsible citizen who is economically engaged and actively seeking solutions for their problems, and that of the engaged and attentive caregiver who exhibits ideal motherhood. This is done in order to be read as ‘legible’ in the eyes of the state, to gain status in their interactions with authorities and access resources they need.

The implicit tension in these two contradictory discourses is also evident in the work of Evans (2022), who found that mothers claiming welfare faced stigma that was deeply gendered, as women were judged on their mothering standards. They were held responsible for not only themselves, but their children also. In both of these authors’ research, runs a thread of an individualised narrative that requires women to take responsibility for resolving structural inequalities. Women are expected to be both economically independent, and active mothers. They are stigmatised as failed economic citizens, and as failed mothers.

As a result of stigmatising discourses, women experiencing homelessness are positioned as irresponsible, unable to make their own decisions, and undeserving of care (Löfstand & Quilgars, 2015). Saunders (2021) discusses how stigmatising narratives operate in the context of women's SRH decision-making, arguing they position poor and working-class women as personally responsible for their so-called wrong choices, evoking notions of 'failed' femininity, and thereby excluding them from the category of the 'valued' reproductive citizen. This is particularly apparent in the case of mothers experiencing homelessness who are separated from their children, who are designated as deviant for falling outside of the parameters of what 'good motherhood' looks like. As Lowe (2016) suggests, these ideals stem from norms rooted in whiteness, middle-class respectability, and heterosexuality, casting all those in opposition to these ideals as morally deficient.

Broadhurst and Mason (2013) discuss spoiled identities in relation to motherhood, arguing women who have had multiple children permanently removed from their care are positioned as 'maternal outcasts' for failing to meet normative ideals of motherhood. Here, stigma functions to individualise women's contexts of poverty and deprivation as bad parenting practices, in the process masking the structural conditions that constrain their mothering abilities. This is important in the context of this thesis, as repeat child removal is a common experience for mothers that face homelessness: this signals how intersections of housing insecurity, domestic violence and neglect are shaped by poverty (Bimpson et al., 2020).

The intense emotional reaction generated in public attitudes towards 'maternal outcasts' (Goc, 2007; Heffernan & Wilgus, 2018) reflect the harsh moral judgements that women experiencing homelessness face for transgressing idealised notions of care. Such judgements are informed by complex interactions of gender, race and class (Broadhurst & Mason, 2020). Boddy and Wheeler (2020) identify these reactions being bolstered and fed by the political economy of stigma that positions mothers who have had their children removed as 'other'. They argue that this stigma also sustains and legitimises punitive child protection systems, demonstrating how stigma is reproduced through institutions. The intense social stigma surrounding child removal has been demonstrated to shape women's interactions in both personal and professional contexts, often leading to heightened vulnerability and isolation (Broadhurst & Mason, 2013). Savage (2016) similarly argues that such women are stigmatised for 'failing' in their socially assigned role as primary carers, with the label of failure itself carrying significant stigma. These responses reveal the powerful affective implications of gendered stereotypes. They underscore that in a society where caregiving is disproportionately placed on women, 'the salience of the affective domain for developing gender-sensitive approaches in homeless policy cannot be overstated' (Savage, 2016: 56).

Stigmatising narratives surrounding women's homelessness are fortified and compounded by government policies that prioritise a heteronormative family model, reproducing traditional gender roles in which women are positioned as primary caregivers. Such policies tend to homogenise women's experiences, failing to recognise the diverse realities of women's lives, and in doing so, further marginalise those already excluded (Graham et al., 2022). As Bretherton (2020) argues, policy responses to women's homelessness are deeply shaped by gendered assumptions that imagine women primarily in caregiving roles. Women's chance of exiting homelessness, or even receiving support, is often contingent upon how closely they conform to normative ideals of femininity and motherhood. The gendered nature of these policy frameworks reveals that responses to homelessness are far from neutral; rather, they impose implicit expectations that women perform specific roles to be read as deserving (Löfstrand & Quilgars, 2015).

Within both public and policy discourse, women experiencing homelessness are frequently constructed as deviant, criminal, or morally deficient, and blamed for their own homelessness through narratives of personal failure (Reeve, 2018; Mayock & Sheridan, 2020; Parr, 2024). This masking of structural causes of homelessness takes place within a broader context of individualisation, something that McNaughton (2006) argues has been hidden, rather than eroded, by neoliberal narratives. She describes this as an 'epistemological fallacy'; the assumption that people can negotiate risks without recognising that their ability to negotiate is bounded, to a certain extent, by structural factors.

In contrast, this thesis seeks to move beyond reductive framings of women by examining the complex structural and relational processes that underpin women's experiences of homelessness. To follow this line of enquiry and explore how women navigate SRH decision-making, applying this conceptualisation of structural stigma is useful because it offers a more nuanced understanding of the barriers faced beyond exclusively individualising and pathologising narratives. This theoretical lens has not yet been applied to understand the SRH of women experiencing homelessness. As such, this thesis offers a novel critical analysis, grounded in a reproductive justice approach, that questions taken-for-granted notions of free choice, and calls to attention the structural conditions under which decision-making occurs.

2.6. Conclusion

Through reviewing the existing literature on women’s homelessness and SRH experiences, this chapter has provided context and rationale for this thesis by pointing to the gaps in an evidence base that is predominantly quantitative, centred on a few distinct SRH experiences, and coming out of the U.S. It has shown the research that does exist points to a bleak picture of SRH for these women, whose autonomy is frequently denied. The theoretical framework put forward in the second half of this chapter addresses the lack of attention given to how structural forces contribute to poor SRH outcomes. It argues that a reproductive justice framework is an effective way to explore the inequities that women experiencing homelessness face in their SRH by highlighting the structural forces that generate such inequities. This lens reveals the gendered expectations that women are held to, and how these intersect and are amplified by systems of racism, classism, and ableism, to curtail their bodily autonomy. A reproductive justice framework is enacted in this thesis by focusing on one form of injustice, structural stigma, that the extant evidence suggests women experiencing homelessness face.

Chapter 3: Methodology

In this chapter I provide details of the processes behind how this research was designed and conducted to address the research aim of exploring the SRH decision-making of women experiencing homelessness in England and Australia. Firstly, the epistemological underpinnings, and my own positionality and orientation to the research, are established. The chapter then moves on to detail the practicalities of how this research was carried out, including information about: the recruitment strategy; methods employed to investigate the research questions; the analytical process of coding; and the ethical procedures implemented to ensure the safety of the women and myself as a researcher, a particularly important concern when researching sensitive topics.

3.1. Feminist epistemologies

Our epistemological orientations are the backdrop against which research is conducted; they inform every decision that is made when designing and carrying out research. As Stanczak (2007) notes, it is vital to make clear the epistemological standpoint of the researcher because 'epistemological assumptions affect the types of methods that we choose, just as the methods that we use- their strengths and their limitations- act on our ways of thinking about the way we generate valid social knowledge' (p9). As such, before discussing the details of how this research was carried out, it is important to discuss the epistemological underpinnings that informed its design.

The current research is addressed from, and situated within, feminist epistemologies that seek to centre women's experiences as valid, and essential, forms of knowledge and recognises the value of emotion, memories, and other abstract experiences (Smart, 2009). Specifically, I adopted an intersectional feminist approach which acknowledges the differences in women's lived experiences, rather than viewing women as a homogeneous group (Crenshaw, 1989). I was drawn to this way of situating knowledge as it is an open and flexible approach, but also one that guided my questioning of how identities interact with one another and inform experiences of inclusion and exclusion. As Davis (2008) argues, 'Intersectionality does not produce a normative straitjacket for monitoring feminist inquiry in search of the 'correct line'. Instead, it encourages each feminist scholar to engage critically with her own assumptions in the interests of reflexive, critical, and accountable feminist inquiry' (p79). I chose this approach to move past reductive and exclusionary feminisms to a more inclusive and nuanced lens that pays attention to how systems of power informed women's lives in varying ways.

I was initially drawn to feminist epistemologies for their liberatory potential because, as Tuana (2017) describes, they 'provide tools for undermining the knowledges and practices implicated in oppression' (p125). Although there is no standard set of feminist research principles to follow, there are shared characteristics around which feminist research is organised, that seek to move away from positivist research traditions which separate researcher and research subject, thoughts and feelings, and the political and personal (Stacey, 1988). Indeed, a feminist orientation often rejects the notion that research ever can, or should, be objective. Instead, it recognises the ways that researchers are embedded in their experiences, and the value that these subjectivities contribute to research. However, the rejection of objectivity by feminist epistemologies is not universal, and some argue for a different conceptualisation of objectivity altogether. Toole (2022), for example, coins an alternative understanding of objectivity as a 'view from many places' (p8), arguing that the act of understanding and situating influences on belief creates and achieves greater objectivity, rather than seeking to move away from it.

Additionally, feminist epistemologies are characterised by relationality and an ethics of care. These two principles were integral to every stage of the research process. López Radrigán et al (2025) describe an ethic of care as underpinning ‘the quest for practices that improve the emotional and material conditions in which researchers and participants alike are involved in processes of knowledge production, while attending to matters of justice and equality’ (p14). Brannelly & Barnes (2022) propose that an ethics of care can been understood as a research paradigm, encompassing not only the thinking about, but the doing of research. It was essential to embed an ethics of care into fieldwork procedures, particularly due to the marginalisation of the participant group and sensitive nature of the research topic, which meant that women were often re-telling traumatic stories. Details on how this looked in practice are presented in section 3.5.

Feminist epistemologies address epistemic injustices, shining light on the power mechanisms involved in knowledge creation and reconfiguring whose knowledge is deemed valuable (Milián Bernal, 2023). Qualitative methods were chosen with the intention of moving toward what Alcoff (1991) terms ‘speaking with’ others, a practice that aims to reduce power dynamics in knowledge production and amplify marginalised voices that have traditionally been silenced to produce counter-narratives. Specifically, unstructured interviewing was selected for its alignment with feminist research principles. As posited by Rubin & Rubin (2005), in feminist research ‘an interview should not involve applying a sterile instrument to a passive object but should resemble normal conversation in which the interviewee influences the exchanges’ (p26). Generally, different feminisms share the same core belief that research should utilise loosely structured methods that centre the participant’s experiences and allow them to have a level of control over the data collection process. The decision to use unstructured interviews was an intentional move away from methods which have positivist scientific foundations, and towards a style of interviewing that is better placed to capture the complexity of human experiences (Walton et al., 2022).

Brinkmann and Kvale (2015) note that it is crucial for researchers to reflect on the relationship between themselves and the interviewee and be mindful of unequal power dynamics during interviews. Scholars have identified a number of techniques that can be used in interviews, such as having an awareness of the participant's cultural norms (Collins & Cooper, 2014), using physical cues to show active listening, for instance leaning forwards (Robinson & Schulz, 2016), and allowing participants to control the pace of the interview in order to build trust (Brinkmann & Kvale, 2015). Implementing these techniques cultivates an environment in which 'the interviewer and participant develop rapport and a mutual orientation to be co-constructors of knowledge so that participants do not feel like they are just having information extracted from them' (Walton et al., 2022: 3)

It is important to note here that we should not have an uncritical view of adopting methods that are feminist-informed, and that such approaches are not without pitfalls. Stacey (1988), for example, argues work that is caring and relational still holds the potential to be extractive, albeit in a more hidden way. She cautions against the temptation to view such work as free from exploitation and urges us to consider the ethical questions and harms that may arise from building rapport with participants and being granted entry into their worlds. I carried this awareness throughout the research process, particularly in how I engaged with the women during fieldwork (see section 3.5.4).

While it may never be possible to conduct research that is completely non-extractive, arts-based methods were adopted as a further attempt to reduce exploitative effects. Such methodologies are argued to offer an avenue to seek out alternative ways of knowing and sharing knowledge. Through these methodologies, participants can express themselves through unconventional mediums that go beyond language. For this reason, I chose collage as a methodological tool to interrogate how women think about, and interact in, their social worlds, to begin to understand the 'messiness' of their lived experiences (Law, 2006). The act of fragmenting images and piecing them together to represent something entirely new challenges dominant Western positivist paradigms that sees the world through a lens of objectivity, suggesting that there is no ‘truth’ out there to be discovered, instead valuing lived experiences as valid forms of knowledge (Yuen, 2016). Visual methodologies offer a different way of knowing, and a different vehicle through which to share knowledge; this is not just about the ways that knowledge is presented, but how it is generated (Roberts & Woods, 2018). These methods take seriously participants as producers of knowledge and offer different non-verbal avenues for sharing experiences that allow for nondiscursive forms of knowing (Eisner, 2008). Offering non-verbal avenues of storytelling also means that these methods align with a feminist ethics of care by avoiding asking women to re-tell painful or traumatic experiences.

3.2. Reflexivity and positionality

Reflexivity and recognising positionality have become standards of good practice when undertaking qualitative research and are also consistent with a feminist ethic of care approach to research (Sibbald et al., 2025). Reflexivity is the interrogation of how conscious and unconscious biases impact research and, in doing so, challenges taken-for-granted assumptions (Trundle et al., 2025). In line with the interpretive nature of qualitative research, reflexivity work moves away from notions of ‘objectivity’, that data is only legitimate when it is ‘objective’, and that objectivity is even possible. Through undertaking reflexivity practices, a researcher establishes their positionality, situates themselves in relation to their research and ‘self-consciously refers to him or herself in relation to the production of knowledge about research topics’ (Roulston, 2010: 116). Engaging in reflexivity is to recognise that subjectivity is inevitable, and not only this, but that subjectivity contributes richness to the research.

Scholars caution against reducing reflexivity practices into a ‘shopping list’ of identity markers or oversimplifying one’s relation to their participants by neatly fitting themselves into an insider/outsider dichotomy (O’Boyle, 2017). They argue reflexivity can help clarify researcher’s positionality, but that it does not guarantee more honest or ethical work, and at times can be co-opted to reinscribe inequalities (Holmes, 2020). Additionally, they note that reflexivity is rarely a neutral exercise, and that statements of positionality are developed in accordance with what the researcher anticipates the intended audience will expect or want from them (Salzman, 2002).

In keeping in mind the discussion above, it is nevertheless important to locate myself within this research and reflect on how my positionalities have shaped the process. I am a white, cisgendered, heterosexual woman. I have never experienced housing insecurity and come from a middle-class background where I have never had to worry about where my next meal is coming from, whether I will have a roof over my head, or had to fight to secure my basic needs. I have never experienced addiction to substances or faced domestic violence. As has already been established in this chapter, I am also a feminist researcher. This sparked my interest in my research topic, informing the lens through which I view SRH and the ways that I conducted this research. Seeing the world through a feminist lens means that I am interested in the ways in which gender intersects with other identities and creates experiences of inequality. In particular, in interrogating structures to understand how gendered power imbalances cause inequalities. My feminist standpoint means that I believe in centring the voices and experiences of women in research. I am left leaning politically; my beliefs are firmly rooted in the notion that poverty is an unacceptable social inequality and that there should be a functioning welfare state provided for all.

In the spirit of honest and truthful reflexive practice, I have not engaged in reflexivity during the research in the ways that I hoped to at the start of the process. Part of this has been down to ambiguity around what reflexivity actually *looks like* in practice, what undertaking reflexivity involves. My reflexive work began with writing a positionality statement in relation to the research and beginning to keep a fieldwork journal. However, as I will discuss in more detail in section 3.5.5, I found it difficult to be consistent with my journalling and continue this practice. Another large and looming reality is the uncomfortableness (and often painful experience) of doing reflexive work, looking at oneself, and having to face truths about one's position to the research and participants. I have frequently struggled with being reflexive about my role as a researcher, and as a person who cares deeply about the issues central to this research, and the boundaries between the two.

Another way that I engaged in reflexivity was through reflecting on my interviewing style, which happened most frequently in my post-interview debriefs with a supervisor. Walton et al (2022) encourages researchers to consciously think through how they 'use themselves as research instruments… what they leave with their research participants when the individual interview ends', and the power relations present in research encounters (p11). I caught myself acting in ways, often subconsciously, that I believed would make me appear more 'approachable' to my participants. This looked different depending on who I was interviewing on a given day but included: expressing my newness to an interview environment and role as the researcher (in an attempt to avoid being perceived as a knowledgeable 'professional'); adopting the women's phrases; swearing; or, on a couple of occasions, smoking a cigarette with a participant. In keeping with a feminist ethics of care, efforts to create a comfortable interview environment and reduce the power dynamic between interviewer/interviewee were foundational to my interview style. However, adopting strategies to try and appear as a trustworthy and unthreatening presence shone light on the differences between myself and the women and uncovered further ethical quandaries regarding forging rapport with them.

3.3. The research process (methods)

The following section details the practical processes of carrying out the fieldwork, and specifically discusses the sampling strategy, recruitment procedures and the research methods used to investigate the research questions and aims.

3.3.1. Participant Sampling

Fieldwork was conducted in England between February and August 2023, and in Australia between September 2023 and March 2024. A purposive sampling strategy was employed in each location. I intentionally set broad parameters for participation to allow for a wide net to be cast, knowing that women experiencing homelessness can be a difficult group to access, in part due to being less likely to access services and inhabiting more 'hidden' kinds of homelessness (Baptista, 2010; Reeve, 2018; Nicholas & Pleace, 2024). Another benefit of having a broad sampling criteria was that it allowed for a breadth of experiences to be represented in the research.

The eligibility criteria for participation specified that the participant identified as a cis-gender woman, was aged 18 years or more, and had experienced homelessness based on the ETHOS definition of homelessness (Edgar et al., 2007). There was no specified time period for how recently women had been homeless (women did not have to be homeless at the time of participation), or regarding the length of their period(s) of homelessness. Despite this, the majority of the women were homeless at the time of their participation.

After discussions with the supervisory team, it was decided that being a cis-gender woman would be specified, because whilst the experiences of trans women and gender non-conforming individuals are important and much needed areas of exploration, I would not have been able to do justice to these experiences within the constraints of a PhD. This is because it was anticipated these groups would have different kinds of SRH experiences. Despite this, one trans woman (Scarlett) from the Australian sample took part in the research. This woman became aware of the study through a friend, also a participant, at the crisis accommodation that they both lived in at the time of their interviews. After a discussion with the supervisory team, it was decided that the harm of denying Scarlett, a migrant, person-of-colour, trans woman who had already experienced extensive marginalisation and exclusion, the opportunity to participate would far outweigh any complications of including her in the study. Including Scarlett's data in the final dataset did not raise any significant complications, as her experiences relating to SRH (sex work, substance use, domestic violence) mirrored those of many of the other women. However, I did not feel that I was fully able to address her transness, and how this cast a different shade on these experiences, again due to the time and resource constraints of a PhD.

I planned to conduct interviews with 10-15 women in each geographical location. This is an appropriate sample size, as small samples are common for qualitative research and can yield rich responses and in-depth insights of the subject matter (Sandelowski, 1995). In England, 14 interviews were conducted in total. In Australia, 11 interviews were conducted in total. In total, 25 interviews were conducted. Within these samples, four women took part in the collaging activity in England, and five women in Australia.

The sample across both countries represented a diverse range of experiences of homelessness, including sofa surfing, rough sleeping and living in crisis accommodation or in a domestic violence refuge. A breadth of ages was also represented between 20 and 62. Before analysis began, two women from the England sample were excluded from the final dataset. This decision was made on the basis that they had not experienced homelessness under the ETHOS definition that was used for this research.

Out of the 23 women included in the final sample size, 17 are mothers. Of those mothers, 12 had experienced at least one of their children being removed from their care. The following section provides profiles of the each of the women, to offer a more in-depth description of their circumstances and experiences of homelessness.

3.3.2. Participant profiles

I recognise the potentially problematic nature of providing a snapshot of my participants' lives, where the notable elements of their stories have been decided and summarised by myself. In providing profiles of the women who participated, I do not wish to flatten out the nuances of their lives. However, it is important to offer a brief introduction to their circumstances and provide some context for the findings that will follow.

Sharing these profiles also serves to highlight the multiple and overlapping disadvantage that women faced across their lives. Women were never facing homelessness in isolation: this was often accompanied and compounded by other markers of disadvantage, including problematic substance use, experiences of domestic violence, adverse childhood experiences and child removal. These disadvantages were further amplified by intersecting with other social identities, for example Black, ethnic minority, and First Nations women, and those with physical and/ or intellectual disabilities.

It is important to note here that some women in the Australian sample have historic experiences of homelessness that date back as far as fifty years ago and had been stably housed for many years at the time of our interview. The methods used to collect the data, and the diverse age range of women in the sample, meant that women were reflecting on experiences from across their life course, and so the findings include insights from a broad period spanning from the 1980s to the present day. Consequently, some of the experiences discussed in the findings chapter relate to situations that happened years ago, where the policy and practice landscape differed to that of the present day.

In this section, I offer a brief profile of each woman's story, rather than a linear presentation of their lives, as the methods I chose did not allow for an accurate chronology of events. This was particularly the case due to this research's focus, where traumatic experiences and mental ill health meant that events were often not recalled in a linear way and sometimes murky.

English Sample

Beth

Beth was 25 at the time of interviewing and lived in supported housing. She had lived in a number of supported accommodations over the years, and strongly disliked the accommodation she was currently living in. Beth had mental health struggles and learning disabilities; we did not discuss the specifics of her diagnoses, but she shared that she had been told by a doctor that she has the mental age of a five-year-old (a diagnosis that she disagreed with). She had been in an abusive relationship with her ex-partner, but at the time of interview was in a recently new relationship and spoke very positively about her new partner.

Alison

Alison was 49 at the time of interviewing, and her housing situation at that time was not discussed. She had been homeless intermittently throughout her adult life, including living in temporary accommodation after fleeing domestic violence, and after she was released from prison for shoplifting. Alison has four sons; she raised her middle two sons as a single mother and had her eldest and youngest permanently removed from her care. Alison used crack and was introduced to it by an abusive ex-partner, although said that she had not used it for six weeks at the time of our interview and felt that she had never had an addiction to it. Alison is a sex worker and had worked in massage parlours. At the time of interviewing, she was engaged in street sex work.

Clara

Clara was 54 and lived in council housing at the time of interviewing. She had been in and out of prison on multiple occasions, for unpaid fines, street sex work and several assaults. Clara had experienced homelessness once coming out of prison, and had lived in mix-gender hostels, which was a negative experience for her. She had been a sex worker since she was a teenager and entered sex work after leaving the care system with little follow-up care and needing money to survive. She spoke of the increasing difficulties of advertising her work online as she was getting older, particularly her struggle to find new clients. Clara has two children, both of whom had been permanently removed from her care. One of her children was with an ex-partner, and one was conceived after an incident of stealthing by a client.

Nicole

Nicole was 32 and housed (unclear what kind of accommodation this was) with her partner at the time of interviewing. Nicole has four children, all of whom have been permanently removed from her care. Nicole had never planned any of her pregnancies and had become pregnant due to not regularly taking her contraceptive pill and after deciding to remove her implant. She had been in and out of homelessness, living in hotels and other temporary accommodations, including when she was pregnant. She had also experienced a period of street homelessness the year prior, just after giving birth to her fourth child. She has experienced domestic and sexual violence from multiple partners.

Ellie

Ellie was in her early 30's and housed (it was unclear what kind of housing Ellie lived in) at the time of interviewing. She had multiple experiences of homelessness, her first experience being street homelessness after being told she could not stay in the property that she was living in with her dog. She described extended periods of housing insecurity, including being pregnant whilst street homeless, after which she was offered accommodation in a hotel. Ellie has two children who have been removed from her care and placed with her mother. Ellie grew up in the care system, although now had a relationship with her mother. She talked about her fears of her children going into the care system, and so her children living with her mother was a source of comfort. She described wanting another child and removing her implant to try to become pregnant again, but at the time of interviewing had not been.

Sarah

Sarah was in her late 40's at the time of interviewing and had just been provided her own council accommodation after living in a refuge for an extended period of time. She spoke about her experience of living in the refuge very positively, particularly a training course offered there on healthy relationships, and aspired to return to work to support other women after moving out. Sarah had experienced extensive sexual abuse from her mother's partners as a child, which she talked about heavily impacting her adult relationships. She has three children, all of whom she conceived whilst on the pill and then the contraceptive injection; she had never planned to have children, because of the abuse she'd suffered. Sarah had a fraught relationship with her mother, whom she was in a custody battle with over her youngest child (who was currently in her mother's care). This was a great source of worry and stress, as her daughter was living in the house with Sarah's step-father, who had abused her as a child.

Becca

Becca was in her late 40's and living in a refuge at the time of interviewing. Becca has come to the refuge after a life-threatening attack from her ex-partner which left her hospitalised. She talked about receiving minimal support in the wake of the attack and turning to alcohol to cope with the trauma; this culminated in Becca taking an overdose of pills to get back into hospital and recognised as needing to be moved from her home where the assault had taken place. Becca has two children. Her eldest, her daughter, was from a relationship with her ex-husband, who had untreated schizophrenia and committed suicide when her daughter was young, and who she raised in her care. She also has a son who at the time of interviewing was not in her care due to concerns over her alcohol usage. Her son was living with her abusive ex-partner, and Becca was only allowed to see him for one hour a week, which hugely frustrated and concerned her. At the time of interviewing, Becca was in a custody battle to return her son to her care.

Abigail

Abigail was 45 and living in a refuge at the time of interviewing after escaping violence from her ex-husband, that she had been subject to for many years. Before arriving at the refuge, Abigail had lived in two temporary accommodations, but had to leave both due to safety concerns after her ex-husband had discovered her location. At the time of the interview, Abigail was in a fight to gain full custody of her two children, one of whom is autistic, who were living with her ex-husband. Abigail had minimal contact time with her children, and described her frustration at her social worker who she felt was inattentive and absent. She described using alcohol to self-medicate after the death of her mother, the biggest support in her life, which she believed was being used against her in the court case.

Rosie

Rosie was 29 at the time of interviewing and was living in a refuge with her young son. She had escaped from an emotionally abusive relationship and spoke extensively about not realising that her situation was abusive until being referred to the refuge. Rosie had experienced debilitating endometriosis and had fought to get diagnosed. She experienced trauma from genital examinations associated with her endometriosis, and getting the IUD fitted. She had not planned her pregnancy, as she believed that she could never get pregnant because of her condition. Her ex-partner had been in prison through her entire pregnancy, during which time she had just moved back from abroad and was living with his mother to avoid becoming homeless. Rosie later ended up being a full-time carer to her ex-partner's mother whilst heavily pregnant, who became impaired after an adverse reaction to a vaccination.

Fatima

Fatima was 24 and living in a refuge at the time of interviewing. Fatima is from a South Asian country and spoke limited English and so a translator (who was also a staff member at the refuge) was present for our interview. Fatima had moved to England for an arranged marriage; she had never met her husband before moving. After moving, Fatima experienced abuse from her husband and his extended family. She has twin girls, one of whom lived with her at the refuge, and one whom she was in a custody battle for to try and gain full custody of both girls. Fatima thought that it was impossible for her to get pregnant, as she said she'd never had a period. Her abuse started after it was discovered that she was pregnant with girls rather than boys. Her children were born very prematurely due to the stress of the abuse.

Sanaya

Sanaya was in her 40's and living in a refuge at the time of interviewing. Sanaya is from a South Asian country and spoke little English and so a translator (who was also a staff member at the refuge) was present for our interview. Sanaya showed visible signs of distress during our interview. The translator informed me that Sanaya had given permission for her to share her story with me, but that she would not be able to directly answer any questions. Sanaya had moved to the UK for an arranged marriage to a family member. She had experienced extreme sexual and physical abuse and torture from her husband and his family, and as a result had life-long injuries. After a brief explanation of her story from the translator, and with Sanaya's agreement, I decided to end the interview, to avoid causing further harm or distress.

Rachel

Rachel was in her late 40's and living in women's-only temporary accommodation at the time of interviewing. She came into the interview in a distressed state but after a long chat (during which she was reassured that she did not have to take part on that day), and after letting her case worker know her emotional state, we commenced the interview. Rachel had experienced street homelessness on and off for many years. She has two sons, both of whom have been permanently removed from her care. She expressed that she greatly wished to be part of their lives in the future and make amends. Rachel used heroin and crack and had begun using heroin to cope with post-natal depression after the birth of her eldest son. It was difficult to ask Rachel questions, as she was very emotional, and hard at times to follow her narrative. Eventually, I ended the interview early to avoid further emotional distress.

Australian sample

Olivia

Olivia was 20 and living in transitional housing with her young son at the time of interviewing. She became homeless after being forced to leave her mother's home following an argument with her mother's partner, whom she does not get along with. Olivia then sofa surfed for three months, until she accessed her accommodation through the youth homelessness service that she was recruited through. Olivia's pregnancy was unplanned; she was not on any contraception due to her epilepsy, which she had been advised by doctors removed the option of hormonal contraception, and did not use condoms with her partner as he refused to wear them. At the time of interviewing, Olivia was hoping to move into social housing with her partner, although the accommodation had not yet finished being built, and there was concern that it would not be complete in time.

Grace

Grace was 23 and living in transitional housing at the time of interviewing. She has two children; a daughter, who Grace had as a young teenager, that lives with Grace's mother full-time, and a young son who lives with her. Child protection services had been present throughout her children's lives. Grace was evicted from her previous tenancy whilst heavily pregnant due to being in rent arrears and then lived in a caravan in her mother's garden with no running water or heating. She had to bring her newborn son into this environment before moving into transitional housing. Grace had planned to have an abortion with her son, but left the decision until late in her pregnancy, and then discovered she had COVID-19 when she was scheduled to have the surgery. She had to wait two weeks before being able to return, by which time the doctor's denied her the abortion, and she had to give birth to her son with little time for preparation. She had been pregnant seven times whilst being on different kinds of contraceptives and has experienced several miscarriages and two medication abortions. Grace has been a sex worker in a brothel to support herself and her partner financially but was not working at the time of interviewing.

Ariana

Ariana was 36 and living in a women's-only crisis accommodation at the time of interviewing. Ariana is a migrant from a West Asian country, who spoke about the pressures of family expectations and having to send money home. She had previously worked at a university but had been forced to leave her job due to workplace stress as a result of harassment and xenophobia from colleagues. She had become pregnant and had a late-term abortion due to financial insecurity, job stress and lack of support from her partner, which was a highly distressing experience. Following the abortion, she moved to a different state and quickly entered an abusive relationship. Escaping this, Ariana had become homeless and ended up in the crisis accommodation.

Scarlett

Scarlett was 34 and living in a women's-only crisis accommodation at the time of interviewing. Scarlett had experienced multiple kinds of homelessness; street homelessness, sofa surfing and various kind of temporary accommodation. She is a sex worker, previously working in brothels but worked independently at the time of interviewing. Scarlett is originally from a Southeast Asian country and had to leave her family home because of the shame she expressed she would bring on her family for being an openly transgender woman. Being separated from them was a source of pain for her. Scarlett had multiple substance and gambling addictions, which put her in a precarious financial situation and were a causal factor of her homelessness.

Maggie

Maggie was 59 and living in a women's-only accommodation for several years at the time of interviewing. Before this, Maggie had been street homeless for a number of years. Maggie had been a heroin user for the majority of her life, following a car accident in her teenage years which left her with a chronic injury, for which she was prescribed opioids to manage the pain, which subsequently led to addiction. Maggie is a lesbian and became homeless after separating from her ex-wife due to her partner's infidelity. She has one adult son who, at the time of interviewing, she had not spoken to for many years after her ex-wife had revealed Maggie's heroin usage to him.

Darcy

Darcy was in her mid-40's and living in the apartment of a friend who had passed away, who she had been caring for, at the time of interviewing. Darcy did not pay rent on the apartment and was unsure when she would be asked to leave. Prior to this, Darcy was street homeless for a year after being forced to leave her boarding house following a home invasion which damaged the property, and which she was blamed for. Darcy has four children, none of whom are in her care. Her two youngest children are First Nations, and her eldest child has a neurological disorder. Darcy had experienced extensive and life-threatening domestic violence from an ex-partner, which she believed led to her eldest children being removed. Darcy has contact with her two youngest children.

Nisha

Nisha was 38 and lived in social housing at the time of interviewing. Nisha is a migrant from a South Asian country who originally came to Australia to study. She has experienced prolonged periods of housing insecurity since shortly after her arrival, which included moving around the homes of friends and members of a religious community that she eventually converted to. This conversion led to exile from her own community, and led to Nisha applying for refugee status as she could no longer return to her home country. During this time, Nisha was unable to work or access welfare supports and lived in crisis accommodation and on the streets. Nisha had a husband, whom she met online and did not live in Australia, who had recently passed away at the time of interviewing. They had planned to start a family together.

Florence

Florence was 57 and lived in social housing at the time of interviewing. She had experienced domestic violence from her ex-partner for many years of her life and has lived in multiple refuges. She has three adult children with this abusive partner, whom she had to raise in the refuge, which she found a very challenging environment. Florence spoke about the intense isolation she felt during that time. Florence talked about none of her pregnancies being planned and becoming pregnant due to irregularly taking contraceptive pills and not having her IUD replaced after it expired.

Nellie

Nellie was 62 and living in social housing at the time of interviewing. Nellie had grown up in the care system and had run away at a young age, which led her to becoming street homeless and living on the street in her early teenage years. During this time, Nellie became a sex worker and a drug dealer in order to survive. She has three sons, all of which she raised as a single parent. She was homeless when her eldest son was born and talked about living in a car with him when he was only a few months old. From there, Nellie managed to get into social housing and has two more children. Nellie had been a meth and speed user in the past, and talked about starting using to keep herself awake while having to run her own business and looking after her first born on her own.

Pippa

Pippa was 44 and living in social housing at the time of interviewing. Pippa had a long history of insecure housing, starting with a decline in her mental health following a bad work experience placement at university. She has five mental health conditions, including schizophrenia and anxiety. Pippa has had multiple stays in and out of hospital and had used the hospital as a housing solution when she was provided with no other accommodation. Pippa also lived in a residential home for people with mental ill health when she was in her early 20's and had to leave following an abusive relationship with another resident there. Pippa liked her current housing and had lived there for many years but faced the issue of her neighbour being an abusive ex-partner who also struggled with mental illness. Despite this, Pippa talked about not wanting to move due to feeling settled and having nowhere else to go.

Sage

Sage was in her mid-40's and living in a boarding house at the time of interviewing. She described herself as a proud Aboriginal woman. She came to the city in which the interview took place after fleeing violence from her ex-partner and her extended family. She has two children, whom she has a good relationship with but had to leave behind when she fled. Sage has previously lived in a women's-only accommodation, which she described as a positive experience. However, she was very unhappy in the boarding house, in which she was the only woman, and talked about the continuous abuse she experienced from the men living there. She talked about desperately wanting to leave but having nowhere else to go. Sage had also experienced street homelessness and talked about the violence and rape she experienced whilst living on the street.

3.3.3. Recruitment strategy

Women were recruited through services that women experiencing homelessness were likely to frequent, as I decided that this would be the most effective and most ethical strategy for finding participants. Recruiting in this way ensured that participants had access to a service and would have avenues to access support following the interviews. However, it also meant the experiences of women who were not engaged in services were not captured. This is, of course, a limitation of the recruitment strategy. It meant excluding the experiences of women on the outermost fringes of homelessness, those who did not access support services, and who would have distinct experiences that would add alternative dimensions to this research.

I identified suitable organisations through which to recruit through conversations with supervisors and google searches of homelessness or women's services in the respective fieldwork cities. From there, I called or emailed a specific member of the organisation directly (where possible) to enquire into advertising the study in their service. A recruitment poster, containing information about the research, and what participation would involve, was shared with organisations (Appendix 1). It was made clear on the poster that all participants would receive a £15/$50 voucher to thank them for their time. The participant information sheet, containing more detailed information about the research, was also shared. I created a spreadsheet to keep track of who I had contacted, how many times, and their response. In addition to this approach, I began volunteering weekly at a women's organisation in England, during which time I built relationships with staff members and women attending the service. In Australia, I attended the Pregnancy and Homelessness Coalition, a group of academics and practitioners working in this space, to advertise my research.

Once approval to recruit through an organisation had been granted, the recruitment strategy varied according to the preferences of the specific organisation. Some organisations simply advertised the poster in their communal or waiting area. This was the least effective strategy, and no participants were recruited in this way. Other organisations spoke to women they identified as potential participants, using the recruitment poster as a visual aid, and then either encouraged the women to contact me directly, or contacted me on behalf of the women. In several settings, with the permission of the organisation, I went to a shared space and spoke to women to see whether they might be interested in participating. This proved to be the most fruitful mode of recruitment, as it gave me the opportunity to engage with women, answer any concerns they had about participating and reassure them. A couple of women were also recruited through their friends who had participated in the research.

In England, women were recruited via a drop-in meal service, a street sex worker organisation, a domestic violence refuge, and a women's organisation. In Australia, women were recruited through a youth homelessness service, a women's-only crisis accommodation service, a health service providing support for marginalised communities, and a women's group for victim/survivors of domestic violence. Recruiting through a diversity of organisations meant that women from a variety of ages and experiences of homelessness were represented in the research. It is possible that some homelessness experiences are overrepresented in this research because of where women were recruited from. For example, in England, six of the 12 women were recruited through a women's refuge due to lots of interest in the research from that service. As such, experiences of domestic violence featured heavily in the women's narratives. Having said this, domestic violence is known to be a main driver of homelessness for women and so may not actually have significantly impacted the findings (Bretherton & Mayock, 2021).

It should be noted here that women often did not consider themselves to be, or have been, homeless. This was particularly true amongst women who were sofa surfing with family or friends or had lived in temporary accommodation (including refuges). It was in these moments that I found it useful to be present in organisations to recruit in person and provide an explain for the definition of homelessness employed in this research.

3.3.4. Unstructured interviews

In line with the feminist research principles discussed in section 3.1, interviews were unstructured. To guide the interview, I used a loosely structured interview guide which included a series of prompts and probes to elicit rich accounts of the women's experiences (Appendix 2). At the start of every interview, women were asked to share a bit about themselves and their current housing situation. This question was kept broad to allow women to start from a point that they felt comfortable with and ease into a dialogue. In some circumstances, women began talking about issues related to their SRH unprompted; women knew the focus of the research and had read the information sheet prior to the interview commencing.

However, in most interviews the introductory chat was followed by the question: ‘Can you tell me about your experiences of sexual and/or reproductive decision-making whilst you have been homeless? By this, I mean anything related to your sexual wellbeing and/or reproductive system during any period of your life. This may include access to contraception, menstruation management, sexual activity and consent, your decision to have children and how many children to have, or experiences of childcare.’ This question was deliberately kept broad to create an environment in which the women could lead the discussion and talk about experiences they identified as most important to them. Some women expressed confusion about what constituted SRH decision-making, or anxiety over talking about the ‘wrong’ thing. In these circumstances, I provided more examples about different types of SRH experiences or revisited something that the woman had mentioned in the introductory chat to encourage conversation. In accordance with feminist research principles that centre women’s voices and creating environments of care, I also reassured women that there was no ‘wrong’ experience to share, and that whatever they saw as most important to them in relation to the topic was relevant and valuable.

Because of the flexible nature of the interviews, each one transpired differently and greatly varied in length and topics covered. Some interviews lasted less than 30 minutes, whereas others lasted for over two hours. Often women spoke at length without needing any prompts, recounting a linear version of their life events from their childhoods or when they had first become homeless. Others focused on a few specific incidents that were most salient to them in relation to the research focus. Taking a reproductive justice approach was not only a core component of my theoretical framework but also informed the way I conducted interviews. Such a lens considers all the contextual factors that influence SRH and sees all experiences as interconnected and holding relevance, even if not obviously related to SRH and homelessness. Although it was common for women to veer away from matters regarding SRH, I tried to minimally interject in their narratives once they had started to go in-depth into a story. This was to allow space for women to share things that were most important to them and to build feelings of comfort and rapport.

All interviews took place face-to-face in a quiet and private environment that was familiar to the women and subject to their agreement; this was most frequently in a room within the organisation through which they were recruited. In the sample from England there were a few occasions where it was not possible to interview the participant at the organisation. In these circumstances, with the woman's consent, interviews took place in a private room on the university campus. All interviews were audio-recorded, with the women's consent.

In England, two interviews took place with a translator present. This was because English was not the first language of these two women, and I did not want language to be a barrier to participation. The translator was a staff member at the refuge where the women were living at the time of their interviews, who already had relationships with them and knew their stories. This meant there was an existing foundation of trust between the women and the translator, which averted some of the ethical concerns regarding using translators for interviews.

After each interview, there was a debriefing session. This was designated time to check in with the women and see how they were feeling, and where they could express concerns and ask any questions about the interview. This time was also used to ask if they wanted to participate in the collaging activity, and to provide women with a resources list to signpost them to relevant support services. In many interviews, women had a support worker present in the building where the interview took place and were encouraged to seek them out if they felt they wanted to talk further. I also had my own debriefing session with a member of my supervisory team after each interview, to check in on my own mental wellbeing and discuss notable moments.

3.3.5. Collaging sessions

'Collage is the process of using fragments of images or materials and sticking them onto a surface to portray a phenomena' (Butler-Kisber & Poldma, 2010: 3). It is an arts-based visual method where ideas are portrayed by piecing fragments of images together to represent something completely new. There is a growing body of academic literature which argues the benefits of collage, particularly as a tool to explore sensitive and difficult research topics. Collage has been described as a 'liberatory method' (Vaughan, 2005: 31): one that holds the potential to be an empowering experience for participants, who are given greater control over the research process and more time to reflect and respond to research questions at their own pace (Guillemin & Drew, 2010). It is less intimidating than other visual methods, such as drawing or photography, in that it does not require technical skill and so is more widely accessible (Butler-Kisber & Poldma, 2010). Additionally, collage has been suggested to move beyond preconceived and dominant understandings of a topic and to offer more nuanced insights (Mannay et al., 2018). For all these reasons collage aligns with feminist epistemologies, and as such it felt important to include this method in the research to offer the women a variety of ways to share stories. However, this was my first time using an arts-based method, and so there was an element of experimentation and the unknown when using collage (I reflect on this further in section 3.4.2). From the outset, the collaging was intended to be a supplementary activity in addition to the interviews and used to elicit conversation about their SRH. The women's reflections on the collages they created, rather than the collages themselves, would be the data, and I would not offer any interpretation of their art.

Initially I planned to conduct the collaging activity on a one-to-one basis with participants. This was due to ethical concerns regarding women disclosing personal and sensitive information to others in a group setting. However, the collaging shifted to a group activity in England because the majority of women who were recruited through a refuge showed interest in taking part in the collaging activity and expressed that they were keen to do so as a group. Four women took part in the group session. These women had been living closely together for an extended period of time, had established relationships with each other and intimately knew each other's stories. As such, some of the ethical issues of carrying out group research were avoided in this context, and I decided that group sessions would provide a more relaxed and friendly space for the women to collage in. This decision was supported by literature that discusses the benefits of using the collaging method in group settings (Roberts & Woods, 2018). As the group sessions worked well for the women, I proposed that the collaging was carried out in the same way in Australia, and this was met with enthusiasm by the women who wanted to take part in this sample. Two separate groups were conducted, one with two women who lived in the same accommodation and one with two women who attended a weekly support group. One woman did the collaging one-on-one with me, as she was unwell on the day that the group session happened.

The women who indicated that they would like to take part in the collaging activity took part in a group session after their interview; this was to allow rapport to build between myself and the women beforehand. Holding the collaging sessions after the interviews was also done intentionally to allow for the women to expand on experiences they may have wanted to speak about in greater length or felt unable to express in the interview setting. As is commonplace in qualitative research to conduct follow-up interviews, I used the collaging as a more relaxed approach to doing these secondary interviews. They were supplementary conversations with the women who participated, rather than a method of primary data collection. Through discussing their creations, the images produced by the women were used to illicit further conversation proceeding from their interview. Two of the women that created collages did not offer explanations of what they had made. As such, their collages are not included in the analysis. This is because the collages were not themselves the data but rather used as an elicitation tool to stimulate further discussion. However, to still honour the collages these women created, they are included in Appendix 3.

All collaging sessions took place in a familiar environment to the women. The women were given the option of sharing what they had made with the group, or to discuss their collage individually with me after the session. Before the session started, it was emphasised to the women that there was no pressure for them to talk about their collage in front of the group, or to share any details that they did not want to. Despite this, all women did decide to talk about their collages in front of the group. All discussions that took place at the end of the collaging sessions were audio-recorded, with the women's consent. I decided not to record the entirety of the sessions and to only record the discussions at the end. This decision was made because I wanted to create a relaxed and informal environment while women were making their collages and did not want them to feel self-conscious about any conversations they were having.

The women were invited to make a collage based on their 'sexual and reproductive health journey'. All discussions were guided by the women, and I asked prompt questions stemming from observations that I made during the making process, which I jotted down in my fieldwork notebook as moments I wanted to ask about. The collaging prompt was kept broad to allow space for the women to address any SRH experience(s) they wanted to create a collage about. I provided all the collaging materials, which were collected from scrap newspapers, magazines, books, and other visual media (images of the materials used are displayed in Appendix 4). Whilst the women created their collages, I also made a collage, so as not to make them feel observed. At the end of the session the collages were photographed, with the women's consent, and the women were invited to take their collages with them. Any collages that were not taken by the women were intended to be destroyed, although in fact all women decided to take their collages with them.

3.3.6. Women's reflections on the collaging sessions

As mentioned, collaging was selected as a method as it aligns with a feminist ethic of care and holds the potential to be an empowering exercise for participants (Gauntlett & Holzwarth, 2006). This was reflected in the feedback on the sessions: many of the women who took part expressed that they enjoyed the activity and some found it therapeutic in nature. Scarlett (34, Aus) and Ariana (36, Aus) took part in a session together and explained that they felt the collaborative experience provided them with a space where they noticed, and felt comfort in, the similarities across their lives. This was despite being from very different backgrounds and having different trajectories into homelessness:

> Scarlett: A kind of relief. Me, I can get a relief.
>
> Ariana: Me too, exactly.
>
> Scarlett: At the same time, motivation from the story. And you can see the similar story. I can conclude– what I did – like saying about that experience of their life, it's the same with my life and then what I carry and everything.

Pippa (44, Aus) also felt like the session had provided a useful space to process some of the difficult times in her life and talk about them openly:

> Talking to you has really helped me reflect on the nasty things that's happened and know I don't want them to happen again.

Mannay et al (2018) posit that creative methods hold the potential to offer nuanced insight into a topic area and encourage reflections from participants that might not otherwise arise from the scheduled interview guide. This was found to be true in this current research, where all the women chose imagery for their collages they felt were positive when reflecting on their SRH journeys, including butterflies, fish, and flowers. This was a departure from the largely negative experiences that were shared in their interviews, where trauma, pain, grief, and loss featured heavily across the women's narratives. In contrast, the collaging generated conversations about the more positive and hopeful elements of their worlds. Some examples of the positive experiences captured in the women's collages are provided below.

Figure 3.1: Scarlett's collage

Scarlett explained that she selected a tropical background with palm trees, lush rainforest, and a gleaming river, alongside various images of animals and plants, to represent her connection with nature and her love of her home country, from which she had migrated many years earlier (Figure 3.1). She explained that when making the collage, she intentionally focused on her family background and her upbringing, rather than her current circumstances, and chose the birds to represent her freedom and decision to move to Australia:

> I don’t touch on my addiction, because I don’t like to talk about my- my bad experience or my hurting thing. But still there with me, but I know what's happening, but I don’t want to put in my- my art or my impression, because that's not good.

Abigail (45, Eng) and Rosie (29, Eng) both incorporated images into their collages that illustrated their hopes for the future.

Figure 3.2: Abigail's collage (1)

Figure 3.3: Rosie's collage

When explaining her thought process whilst making her collage (Figure 3.2), Abigail commented 'The bird, it's kind of like, to set me free. That's where I want to be. I want to be free of all this crap.' Similarly, Rosie said that she 'Tried to pick positive images' when making her collage (Figure 3.3), using feathers to depict where she wanted to be on her journey and what she was working toward in the refuge, butterflies to represent change, and a plant to represent growth.

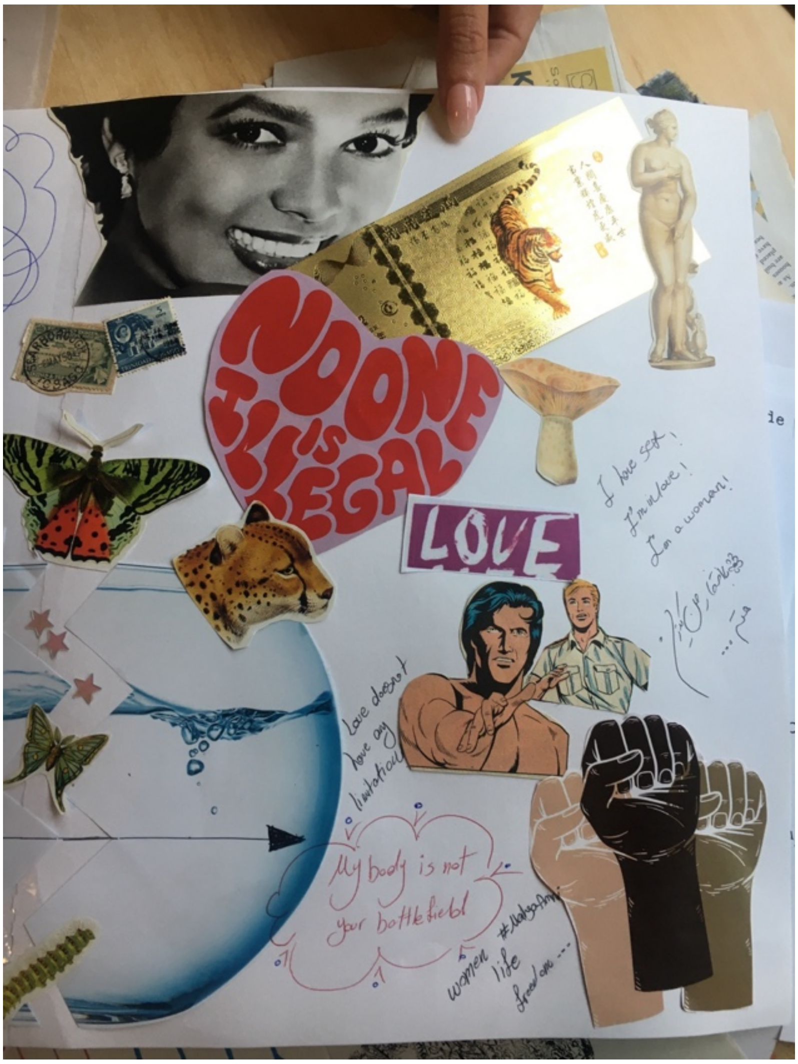

Figure 3.4: One half of Ariana's collage

Ariana explained that she used imagery to depict her strength and growth over the course of moving from her home country and emigrating to Australia, and the many hardships she had faced since then, through using the imagery of the metamorphosis of the butterfly, next to an image of a lion (Figure 3.4):

> As I said, I'm not a butterfly. I suppose that, okay, I just break in everything- I'm a butterfly. But one day I find myself – okay, you're a lion. No, now you are a superwoman. You can manage your life. You can do the things that you really want. Even when you are broken, you still can inspire other people. You can still see the positive things, which is amazing. Yeah. I love that.

These excerpts suggest that the collaging did offer a more holistic understanding of the women's lives and gave them a space to talk about their hopes and aspirations for the future, and things that brought them joy.

Additionally, women reflected on how they went through the process of making their collages, with several expressing surprise at what they had created. For example, Becca (late 40's, Eng) commented:

> I just let my brain go- like looked at anything. And my brain were just picking the things out. Like, I didn't sit and think, 'I'm gonna do this'… My brain just did it.

Rosie expressed the joy she felt at choosing a flower to represent her vagina (Figure 3.3), an image that she saw as positive and illustrative of new life. She explained that she wanted to present it in this way because it 'produced the most amazing thing about me', referring to her son. She felt this choice of image reflected her own growth towards her self-esteem following emotional abuse she had suffered about her appearance:

> Cos I picked this flower to represent my, like, vagina (laughs). So that fact that I picked-. Cos before, I always used to always be like, 'Oh, it's ugly.' Because obviously, like, you lot know, I've, I've had a prolapse and stuff like that. So for me, it's, like, so disgusting and da da da. Whereas

> now, I'm starting to pick, like, you know, flowers to represent it in a different light.

These reflections suggest that collage does indeed provide an alternative avenue into people's experiences and hold the potential to unlock unconscious experiences that haven't before been reflected on (Culshaw, 2019). These experiences indicate that collaging offers the opportunity for other kinds of stories to be told, an important finding in itself which contributes to the body of literature demonstrating that arts-based methods allow for the generation of knowledge in alternative, nonlinear ways (Butler-Kisber & Poldma, 2010; Roberts & Woods, 2018; Mannay et al., 2018).

3.4. Analytical processes

The following section details the steps involved in transcribing and coding the datasets, including the unexpected emotional impacts of transcription and the messy realities of analysing the women's narratives.

3.4.1. Transcription

For the fieldwork conducted in England, I transcribed all the interviews and collaging sessions myself. This was an intentional choice: qualitative research was new to me, and I wanted to immerse myself in the data to familiarise myself with it. Doing the transcription myself was a useful experience in multiple ways. It helped me notice moments that I had missed while conducting an interview and helped me reflect on and improve my interview style, for example by making me aware of how much space I gave a woman to answer a question I had posed or the wording of my questions. However, with this increased awareness came a whole barrage of emotions.

I found the process of transcribing interviews emotionally taxing and, at times, more difficult than the interviews themselves. This was because I had more time to absorb and reflect on what women were sharing with me, often having to listen and re-listen to sections of the interviews to ensure the transcription was as accurate as possible. Consequently, it took me at least several months to be able to shift my perspective to view the conversations that I had with the women as 'data'. Not only was transcribing the interviews and collaging sessions myself extremely time consuming, but it became an emotionally laborious process that I needed to have regular breaks from to avoid becoming overwhelmed by feelings of hopelessness, anger and fatigue.

Learning from this experience, I decided to have my interviews transcribed professionally for my Australian fieldwork. I had an additional pot of research money to spend from La Trobe University and this, combined with the benefit of time saving, made it worth investing in transcription services. Before using the service, I ensured, via a signed agreement, that all of the data shared for transcription would be kept confidential and that the transcriber would abide by the data protection standards set out in my ethics applications. After receiving each transcript, I listened to the interview again while reading it over to check the accuracy of the document. I edited the transcripts to ensure consistency with the formatting style that I had used to transcribe my England dataset e.g. the inclusion of speech fillers (ums, laughter). I read over the Australian transcripts several times to familiarise myself with the conversations in the same way that I had done with my dataset from England.

3.4.2. Coding

Analysis was an iterative process that began with noting my key observations after each interview, and in the post-interview debriefs with my supervisors, where I would share standout moments. I would reflect on these during the familiarisation stage of reading and re-reading the interview transcripts and recording observations of moments that stood out to me in the data. I used familiarisation prompts from Braun and Clarke (2021) to guide this process, such as ‘how does the person make sense of whatever it is they are discussing?’ and ‘why might they be making sense of things in this way (and not in another way)?’ (p43).

I had originally intended to use all six steps of Braun and Clarke’s (2021) reflexive thematic analysis. However, this was not how I ended up conducting the analysis. Following the familiarisation stage, I moved onto stage two: generating initial codes. After rigorously coding all the transcripts in NVIVO12 software, focusing on analytically interesting ideas and experiences that related to my research questions, I generated a large list of codes (201 in total). From this coding phase, I then looked at how these codes fitted into initial themes. I tried to cluster all codes under at least one theme, however realised that some codes only had several data extracts attached to them, whereas others were very large and contained multiple ideas. Although Braun and Clarke (2021) stress the fluidity of their suggested analysis stages, posing them as grounding steps rather than rigid rules to follow, I nevertheless found the steps ultimately unhelpful for the number of codes that I was working with. I felt stuck trying to follow the suggested six steps and became paralysed, unable to make sense of the story the data was telling. With my supervisors’ encouragement, I decided to move away from the recommended steps and return to the observations that I recorded during the familiarisation stage of reading the transcripts.

At this stage of the analysis, I was very familiar with my dataset. After reviewing all the codes multiple times, I turned my attention to themes that stood out to me the most in the datasets. Figure 3.5 is an example of mind mapping exercise I carried out in the early stages of my theme development, provided for illustrative purposes. I used mind mapping as a tool to return to my dataset, begin establishing connections between my codes, and then grouping them to generate themes.

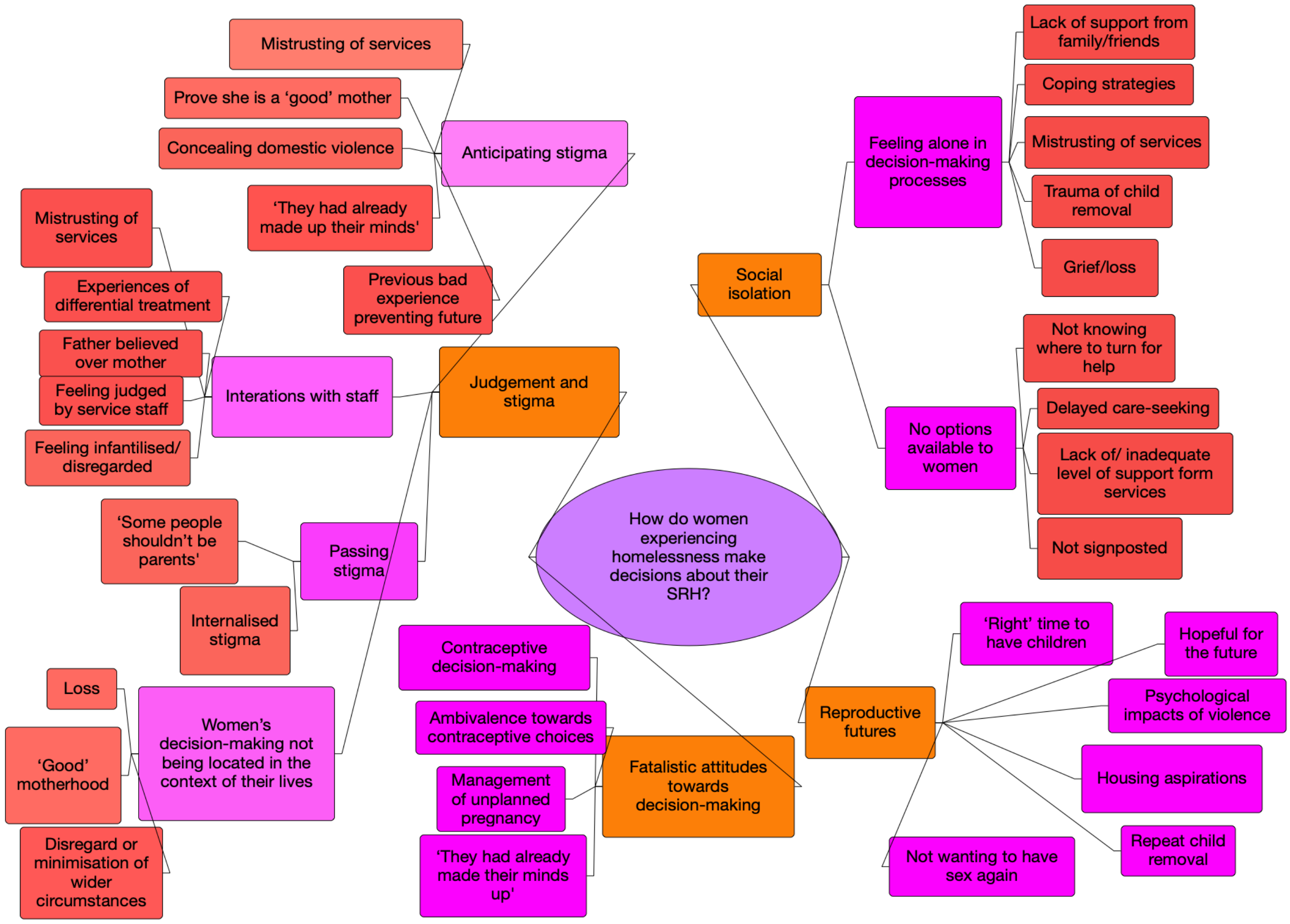

Figure 3.5: Example of mind mapping exercise used to develop my thematic analysis

I guided this thinking by returning to my original research questions and keeping my theoretical framework in mind. When doing so I followed the advice of Braun and Clarke (2021), who move away from the core idea of 'searching' for themes in their influential 2006 paper, to instead encourage thinking about 'generating' themes. Essentially, acknowledging that theme development is not a passive process, rather one that is informed by the theoretical underpinnings of the research, and by one's own subjectivities.

I was conscious that I wanted to keep a broad scope of enquiry to ensure that I was not restricting my analysis or missing anything that was important in the data, to allow my empirical findings to emerge in response to my research questions. Having said this, I knew that experiences of stigma were central to my theoretical lens, and so this was at the forefront of my mind whilst going through the stages of analysis. Simultaneously, I did not limit the analysis to stigma only and took cues from a reproductive justice lens which advocates paying attention to all contextual factors that influence women's SRH choices. Through this process, I generated a list of eight themes that felt most pertinent to understanding the women's SRH decision-making processes. I examined these themes to look for similarities across them and then refined and condensed them into three findings chapters. Interview data is shared throughout the findings chapters in the form of quotes. Quotes are attributed to the women by acknowledging their pseudonym, age, and country where the interview took place.

There is a divide in approaches to analysing arts-based methods, with differing opinion on how best to analyse visual data. In the context of collaging, some take the view that collages should be interpreted as images in their own right (Roberts and Woods, 2018), combined with dialogue from the maker to avoid misinterpretation, whereas others suggest that collages are merely 'tin-openers' for talk and a way to stimulate dialogue (Macbeath, 2002). For this research, I took the later approach. This was because I intended to use the collages to have supplementary conversations with the women and illicit further dialogue, but also this was partially due to my lack of confidence in analysing images. As such, the data generated from the sessions were the reflections women had on the making of the collages about their SRH decision-making and experiences, and the group conversations generated from these reflections. I analysed this data using the same approach as the interview data: to generate themes in relation to the research aims.

The terms of my scholarship required that I conducted fieldwork in England and Australia. Although my research was carried out in these two countries, it was not designed as a comparative study, as such an approach is less appropriate for small-scale, qualitative studies, and would not have helped answer the research questions and aims. However, there were benefits to conducting fieldwork in these two countries. Doing so allowed me to situate this research within existing women's homelessness research from England and Australia (two countries where much of the scholarship in this field emerges) and draw out the commonalities in women's homelessness experiences in both contexts. While I did not carry out a comparative study, I still maintained an awareness of the geo-political contexts of the countries whilst conducting the analysis. For example, considering the differences between the welfare and healthcare systems, such as what expenses the women had to pay for out of pocket versus what they could access for free.

3.5. Ethical considerations

Before I commenced fieldwork, ethical approval was granted from Sheffield Hallam University (approval number ER45548696) and La Trobe University (approval number HEC22254) Human Research Ethics Committees. Seeking approval from two ethics committees posed a set of challenges, as each one had differing expectations regarding ethical procedures. For example, there were different requirements concerning recruitment strategies, notably variation in how much organisations were perceived to be involved in research (and therefore needing to be included as project partners) depending on how they disseminated recruitment materials to potential participants.

When designing and carrying out this research, the responsibility of embedding good ethical practice into every stage of the process was amplified due to the population group, and the highly sensitive and potentially distressing nature of the topic. In asking women to talk about their SRH, accounts of domestic violence, sexual assault, child removal, substance use, and abortion often arose in the conversations. Additionally, many of the women had previously had to relay their stories to services, repeating traumatic experiences over and over, in order to access supports. As such, an ethics of care, a cornerstone of feminist research methods, was adopted to minimise any potential harms of taking part in the research on the women. This section will now detail the ethical processes that were carried out.

3.5.1. Use of incentives

All participants were offered a voucher as a thank you for giving their time and expertise to the research. Participants in England were given a voucher valued at £15, and Australian participants were given a $50 voucher. Differences in monetary value between the countries occurred in line with the standard expectations in each context regarding the monetary value of vouchers given as a thanks to research participants. Collaging was advertised as an optional extra activity that was not financially compensated. All women received a voucher whether they participated in the collaging activity or not.

3.5.2 Informed consent

All women who expressed an interest in taking part in the research were provided with a participant information sheet to read prior to the interview (Appendix 5). This sheet provided information that explained what participation in the study would involve. This included information on the women’s right to withdraw and how their data would be stored, and assured their confidentiality and privacy. Information about the collaging session was included in the same participant information sheet and those who decided to participate were directed to this.

Before the interview began, each of the women was asked if they had read and understood the participant information sheet. To make sure that literacy levels were not a barrier to participation, all women were given the option to read the sheet themselves, or to have it read to them. Sometimes women expressed frustration at having to read the full document and, in these instances, I verbally outlined the main points of the participant information sheet, to ensure that they understood what they were consenting to. I emphasised to women that their participation was voluntary, and that deciding to take part (or not) would not affect their relationship with the service they were recruited through. I then verbally went through a consent form with each participant (Appendix 6). Explaining and obtaining consent verbally allowed space for women to raise any questions or concerns with me after each key point before they consented, to ensure that they were consenting to all the participation requirements. For the two women whose first language was not English, and whose interviews were conducted using a translator, the translator explained each bullet point of the consent form after I had read it out in English and confirmed after each point that they had given informed consent.

Consent was an ongoing process, and I made sure to emphasise this to the women by designating moments before, during and after the sessions for them to reflect on their participation and whether they wanted their stories to be in the research. It was reinforced in the interviews and collaging sessions, as well as being included in the information sheet, that participants would have two weeks after our last point of contact to withdraw from the research. After this point, the women's data was included in the research, as it could not be assured that it would be possible to retract their data once it had been de-identified and begun to be analysed.

3.5.3. Confidentiality, anonymity and data protection protocols

Women were informed in the participant information sheet and the consent form that all the data would be de-identified and confidential, and their privacy maintained, meaning that outside of myself and the supervisory team, nobody would have access to their data. All women's information was de-identified using pseudonyms[1] and through changing any personal information (e.g. places, family member names, service organisations used) that held the potential to reveal identities. Transcripts were stored on Sheffield Hallam University's secure drive (Q drive) and in a password-protected file in NVIVO12 for analysis purposes. Photos of the collages were attached to the pseudonym of the participant; women were asked not to include any identifying information on their collage, and so these were not identifiable. Photographs of the collages were also stored on the secure Q drive.

The women were advised ahead of participation, via the information sheet and during the explanation of consent, that the only instance in which confidentiality would be breached was if there was an immediate risk of the participant committing harm to themselves or to others. During the interviews, there was one instance where a woman shared the severe distress she felt on that day due to an ongoing incident at her accommodation. This woman expressed that she felt at 'rock bottom' and was considering using heroin again after not having used for many years. She also shared with me that she was planning on sleeping on the street that night to avoid having to return to her accommodation. Feeling very concerned for this woman's wellbeing and worried about her actions after the interview, I decided that this met the threshold for breaching confidentiality. I told her that I was feeling concerned

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[1] One woman wrote her name on her collage and explicitly requested that she wanted it to remain on there, and so to respect her wishes it has been kept in.

and would be sharing this information with a staff member at the service where the interview took place, to see whether they could seek out any alternative housing options for her. The woman expressed that she was happy for me to do this, and a staff member then spoke with her following our interview to provide further support.

3.5.4. Discussing sensitive topics

As outlined in section 3.3.3 and 3.3.4, the interviews and collaging sessions were unstructured, however they broadly centred on discussions of SRH decision-making and experiences of homelessness, with the addition of other experiences women felt were important to share. The unstructured nature of both methods was a choice taken in consideration of the sensitive nature of the research focus. Whilst unstructured interviewing did not eliminate the power dynamics between myself as researcher and my participants, it aimed to reduce them. An unstructured approach meant that women had a greater level of control over what they shared with me and allowed for them to lead the conversation (Walton et al., 2022). Additionally, a statement was included in the participant information sheet, which was also read to participants ahead of the start of the interview:

> A possible risk of emotional discomfort relates to discussing your experiences, which may be positive, negative, or neutral. As a result, there is a small possibility you may become concerned or upset during or after interviews. If you do become upset, you are free to not answer particular questions if you don’t want to, take a break and finish the interview later, or cease the interview at any time. You will also be provided with contact details of support organisations for advice on who you can talk to.

To emphasise that women were in control of the conversation, I also stated at the start of each interview that they did not have to answer any questions or share anything that they were not comfortable doing so at any point in the interview.

There is widespread awareness of the complicated, and sometimes blurry, boundary between the roles of researcher and therapist in qualitative research involving sensitive topics, as there are a shared set of skills that are required for both research and therapy interviews (Dickson-Swift et al., 2006). An integrative review of the ethical dilemmas that occur during qualitative research found the main conflict faced by researchers in practice was the risk of inflicting harm on participants and researchers (Taquette & Borges da Matta Souza, 2022). This was something that I was conscious of throughout the research process, and at times it felt difficult to navigate. I was aware that, for some of the women, the interview may have been one of the first times they were able to speak freely about a traumatic history without fear of stigma (Schmid et al., 2024). In fact, several of the women confided that this was the case at the end of their interview. As such, I endeavoured to create an environment characterised by open-listening and empathy. This looked like offering breaks during interviews, checking in with the women who appeared visibly upset, and not probing into any areas that they expressed not wanting to discuss.

The push and pull between wanting to hear about a participant's experiences from a research standpoint, versus wanting to look after a participant's wellbeing, was constant throughout the interviewers. On one occasion, after answering a few general questions at the start of our interview, a woman who I was interviewing through the translator became very distressed and started crying. The translator explained that she did not want to answer any interview questions but had given permission for the translator to tell her story on her behalf. As the translator was also a worker at the refuge and had been working closely with the woman, she was already familiar with the details of her story.

After a brief explanation of the woman's circumstances, I made the decision to bring the interview to a close, as it was clear that she was getting increasingly upset and engaging in the interview was distressing for her. This is one example of an interview where a woman was experiencing high levels of distress. However, this is not to say that this was the only time during fieldwork where a woman became distressed. Due to the nature of the subject matter, women often became teary or upset in interviews, but this did not always mean that the interview itself was harmful and needed to be stopped. This points to the often-tricky terrain of navigating distress in interview settings, and the importance of checking in with participants and giving them options during the interview to ensure they are conducted as ethically as possible.

As part of the interview debrief, signposting to support services was provided in the form of a resource list and given to the women. The debrief was also a time where I checked in to see how the women were feeling, and a space where they could share any concerns. In the debrief, I also sometimes suggested seeking further support from a staff member within the building where the interview took place if a woman had become upset during their interview. Where possible, I tried to end the interviews on a positive note, for example by bringing women back to the present and asking what they were doing with the rest of their day, to ensure that the women were not leaving in distress.

3.5.5. Managing researcher wellbeing

It is well established that researching sensitive topics with marginalised populations can be an emotionally taxing experience for researchers (Dickson-Swift et al., 2006). Early career researchers have been particularly identified as feeling unprepared when conducting sensitive research, and as receiving little support in managing the emotional impacts of such work (Karcher et al., 2024).

Whilst there are strategies in the literature for the minimisation of emotional harm to researchers, formalised supportive processes are lacking, and there is acknowledgement that some level of distress is likely to be felt when conducting this kind of research. Additionally, advised supportive practices are often neoliberal in nature and focused on individual coping strategies of 'self-care' rather than recognising the role of institutional, or collective, modes of support (Schulz et al., 2022).

Ahead of starting the fieldwork, I was aware that I was about to embark on an emotionally challenging piece of work. I had read articles that recommended methods for minimising harm to researchers investigating sensitive topics, with the intention of preparing myself as best I could (Silverio et al., 2022). However, there were often moments during the fieldwork where I felt burnt out and emotionally exhausted. It transpired on several occasions that I conducted two interviews back-to-back; this happened in both fieldwork locations, largely due to the circumstantial nature of recruitment, which meant women wanted to take the opportunity to participate there and then on the days that I had dropped into an organisation. Despite knowing that I found doing more than one interview in a day challenging, both emotionally and in terms of being able to hold the conversation, I pushed myself to do so out of fear that I would not be able to arrange to see a potential participant again. This is one example of tension between the ideal self-care strategies that are recommended, and the realities of conducting fieldwork with this population and in these environments.

An invaluable practice for me throughout the fieldwork process was debriefing with a member of my supervisory team after each interview. I found this was essential to minimising my own emotional distress after interviews that frequently involved difficult and distressing conversations, simply to feel reassured about my handling of a situation or to have an empathetic ear. Another support strategy that is frequently referred to in the literature is research journalling, which I had intended to use as a reflection tool from the commencement of my fieldwork (Silverio et al., 2022). Unfortunately, I did not engage in journalling as I had planned. My lack of consistency with journalling often came down to the weariness that I felt after an interview, particularly after doing them back-to-back, which meant that the last thing I wanted to do was record and reflect on its emotional challenges. I have since reflected on how, at times in the fieldwork process, I would have benefitted from such a practice. This is learning that I take forward with me.

3.6. Conclusion

This chapter has detailed the epistemological, methodological and ethical decisions that were taken to plan and carry out this research. As has been demonstrated, challenges arose throughout the fieldwork process, and I was often confronted with ethical considerations which required thoughtful yet responsive navigation of the situation that was in front of me. Conducting fieldwork was never straightforward, and at times the realities of being in the field felt at odds with bureaucratic ethics procedures. Despite the difficulties and the emotions that came with conducting this research, fieldwork was one of the most enjoyable aspects. Navigating practical and ethical considerations, and managing a large-scale research project, was a stimulating experience and one that came with many learnings.

Guided by feminist epistemologies that hold principles of care and relationality at their heart, I aimed to reduce the possible negative impacts of participating in this research on the women, and instead to create an environment where they felt they could act with agency and dignity. This was particularly important in the context of this research where, as my findings chapters will show, opportunities to act autonomously were so often absent from their narratives. I now move on to present the three findings chapters of this thesis.

Chapter 4: The good/ bad womanhood dichotomy

> ***Cos I'm a mum. I'm not a wrong person. I've had wrong things done. (Rachel, late-40's, Eng)***
>
> ***I think they put me in a... I think they have boxes that they put people in. And I think I'm in one of them boxes. (Becca, late-40's, Eng)***

Women's homelessness is typically understood through hegemonic, essentialist gender categories that naturalise women's role in the home, as mothers and as caregivers (Bretherton, 2020; Savage, 2016). Research has demonstrated how such women have been viewed as transgressing these normative categories, and as such labelled as deviant, abject, and 'other' (Reeve, 2018; Parr, 2024; Savage, 2025). This thesis contributes to this body of scholarship, finding that stigma was an undeniable and pervasive theme that weaved through women's narratives, and deeply impacted how they experienced their SRH. The judgements that women faced were not singular but, in different ways, served to locate them outside of traditional gender expectations: as irresponsible, immoral and in need of regulation. This is reflected in state and service provision in both England and Australia, where policies reinforce the good/bad dichotomy by allocating resources through a conditionality logic that requires women fit narrow categories of femininity (Stonehouse et al., 2022).

This first findings chapter begins by demonstrating how pervasive the dichotomy of good/bad womanhood was in the lives of the women participating in the research, and the impact it had on their decision-making processes. We begin here because understanding this dichotomy sets the context for all that follows.

This chapter first interrogates the gendered, classed, and racialised hierarchies that inform the kinds of judgements the women faced, how their decisions were viewed, and how this in turn functioned to devalue them. The 'stickiness' of the labels attached to women in relation to motherhood, and the implications of these labels for *all* women, regardless of their mothering status, is discussed (Ahmed, 2004a). These labels meant they could not be seen as capable mothers, or considered deserving of motherhood at all. The chapter then moves on to explore the collateral consequences of this binary discourse for women. Namely, it considers the stigma generated through this discourse, how this placed constraints on women's ability to make autonomous SRH choices within services, and the cyclical nature of the mistrust generated. Their anticipation of stigma, and what it meant for how they navigated SRH decision-making processes, is examined. The affective implications of women being positioned on the 'bad' side of binary, and framed as devalued reproductive citizens, are then explored. Lastly, the impacts on women's SRH decision-making, specifically the effects not only on their current circumstances, but their reproductive futures, is examined.

Together, the findings presented underscore the significant, tangible, and enduring consequences of the good/bad womanhood dichotomy on the women's SRH lives. They show the women's positioning in the dichotomy led to a dismissal of their needs by service staff, disbelief of their circumstances, policing of their actions, and their children receiving inadequate care.

4.1. The classed and gendered dimensions of stigma

To begin, this section introduces some of the stigmatising labels that were placed on women and explores how these labels contributed to discursive formulations of a good/bad dichotomy of womanhood. Specifically, it uncovers the ways in which being positioned on the 'bad' side of the good/bad womanhood dichotomy cast the women as unruly and in need of regulation. As the findings will show, stigma did not function singularly/ flatly but operated in multiple ways along gendered and classed lines. For these women, femininity, as conceptualised by Skeggs (1997) as a form of social capital that women learn and perform through various practices, was not a given. In fact, it was something that women had to earn, and that was so often unattainable.

Grace (23, Aus), for example, talked about the judgement she faced after sharing with a nurse that she regularly smoked marijuana, a disclosure which resulted in her being reported to child protection services over concerns about her parenting. Grace explained there were no attempts made to know her beyond this label, meaning that the context of her marijuana usage and her history were overlooked. Not only this, being read as an 'addict' affected the quality of care that her son received, as the hospital visit became focused on questioning her parenting abilities rather than on his check-up:

> I've mentioned I've smoked pot and their views on it are very obviously biased and just the way she spoke about it when I mentioned it to her, she was just - you could tell what her opinion on it was. And then two days later, I had a report made (laughs)… It was a new nurse I've never met before. She didn't know any of my history or how well I've done or come. She just looked at my old history and just went (blows raspberry). [Just made a snap judgement?] Yeah. She like didn't even pay any attention to (son's name). She like weighed him and that was it.

Significantly, no staff member asked Grace about her marijuana use before making the report, leaving her feeling blindsided and betrayed. She was not understood beyond this label, and her work to cut back her marijuana consumption was obscured. A value distinction was made about her substance use which, combined with being a woman and a mother, meant that Grace was marked as ‘deviant’ and in need of being controlled. This demonstrates the tangible consequences of stigma.

Alison (49, Eng) described being policed on the clothing she wore in her temporary accommodation, and feeling singled out because she was a sex worker. She explained that she was subject to a different set of rules to the other women living there, and reprimanded for her clothing choices, which were seen by the staff as inappropriate and overly sexual:

> Because of how I looked, how I acted, d’you know, when I were going up and down on the beat[2] and that. I was the only one that couldn't have people stay. I was the only one had to be in, like, at a certain time, like I’m a little kid. So, they singled me out! [Because of your work?] Because yeah, you know, sort of thing. And I didn’t hide it, d’you know what I mean?... Yeah, they did treat me different, they did treat me different. Because... I don't know. I just told him basically, go fuck yourself, you know? I'll do what I wanna do.

Notably, Alison felt treated ‘like a little kid’, despite being a parent herself. She was disciplined for failing to comply with expectations of how she should dress and resultingly faced unique restrictions on entering and leaving her accommodation. This finding echoes existing literature which shows women who did not conform to traditional femininity practices were more likely to be subject to tighter controls and be designated as unworthy of support (Mayock & Sheridan, 2020). In Alison’s case, she was defiant of the stigma attached to her, yet also reliant on her accommodation, and so was limited in her ability to push back against it. This underscores Pemberton's (2016) comment that people’s ability to respond to stigma is determined by their available resources and social capital.

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[2] ‘The beat’ refers to public spaces that people visit to seek out sex

Similarly, Pippa (44, Aus) shared that she was labelled as displaying ‘excessive’ sexuality as a young adult. She described being labelled a ‘slut’ by staff at the residential home for people with mental ill-health she lived in for expressing extreme distress over her volatile relationship with another resident. This reaction from the staff, and their failure to provide her with the support she needed, eventually led Pippa to leave the home, resulting in many further years of housing insecurity and mental health decline:

> People took sides, that’s why it got bad. Workers took sides, people took sides, his side, my side, it was… That’s one of the reasons why I got out of there too. Because some of the workers were just dismissing me and thinking she’s just a slut or- not a slut, but just thinking she’s a pain in the arse, put it that way. [So, you just felt like they didn’t believe you?] One shut the door on me when we were there, you know, in the staffroom… They really – they just didn’t wanna know. They didn’t wanna know. They’d taken their side and... They thought I was making a big scene because I was crying all the time, but that’s the depression too.

In Grace, Alison and Pippa’s stories, murmurs of ‘respectability’ emerge. Skeggs’ (1997) work is pioneering in showing how social structures such as gender, class and race are essential to the construction of subjectivities. She argues ‘respectability is one of the most ubiquitous signifiers of class’, and that this is a key apparatus through which certain women are excluded and othered due to the value attributed to obtaining respectability (Skeggs, 1997: 1). Skeggs suggests that behaviours which would typically be celebrated, viewed as aspirational, and confer status in middle-class women are seen as deviant and abhorrent for working-class women, precisely because they are read through a classed lens. For the women in this research, these intersecting oppressions were compounded by their homelessness and combined to deny them ways to ‘do’ respectable femininity (Watson et al., 2025). In all their experiences, stigma was rooted in, and fueled by, moralising judgements about sexuality, respectability and responsibility (Finn & Murphy, 2022). Stigma was a disabling force that had tangible consequences for the ways they were treated by staff and the kinds of support they could access.

Figure 4.1: Other half of Ariana's collage

When explaining her collage (Figure 4.1), Ariana (36, Aus) reflected on the weighty gendered expectations placed on her in her conservative Muslim home country. She used the image of the Mona Lisa to represent the ideals of responsibility and sexuality that were imposed on her from a young age. These expectations, she explained, left her feeling highly constrained and deeply disconnected from her own sexuality in her early life:

> I think I was trapped in a ego, in a man ego thing, because they want to control everything. And um this one, Mona Lisa, um I don't know is it good or bad, but people – erm being an angel is very creditable in my home country. So, and they suppose that because of my look, because of my eyes and because of these types of things that I'm angel, and I look like Mona Lisa. Because she's pure, you know, she's clean, she doesn't have any crime. She doesn't fuck.

The gendered nature of the judgements women faced also emerged in the stark contrast of the treatment those who are mothers faced in relation to their male partners. Abigail (45, Eng) explained that she felt totally dismissed by child protection services when trying to gain custody of her children who were, at the time of interview, in full-time care of her abusive ex-husband whilst she was living in refuge:

> They don't understand it and they don't want to know. And then when they come in and see him all 'Charlie Charming'. And they see me. Upset and hysterical. Makeup down me face. And he'll go, see. Told ya. This is what I'm dealing with. You know what I mean? And then I'm getting frustrated and angry because… I'm shouting to people and asking for help and no fucker's listening.

Abigail's frustration at being painted as overemotional and frenzied in comparison to her ex-husband is palpable. Her acknowledgement of being perceived as 'hysterical' speaks to the gendered divide in the expectations placed on parents, and the different and higher set of standards that women are held to.

Conversations with the women quickly revealed that 'good' mothering was framed very differently to 'good' fathering. Acknowledging her label as a 'bad mum', Nicole (32, Eng) articulated that she has been marked as an uncaring and uninterested mother by child protection services, even though she went on weekly visits to see one of her children in care:

> [Do you feel like they're trying to kind of paint a picture of as a...?] Bad mum, yeah. That's what I think they're doing. They're thinking that I'm a bad mum. They're saying that I don't care about my kids. But when I was seeing my third one on her own, I was going on my own, seeing her every week. But the dad, to her, weren't even bothered. Didn't even go and see her.

Nicole draws attention to the contrast in the way that she is viewed versus how her partner is. This highlights the gendered dimensions of the stigma attached to women, and the standards that women are held to. Although Nicole was doing the best she could with the resources available to her at the time, she was deemed not caring enough. This was the reality for many women, pointing to the ways that mothers were uniquely responsibilised under what England and Henley (2024) term 'paternalistic welfare structures' that require women to perform motherhood in particular ways to be seen as 'legible' (p1).

Similarly, Fatima (24, Eng) spoke about the ways that blame narratives were quickly applied to mothers rather than fathers:

> (through a translator): The social care have not been so helpful. The social worker's not been helpful at all. She's always blaming things on Fatima and saying things to her. Every time Fatima raised a complaint… social worker's always said no, he has never done this, or he would have not done this. So social worker's obviously been blaming Fatima, but never taking any responsibility of what dad's ever done. Whenever Fatima's said, dad's (children's father) pushed me or doing this, her social worker's never taken accountability of that. Never acknowledged that. And has always taken sides of the dad. And, bearing in mind, she's a social worker of both sides.

The gendered expectations placed upon the women meant they were not only held responsible for their decisions, often outside of their control, but their partner's decisions too. Alison explained this dual burden of responsibility through describing the reaction of a sympathetic social worker who acknowledged the differential treatment she had experienced after one of her children was removed from her care:

> He even said it was wrong, what happened to me. Cos he said... he turns around and says to me, we send people on courses to get 10% of the parental skills you've got. So, they're getting mad. Because it's just my choice of partner. And it was him what got this risk assessment done.

All the women's narratives are unified by a common experience: they have been judged in comparison to their male partners and deemed insufficient mothers. The stories shared support the assertion by England and Henley (2024) that 'women's homelessness is a location in which heteronormative discourses of good womanhood play out' (p1). They demonstrate how women are attributed stigmatised identities that place them on the 'bad' side of the good/bad womanhood binary: outside of being read 'respectable', and so excluded from receiving the supports, in particular secure housing, that women are typically prioritised for. The dichotomy has most commonly been discussed in the literature in relation to expectations of motherhood (Savage, 2025; Watson et al., 2025), but this can be expanded and applied to notions of womanhood more broadly.

It is implicit in many of the women's experiences discussed so far that women's value is intrinsically linked to reproduction; women are understood as potential mothers and valued for their reproductive potential. However, the women in this research were seen to transgress norms of femininity and so were excluded from being valued for reproduction. Being located on the 'bad' side of womanhood meant they were viewed in contrast to what Saunders (2021) terms ‘valued reproductive citizens’: women who are older, educated, future-oriented, responsible, and middle- class. Additionally, they did not have the same access to resources and material conditions as the idealised mother yet were held to the same set of standards. The ways in which this discourse labelled women as incapable of being good mothers is explored in the following section.

4.2. The good/bad **motherhood** dichotomy: the ‘stickiness’ of labels

This section focuses specifically on how the good/bad womanhood dichotomy operated in relation to those women who are mothers. Watson et al (2025) note that homelessness and motherhood are both sites where women’s subjectivities can be devalued, and where performances of femininity can be enacted to try and gain respectability. Many of the women faced stigmatisation on multiple fronts: being single mothers, without a home, and poor (Finn and Murphy, 2022). This section discusses the implications of living with such labels for the women’s mothering practices: labels that were impossible to shake, but which women worked hard to disprove.

To examine the impacts of stigma in the context of the good/bad motherhood dichotomy, I draw on Ahmed's (2004a; 2004b) conceptualisation of the ‘stickiness’ of labels. Ahmed suggests the labels we apply to people are distributed through emotions that (rather than private) are relational and ‘circulate between bodies and signs’ (2004b: 117). In her conceptualisation, affect accumulates over time and produces truths about people, creating ‘the very outline of different figures or objects of hate, a creation that crucially aligns the figures together and constitutes them as a common threat’ (2004b: 119). This solidifies truths and representations about particular groups. As will be demonstrated in relation to the women in this research, the ‘stickiness’ of such labels marginalises certain bodies and causes real, tangible harm through forming ‘us’ and ‘them’ distinctions which shape how these bodies move through and experience the world.

Women articulated awareness of the negative labels attached to them in relation to their homelessness and their mothering. Existing literature points to the intersection between homelessness and child protection involvement and shows that homelessness is often understood solely as neglect and cited as a reason for removal (Savage, 2016; Bimpson et al., 2020; Watson et al., 2025). As noted by England and Henley (2024), ‘Becoming homeless brings poor families, especially those headed by a lone female, into the full view of the state, and renders their once-private activities public and subject to scrutiny’ (p4). In this current research, many women spoke about the requirement to continuously prove themselves to child protection services in order to be read as credible mothers and disrupt the stigmatising labels attached to them. This appeared in women’s narratives when describing a fight or struggle to stop their children from being removed, or when trying to regain care of them:

> The police either like you or they don't like you. And they tried - because I've got three sons, so they tried desperately to take my children off me. Went to court. And I fought and I fought, and I won every court case. I said you're not going to take - because if the police don't like you, they ring the people that they know in child protection and they say, ‘Oh well, this one here, blah-blah-blah, you know, we want - these kids need to be somewhere else, blah-blah-blah’. (Nellie, 62, Aus)

There was a common feeling that no matter what they did to try and dispute it, the label of ‘bad mum’ stuck. Becca (late-40’s, Eng) articulated this when describing the one hour a week of contact time, supervised, that she had with her son at the time of our interview. During this time, Becca was living in refuge, and her son was living with her abusive ex-partner due to concerns regarding her alcohol consumption:

> I think they put me in a... I think they have boxes that they put people in. And I think I'm in one of them boxes. 'Oh, she- she got dependent on alcohol. So she's in that box.' They're not taking the bigger picture of everything. They're not taking the years of abuse, mental abuse, physical abuse from him, they're not taking that into account. That maybe that just pushed me over as well.

Becca's description of being placed 'in that box' reinforces the feeling of being categorised as unable to adequately parent, the pervasiveness of this label, and the real-world effects it had on her ability to enact mothering practices. Becca is read exclusively through the stigma of alcohol dependency, which is not understood as a response to the severe domestic violence she faced. Women held an acute awareness of the stigmatised identities they inhabited, and the stickiness of these labels. The response that Becca received also points to the gender-blind nature of many services, where issues that predominantly affect women are not recognised, and thus remain invisible. This suggests a dual gendered problem embedded in the service response: Becca was only read through a stigmatising label, and as such her actions were not understood in the context of the gender-based violence she experienced.

Darcy (mid-forties, Aus) had four children, none of whom were in her care. Her two eldest children had been in and out of the care system since they first entered respite care following the death of Darcy's partner. Darcy recounted her shock at going to pick them up to go home, but instead being met with a pile of paperwork and being informed they were being taken into foster care. She explained that it took two years to have them returned to her care, only to have them removed again a year later for violating the rules of their care order by taking them on holiday outside of the state they lived in. Because her two eldest were eventually permanently removed from her care, she was under scrutiny from child protection when her third child was born. She attended parenting classes and was under observation for six months before going back to the courts, where she was informed that she was ‘number one in the class’, and no further intervention was needed. However, her child was later taken into care over concerns of drug use and her relationship with her baby’s father. Following this, her youngest child was removed a month after the birth. Darcy poignantly expressed the emotional and psychological impacts of being labelled as a ‘bad mum’, and the toll it took on her self-esteem:

> They always say, whatever don’t kill ya only makes you stronger. Well, my comeback for that is, honestly, how strong does one person have to be? Because I think I’ve proven to everybody how strong that I am, but they just keep throwing stuff at me and I have to show them again. Sometimes I just don’t want to deal with it. Sometimes you feel like you’ve proven yourself, but no one cares. Yeah. You sort of feel- It makes you feel empty.

Darcy, like Becca, described feeling totally beaten down and defeated by this label. This was a sentiment shared by many women, who felt that their motherhood was viewed singularly through a ‘problem-saturated lens’ (Boddy & Wheeler, 2020: 17). Broadhurst and Mason's (2020) research similarly points to the devastation of child removal, the deep loss and isolation felt, and the heightened vulnerability of women already facing profound and deep-rooted disadvantage.

This current research found that stigma informed the women’s interactions with child protection services. The enduring consequences of the good/bad womanhood dichotomy became apparent in the women’s reflections on their experiences of child removal. As has been discussed, the women were well aware of their positioning on the ‘bad’ side of the dichotomy, evident through recounting that they felt put into a ‘category’, ‘a box’, and marked as a ‘bad mum'. Their frustration towards the stickiness of these labels was evident in feeling they had never been given a chance in child protection cases because of the judgements held by social workers. Clara (54, Eng) articulated this when discussing being assessed from child protection services to determine whether she could retain care of her children. She described feeling powerless in her interactions with social workers and explained feeling her past experiences of being in prison were used unfairly to justify their removal:

> They used it against me! And none of my convictions were anything to even do with kids. All me reports were excellent and everything. But all they were bothered about was them at risk of emotional abuse, for arguing with people and stuff. When I got kicked out of that assessment unit, they were on about emotional abuse. But at that time, they were just taking everybody's kids of 'em for no good reason. But all me past and that, they just brought all me past up just to make me look bad when they went to the courts. [Did you feel like you kind of had to prove yourself to people?] Their minds were already made up, so I didn't have a choice anyway. I mean, that last mess up with me assessment, that were last um-, that just made it worse. I had no chance of getting to keep her.

Clara acknowledged that she was not alone in facing this treatment from child protection services, and the sentiment that child protection workers were conspiring against women to remove their children was common. An 'us' versus 'them' narrative became quickly apparent in the interviews, a divide which underscored the power of the labels placed on women. Clara stating that she did not have a choice because they had already decided her fate suggests a resignation to their removal.

The feeling that a path had already been charted was echoed by Alison (49, Eng), who spoke about the shock of realising that her youngest child was going to be removed from the hospital following the birth. She explained this shock was partially because she had raised two of her sons from birth and, despite child protection involvement in their lives, had always retained care of them. Like Clara, Alison felt powerless to change the perception of the social workers involved:

> I didn't realise the gravity of the situation. I just assumed because I brought my kids up, you know what I mean? What the fuck is all this about? I didn't realise it until it got to the end of the pregnancy and by then I was... I don't know, my head had just gone, you know like. And when they come in hospital and they're fucking going on about taking him and all this, that and the other. I just thought, you know what, ain’t gonna matter what I do, they’re still going to do the same thing. They're going to do the same fucking thing as what they did. Do you know what I mean?

Clara and Alison’s responses to punitive child protection systems they felt disregarded by could be read as fatalistic. Fatalism can be defined as ‘an individual’s feeling of lack of control over life events, notions of fate, luck and predestination and feelings of powerlessness, hopelessness and meaninglessness’ (Perfetti, 2018: 59). Fatalism has been suggested as a barrier to health-seeking behaviours, associated with negative health outcomes, and shown to be more prevalent in low income and marginalised populations. In these women’s stories, fatalistic attitudes towards their children’s removal acted as a barrier to feeling able to act autonomously. This demonstrates how women are further marginalised by systems that discount them by having their agency removed. It suggests that, rather than stigmatising portrayals of women as lazy or uncaring, some women simply may choose to not engage, because they feel the stigma is too great to overcome.

It is important to note that the implications for good/bad motherhood discourses also extend to women who are not mothers. Defining who is and is not capable of being understood as a 'good' mother had consequences for the ways that *all* women in this research managed their SRH, as their reproductive choices were judged through this lens. Through this discourse, women are responsibilised and expected to make 'correct' choices regarding their reproduction. What is considered a correct choice is determined by which side of the binary a woman falls under, informing whether decisions are read as 'appropriate' or valuable, or as the opposite. These discourses mark certain stigmatised bodies, including women experiencing homelessness, in need of regulation. This bifurcation had consequences for *all* women's reproductive trajectories, as this binary stems from the *potential* for all women to become mothers. The next section of this chapter unpacks some of these consequences on the women's SRH.

4.3. The collateral consequences of the good/bad womanhood dichotomy: living with stigma

So far, this chapter has detailed the ways in which the women's actions were made legible exclusively through stigmatising portrayals of them as 'failed' women and 'bad' mothers. Researching in the context of repeat child removal, Morriss (2018) and Broadhurst and Mason (2020) spotlight the immediate and lasting consequences of stigma on women's lives: revealing the formal and informal penalties women faced, the isolation they faced, and the cumulative negative consequences of child removal. Similarly, this research found the women could not escape their stigmatised identities.

This section now turns to unpack the consequences of this stigmatisation on women's lives, asking what it meant for them to live with stigma, and its effects on their SRH. In doing so, this section identifies four key consequences of the good/bad womanhood dichotomy: the denial of maternal identity; the removal of the women's autonomy through techniques of infantilisation and surveillance; the affective implications for how the women perceived themselves and shifted blame onto others; and the constraints on their reproductive futures.

4.3.1. The denial of maternal identity

So far, this chapter has explored the ways in which the good/bad womanhood dichotomy devalued and othered women, positioning them as outside of respectability, and inherently unfit to be mothers. For many of the women in this research, the most severe material consequence of this discourse was the permanent removal of their children from their care. Nine women in the England sample (out of the ten who are mothers) and two women in the Australia sample (out of the seven who are mothers) had at least one child removed from their care. Six women in the England sample, and both women in the Australia sample, had more than one child removed from their care.

Darcy (mid-40's, Aus) shared a particularly striking experience that illustrated how child protection services operated in harmful ways. As introduced in section 4.2, child protection had been involved in all four of her children's lives and, after several temporary removals and prolonged periods of foster care, all had eventually been permanently removed from her care. Darcy recounted the shock of her two eldest children being removed for the first time, after she had briefly placed them in foster care following the sudden and unexpected death of her partner:

> I put the kids in respite care for the week, or whatever it was. I went back after that time- after I had the funeral, and everything. I grieved. I felt better now, you know? Well, the best I could, anyway. Went back in to pick up my children and take 'em home and the woman walked out the

> back. I was in the waiting room. I'm thinking, okay, me little ones are going to come bolting out the door any second now. No. They just pulled out a pile of paperwork- that's it- saying why they were um- why they had made the decision to take my children off me for the next 24 months. As they felt that I was an unfit mother.

Darcy repeatedly had to prove herself as a capable mother to child protection services, despite decisions from the courts that she was not a risk. She expressed feeling de-humanised and totally powerless in her interactions with social workers. Darcy articulated the contradiction of feeling totally unsupported, yet at the same time under strict surveillance from the system:

> So, I thought the kids are back. They've been living with me for 12 months. I hadn't heard a word. Nothing. No, how are ya? Nothing. So, I naturally thought, well, the kids are living with me, I've got power and control over them. No. They had power and control over my kids. They still do now.

For other women, their children were removed at birth from the hospital. For these women, this was not their first experience of child removal. Again, women felt that pre-cast judgements about them meant they were not given the chance to prove themselves as 'capable' mothers:

> [What was your experience like with them?] It was hard, because they'd got an idea of what were gonna happen. Cos obviously me eldest had been took. (Rachel, late- 40's, Eng)

> If they wanna drug test you when you come back, so be it. I don't give a damn. D'you know what I mean? I would have done anything like that. But no, they don't give you that opportunity. If they do, I haven't known. Some people might have had them things, might have... they might do

> that for some people. But it hasn't been my experience and I can't understand why. (Alison, 49, Eng)

In the UK, Boddy and Wheeler (2020) found that over the past two decades there has been a significant increase in the number of children born into care and posit that this is partly a consequence of increased poverty and extensive cuts to preventative services. They situate this within the broader context of welfare austerity, and a punitive child protection system that diverts blame from increasingly under-funded state support and holds mothers responsible for neglect. These systems conflate poverty and neglect and disregard the conditions of homelessness that make ‘good’ parenting extremely challenging (Bimpson et al., 2020).

Similarly, Abigail (45, Eng) talked about the pain of living in a refuge without her children and being unable to enact her normal mothering practices:

> The night times and the weekends are the longest and the hardest. Because it's the night times, it's like me putting my kids to bed. I've cried, I’ve cried for fucking weeks. Excuse my French. But it broke my heart for
>
> weeks because I wasn't the one tucking ‘em up in bed. I wasn't the one reading the story. I wasn't the one erm… doing the things that I've done for seven and nine years and- (starts to cry).

Figure 4.2: Abigail's collage (2)

In both collages that Abigail made, her children were the focal point. 'Sadness', 'pain', and 'solidarity' were all words she had chosen in her second collage (Figure 4.2) to articulate how she felt at the time of the collaging session and words that characterised living in the refuge and apart from her children. When asked why she'd chosen the word 'power', Abigail responded 'Although I've put power there, I feel powerless at the minute, with what's going on.' These parts of Abigail's collage depict the pain and struggle of being denied access to her children, feelings that she also articulated strongly in her interview.

Women being positioned as 'bad mothers' meant that there was, at times, no recognition of their role as mothers at all. Insufficient recognition of women as mothers by professional services following child removal meant the grief and loss they experienced was also not recognised. Boddy and Wheeler (2020) refer to the power the state has to constrain women's possibilities for grief as 'disenfranchised grief' (p11). As this section has demonstrated, this grief was an experience shared by many of the women, pointing to the psychosocial impacts of stigma. Morriss (2018) describes women subject to repeat care proceedings as existing in a state of 'haunted motherhood'; a future motherhood that continues to be stigmatised by the past and is characterised by their children lost to the care system as a 'ghostly presence', at once present and absent (p821).

In the absence of recognition of their motherhood status, women were left to manage their grief alone and resorted to coping mechanisms which led to further adversity and homelessness (discussed in detail in section 5.2). Ellie (early-30's, Eng) described the pain of seeing children while going about her daily life, serving as a constant reminder of the loss she had experienced after her two children were removed:

> But I bought myself-, my partner bought it, because I lost my daughter and I lost my son when they were born. And I knew... Yeah, I know it's not real. Yeah, I know it's not going to do the same thing as a normal baby. But it takes my mind off. [Sorry. What did he buy you, a…?] A (brand name) doll. It's not really like a doll. It's like a real, a real baby. But it took-, takes my mind off a bit. But I keep saying to my partner, it doesn't take my mind off. When you're walking round and you're seeing other kids.

The women recounted that the pain they experienced in the wake of child removal was beyond measure and described attempting to cope with whatever limited resources they had available to draw upon. The consequences of child removal extended far beyond the immediate impacts on their life regarding their children. The cumulative, long-term impacts of this grief have been discussed in the literature and is a strong finding of this thesis. Scholars including Broadhurst and Mason (2020), Parr (2024), and Morriss (2018) have underscored how the stigma of child removal leads to ostracisation from interpersonal support networks, and isolation from institutional settings, as motherhood depicted as flawed or failed is seen as a spoiled identity.

The message from the women was clear: they felt totally unsupported once their children had been removed:

> {Did you get did you get support after your children were removed?] No. I didn't get no support at all. No one was supporting me through it. It's like, sometimes I'll start crying because I'm missing them. Because they're not in my care. (Nicole, 32, Eng)

Their experiences demonstrate the power of stigmatising labels by showing that after their children were removed, the women were no longer seen by service providers as mothers at all. Not only this, but the stickiness of these labels sometimes obstructed access to services that may have helped to prevent care proceedings in the first place (this is discussed further in section 5.3).

4.3.2. The removal of the women's agency in services: infantilisation and surveillance

This section explores infantilisation and surveillance as two powerful forces that obstructed women's SRH lives and their capacity for decision-making. It considers how these techniques reproduced, and were fed by, the good/bad womanhood dichotomy. Through this, the cycles of mistrust generated between professional services and women is explored.

Several women reported feeling infantilised by services. This was evident in Beth's (25, Eng) account of the frustration she felt towards the supported accommodation for individuals with additional needs that she lived in at the time of her interview. She explained that she wanted to stay overnight at her partner's house, a normal occurrence for most people in their mid-20's, but was prohibited from doing so by the accommodation staff:

> I'm well known to the police anyway… Because the staff keep reporting me missing... [Because you're at your new partner's place?] And it's like, what

> do you do? When they have to come and do a safeguarding check on you every three days.

Not only this, but Beth’s partner was not allowed to stay in her accommodation either, a rule she explained was not applied to other residents. She explicitly stated she felt ‘picked on’ by staff, saying ‘I haven’t been treated right’. Beth recounted the strict rules of her accommodation, and being treated with suspicion by the staff, who had on multiple occasions reported her as missing for staying overnight at her partner’s house. The mistrust women faced meant they experienced differential treatment to others, which often came in tandem with intense levels of surveillance.

Alison (49, Eng) also recounted experiencing differential treatment from hospital staff who, following an incident where she was seen falling asleep whilst feeding her son with a bottle shortly after his birth, subjected her to constant monitoring:

> I had somebody come to the hospital, yeah? Tell me everything was all right. That same day, somebody comes to the hospital. They sent a social worker. What had to sit in the room with me while I was in the fucking hospital. And monitor me! [Just after you've given birth?] Yeah, to monitor me. And the midwives were talking about it. She goes, I can't believe they've done that. They told her everything was all right. And now they've gone and done a total 360 and put somebody in the same room. Wait a minute, there's hospital staff there. There's all these people there, why the fuck do I need a social worker to sit with me?... All because I fucking gave him the bottle like that!

She explained the scrutiny she faced from child protection services because of their awareness of her substance use during pregnancy. This was despite assurance that she would have some time alone with her son following his birth, knowing he was going to be removed from the hospital into the care system. Her account demonstrates the different set of rules and standards she was held to. Behaviours that might be read in any other mother as tiredness after giving birth were labelled in her case as cause for concern, resulting in constant monitoring by a social worker. Alison talked about the stigmatising labels stuck to her, as a mother who was a substance user and a sex worker with a previous child removal, and how these led to heightened surveillance:

> You know, it's when they've got this bee in their bonnet with ya, that's it. They've got it… [So, do you feel quite singled out by them?] Mmm! It's when they got this thing with you. The either wanna work with ya, or they don't.

Similarly, Grace (23, Aus) articulated the different set of standards the women were held to and the intense surveillance they faced. She described the scrutiny she was under from child protection services while trying to make a suitable space to raise her son in the inadequate accommodation that she had been provided: a run-down caravan in her mother's garden:

> Water would come in the caravan. I had to use a heater that you would plug in. But you can't leave it on all night because child protection said that's dangerous. But it's also cold. So, they're worried about him being cold, but they're also worried about me leaving the heater on. [So, you can't win]. I can't win. There was no winning. It was - can't leave an air conditioner on either when it's hot. I had a mobile hanging over his bed, like any baby does, and they made me take it down. Because they're like, what if that falls and kills him in his sleep? And I'm like- like you go to any parent's house and I'm pretty sure everyone has a mobile hanging over their baby's bed.

Grace explained the simple act of hanging a mobile above her child's cot was flagged by child protection services, labelled as dangerous, and ultimately forbidden. She was at once penalised for not ensuring that the caravan was warm enough for her child whilst also not given the resources to do so in a way that was classified as safe, or offered housing with a properly functioning heating system. Her quote exemplifies the feeling evident in many women's narratives that they couldn't win, no matter how much they tried to disprove the labels that stuck to them.

These findings are consistent with research conducted by Mayock and Sheridan (2020) in a hostel, who found women reported their everyday experiences of living there were characterised by intense infantilisation and surveillance, where they had a lack of control over their everyday lives. Notably, they found the women who were unaccompanied by their children felt they themselves were treated as children, especially when scolded by the staff, and described this as dehumanising and punishing.

Attending to the modes of infantilisation and surveillance women were subject to highlights the ways that their capacity for agency was denied within services. This created and sustained a cyclical relationship of mistrust between the women and professional services, which sometimes meant the women were reluctant to return. This demonstrates the damaging and enduring consequences of the good/bad womanhood dichotomy: women feared judgement due to previous stigmatising experiences and so did not want to engage, which fuelled stigmatising narratives of women as uninterested and irresponsible.

4.3.3. Affective implications of stigma

This section explores the emotional consequences of being placed on the 'bad' side of the good/bad womanhood dichotomy, and the impacts of the labels associated with this positioning. Firstly, it looks at how some of the women internalised stigmatising narratives and held themselves responsible for their homelessness, in the process obscuring the structural barriers they faced.

Secondly, it explores the ways the women distanced themselves from other women in similar contexts and claimed difference from them in the face of being 'othered', in order to legitimise their own deservingness. The ways these affective implications may limit the women's capacity for decision-making is then explored.

So far, this chapter has demonstrated the many ways that stigma operated as a significant barrier to autonomous decision-making. Despite the absence of structural supports in their lives (explored more fully in chapter Five), this research found the women frequently held themselves solely accountable for their circumstances. As will be shown, this commonly appeared in the women's narratives as self-blame and shame. In many cases, their inability to access care for themselves and their children was understood through a lens of individual responsibility. This mirrored systematic messaging fuelled through austerity logic that women's circumstances were the result of their own failed actions and lack of responsibility: that ultimately, they were to blame (Clarke, Watts & Parsell, 2019; Pearson, 2019; Price & McGowan, 2025). This was the case for Rachel (late 40's, England), who began using heroin after the birth of her first son to manage her postnatal depression. Whilst acknowledging she was not given the support she needed following the birth, Rachel ultimately understood her addiction as the result of her own 'poor' decision-making:

> I went through postnatal depression, and I didn't get the right help. I went down to where his dad were using. Er, me own choice cos I were an adult, but yeah, I choose to use heroin. Started injecting, erm. [As a way of, kind of, dealing with the feelings?] Yeah. But it's only, like I say, a blocker. But I'm not going to be the first mum to do things and lost their child-, children to care.

In stating she is an adult, and that having her children removed is not exceptional, there are connotations that she 'should have known better' and was irresponsible in how she managed her pain. Rachel viewed the loss of her children, her substance use, and her homelessness, through this lens. This perspective was particularly evident in the guilt she carried over the removal of her children and her strong desire to rebuild their relationships. It became the foundation on which all her decisions were made- her driving her motivation to address her substance use, while also casting a shadow over her sense of self:

> In the cells before I went into prison. Yeah, social services came to me. Me head were all over the place. But signed him over, (indistinguishable) willingly. So then they got-, well me eldest first cos like I said, me youngest weren't even considered and went with his dad. And yeah. Signed forms. Not knowing probably what I was signing and that… There weren't basically-, there weren't no-. He wasn't at that time- cos he was on his own, me eldest, wasn't no good in my care. Cos I was making very wrong choices. And I still make the wrong decisions. But I believe that there's more than meets the eye now. A lot more than meets the eye… Cos I'd like to think that I can speak to 'em and talk 'em round it.

Rachel articulated an awareness of being an 'abject figure', a mother who is read as flawed because her children have been removed by the state (Tyler, 2013). It should be recognised here that taking responsibility should not always be solely read as indicative of stigma being internalised. However, in Rachel's case, the language she used to talk about her drug use indicated that she had internalised stigma around her usage.

Scarlett (34, Aus), a migrant, trans woman with multiple addictions, explained that she had started using substances to stay awake late at night to perform sex work:

> So, you need to be thinking about – you need to keep awake, everything. And then like that's why I'm in- I'm like er got some of a problem and issue in terms of using of the substance. Methamphetamine, ice, drugs

> thing. Yeah, I'll be open like that, I do MDMA, I do cocaine and then I do GBH everything… It's not like because I'm like wanna having fun or I want to party, I want to be high. It's not… It's like I need money for life, for keep a life. It's not like I'm alive for money. No. I might need to find money for keep me alive, food, to pay for the rent, everything. Because I came here without any kind of like depending on any family financial support.

Although recognising that using substances to be able to work was a necessity to support herself, as she has no one to rely on financially, she also framed her methamphetamine use (as well as her gambling addiction and her homelessness) through a lens of responsibility. She further explained that her addictions had become increasingly out of control during lengthy COVID-19 lockdowns in the pandemic, a time when she was isolated and had a lot of free time. Scarlett recognised that she took drugs out of necessity, as well as the impact of the lockdowns on worsening her addictions, but ultimately came back to situating the blame with herself. This was evident when she spoke about her relationships with her friends and family, and shared that ultimately, she felt her circumstances were the result of her own actions, and so could not blame anyone else:

> So, when this happened, it's not like I blame it on that- on that behaviour. I'm not blaming on that making me in this position. I don't blame them because of this is what I choose, this is what I want to.

For Rachel and Scarlett, it appeared they had internalised the stigma they faced, which in turn had consequences for their own subjectivity. This is an important finding, because existing research suggests that viewing oneself as having a stigmatised identity had a considerable part to play in the non-take-up of support for those who are eligible (Baumberg, 2016; Patrick, 2016). Stigma acting as a barrier to care seeking is explored in more detail in section 5.3.

Several women talked about their experiences of domestic violence with a sense of frustration toward themselves for ‘letting it happen’ or staying in their relationships. In framing their experiences in this way, there was an implicit powerlessness in their narratives, but also a tendency to hold themselves responsible rather than locating accountability with the perpetrator, despite the little control they had over the situation:

> And sometimes I’m a bit disappointed with myself. Cos I’m like-. When I think about the stuff that I've allowed to happen, I think what's wrong with me? Do you know what I mean? And then I get angry with myself. (Rosie, 29, Eng)

Their frustration was sometimes articulated as a comparison of the self they were before their violent relationship in contrast to their present self. Abigail (45, Eng) talked about writing down the years of domestic violence she had experienced to provide evidence to the police when bringing a legal case against her ex-husband. She described the traumatising process of reading over and re-living the abuse, and shared how she would have advised a friend in her position to leave the relationship:

> I can hear meself going, ‘What the fuck are you doing there?’ And, ‘Why haven't you fucking told him and just put your foot down?’. I said, ‘I can give meself-, me old self advice on this. And I feel angry that I've put myself through this and let him-. Because I seem to have gone from this strong businesswoman that had her own house, four-bedroomed house. Her own car. To this fucking little timid woman that's going, ‘yes, Sir, no, Sir.’ And fucking doing anything to keep the peace. And treading on eggshells every time he comes home. I said, ‘I don't recognise myself. I really don't.’ And it was a shock.

In the quote above, Abigail expressed an almost out-of-body experience—feeling unrecognisable to herself and totally disconnected from her decision-making—as well as anger at having ‘let’ her partner abuse her and feeling like a ‘timid woman’. This internalisation of stigma could be read as reflecting structural stigma from systems that invertedly hold women accountable for their partners’ violence, most evident in the removal of children.

Similarly, Florence (57, Aus) located the blame with herself for leaving and re-entering her abusive relationship over the course of many years. Additionally, she held herself accountable for the abuse that her children suffered at the hands of ex-partner. Florence blamed herself for, as she saw it, sacrificing her children by letting them get verbally abused by her partner. However, she also recognised the actions of her ex-partner in this blame and held him culpable. This demonstrates the tensions and nuance in women’s decision-making, and how choice and agency is mediated by violence:

> I should have left him heaps earlier because I look back and look at my son. He's only 28. He's been in about three relationships, and I see his dad in him, and I don't like that. I don't. And I'm thinking, yeah - I blame myself for that, for not leaving earlier. I blame - my eldest daughter, she's got heaps of anxiety because she was a chubby girl and he used to call her names, like bad names. Like she was in primary school, called her a fat slob. What the fuck? And I used to let that happen, because he left me alone. Is that bad? That is bad. As a parent, it's bad. But he left me alone.

In partially holding herself accountable for the abuse her children suffered, Florence narrative reflects the broader discourse about women’s role as protectors, and the specific set of gender expectations that intertwine with how women interpreted their own decisions. In Florence’s case, she perceived herself as a ‘bad parent’ because of the long-term effects the violence had on her children. Her account is a stark example of the impossible decision-making that women had to engage in to survive, decisions that were compounded and made even more impossible by their housing insecurity.

In all the examples discussed in this section, the sticky labels that had been applied to women were internalised as self-blame and shame. This finding is significant for understanding decision-making, as literature indicates that experiencing stigma causes invisible social harms and ‘impacts on possibilities of agency’ (Finn & Murphy, 2022: 8). In their research with single mothers, Addison (2023) demonstrates how stigma hindered the ways women interacted with services, worsened their mental health and intensified feelings of exclusion from society. In broader homelessness research, internalised stigma has been shown to undermine individual’s sense of stability and self, even after they had obtained stable housing. Padgett (2007), for example, found participants continued to report feelings of isolation from society and difficulty in sustaining a coherent identity. This demonstrates the long-lasting impacts of stigma on people and opens up questions regarding how stigmatisation shapes women’s reproductive experiences: past, present and future.

So far in this section internalised stigma, appearing in the form of self-blame and shame, has been explored. However, this was not the only way that internalised stigma came through in the women’s narratives. In addition to evidence that some women interpreted their actions as the result of poor decision-making, there were also examples of women attempting to reject the stigma attached to them by passing it onto other women. The deflection of stigma appeared most strongly in narratives about mothering practices: particularly the experience, or threat, of being separated from their children. Ellie and Alison both had their children removed from their care, and contrasted their experiences against other women who had their children in their care:

> But you know, there was a girl, pregnant same time as me. She used to work on the beat, yeah? Used to inject. She got her kid. She got her kid, even though they know about all the drug use. So, you tell me why has

> she got her kid when she was an injecting drug addict? I never injected. (Alison, 49, Eng)
>
> I've known anyway that they were getting removed. But it's not that. There's people out there that take drugs and stuff, but they can keep their kids. And there's people that got mental health issues, but don't take drugs, but they still take the kids. And I'm like, nah. That's not fair. (Ellie, early-30's, Eng)

In both of their accounts, hierarchies of deservingness were created between women who were deemed worthy of having their children in their care, and those who were positioned as irresponsible. Alison, a heroin and crack user, positioned those who are injecting drugs as more problematic and therefore in need of intervention. Ellie, whose children were removed due to her poor mental health, broadly characterised drug users as less deserving of maintaining care of their children. In both of their accounts, 'passing stigma' is present. 'Passing stigma' involves moralising judgements that are passed onto imaginary 'others' and, by extension, to 'pass' as deserving in comparison (Boland et al., 2022). In this context, it was used by the women as a technique to affirm their own identity and legitimacy as mothers by distancing themselves from the stigmatised group they knew they had been ascribed. The demarcations drawn between themselves and others highlights the divisive nature of stigma. This could be understood as a way of legitimising and securing oneself in a system that is chronically underfunded, has depleted resources and teaches women that proving oneself as 'worthy' is essential to accessing support. 'Passing stigma' has been found across other research, where the most identified targets of 'othering' include immigrants, substance users, and welfare claimants (Finn & Murphy, 2022; Patrick, 2016).

Grace and Olivia, both young mothers, enacted ‘passing stigma’ when discussing being in environments with other young mothers, at once cognisant of, and rejecting, the stereotypical images attached to them:

> I do go to a mums' group, and I think the other mums in there I don't quite match with. Their stories are a lot- er more rough and they're a lot more rough. And so sometimes I question. I'm like, why did you put me in here? I'm not sure if this is the safest group for my child to be around (laughs). (Olivia, 20, Aus)

> I’ve always said there's young mums and then there's *young mums* (emphasis in tone and facial expressions). There was a lot of young mums at the school and there just wasn’t a good mix for me unfortunately. Because they would all just stand out front like smoking. They'd have baby on their hip with a cigarette in their mouth. It just wasn’t… Wasn’t a vibe. [You didn’t feel like you fit in?] No, it wasn't a vibe. It was just - you can tell they're going on one path only. (Grace, 23, Aus)

In these examples, both women talk of feeling out of place and distinguish themselves from the other young mums. ‘Passing stigma’ functioned to position them as ‘good’ parents who were not in need of social services intervention. This can be read as a way the women attempted to gain respectability as capable mothers in contexts where they had little control:

> I’m very much like I think they were picking on the wrong person here. Like there are so many other people that need child protection in their lives and I'm not one of them. That's why I got so shitty about the recent report. I was like there is no need to report me. Like there's children that are literally getting starved or beaten. You just wasted someone's time. Which she did, because the report got closed. (Grace)

Similarly to Alison and Beth, Grace talked about certain, imaginary, 'other' mothers who need intervention, and set themselves apart from them. In all these examples, 'passing stigma' can be understood as a strategy to try and gain control of the narrative in a system which allows women very little control over their circumstances. This discursive act simultaneously recognises and rejects stigma labels, in an attempt to reverse the flow of stigma power (Boland et al., 2022). However, in doing so the power of stigma is diffused, cultivating resentment among women which in turn reproduces and reinforces stigma. As noted by Patrick (2016), this diffusion of stigma allows little room for alternative narratives or changes to the status quo and is detrimental to the women's own societal inclusion. This is important because it fuels stigmatising depictions of homelessness: stigma that has been evidenced throughout this chapter to limit women's autonomy regarding SRH decision-making. Boland et al (2022) argue stigmatisation has consequences for people's subjectivity and for their sense of citizenship, stating that 'the rearticulation of stigma against others can become a constitutive element of their identity' (p4). As such, stigma can be understood as used as a mode of covert governance by institutions.

4.4. Reproductive futures

One of the novel contributions of this research is that the good/ bad womanhood dichotomy impacted not only the women's decision-making in the present, but their reproductive futures too. Several women talked about their experiences of child removal as a motivation for wanting to have more children in the future:

> [So you would like to have another child?] Yeah. I want one to be with me. So, I can prove that I can have kids. Because I know I won't be able to have these two back. (Nicole, 32, Eng)

In this quote, Nicole expresses wanting to be a mother and enact her maternal identity, but also a strong desire to 'prove' that she could raise children. This shows the power of the 'bad mum' label, as Nicole feels a need to have another child that she can keep in her care to disprove it. As Skeggs (1997) argues, motherhood offers the possibility of being seen as respectable and responsible, and a way for working-class women to assert their moral value. However, for Nicole, the stigma attached to her as irresponsible and lazy means that gaining respectability through motherhood is out of reach.

The desire to have more children to prove oneself as a capable mother echoes the work of Broadhurst and Mason (2013; 2020), who found that women who have had children removed may see pregnancy as a chance for redemption and personal growth. Their research also details the devastating consequences for these women, who become caught in cycles of child removal, remain in a heightened state of vulnerability, and so become susceptible to relapse and further adversity. It shows the inescapable stigma these women face as 'maternal outcasts' in both interpersonal and professional encounters for failing to meet 'good' mothering norms (Broadhurst & Mason, 2013).

Another way in which the 'bad' mother label impacted the women's future decision-making was through curbing possibilities for their reproductive futures, which acted as a powerful deterrent to women having more children:

> [if you wanted to have children again, did it kind of impact that decision?] I'm too… well it would do, but I'm too old to have 'em now anyway. It would've done, yeah. They're not gonna let me forget it even if I was gonna want any more. They'd bring it all up again, won't they? Cos it'd be on me records. (Clara, 54, Eng)

> I'm thinking, yeah, I might be able to keep this one. But I don't want to risk it and then go. (Ellie, early-30's, Eng)

Ellie and Clara talked about having more children as futile because they knew they would not be able to keep their children in their care. This demonstrates how the power of labels impacted some of the women's imagining of their reproductive futures, as they knew that their future pregnancies would likely also be subject to child protection intervention. Morriss (2018) and Parr (2024) draw on hauntology theory to refer to this ongoing trauma and loss as a state of 'haunted motherhood', women's lives at once haunted by the absence and presence of their removed children, and by the lingering emotional impacts on their anticipated futures: a future motherhood continuing to be stigmatised by the pasts. This was evident in the women's experiences shared in this section: their motherhood had been viewed solely through a '"problem-saturated" lens', which in turn had significant implications for the ways they made decisions about their reproductive futures (Boddy & Wheeler, 2020: 17).

4.5. Conclusion

This chapter has introduced the good/bad womanhood dichotomy and demonstrated how the stigma generated through this binary is a productive and injurious force that had tangible consequences for the women's SRH decision-making. It has discussed the 'stickiness' of the labels attached to the women, and the moral judgements associated with such labels. The ways in which institutions responsibilise and designate women as making 'poor' decisions is stark in a system that ultimately positions women as failures and leaves them isolated, with few resources and no 'good' decisions to make.

Interrogating the impacts of the good/bad womanhood dichotomy on the decision-making of the women makes visible how this stigmatising discourse places significant constraints on how they navigated their SRH lives. It rejects and pushes back against common framings of women experiencing homelessness as irresponsible, immoral and unable to make decisions about their reproductive lives. On the contrary, these findings show that women did indeed engage in constant decision-making and continued to fight to rebut discourses which served to disempower them. This chapter has provided important context for the following two findings chapters. The next chapter presents the second theme of findings from this research and explores the ways that women fell through the cracks of service support, and what this meant for how they navigated their SRH.

Chapter 5: Falling through the cracks

> ***[Does it feel a bit like a relief as well when it [a miscarriage] happens?] Yes. Yeah. It saves me from having to go down to an abortion clinic and sit through all that shit and get judged for that. So, if it naturally sorts itself out then that's good. (Grace, 23, Aus)***

Chapter Four detailed the multitude of stigmas the women faced for failing to meet traditional gender expectations, which meant being relegated to the 'bad' side of the good/bad womanhood dichotomy. It examined the 'stickiness' of these labels and how they designated women as deviant, irresponsible and unworthy of care. It explored the consequences of stigma for the women's SRH decision-making, a lens through which their choices were made legible. In particular, the ways in which the dichotomy informed how women's mothering practices were viewed, and the consequences this had for all women's reproductive possibilities, were examined.

This chapter now turns to consider more fully how, in the context of these stigmatising discourses, the women experienced social welfare systems. This was introduced in Chapter Four, but this chapter focuses more directly on how women drew upon professional supports and how this informed the ways they engaged in SRH decision-making. Specifically, it looks at how women navigated complex health, welfare and justice systems, and how their choices were enabled or constrained by these entangled webs of governance. The analysis focuses on women's access to services in matters directly relating to their SRH, and on the wider decision-making that occurred within the context of, and which impacted, their reproductive lives. It unpacks how stigma worked to conceal the ways that systems failed to support women to make autonomous choices by not providing them with suitable options.

As this chapter will illustrate, women were navigating decision-making in highly restricted contexts. It quickly became clear in the interviews there were very few options available for women regarding their SRH: they felt that they had nowhere to go to receive help and that there was little or no professional support available to them. Women felt left alone to make decisions and were navigating complicated systems that devalued and labelled them as unable to make 'good' decisions, and incapable of 'good' mothering. Their stories revealed the contradictory experience of being disregarded and unsupported, yet at the same time under intense surveillance from professional service providers and without any of the freedoms that usually come with being left alone. Despite the women being beyond the reach of services, 'free' choice was still not possible. There were countless examples of women falling through the cracks, which had direct and ripple effects on their SRH.

In this chapter, the marks left by stigma explored in Chapter Four are used as a springboard to explore some of the ways in which the women's bodily autonomy was denied by services. The enduring consequences of anticipated stigma on how women engaged with services is then discussed. The findings show that women often had to prioritise securing housing at the expense of their SRH and their mothering. Finally, the devastating consequences of women being left alone to manage the often-traumatic experiences they endured, and the survival strategies they used, is explored.

5.1. Falling through the cracks: women's experiences of accessing professional services

As has been explored in Chapter Four, women experiencing homelessness are compelled to make 'correct' choices about their SRH, informed by discourses about 'good motherhood' and neoliberal notions of responsibility. However, this research found women often lacked the basic resources needed to have legitimate options for their SRH. It found women were excluded from systems that may have assisted in providing them the tools to enact autonomous decision-making regarding their bodies. Before discussing the experiences of women who were able to access support services, this chapter firstly pays attention to the many stories where women could not access material resources for affective care, and the significant implications this had for their SRH. Overwhelmingly, women talked about their SRH choices being constrained by a lack of support from professional services. They described feeling totally neglected and overlooked by services, leaving their needs unaddressed. It should be noted here that the women did not only lack professional supports, but also received little support from informal care networks of friends and family. This was another contributing factor to women falling through the cracks, and together with a dearth of professional support, contributed to the feeling of being alone in their decision-making. However, this thesis does not have the space to give full consideration to the impact of informal support networks on decision-making, and so the focus of this section remains on professional services only. This section introduces some of the ways that women fell through the cracks through discussing the various barriers they faced to accessing professional services, and how their positionalities informed such obstacles.

Some women reported being denied access to services due to complex eligibility criteria which sometimes acted in conflict with each other, meaning they fell in and out of the remit of service provision. Nisha (38, Aus), for example, lost access to the housing she was in at the time after receiving her first Status Resolution Support Services (SRSS)[3] payment:

> Then when I stayed with [organisation] for about two years, then I applied for - I got a case manager, she applied for SRSS payment. That's

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[3] SRSS is a small welfare payment given to help with basic living costs while waiting to hear the outcome of one’s asylum claim.

> not really Centrelink[4], but that's something you're eligible when you're an asylum seeker… The ruling for [organisation] is if you get a payment, I can't use that house anymore. Why? Because you get a payment. Because it's the church property. New challenge.

The SRSS payment that Nisha received meant she was no longer deemed 'in need' enough at the church property that she lived in, the only temporary accommodation she could access at the time, and so was forced to leave. Not only this, but she lost access to all additional supports that came with being a resident, such as the emotional support of a women's group, and free meals. Her account demonstrates how easily women can fall through the cracks of services for not meeting a strict set of criteria. This finding supports existing literature that demonstrates services are often only able to help individuals that exhibit high level of need (Theobald et al., 2023). This is in part due to the overstretched and underfunded nature of homelessness support services (Theobald et al, 2025). However, this finding demonstrates that the scarcity of resources faced by services had consequences for the choices the women could make and placed material constraints on their ability to improve their circumstances. At times, this created a paradox whereby a woman's situation needed to get worse before she could access the resources to improve it.

Similarly, Abigail (45, Eng) shared the difficulties she faced navigating England's complex welfare system, where she encountered multiple barriers to legal aid and was also unable to receive benefits payments. Abigail faced financial abuse from her ex-husband, who had falsified paying her a wage using his business account, which meant she appeared ineligible for welfare payments. She described the frustration of being bounced between various services, always told that she needed to speak to someone different, and left waiting in a state of uncertainty and fear for a month with no access to money:

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[4] Centrelink is the Australian government organisation that delivers welfare payments and other social services (e.g. employment services) to individuals.

> Everything was put on hold. And I had to argue for over a month and live off charity, hand-to-mouth, argue with HMRC[5] and with Universal Credits[6]. Cos every time you went to one department, and you got put through: ‘No, that's not our thingy. It’s Universal Credits you need to speak to.’ ‘Yeah, but they’re saying I need to speak to you.’ And I had a month of erm sending them me bank statements, proving that I’d not been paid any money. It was a nightmare. [Did they know about your situation?] Yeah, they knew about me situation and all that. But they said, ‘Well, as far as we're concerned, if the computer says you've been-, you've took away each…’ So, I had to get me auntie to message (ex-husband), to get in touch with his accountant. To send er me P45[7] and to send another slip, saying that, ‘No, they’ve paid that wrongly and refund it, sort of thing, back to the company.’ But it took over four weeks of me being without money. And-, and like I say, put me legal aid on hold.

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[5] His Majesty’s Revenue and Customs (HMRC) is the tax authority of the UK government.

[6] Universal Credit is a means-tested monthly welfare payment for individuals on a low income or unemployed in the UK.

[7] In the UK, a P45 is a document issued by an employer when an employee leaves a job. It provides details of the employee’s earnings and the tax they have paid on their salary in a tax year.

Figure 5.1: Abigail's collage (1)

Abigail represented her experience of navigating these complex systems in her second collage (Figure 5.1), explaining that she chose multiple images that were busy and full of detail because 'That's been my life for the past few years… It's one fight after another.' She talked about her mind feeling as chaotic as the images, offering a picture of her inner mental world and experience of battling with services that is also shared in her interview quote above.

For other women, falling through the cracks meant not being referred to services that could have assisted them. Several women explained they had been suddenly evicted from their accommodation with no offer of alternative accommodation, and nowhere to go:

> [When you got evicted, did they take into account that you were very pregnant?] No, they didn't give a fuck. We went to VCAT[8] and

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[8] The Victorian Civil and Administrative Tribunal (VCAT) is a tribunal in the state of Victoria, Australia, that resolves civil and administrative disputes.

> everything, they did not care. [They didn't care?] We were a lot behind though. We were about $8,000 behind in rent. [But there was no sort of…] Leniency? No. Not at all. (Grace, 23, Aus)

> [Did they know that after that, you were going to be on the streets?] Yep. Even the police told them – you're going to kick this woman out after what's just happened to her? That's pretty traumatising for anybody, but you're going to kick her out on the street. So you's are just going to basically cause this woman more drama that she doesn't need? [And they didn't care?] They did not want to know about it. (Darcy, mid-40's, Aus)

> I needed somewhere to stay… Yeah, I needed mental health too- I was sick too- but there was also that element. And the nurses said… you can't live in the hospital, we can't have you stay here. It was like – because my mum didn't want me, it was very murky. Not murky, it's the wrong word, very tense with my mum and my stepdad because he's alcoholic, and my mum was mentally ill. And there's a lot of issues. But they did have me back in and out, then I'd go to [hospital name], then I'd back to there, then I'd go to [hospital name]. (Pippa, 44, Aus)

In all of these narratives, welfare systems were depicted as punitive and as increasing the women's vulnerability to homelessness. The findings from Chapter Four highlight how women were responsibilised by stigmatising discourses, however the examples discussed in this section show that women were constrained by homelessness systems, and coupled with a wider absence of personal and social resources, had no tools to make the 'right' choices.

For women who were not native-born, their migration status raised an additional set of constraints and amplified their isolation from support services. For example, Nisha (38, Aus) found she was excluded from healthcare services because she did not have access to Medicare[9], yet was also classed as not having the level of need necessary to qualify for free medical treatment from a local community health service providing care to people experiencing homelessness and other marginalised communities. Nisha described contracting a genital infection and the difficulties she faced accessing the service because was assessed as not having the required level of support needs:

> I got contact of an infection in my genital area and then I didn't have Medicare and then she recommended me I could go see this female- the [community health centre]. I was like I came here and [community health centre] was like, are you a sex worker? I said no. Do you use drugs and alcohol? I said no. Oh, you don't fit in the criteria. But then I said, I'm in pain, I need to see a doctor. I'm in pain like I couldn’t even walk. That’s when I think they had a chat, Dr [name] agreed to see me. And I think they felt with my story and they agreed for me to come for women's group.

Although the dominant finding from this research was that women fell through the cracks of support, there was also an example of when SRH care provided a crucial opportunity for support to be accessed. In her interview, Fatima (24, Eng) painted a picture of life in England where she was totally isolated beyond the immediate family of her arranged marriage and a couple of her distant family members. This, combined with her very limited English, made it extremely difficult to escape the violence she experienced at home from her husband and his mother, leaving Fatima trapped. It was only once she was admitted to hospital for a prolonged stay, after the premature birth of her twins, that the abuse was noticed by the staff:

> (through a translator): They've never let her go out anywhere since she's coming to the UK. She's never been anywhere. She's always just been-,

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[9] Medicare is Australia’s universal health insurance scheme.

> they've closed behind doors… The only opportunity she had was when she, obviously, got pregnant and she went to hospital. That's when she had access to the community and the support, because that's when staff nurses were around. And she had people, like other patients there. So, through that, that's how she managed to get the support, erm through people around there. But obviously, if she hadn't gone to hospital, it would have just been...

This experience was transformative for Fatima because it was the first time she was able to speak to staff and patients, people outside of her abusive household, and eventually escape and enter a refuge. Her experience illustrates that SRH care could act as an intervention point to engage with women who might otherwise be invisible to professional services and fall through the cracks.

5.2. The adverse consequences of a lack of choice: living under the threat of violence

As has been demonstrated, there were multiple intersecting ways that women did not access professional supports. In addition to this, there were many examples of women accessing services but having negative experiences within them where they could not act autonomously and, at times, their situations worsened. In keeping with the core tenets of a reproductive justice framework, that ‘free choice’ must be understood within the context of the intersecting oppressions in which women are situated, this section moves beyond exploring whether services were simply available and asks *how* women experienced services.

A theme that emerged persistently across women’s narratives was the predominantly negative experiences they had with providers in homelessness and healthcare services. This was not universal across all women’s experiences:

many also spoke about humanising moments where they felt cared for, trusted and empowered (these are shared in Chapter Seven, section 7.6). However, these moments were brief and fleeting. The narratives presented in this section provide insight into a different way women fell through the cracks: women accessing professional supports, yet their experiences being so negative that they led to future disengagement with services, mistrust of professionals, and a continuation of the violence they experienced in their interpersonal relationships.

In line with existing research that has documented the correlation between domestic violence and homelessness, findings from this research showed that violence was core to the majority of the women's narratives (Mayock et al., 2015; Bretherton, 2020). Despite awareness of the correlation between violence and homelessness across academic, policy and service provider landscapes, multiple women talked about being placed in accommodation where men were present and, sometimes, they were the only woman living there.

Maggie (60, Aus) and Sage (mid-40's, Aus) had both experienced abuse in their respective accommodations the day before participating in their interviews. They had extensive histories of physical and sexual violence prior to and during experiences of homelessness. Both expressed distress, and desperation to leave their accommodation, but had no alternative accommodation to go to:

> Like I said, I don't understand why there's a man in women's housing at all… [Yeah, that must make you feel-] Oh, it's terrible, because people getting evicted and people- it's just- yeah, it's just (unclear). And any woman there has been through trauma, and triggers herself, and this morning has triggered me big time. Big time. I spent the night being abused by him… but yeah um, like, tonight I'm going back to the street. Because I'm not going back there. (Maggie)

> They went and put me in a house, a rooming house full of men. I'm the only woman. And the reason why I'm here today is because one man last night sprayed me. Like, he tried to mace me with something. That's what's all over me. And erm, so they've got to take photos today. Document everything. (Sage)

Nisha (38, Aus) described being placed in accommodation where she lived with multiple men and was the only woman present. She explained that she was not given this information prior to moving in, and that if she had known this was the case, would have rejected the accommodation:

> Then the housing owner, she said it's a transition period. You have accommodation. It was (place name) community housing, but she should have told me it was with 11 men. [… if you had known, would you have said no?] I wouldn't (have gone). In my head, I thought it's something like shared accommodation, there will be some women. There were no women, there was only men.

Nisha described the fear that was ever-present throughout her experience of homelessness, which prevented her from sleeping at night and kept her constantly on the move. Her fear was compounded by wearing the hijab while staying in crisis shelters, which made her hyper-visible and under intense scrutiny in largely male-dominated environments. A particularly distressing experience for Nisha occurred when witnessing an assault on a woman in an overnight shelter:

> They also let people sleep in the nighttime. I- without doing my background check, I went there and next thing I know - I used to not sleep in the night. I used to keep myself awake because I was, like, scared. Also, it was a challenge because I- I was covering. It worked in the community, you know? [When you were in a hijab?] Yeah, when you're in this community, you're looked at as an odd man out. It's

> another challenge, you know? But I'm scared for my dear life, you know, like- and then I came across this - you know, the rough people who are intoxicated. The man, he is forcefully having sex with the woman. Like they were all, like, rough sleepers, you know? But when I encountered that in that night stay, I freaked out for my dear life. I didn't want to go for [crisis shelter name] anymore. Even though there was- [Sorry, you saw someone being assaulted?] Yeah, and I was like- that really triggered me badly.

Maggie, Sage, and Nisha were constantly forced to be alert and in defence mode, unable to attend to any of their other needs because they were stuck in violent environments, mirroring those they had escaped from. Although these women had secured accommodation (with varying degrees of temporality), they had no choice over where they stayed. Their lack of choices meant they were unable to move away from the violence that was a persistent shadow over their lives.

This research contributes to a body of evidence that highlights how neglectful responses from housing services (contextualised in a mounting housing crisis in both countries, a woefully underfunded homelessness sector and increasingly scarce resources) leads to the continued violent victimisation of women (Bretherton & Mayock, 2021). For Sage, the violence she experienced was impossible to escape from, and was another way in which her choice was denied. She described constantly getting in touch with her housing provider, who were aware of the abuse she suffered from the men living in her accommodation, to try and find alternative suitable housing:

> [I wonder with the place that you’re in now, has there ever been any kind of talk of being - to go elsewhere, or like has that been an option for

> you?] We've tried. [When you say we?] As in my NDIS[10] worker, um, we've tried, because I'm having trouble with having and getting a NDIS co-ordinator, manager, erm… so the support worker's been doing the manager's job. It's not his job to be doing this, but he's been doing it, he's been the one backing me the whole way. He's even been abused by these men. So, he knows what's going on in that building. We've tried talking to management, asking can they shift me, transfer me somewhere else. No, they can't, they reckon. All this and that.

The examples discussed in this section demonstrate how homelessness systems, at times, enabled and perpetuated gendered violence. This meant the women lived under a constant threat of violence, even within systems that were intended to provide spaces of safety.

Rachel (late 40's, England) also expressed that she much preferred living in the accommodation she was in at the time of her interview over her previous housing. She explained that she felt more comfortable and at home in the accommodation because it was women-only, which acted as a barrier to entering tumultuous and de-stabilising relationships with men:

> And I do feel more at home than what I did at the place before. Not because of the staff or anything… But I'm in a place where it's all females and there's not completely relationships straight at ya. And cos I'm not completely strong on that part at the moment. It hurts. It really hurts.

These experiences point to a need for housing options and homelessness support services that are specialised, women-only and trauma-informed. This echoes findings from a recent report by Theobald et al (2025) into the practices of domestic violence refuges in Victoria, which found feminist and trauma-

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[10] National Disability Insurance Scheme (NDIS) is an Australian government initiative that supports individuals with a disability, including welfare payments and a personalised support plan.

informed service provision was essential for providing emotional and physical safety for women escaping violence.

The injustice of escaping from violence and being placed into more violence was articulated by Sage, who conveyed the emotional toll of a lack of choices in this context. Her agency being denied in relation to her housing situation (‘everything being forced on me’) and the knock-on effects this had on her mental and physical health were clear:

> I’m sick of being fucking attacked. I’m sick of being homeless. I’m sick of having to be put in with dirty, filthy, dysfunctional men, and women, that don’t wanna mind their own business. I’m not one of them ones that sits in circles. I don’t roll that way and never have. And they try and force it on me and force it on me, and I keep saying, no, no, no, no. I’m sick of fucking shit, everything being forced on me.

This section has illustrated that the accommodation provided to women often replicated the violence they experienced throughout their lives and homelessness journeys. This demonstrates the relationship between housing insecurity and reproductive justice, as the women could not meet their basic needs while homeless and were placed in unsafe environments, which in turn meant attention could not be given to SRH. When women did not have access to safe and secure housing, they were forced to prioritise safety and unable to plan the other areas of their lives.

5.3. Anticipated stigma preventing seeking care

So far, this chapter has detailed the myriad ways women fell through the cracks and were unable to access material or affective resources. It has shown the women who *could* access professional supports and resources often experienced a continuation of the violence they faced in other areas of their lives. The analysis now proceeds to further explore *why* falling through the cracks was such a common experience for women and presents stigma as one important barrier to care. Chapter Four revealed the many layers of stigmatisation that the women faced, and the tangible implications stigma had on their SRH decision-making. The ways in which women were subject to mechanisms of infantilisation and surveillance when engaging with professional supports were detailed. Stigma was shown to permeate many areas of the women's lives, with devastating consequences.

This section builds on the previous chapter's analysis to unpack how care-seeking behaviours were hindered by stigma, demonstrating how stigma operated as a powerful barrier to accessing professional services and in turn how this led to women falling through the cracks. This was powerfully articulated by Grace (23, Aus) in her description of leaving the hospital while she was having a miscarriage to miscarry at home:

> [Were you miscarrying?] Yeah, I just left. I was like this is bullshit. I'd rather do it at home. I'm really-, I'm not a fan of hospitals. It takes me a lot to go. Because I just feel like it's such a gross place. And they're all really judgemental cunts and I've-, I've been reported a handful of times to child protection, and they've always closed the case. Especially in recent times, where I've finally got my shit together. I've been reported maybe twice, and they've just closed the case. But it's just like - it's given me a fear of going to professional people because it makes me just feel like they're going to take one look at me and be like, reported.

Grace spoke about how uncomfortable she felt in hospitals, and how she tried to avoid going because of the judgement she faced in clinical settings. Another layer to the stigma attached to Grace was her fear of child protection involvement, specifically being read as a 'bad mum' (as discussed in Chapter Four) and this label amplifying her risk of child removal. Despite making the decision to miscarry at home, her aversion to clinical settings raises the question of how much of a 'free' choice this was, when the options available were both undesirable. The stigma she felt manifested into genuine fear, due in part to her previous experiences of being reported to child protection services by hospital staff. This meant she decided to have her miscarriage unsupervised: a medically riskier option, but one that brought her greater emotional safety. Her experience demonstrates the lengths to which women will go to avoid stigmatisation.

Grace had been pregnant seven times, never intentionally. She explained the relief she felt when she would miscarry, as it meant that she would not have to go through having an abortion, an experience that can be stigmatising in itself, but one that was intensified by her age and housing insecurity:

> So if they just sorted themselves out, it didn't bother me too much…. [Does it feel a bit like a relief as well when it happens?] Yes. Yeah. It saves me from having to go down to an abortion clinic and sit through all that shit and get judged for that. So, if it naturally sorts itself out then that's good.

This quote is striking because it points to the power of stigma on Grace's SRH decision-making, that she would prefer to experience a miscarriage as it meant avoiding facing the judgement of seeking an abortion. This underscores the stark reality of Grace's limited agency over her reproductive choices, where miscarriage was the only option that she could rely on to avoid having a child. Stigma meant that she could not exercise her reproductive right to access either supervised miscarriage or abortion.

Like Grace, Alison (49, Eng) talked about the stigma she faced from child protection services being a powerful deterrent to seeking support. She explained that she did not disclose her life history, and the many hardships she had been through, to social workers and other practitioners because she knew the judgement she would face. She knew the labels that would stick to her, and the consequences of such labels would have for retaining the care of her children:

> And because nobody, you know in social services, they just judge so much. So, they never would have got this information out of me. They would never have got to find out, because of the shit that I've been through in the past with them.

Alison's quote emphasises the enduring and injurious consequences of stigma: previous bad interactions with staff and fear of judgement deterred her from sharing information about herself that might have prevented further harms (a more detailed look into how a fear of child removal created further adversity is discussed in section 6.1.3). This demonstrates how stigma served as a tool of exclusion and domination and, as articulated by Finn and Murphy (2022), 'impacts on possibilities of agency' (p8).

Similarly, Nellie (62, Aus) anticipated that reaching out for help would be met with judgement. This expectation affected the way she interacted with systems and sought support, meaning that she did not access services that could have provided protection and care, and instead fended for herself on the streets from the age of 11 after running away from her care home. Nellie conveyed the lasting impacts of stigmatisation, which informed her relationship with authority figures, and created a reciprocal mistrust between herself and professional supports:

> And the police, they would just take one look at you and say 'oh, she's just a shoplifter, a thief, a junkie', you know, so you just didn't go near the coppers. You'd always run- being on the street, you always ran away from the coppers. You know? [You don't trust them?] No. Even now, but you know. [Yeah, but that experience stays with you, right?] It does, it does.

This finding is in line with existing literature, which demonstrates that mistrust leads to communication failure with service providers, as women conceal their needs. This leads to missed opportunities to provide them with support and creates further social exclusion (Gordon et al., 2019; Gunner et al., 2019).

As noted in the introduction to this chapter, women also lack support from informal care networks, which often came in the form of stigmatisation. While this is not the primary focus of this chapter, and is an area that warrants further research, it is important to acknowledge that stigma also manifested in a non-professional context. For example, Florence (57, Aus) explicitly named stigma as a preventative force to accessing support from her friendship group. She explained that she concealed the domestic violence she experienced at the time due to shame:

> Hopefully there's got… the stigma of erm - yeah, it was all stigma back then, I think, about being embarrassed about people knowing... [That you were living in refuge and you-?] Yeah, that I was getting my head kicked - punched every day and stuff, or-. And so, it was more of erm, embarrassment. [That stops you from reaching out?] Yeah.

In all the accounts shared in this section, stigma has been shown to be a powerful disabling force: one that stopped women from accessing the SRH care they needed, and also other kinds of care and resources necessary for creating conditions to make autonomous SRH choices.

Research overwhelmingly demonstrates that experiences of stigma and marginalisation in healthcare settings have a severely negative impact on future health-seeking behaviours for people experiencing homelessness (O’Caroll & Wainwright, 2019; Rae & Rees, 2015). The current research contributes to this body of literature, showing that women avoided professional services and remained in dangerous and harmful situations due to the depth of the stigma they experienced. These findings are important because, as the literature suggests, stigmatising interactions lead to further negative health outcomes, and in some cases are a ‘decider between life and death’ for people experiencing homelessness (Gunner et al., 2019: 532). Stigma was a powerful constraint on enacting bodily autonomy, highlighting that the women’s agency was severely hindered in this context.

5.4. Prioritising housing at the expense of SRH and preparing for motherhood

All women spoke about having to work hard to secure resources for themselves in severely restricted contexts. For those with children, there were additional constraints on their decision-making. Notably, several women in both geographical contexts were pregnant or caring for young children when they faced, or were at risk of becoming, homeless. Hearing their stories underlined the specific and gendered contexts in which they were navigating housing support systems, and the unique set of challenges they faced as mothers. This is an important part of SRH, as set out by a reproductive justice framework which emphasises the right to parent in safe and healthy environments (Ross, 2017).

Olivia (20, Aus) became homeless after being forced to leave her family home following an argument with her mother’s partner. She recalled struggling to secure accommodation while couch surfing with her son, who was six months old at the time. Despite her efforts to find housing through constant engagement with housing support services, there was a powerlessness to Olivia’s narrative. Even though she exhibited what would be read as ‘good’ behaviour (active engagement with services to find accommodation) through acting in ways that painted her as responsible, and therefore ‘deserving’ of support, it still took months before she was able to find housing:

> I made heaps of calls to all the [community service organisation] people and I was like: I have a kid. I need somewhere to stay. I don't have

> anywhere to go. I'm couch surfing. And so, I went through so many different people until one of them, like kind of, grabbed me and was like, I'll really help you find a house. [So you had to do a lot of searching around?] Yeah. If you don't put in that effort, you're not going to get into them considering you (laughs)... Like I was making calls every day until someone, you know, got me in. I was checking up on how it was going. And I think if I didn't make those calls every day, I probably wouldn't have gotten a house as quick as I did.

Notably, in her description of continuously contacting housing support services, Olivia recounted eventually being 'grabbed' by someone in the system who was able to provide her with support. Despite her persistent efforts to find housing, her lack of control is evident: she needed to rely on a chance encounter where someone offered her help in order to exit homelessness. For Olivia, attention that she was able to give to mothering was heavily impacted by systemic failures to offer secure, long-term housing support.

In some instances, women were placed in scenarios where they were confronted with having no housing in which to raise their newborn. Feeling powerless when navigating complex systems was similarly articulated by Rosie (29, Eng), who described failing to secure accommodation for herself while heavily pregnant. Despite her perseverance in contacting her local authority, she was rejected for housing on the grounds that she did not have 'legitimate' ties to the locality. This was despite making her pregnancy known to the housing worker she spoke to:

> And the thing is, I kept going to the council and they were like, you've got no connection here. So, we're not going to help you... I said, yeah, but my partner, who I'm having a baby, he's currently in prison. Um I said, as soon as he gets out-. He's lived in this area for five years. And they were like, no. And the thing is I rang them. I rang the homeless team.

> And I said to them, oh I'm homeless. I've just got back from abroad. My partner's here. We're going to have a baby together. I've got all the evidence. And they were like, you need to go to your own council or wherever you've lived before… In the end, we started arguing on the phone because I was like, I'm going to be homeless on the streets. Like, I'm literally going to be homeless. And she hung up on me. She just didn't care. And I was crying my eyes out.

Rosie received no further signposting on where to access help. Her impending homelessness meant that she could not engage in the normal decisions one might expect in preparing for motherhood, as her sole concern had to be securing housing for herself and her baby. For both Olivia and Rosie, the fact they had dependent children did not appear to factor into decisions regarding their housing. Their experiences mirror research conducted in Australia, which found that being pregnant did not give women a greater chance of securing housing. This research demonstrates that policy and practice are often gender-blind and exclusionary, thus neglecting the unique challenges pregnant women experiencing homelessness face (Theobald et al., 2023).

Figure 5.2: Rosie's collage

Rosie depicted the difficult journey she'd been on by cutting up pieces of a map and creating a road (Figure 5.2). She explained that the words she stuck on her collage related to the pain she had been through and her anger at health and social care systems that her let her down. She described her collage (in addition to all of the positive imagery discussed in section 3.4.4) as representing 'living in that fight or flight mode. That survival mode.' In both Rosie's interview and her collaging session, her fight to secure resources for herself and her son were central to her narrative.

Similarly, Nicole (32, Eng) had become pregnant while homeless. She explained that she was denied common practice preparation rituals, such as setting up a space for her child to sleep in, due to having no secure accommodation. This meant she had to navigate the birth of her baby with very few resources, and was left unable to prepare for motherhood:

> [Would you mind telling me a bit about your experience of being pregnant? When you were moving about? That must have been quite stressful?] It was, cos um obviously I had to move about-, move all my stuff. But where I was staying before I got kicked out, I had a lot of stuff. I had a lot of stuff for my baby. But because I had nowhere to put it, they threw everything out. So, I had to go through fresh start. Everything brand new. Like now, I've still not got all my stuff, I've only got bits and bobs for my clothes. [So, who threw it out, the...?] The landlord.

Stories of the difficulties women faced preparing for motherhood when experiencing homelessness echo research from Murray et al (2020), who found that mothers without stable housing faced practical, physical and emotional challenges to becoming a mother, which had negative consequences for both the woman and her child. These findings point to a clear relationship between housing and SRH: that not having suitable or stable housing had significant implications for how women navigated their reproductive lives, including their mothering practices. A lack of support from professional services shaped how women were (un)able to form their motherhood identities.

Grace (23, Aus) was evicted from her home while heavily pregnant due to being in rent arrears. As staying in her mother's house was not option due to it being labelled as overcrowded, the only housing option presented to her was to stay in a run-down caravan in the garden, an option that was highly unsuitable and made it very difficult to prepare for the birth of her child:

> My mum didn't have enough bedrooms in her house, so I accessed a housing social worker, and she managed to hire me out a caravan um for my mum's backyard. But it was really beaten down and mouldy and I had to go in it when I was pregnant and then I had to bring my premi newborn home there. It had no heating. It had like – um didn't have running water or anything like that. So, it was like just a tin shed. It was fucked (laughs)… [That must have been really tough being in that kind of environment?] Yeah. It was-, it was better than being on the street, but it was still really shit (laughs). Couldn't make a nursery proper or anything.

Grace's is an example of women being situated in impossible circumstances beyond her control. With no access to appropriate housing, her capacity for autonomous decision-making and ability to prepare for motherhood was curtailed. Additionally, she was unable to meet child protection's requirements and so they remained a constant source of stress in her life. Her powerlessness in this situation was stark: the system had failed to provide her with accommodation, whilst simultaneously penalising her for not having a suitable home for her baby. This underscores the impact of inadequate housing on women's ability to enact mothering practices and being kept under surveillance from child protection services. Rather than being understood as a mother with housing need, Grace was marked as neglectful and therefore not seen as worthy of support. This finding is similar to prior research which found that pregnant women experiencing homelessness often had few housing options, and their homelessness was positioned as their own burden to fix (Theobald et al., 2024).

Alongside their housing insecurity, many women faced precarious visa situations that compelled them to prioritise their migration status, often at the expense of other personal needs. For example, Scarlett (34, Aus) shared her fears about going to the police following an incident where she had been threatened with a taser by a client she was staying with after becoming homeless. Her concerns about interacting with the police were multi-layered: she had (unspecified) unpaid fines, was a meth user, and was worried it would be discovered that her visa was expiring. Although, in the end, Scarlett did feel able to report the violence she had experienced, she faced multiple barriers to doing so. Her story illustrates how the precarious conditions women faced hindered their ability to make autonomous decisions, often forcing them to act out of survival, and ultimately preventing justice from being realised:

> [Did you feel like you couldn't go to the police because of your visa?] Yeah. Yeah, okay, what making me scared because of my- my fine. I got some of fine. But at the same-, I'm using drugs. So, by the time I go to the… [You're kind of trapped? You can't-]. I'm trapped, but at the end- at the end I have to go through that. I have to being honest. I need to, like, try to like let go, the feeling of scared – not to be scared anything.

In the Australian context, migrant women without permanent residency faced a particular set of vulnerabilities towards their SRH, as they did not have the same access to healthcare as those who were citizens. Ariana (36, Aus) described having to use private health insurance to have an abortion. Upon discovering her pregnancy at 19 weeks, she was placed on a waitlist at a public hospital. However, the length of the wait meant she would exceed the legal gestational limit for abortion by the time she was seen.

> Because I'm not citizen, I'm not Australian, I didn't have permanent residence. And nobody in the hospital… Nobody accepted me, because it was big and they said you have to be in a waiting list because we have other important things to do. Waiting list for how long?

Ariana spent a rough total of $13,000 to $14,000 on her abortion, including travel and accommodation costs, as she had to travel outside of the remote area where she lived at the time to procure the abortion. The repercussions of the abortion were vast; her savings were drained, and she experienced significant emotional distress in the wake of the abortion. Not long after, she found herself homeless after exiting a violent relationship with no savings to fall back on, and nowhere to escape to:

> They said there was some domestic loans from charity, to help people for termination of the pregnancy, but it's time consuming. I cannot keep my baby for five weeks, you know, and find some more help… because if I had that money, definitely I wouldn't be here. Because it was roughly $13,000, $14,000 in total, with everything, everything. I wasn't here. If I had that money… I saved, I'm a good saver. I'm very good at saving money, you know? I look after my things. But if I had that money I wouldn't be here.

Ariana's experience offers a contrast to the other women: rather than prioritising her housing needs over her SRH, she prioritised her SRH, which then had implications for her housing status, as the associated costs left her unable to secure accommodation and she became homeless. This shows how SRH expenses that migrant women without permanent residency may shoulder alone, such as abortion costs, can put them in increased financial instability and without safety nets. Financial instability removes choice, as women have few options and are forced to choose between their SRH care and other basic needs.

A reproductive justice framing reminds us that reproductive choices are not made in isolation and insists that we consider the contexts in which women make decisions about their SRH (Ross, 2017). In all the women's accounts discussed in this section, their ability to enact autonomous decision-making in other areas of their lives, and the attention they were able to give to mothering, was heavily impacted by systemic failures to offer secure, long-term housing support. These findings demonstrate that if secure housing was not present in the women's lives, all the other decisions they had to make became constrained. This suggests that bodily autonomy was not possible in the context of survival. The women had no choice but to prioritise their unmet basic needs, which in turn impacted their time and capacity for SRH decision-making, and possibilities for their reproductive lives.

5.5. SRH decision-making as chance: 'lucky escapes'

Another way women fell through the cracks of professional support emerged in their accounts of receiving no information about SRH during adolescence, particularly concerning contraception. This led to women having to figure out how to manage their SRH on their own. Minimal and insufficient sex education is not an uncommon experience for many young people (National Children's Bureau, 2016). However, this was not the only barrier for the women in this research, whose lack of knowledge was situated in a broader context of limited control and deprivation. This meant that for these women, legitimate choices were absent, and so they understood and framed their reproductive lives through a lens of chance.

An absence of choices, conveyed through the notion of having had a 'lucky escape', was evident in Pippa's story. Pippa (44, Aus) recalled a dearth of sex education in her teenage years and her twenties, having only learnt the absolute basics at school. In her early twenties, Pippa lived in a mixed-gender residential home for adults with complex mental health issues. She described support she received as primarily focused on the clinical aspects of her care (namely, her psychiatrist prescribing her medication), and minimal regarding the life skills she needed as a young person: this included sex and relationships education. Without any knowledge of her contraceptive options, Pippa took an unplanned approach to pregnancy, evident in her explanation that the only time she sought medical advice for SRH-related matters was to get pregnancy tests:

> There wasn't anything- there wasn't the supports available now to young people with mental illness, and there's not many now, but there are more now than there were back then… it was only there (the residential home) and my doctor and psychiatrist and he'd talk about tablets and then we'd go back to there and have the workers there and that's all I had. There was nowhere else to go. [In terms of sex, and like things around sex, did you feel like you kind of knew about…?] Not really, no. And that's the thing. I sort of knew what basics, but because we learnt in health at school, I went to a girls' school, but very basic, very basic… I didn't go to doctors for family planning or anything like that, I would go – I didn't, I just didn't – I would go to them for pregnancy tests [laughs].

It was not only Pippa's lack of knowledge that left her in a vulnerable position regarding her SRH. Her volatile housing situation, marked by living in proximity with other young people who also had complex mental health issues and where there were minimal support staff, combined with her multiple mental health issues, contributed to her engagement in risky sexual relationships. Pippa explained that she was often not well enough to request that her sexual partner use a condom and regularly felt dismissed by partners who did not want to use condoms. She painted a picture of a turbulent life in the residential home where agentic SRH decision-making was not possible:

> And I had tests, and the woman said, you grow up quickly in that home, don't you? I said, yeah. I was 21 and I was having an AIDS test and pregnancy tests, and this and this, and STD tests. And yeah. [Yeah, it sounds like it was all just a bit out of control.] Everything- I wasn't in control up here and I was young and inexperienced and there were- everything was out of control.

Pippa explained she had made a conscious decision not to have children because she feared passing on her illnesses and felt too unwell to look after a child. Despite this decision, she described sporadically using different forms of contraception throughout her adult life, including condoms. She framed having never been pregnant with her abusive ex-partner in terms of luck:

> [Did you ever get pregnant?] No. No. I've been very lucky. [So were there times with him when you didn't use-?] Yeah, there were times. There were times. And there were times that I had tests for pregnancy and things like that, so yeah.

Figure 5.3: Pippa's collage

Pippa represented these tumultuous years of housing insecurity in her collage (Figure 5.3). When talking through what she'd made, she explained that multiple images symbolised a sense of her relationships being out of control, a feeling that characterised that period of her life:

> I was skiing in and out of relationships, going down a slippery slope. And there was stormy weather. And I was the boat on the storm. And just lots in that group home…

Pippa also explained that she'd included the word 'grateful' in her collage which, mirroring her interview, illustrated her feeling of having had a 'lucky escape' when it came to her SRH:

> Grateful that I didn't get pregnant. Grateful that I didn't catch AIDS. Grateful that I didn't get really damaged from- I got damaged mentally, but physically I didn't get damaged from any of these relationships… Grateful that I got through it and unscathed. I've just been lucky.

Pippa's collage is a powerful depiction of the chaos she described experiencing throughout much of her life. Although she describes herself as coming away 'unscathed', as she did not experience physical harm, her collage portrays her repeated lack of control over her body and SRH due to a combination of her tumultuous housing environments and poor mental health.

Nellie (62, Aus) also framed her contraceptive decision-making in her early adulthood using the language of chance and luck. She had lived on the streets since the age of 11 and so had looked after herself from an early age. Nellie did not access any support services during this time, and was exposed to sexual violence from a very young age:

> Um when I finally got here… I didn't know what to do, where to go. I was sleeping in the alleyways, under bridges. It was really scary. and you had to have your wits about you, cos I was raped a couple of times

> while I was very young, so that didn't help matters. So that made me more determined to survive.

Nellie’s early experiences of street homelessness conjure an image of having completely fallen through the cracks and existing outside of any kinds of support. Because of this, she had no avenues through which to receive SRH information:

> I wasn't on any contraceptive, so I was very lucky that before I was 25, I didn't get pregnant. It was the luck of the draw. […was that an active decision not to be on anything or was it just you were worrying about-?] I didn't know. I didn't know. [Because you had no one to-?] No-one to talk to. It was like I had to learn everything myself. You know, where was I gonna go? Who was I going to talk to? You know?

Again, Nellie’s lack of SRH information was not an isolated issue and, in fact, was directly informed by her homelessness. Not only did her experience of homelessness impact what she knew about SRH, but it also increased the adverse consequences of her lack of knowledge. Nellie was in a vulnerable position whilst living on the street: she was a sex worker and talked about using condoms with clients roughly half the time, but that this was dependent on ‘if I was off my face or not. Most of the time I just wanted to block everything out, you know’. As such, her limited autonomy over her housing circumstances generated limited autonomy over her body and her SRH.

In both accounts, Pippa and Nellie were not given the tools to make informed and autonomous decisions about their SRH which, combined with their housing situations, meant a denial of their bodily autonomy. Both shared that they never intended to have children, yet were unable to negotiate contraceptive usage or even have awareness of what contraceptive options were available to them. This meant that making choices could only be perceived through a lens of chance. This formulates part of a broader finding: that housing insecurity creates circumstances where there was little room for agency in decision-making, because it contributes to a broader lack of control in the women's lives and intensifies already volatile situations. Reproductive justice reminds us that we must move past a sole focus on reproductive rights and foreground 'conditions that may obstruct the realisation of these rights', and this finding reveals that housing insecurity is one condition that impedes such rights (Morison & Herbert, 2019: 442).

5.6. Survival strategies

The prior two sections have discussed two ways in which falling through the cracks affected the women's SRH decision-making: SRH being de-prioritised due to unmet basic needs and insecure housing, and SRH decisions being framed entirely through the lens of chance. The evidence presented in this chapter so far points to the ways that services did not adequately provide care for the women. This failure left gaps, which women were left to fill on their own. This often led to women seeking out ways to care for themselves and manage the cumulative grief and trauma they faced in the absence of professional support. This section uncovers how some of the women responded to falling through the cracks, the survival strategies they adopted and how these often lead to further adversity and housing insecurity. This is important because it points to the consequences of the failure of homelessness systems to properly support women, and how this furthers reproductive injustices.

Several women recounted the necessity of using drugs in order to be able to work and earn money to meet their basic needs. Nellie (62, Aus) shared that the long, late-night hours she was required to work meant her drug use was not recreational, but in fact a crucial element of her working life:

> [Okay, so you were a like young single parent with a business?]…Yeah. And cos they're long - in summertime it's really long hours, you know.

> You'd have to get up at four or five in the morning, grease the Bobcat and then travelling time over to this side of town. And then you wouldn't leave until, what, nine at night when it's daylight savings. Then you'd have to get home and then I had to look after the child. Then I had to look after the books and then look after the Bobcat and everything else. Then get an hours sleep and then go back. So, I was on drugs then. [Okay, just to stay awake?] Yeah.

For Rachel (late-40's, Eng), there was a clear relationship between her reproductive health and her substance use. We saw in Chapter Four, section 4.4.3, that Rachel explained that the lack of support she received for her postnatal depression following the birth of her first son led to the beginning of her heroin addiction. The devastating consequences of the absence of mental health support meant she sought relief wherever she could find it. Rachel's account powerfully demonstrates the injurious impacts of falling through the cracks of professional support services, and the consequences that reproductive injustice had on all other areas of her life.

Clara (54, Eng) spoke about exiting the care system at 17 and receiving no support once she had left. She went from living in a relatively high support environment for the majority of her life to being placed in unsupported accommodation which she was solely responsible for repairing and maintaining. Additionally, she had not been taught basic life skills such as cooking or money management, and received very minimal welfare payments that were impossible to live on. To survive, she followed the advice of a friend who also had lived in her children's home and began street sex work:

> They just threw me in t' deep end. Didn't even know how to cook or owt I mean, d'you know what I mean? They had some houses where they put people when they were due to be leaving care, to show them how to like um cook and all that, but they never put me in that part. I don't know

> why. They just shoved me out, yeah. [So once you moved out, was there anyone that came and like visited you or checked up on you?] I did go back to the home to visit there and then I just stopped going eventually. I can't remember anybody coming out to see me at the flat, it were like years ago, but…not very helpful. No help at all… Like I don't know, it's probably a lot better for people now, it just weren't a good environment at that time when I were there… I thought 30 quid were great when I first started. You know, young and that. It's nothing now, is it?

Clara's description of feeling 'shoved out' demonstrates the total lack of care she received upon leaving the care system. She spoke about finding it very difficult to leave sex work, which she had done for the entirety of her adult life. Like the other women's experiences discussed in this section, Clara's ability to enact bodily autonomy was not possible due to the very limited options she had to choose between in order to survive.

In the women's narratives in this section, falling through the cracks of professional supports (experiencing poverty, mental health issues, and leaving the care system) meant that women had to use whatever resources were available to them to survive. As the evidence illustrates, this frequently catapulted women into further adversity, and created even more constrained conditions under which to make decisions regarding their SRH. In the face of a lack of professional support, their survival strategies, at times, entrenched them in poverty, exacerbated housing insecurity, and, for mothers, subjected them to increased scrutiny from child protection services.

5.7. Conclusion

This chapter has highlighted systemic failures across housing, welfare and child protection services in adequately supporting women and creating environments that enable autonomous choices to be made. It has illustrated how women fell through the cracks of support services and were left alone to manage their homelessness and their SRH. It has shown that even in circumstances where women *were* able to access support, their experiences within services left little room for choice. For example, women being placed in inappropriate housing that was a continuation of the violence that had led to their homelessness in the first place. The ways in which the stigmatising labels women experienced permeated their lives and created significant barriers to seeking care, directly relating to SRH and in a broader sense, have been explored. All these findings evidence different scenarios in which women had to work hard to secure basic resources for themselves in the face of minimal professional supports. They demonstrate that a lack of support meant oftentimes women had to prioritise looking for stable housing at the expense of their SRH and motherhood. A lack of resources meant that SRH was understood by some women through the lens of luck, rather than something that they had autonomy over.

Interrogating how women fell through the cracks of professional support, in the context of homelessness, reveals how reproductive injustice shaped their lives. Specifically, reproductive justice's third principle, 'The right to parent children in safe and healthy environments free from violence by individuals or the state' is shown to be unequivocally absent (Ross, 2017). Housing precarity meant women were forced into living situations that were neither safe nor healthy, where they were unable to attend to their reproductive needs, and faced constraints on their parenting, as they had to prioritise their survival. The survival strategies women adopted in response to inadequate professional supports often worsened their situations and led to further adversity, which perpetuated these unsafe environments and constrained decision-making even further.

In the following, and final, findings chapter, the different modes of SRH decision-making that women engaged in are examined. The intense, muti-layered stigma women experienced, combined with constraints to accessing professional supports, are examined together to reveal the ways choice was denied to women in relation to their homelessness and their SRH. As the next chapter will outline, this resulted in women having limited pseudo-, and paradoxical, choices to engage in.

Chapter 6: Revealing (the violence of) invisible labour

> ***They always say, whatever don't kill ya, only makes you stronger. Well, my comeback for that is, honestly, how strong does one person have to be? Because I think I've proven to everybody how strong that I am, but they just keep throwing stuff at me and I have to show them again. Sometimes I just don't want to deal with it. Sometimes you feel like you've proven yourself, but no one cares. You sort of feel- It makes you feel empty. (Darcy, 44, Aus)***

Findings from the preceding two chapters ('the good/bad womanhood dichotomy' and 'falling through the cracks') have illustrated the constricted environments in which women had to make decisions about their SRH. Weaving together their narratives has created a picture of how, through processes of stigmatisation, women experiencing homelessness are systematically denied bodily autonomy.

The first findings chapter detailed the ways in which women experiencing homelessness are already positioned as suspect for falling outside of norms, stemming from gendered, racialised and classed hierarchies, that dictate what 'good womanhood' looks like. It demonstrated that these women are denied certain SRH choices from the start through questioning their capabilities to be mothers, and whether they *should* be mothers at all. Through explaining how they are 'othered' and constructed as devalued reproductive citizens, the right to have a child, the first principle of reproductive justice, is shown to be absent from these women's realities.

Chapter Five built on these experiences of exclusion, outlining the tension between systems that demand that women take responsibility for their SRH, whilst simultaneously denying them the agency to make autonomous decisions about their bodies. Expectations of responsibility are shown to be very different for women experiencing homelessness, who are positioned as morally irresponsible via the stigmatising constructions explored in Chapter Four, meaning their actions are read as irresponsible from the start. This chapter revealed the messiness of SRH decision-making, highlighting all of life's moments that influence SRH (outside of what we might typically think of as SRH choices). In taking a broad view of how decision-making occurs, the ways that women's capacity for autonomy is constrained by their environments, where their basic needs are not being met, is revealed.

A foundational belief of reproductive justice is that choice cannot happen without access. So far, a total lack of access, and systematic denial of SRH freedoms for the women in this research, have been documented. In this final chapter, the analysis turns to spotlighting otherwise invisible layers of the women's decision-making processes that occur within highly restrictive and precarious contexts of homelessness. While decision- making has been at the heart of all the findings chapters, this chapter spotlights and draws out the tensions and constraints that women encountered navigating choice. Exploring these tensions reveals the invisible labour that women constantly engaged in when negotiating their SRH. Violence is demonstrated to be an undercurrent that permeates all of these processes.

Experiences of paradoxical, or pseudo-, choice- making have appeared throughout the findings. These will now be brought to the fore in this final chapter to show that, despite the illusion of choice, bodily autonomy is routinely denied to women experiencing homelessness. This chapter will first provide examples of different contexts in which paradoxical decision-making took place, moments where women described having to compromise their reproductive autonomy to keep themselves safe. These stories underscore the contradiction in women being subject to violence to ensure their self-preservation. Specifically, moments of violence, leading to further violence and constraints on the women's reproductive lives, are explored.

The analysis then moves on to centre moments of resignation. It suggests that rather than this mode of decision-making stemming from a lack of care or amotivation, as stigmatising portrayals of women experiencing homelessness suggest, resignation could be a response to feeling unable to plan for one's reproductive future. This feeling, therefore, may be the result of structures that obstruct women's ability to plan, and that create circumstances where no matter what choice is made, a harmful outcome is the result.

Finally, explicit moments where women had no opportunity to exercise their reproductive autonomy are looked at. Here, the analysis centres on overt ways in which the women's autonomy was denied in relation to contraception and unintended pregnancy, where there were no 'good' options for women, and no space for decision-making at all. In these sections, choice is suggested to be a phantom, appearing to exist but in fact an illusionary presence in the women's lives.

The analysis builds on the previous two chapters to explore the tension between women being held responsible for their reproductive wellbeing, whilst being systematically denied the resources to do so, and the laborious experience of navigating this dualism. Exploring this tension reveals the further adversity that women were often pushed into, and the opportunities for intervention that were lost in perpetuating this unwinnable cycle. Ultimately, this chapter outlines the multitude of ways that choice is absent for women experiencing homelessness and, stemming from this absence, the injurious consequences for their SRH.

6.1. Pseudo decision-making

Informed by a reproductive justice lens, this analysis interrogates the intersecting systems of oppression (including poverty, homelessness, gendered violence, childhood adversity, classism and ableism) in which women are located and identifies them as essential to understanding the decisions that they made. It became quickly apparent in the interviews that moments of pseudo-choices, where women explained situations in which harmful outcomes happened despite their best efforts to evade them, occurred frequently. In some cases, women had to knowingly act in ways that were detrimental to their own health to create pathways to receive care. In many of the examples provided, attempts to mitigate violence were a driving force behind women's decisions, which in turn impacted the possibility of *agentic* choices being made. Pseudo-choices appeared both in relation to direct SRH experiences, and in the broader conditions of women's lives. Section 6.1.1 first looks at decision-making in direct relation to SRH and then expands to explore decision-making related to housing options, and the consequences this had for SRH, in section 6.1.2.

6.1.1. Methods of mitigating violence: direct SRH

Two striking examples of paradoxical choices relating to contraceptive decision-making emerged from the data. Existing research shows that women experiencing homelessness face barriers to accessing contraception, including: financial constraints; not knowing their available options; uncertainty about usage; or having to prioritise other basic unmet needs (Eapen et al., 2023; Galvin et al., 2023a; Galvin et al., 2023b). Gelberg et al's (2002) US study on perceived deterrents to contraception found women experiencing homelessness were less likely to choose a contraceptive that their partner held a negative attitude about. However, this current research found women raised an additional set of constraints to exercising autonomy when choosing their contraception. The experiences described below show that some women opted for a contraceptive method *based on the anticipation of their partners violence*. These findings suggest that several women weighed up their contraceptive options with an expectation of violence at the forefront of their decision-making.

Becca (47, Eng) has two children: a son with her abusive ex-partner, and an adult daughter with a different ex-partner. She had considered having another baby to give her son a sibling close to his age (Becca had siblings who were much older than her and described her childhood as lonely) but ultimately knew that she did not want to have another child with her abusive ex-partner. Despite her decision to not have another child, Becca explained that she had intentionally stopped using any form of contraception. This was because she knew that her partner also did not want to have another child, and believed that not using any contraception would deter him from sexually assaulting her:

> Because of the abuse that was going off, the sexual abuse kind of thing, it was like I just... I just thought, I thought it were like another barrier, 'Oh, cos he'll not want another baby.' So, I thought were like, another barrier kind of thing, to protect myself. But I ended up getting pregnant. [When you say a barrier, do you mean having sex?] Yeah. Like... he wouldn't want another child so. But no, it wasn't a barrier, but in my brain, it was kind of a barrier. If that makes sense?

Becca was unable to make the contraceptive choice that she wanted to make to prevent pregnancy, because of the primacy of trying to prevent violence from her perpetrator. Her attempts did not work. Becca continued to be raped by her partner, and she became pregnant again. This led to her seeking an abortion, which she described as an emotionally and physically difficult experience:

> But I had to go that extra week because I found out that I was pregnant the week before we were taking my son on holiday for his birthday. So, I had to go on holiday, yeah. And I had proper like morning sickness with that pregnancy and everything. That's how I knew. And I were like, 'Oh

> my, like, that was hard that.’ Like, just acting normal on that holiday and then erm... [did your partner not know that you were pregnant on holiday?] Yeah, he knew. He didn’t give me no leeway though (laughs). But yeah. And then when I came back, when we came back, I went in. So, I think the baby would have, was around the eight-week mark, 8-9 weeks… I was feeling poorly, like really poorly with that pregnancy because the doctors gave me some tablets to stop the sickness. Erm, so yeah so imagine I'm at [holiday park] with a three-year old hyper boy, ugh yeah. And knew what I were going back home to do.

Becca would have been protected from enduring the stressful and physically demanding experience of pregnancy, and then an abortion, if she had been able to enact her contraceptive preference in the first place. She was unable to make autonomous choices about her reproductive future because of the constraints she faced that arose from her partner’s violence. She was unable to think about the future at all, because of the necessity of preserving her survival in the present.

Figure 6.1: Becca's collage

In her collage (Figure 6.1), Becca expressed polarity in the ways she perceived her SRH. She explained that the red tissue paper represented her womb, with flowers facing up and down, and hearts both empty and full, orbiting it. The 'on and offline' conveyed her womb and her sex life. Another element of Becca's collage was how she felt about aging, shown through the words 'tick' and 'tock' and the greying butterflies. Reflecting on her collage as a whole, Becca commented:

> I think, when I look at mine. Mine's like bad. Mine's like… trauma, to do with, like, sexual and… getting older and… Cos if you look, my love's upside down. God- I've shocked myself with that one. Like, is that what's going off in my brain?... It reminds me of the ying and the yang, the good and the bad. But in the centre, I'd say there's quite a lot of trauma.

In addition to happy elements, her collage was a visual representation of the pain that accompanied thinking about her SRH, and the fluctuating and complex emotions that she felt towards it.

Beth (25, Eng) also spoke about making contraceptive decisions with the intention of reducing the impacts of sexual violence on her future. She explained that she had to get long-acting reversible contraception inserted, despite not wanting it because it was making her rapidly gain weight. This was because her partner was sexually assaulting her, and this was the only way she could protect herself from pregnancy. In the way that Beth frames her contraceptive decision-making, there are no real options for her, and choice is not possible:

> [And when you got the implant… can you tell me a little bit about why you decided to get that?] I was sexually assaulted by my ex-partner… So yeah. It was harder than- I didn't want it in, but I had to have it in. I had no choice.

Whilst referring to different experiences— one woman using a contraception that she did not want to use and one not using contraception *at all*— these are two examples of strategies that women used to reduce the possibility of being tied to their abusive partners long-term, but which went against their contraceptive preferences.

Beth and Becca's stories emphasise the lack of options that women had, and the survival strategies they enacted when making SRH decisions to create protective mechanisms for themselves. Ultimately, women were trying to care for themselves in extremely limited circumstances and with few resources. The value of adopting a reproductive justice framework when considering how choices are made in the context of homelessness is clear: it is more than just about whether women have the right to access contraceptives, but whether they have the means and resources to exercise their rights. These women had limited capacity to escape their violent relationships, and a lack of control over their SRH, exacerbated by their precarious housing situations. In Becca's case, she was unable to leave due to being informed by her local council that doing so would be interpreted as making herself 'intentionally' homeless. These findings support research which points to the intersection between sexual violence and homelessness (Johnsen, 2025; McMordie et al., 2025). Illuminating the barriers women faced, through asking them how they made decisions about their SRH, suggests that sexual violence was an important factor in preventing some women from choosing a contraception option that best suited their body, needs, and desires for their future.

The impossible decisions that women had to make often took place in contexts where they faced inescapable violence, where whatever choice they made would end in a violent outcome. Florence (57, Aus) explained she had felt compelled to engage in sex she did not want with her partner to avoid facing physical violence from him:

> And it was like - the relationship that we had was like, when he wanted sex, he got sex, you know? I had no choice. And even when I was in the youth refuge, it used to be on a laneway, and he used to come, and I used to go and have sex in the car on the laneway. Just- and I used to stick me nails into me legs. I- seriously, I really hurt myself, because it was awful. And so, with the sexual thing, urgh I was just forced to have sex. Not forced, forced, but… [But you weren't consenting, really?] No, and I didn't want to get hit anymore. [Okay, so it was a way of avoiding…] Getting hit.

Florence's is another example of the bodily sacrifices that women had to make to ensure their survival. Having to engage in decision-making in this way meant her capacity for bodily autonomy was completely removed. Florence had to choose what she felt would be the least harmful option: being subject to sexual violence to avoid being hit. Not only this, but she described facing another form of violence, self-harm, to cope with the emotional and psychological impacts of sexual violence. Again, decision-making operated according to foreseeing, and hoping to minimise, the impacts of violence at the hands of a partner. This finding echoes the work of Henze-Pedersen (2021), whose research uncovered how shifting temporal dimensions of violence impacted the daily lives of women living in a refuge. She found that violence was constantly present in the women's lives, even if it was not actualised, as the potential for violence to take place shaped their everyday practices. The anticipation of violence was enough to have real-life consequences, a finding consistent in the ways that some women in this current research engaged in SRH decision-making.

The violence that is front and centre in the examples discussed in this section shows the importance of connecting reproductive rights to other structural constraints, such as gendered violence, in women's lives. For the women in this research, housing insecurity was a key contextual factor in their lives, and so was irremovably bound up in their processes of decision-making. The next section explores some of the ways that housing impacted the level of autonomy that they were able to exert over their SRH.

6.1.2. Methods of mitigating violence: housing insecurity

As the findings have shown, women had very limited housing options and reported often being placed in accommodation that was not appropriate for their needs. Chapter Five examined the adverse consequences of a lack of choice in relation to housing provision in the ways that women were exposed to, and had to live under the threat of, further violence. In this section, how living in dangerous environments informed women's capacity for decision-making is explored.

Reproductive justice encourages a critical examination of how women's environments enable or hinder the exercising of SRH choices through illuminating the structures which impede the realisation of rights (Morison & Herbert, 2019). In this current research, the homelessness women faced was a key factor in shaping how they approached decision-making. This, in turn, informed women's ability to enact bodily autonomy, in relation to SRH and in their lives more broadly. The ways that housing insecurity and homelessness put women in situations of danger, and the direct and indirect impacts this had on their SRH, will now be discussed.

For several of the women, feeling unable to remain in their government funded/ provided accommodation led to the 'decision' to completely remove themselves, as a survival strategy. Maggie (59, Aus) had reached what she described as 'rock bottom' on the day of our interview. She explained how she intended to sleep on the street that night to avoid the verbal abuse that she was facing from a man living in her purportedly 'women's-only' accommodation. Another example of having to navigate impossible decision-making emerged:

> Erm... (long pause) yeah, I've been in women's housing for the past four years but that's not very-, it hasn't been very well because there's a man living there, been living in women's housing and so, even though I've had housing, I've been on the street... Yeah, any time there's any upheaval, I go to the street.

Maggie described the benefits that came from sleeping on the street: she had community networks and people looking out for her and, with that, a sense of safety. At the same time, she spoke about the violence she had been exposed to when sleeping rough. She recounted multiple experiences of sexual violence and rape, explaining that her age did not save her from these attacks. Even so, for Maggie, sleeping rough felt like a better and safer option than staying in the accommodation that she had lived in for roughly four years. The unsuitability of the accommodation provided for her was apparent throughout our conversation, both in terms of the abusive man living there and for Maggie's impairment. Maggie was in a car accident when she was young, had severe scoliosis, and needed a mobility walker to move around. She talked about her room being too small to turn her walker in. Feeling constrained both physically and emotionally in her accommodation, Maggie's preference to stay on the street, where she felt safer and could draw on her support networks, was a decision, but one that held the risk of further sexual and physical violence.

Similarly to Maggie, Darcy (44, Aus) described the safety she felt on the streets in one particular neighbourhood. She spoke of her strong support networks in the area, including the local First Nations community, as her two youngest children have First Nations ancestry. Darcy explained that she had become street homeless after her two eldest children were removed from her care, she lost nearly all her possessions after a break-in, and someone stole her dog. Things that made her house feel like a home were no longer there, which left her feeling that moving to a different state and living on the street was her only option:

> But when they broke in and took everything, well, pretty much that rendered me homeless from then. Then they come and took my kids off me and then someone decided to steal my dog so there was literally nothing to go back to in [place name] for. I just didn't want to go home to an empty house – with no dog, no kids. It would be weird... That wasn't home to me. My home's got laughter, and kids, and toys, and now it's just an empty, blank slab of concrete.

Darcy later stated that she would 'probably not be here now' if she had returned to her family home, that it would have been too emotionally difficult for her to handle. Like Maggie, Darcy had also experienced physical and sexual violence on the streets. Rough sleeping was a reluctant choice, and one which came with constraints on her bodily autonomy through exposure to sexual violence.

For Becca (47, England), an inability to leave the violence she was experiencing at home significantly worsened her situation, eventually leading to her son being removed from her care. Becca described approaching her local council to discuss her options for escaping her abusive partner, with whom she lived at the time. She was met with limited advice that failed to recognise the multiple levels of abuse that she was experiencing: physical, psychological *and* financial. Becca said that she did not know that refuges existed before coming to live in one:

> I went to the council once. And asked about what I could do about getting, like, my own place again. And they basically told me I'd have to go on, like, a waiting list and I couldn't make myself potentially homeless and all like this, and there were never any talk of anything else. So it were, like, basically you're... [You're stuck there?] Yeah. Save up and go into private rented. [Was that the advice that you were given?] That was basically the advice, yeah.

This advice goes directly against legislation in England which states that local councils have a duty to provide individuals escaping domestic violence with housing, as they are designated an automatic priority need category under the Domestic Abuse Act (2022). The advice given to save up for a private rental property also failed to acknowledge that Becca's partner had total control over her finances, making this option impossible for her. In being told that she would be making herself 'intentionally homeless', and as such would be placed further down the waiting list, this advice fell woefully short on providing the support she needed. With no further signposting given, totally isolated from her friends and family, and in the wake of the death of her mother (her only viable escape route), Becca had no choice but to return to her abusive home. As outlined in section 6.1.1, Becca's lack of housing options had implications for her SRH. With nowhere to escape to she continued to experience sexual violence, which resulted in an unwanted pregnancy and then an abortion.

All the stories discussed in this section feature housing insecurity as a significant determinant that denied women autonomy over their bodies and SRH. They raise the question of whether it is possible to view experiences of remaining in violent households or sleeping on the streets as 'choices', when all the options available are harmful and detrimental to the women's SRH. In Darcy's case, her housing situation contributed to being unable to reunite with her children, and for Becca, living in insecure housing was a factor in her child being removed from her care. Darcy and Becca's experiences spotlight that housing precarity, and the vulnerability that comes with it, was a significant barrier to their reproductive autonomy. In particular, a lack of appropriate housing denied them the third principle of reproductive justice: 'the right to parent children in safe and healthy environments free from violence by individuals or the state' (Ross, 2017: 290). Their experiences highlight the importance of interrogating how insecure housing can significantly hinder women's ability to make autonomous choices about their SRH.

6.1.3. Further adversity (violence leading to more violence) stemming from a lack of autonomy

As has been shown, violence was a persistent undercurrent in women's lives and a significant constraint on their capacity to act with agency. Often, women made decisions about their SRH in the hope of mitigating violence. Additionally, this research found that, at times, women decided to remain in and conceal their current adverse circumstances, or even to worsen their situations, in the hope of being able to improve them long-term. This contradiction reflects the structuring of many homelessness services in England and Australia that operate on a crisis-response basis and, due to resource and funding constraints, require that individuals present with a high level of need before they are eligible to access supports (Theobald et al., 2023).

Some women felt the need to conceal the violence they faced from their partners, as they knew that revealing such violence would lead to scrutiny from social services and the possibility of losing the care of their children. To prevent this from happening women remained in situations of, at times, life-threatening danger. Florence (57, Aus) explained that she felt unable to disclose to any of the healthcare staff she encountered on a regular basis throughout her last pregnancy that she was in a violent relationship:

> [When you were going into the hospital and when you were pregnant… were there any staff or people that were aware of what was going on… Or was there any support available for you at that time?] Maybe there might have been, but maybe I was too scared to lose my children. Because honestly I've never - I think I've had DHS in me life once.

Florence’s decision to conceal the violence that she experienced from DHS (Department of Human Services) speaks to an environment of fear, consistent across the interviews, which left women feeling unable to speak out about, or exit, their abusive relationships. This is consistent with existing literature which points to women concealing their circumstances due to fear of losing care of, or being unable to regain access to, their children (Gordon et al, 2019; Johnsen, 2025). As outlined in Chapter Four, this is a way in which women are held responsible in punitive ways by the state (in this case, child protection services) for the actions of their violent partner.

Nicole (32, Eng) also talked about hiding the abuse she was experiencing, with the intention of preserving her family. Nicole explained that she decided to conceal the violence she was experiencing at home, despite her son’s school detecting and directly questioning her about it, to prevent child protection involvement:

> But sometimes when his mum and dad weren’t there, he was beating me up because my son turned around and told his school that, ‘My daddy beat my mummy up’. Cos they pulled me over and I was like, ‘What do they want me for?’. So, I've gone into the room, private room with ‘em , they went, ‘I need to have a word with ya. (Eldest son) told us that you've been beat up by your partner… He’s said he’s seen you and your partner fighting.’ So, I lied and said we were play fighting, because I didn't want social services to get involved at the time.

A fear of child removal had paradoxical and deeply damaging consequences. At once, women were unable to access the help that could have supported them to leave their abusive partners and regain bodily autonomy, yet remaining in violent households was often cited by women as a reason for their children being removed. Women were trapped in a position where they were unable to regain control over their SRH because of the awareness they would be penalised for their partner’s violence, whilst also blamed for not taking their children out of danger. Becoming homeless has also been cited as a reason that children have been removed from mothers. Consequently, for many women the risk of leaving their relationship was exacerbated by housing insecurity: if they had left the relationship, they would have had nowhere else to go (Bimpson et al., 2020).

These examples underscore that, for many of the women who are mothers, their children were their primary motivation and the paramount concern around which all their other decisions were made. This suggests that the child protection system creates and upholds conditions that risk permanently excluding and isolating women, as through these (often permanent) separations, they remove women’s motivation to engage with services. This demonstrates the insidious impact of policies that fail to recognise the structural constraints on the women’s lives, and the cycles of violence and further adversity that are fueled by placing the responsibility for men’s violence with women.

Cycles of violence that hindered women’s autonomy and created situations of impossible decision-making were also evident outside of the context of child removal. Alison (49, Eng) spoke about being trapped in a violent relationship and being unable to escape. In an attempt to exit her situation, Alison decided to begin working in a brothel, knowing that her partner disliked sex workers, as a strategy to encourage him to end their relationship. Her experience points to a total lack of alternative options she had to leave the relationship, and her decision to engage in sex work could be understood as a sacrifice of bodily autonomy to survive:

> And I wasn't involved in no prostitution, nothing like that all them years while I used... why I got involved in prostitution weren’t for crack, it were to get rid of my baby father. Because he didn't like girls what worked. So, I thought if I do that he will leave... and that didn't work!

Alison’s experience points to the further danger women sometimes had to enter to try to exit a violent situation. Another particularly striking example of the injurious consequences of taking drastic measures to try and escape male violence came from Becca (47, Eng). Becca had experienced a total lack of support in the wake of a particularly violent attack from her ex-partner, which left her hospitalised. She recalled the hospital report stating that her head injury could have caused death. Becca’s partner was arrested; however, she was sent back to her home where the assault had taken place, with minimal follow-up care. She described being left alone in the house, unable to see her son who was staying with a family member. A total lack of support, combined with her isolation in the wake of the assault, meant that Becca took a life-threatening measure in the form of an overdose as a means of being readmitted to hospital and accessing help:

> The hospital, sent me home. ‘Bye’. Crisis team came to see me a couple of days later. By time I've got from the bed to the bottom of the stairs, they’d gone. And they left me on me own. Oh, and then I got a full parcel dropped behind the bin… I took an overdose to get back in. Well, I took an overdose to get back in, to get some help. But the overdose was a strong overdose. [To go back to hospital?] Yeah. So, I was unconscious, so the fire brigade had to break in. Cos I really did like, take enough.
>
> And then they wonder why you turn to alcohol… My brain was anywhere but on this Earth… I mean the day after when I came home from hospital, after the assault and you've got forensics coming through your house, packaging things up in big brown envelopes and that...

Becca’s account of the care she received following the assault denotes the clinical nature of her treatment, almost as if she was an item that needed to be ticked off a list. The de-humanisation she experienced spotlights failure and oversight from professional service systems that, on multiple occasions, put her life in danger. Resorting to overdosing to access care underscores the absolute lack of options she had.

At the same time, her overdose was the event that got Becca out of her home, away from her abusive partner and into the refuge she lived in at the time of our interview. It is poignant that Becca’s only way of being recognised as needing care was to put herself in further danger and at risk of death. This event also contributed to Becca losing custody of her son. In procuring the care she needed, Becca lost her child and home: there was no winning. In the examples discussed in this section— staying in and concealing violent relationships to keep custody of their children and taking drastic measures to escape dangerous situations— an underlying issue is a lack of control over housing and the constant threat of homelessness. This, in turn, perpetuated constraints on women enacting decision-making and reinforced cycles of violence, spotlighting the impossible choices that women had to make.

6.2. The phantom of choice

So far, this chapter has explored moments where women had exclusively harmful choices to decide between. It has considered how violence, specifically minimising the effects of violence, was a central concern in how women managed their reproductive lives. Analysis now turns to other ways that women made decisions about their SRH, moments where bodily autonomy was denied and there were no choices available at all. This showed up in how women spoke about their decision-making in different ways. For some women, they appeared to present their SRH as a fait accompli: their decision-making was framed in terms of inevitability and there was an articulation of submitting to fate, of a 'what will be will be' outlook on pregnancy. For others, their lack of options became apparent in conversations about contraception and unintended pregnancy, where there was no genuine option to choose from. Elsewhere, women spoke about experiencing sexual violence, moments where there was no space for decision-making at all.

The impression that their SRH was totally unmanageable was a tangible thread that ran throughout the women's narratives. This was reflected in their homelessness circumstances and the chaos that housing precarity generates, which sometimes left women without the capacity for routine or the space to consider their options. As will be explored, violence was an undercurrent that dictated women's choices, both in their interpersonal relationships, and in stigma acting as a violent and repressive force in their lives.

6.2.1. No legitimate choices: contraception

Homelessness meant that, for the women, everyday life was oftentimes difficult to manage and bureaucratised, leaving many of their basic needs unmet. It is perhaps unsurprising then that such volatile and vulnerable situations took away the women's control. Having no genuine choices within their control was a theme that emerged frequently in relation to contraceptive options. Many women spoke about the barriers they faced to using their preferred contraceptive method, and the unsuitability of the other options available to them. Understanding the effects of being insecurely housed was crucial to understanding such barriers, as tumultuous everyday lives, uncertainty, and lack of routine meant taking contraceptives that require planning was difficult. For example, some women reported that daily oral contraceptives, such as the pill, were not appropriate because they were difficult to remember to take regularly:

> I was on the implant when I had my first child and my second child. [Oh right, OK. So even with it, you still got pregnant?] But I got, I was on the pill at first, before I found out I were pregnant with my first one. And I must have missed having the pill. And that's when I got caught pregnant with my first child. (Nicole, 32, Eng)

> I probably was on like - in those days, like on the pill and that, but I wasn't very good at taking it. [So, you'd just like forget or miss it?] Yeah, just forget. Yeah. And then I got the IUD put in, and it worked for a little while. Then when that came out, I don't know, I was going to get another one. I can't even remember back then, but I don't know why they couldn't put another one back in. I think I needed to rest. [Okay, so you wanted to get another one, and they…?] Another one, because I didn't wanna have my third child. There's no way, I mean - I love her, but I - no. No. (Florence, 57, Aus)

For both Nicole and Florence, a lack of legitimate contraceptive choices that aligned with their life circumstances led to unintended pregnancy (this is explored in more detail in section 6.2.2). This finding concurs with existing literature which demonstrates that due to the competing demands women experiencing homelessness must manage, SRH is often not a priority and daily contraception is taken erratically (Kennedy et al., 2014).

It quickly became clear in the data that the contraceptive options available to women were not suitable to their needs. Olivia (20, Aus) explained that because of her epilepsy, she was advised by her doctor that no hormonal contraceptive was an option for her:

> So, I have epilepsy, as I said. And I have-, I get migraines along with that. So hormonal contraception was not an option for me. I was taken off the pill because it could increase my risk of stroke, I was told. And then that went for - the doctor I was seeing at the time told me that that was all forms of hormonal birth control would do that to me. So that was a no go. I wasn't for it. And I had the miscarriage, and I started thinking about, 'Well, you know, what are my options? What can I go onto?' And then I had the abortion, and I got the rod put in.

In addition to not having the option of hormonal contraceptives, Olivia faced restrictions to her reproductive autonomy elsewhere. Despite her wishes, her partner refused to wear a condom on the basis that he disliked the feel of them. She explained the emotional toll that this took on her:

> That was a massive stress thing for me because I was like, 'How can I rely on men?' (Laughs). Like, it's like, 'Oh well will you wear a condom?' And my partner, as you can probably tell, he like won't wear a condom. He'll just pull out (laughs). The pull-out method doesn't work (laughs).

An apparent void of any viable contraceptive options, and a total lack of support from both medical professionals and her partner to find an alternative solution that met her SRH wishes, led to Olivia becoming pregnant in circumstances not of her choosing three times. One of these pregnancies she continued through to the birth of her son, one ended in miscarriage, and one in an abortion. Research demonstrates women experiencing homelessness were more likely to have a partner that did not want to use contraception compared to women living in stable housing (Gelberg et al., 2008; Eapen et al., 2023; Galvin et al., 2023b). In Olivia's case, it was not one singular factor that led to a denial of her reproductive autonomy, but a combination of factors that were compounded and amplified by her homelessness.

Another strong finding of this current research was some women decided on a method of contraception, and then found it failed to work, as demonstrated by the quotes below:

> [When you've been in relationships, have you, kind of, used contraception in those?] Yeah, yeah. Not that they've worked. I was er, I was on the pill with my two boys and still ended up pregnant. And I was like, 'Oh, well, I'll go on the injection.' And then I was on the injection for five years and fell pregnant with my daughter. (Laughs) So it's like… [So you-, so you have three children?] Three children. [Three children. And you were on contraception…?] For all of them. Yes (laughs). (Sarah, late 40's, Eng)

> I did use contraception with [son] and [son] but it didn't work. I still fell pregnant... The pill. [So, you take it, like, every day with?] Yeah, and the red section was for your period and the green one was for every other day. [Was it like - did you feel like you took it regularly...?] Yeah, every day, every day, yep. Yeah, still got pregnant. (Nellie, 62, Aus)

> I think Mum made me get on the rod which didn't work very well. The Implanon. I got my period for like six months straight. So. [So that wasn't a good experience.] No. No form of contraception has worked with me. I've gotten pregnant on the pill about three times... I had miscarriages on the pill. Um the Depo[11] shot, I've gotten pregnant on. I don't know, it's just… [So you've been on the rod? The pill?] Yeah. Yep, and the Depo shot... [Has that been since your first pregnancy, that's kind of…?] Not worked, yeah. (Grace, 23, Aus)

Research into global contraceptive failure rates demonstrates women from lower socioeconomic backgrounds, poorer, and younger women are at greater risk of unintended pregnancy from contraceptive failure (Bradley et al., 2019). I did not want to pressure women to talk about the specifics of how they had taken their contraception or question why it had failed for them. However, what their stories *do* show is that contraception often did not work for them, and so they were not able to enact reproductive autonomy. As has been discussed, it is evident that women, at times, did not have the capacity to manage their contraception in addition to the many other things going on in their lives.

The barriers to accessing contraception that have been outlined— difficulties in taking contraception regularly, worries about side effects, and partner's dislike of using contraception— are not unique to women experiencing homelessness. However, this section has shown that, for these women, the context of homelessness exacerbated these barriers, worsened already challenging circumstances and contributed to denying agency over their reproductive lives. This is important, as many women became unintentionally pregnant while homeless, due to a lack of legitimate contraceptive options. In the following section, a lack of contraceptive options acting as a catalyst to further denials of

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[11] 'Depo shot' refers to Depo-Provera, a contraceptive injection.

reproductive autonomy, fuelled by the double-edged stigmas of abortion and homelessness, is explored.

6.2.2. No legitimate options: unintended pregnancy

From contraception failing to work, being difficult to manage, or causing unwanted side effects, is clear women had very limited options for managing their fertility. It is perhaps unsurprising then that many women in this research had experienced at least one unintended pregnancy: nine out of 12 women in the England sample, and six out of 11 women in the Australian sample. This finding is consistent with existing literature. In the UK, women experiencing homelessness have been found to be twice as likely to become pregnant than women in the general population, yet less likely to receive antenatal care (Gordon et al, 2019). In Australia, data on pregnancy status is not routinely collected by homelessness services, meaning the number of women experiencing pregnancy while homeless is difficult to measure. However, a two-week snapshot survey of Launch Housing and the Salvation Army Crisis Services Network (two housing and homelessness organisations) clients found that 6.4% of women using their services were pregnant. The actual number of women experiencing pregnancy while homeless is thought to be higher because, as detailed in section 2.2.2, women often do not access homelessness services (Murray et al., 2018). In the US, Corey et al (2020) report that almost 75% of pregnancies are unintended among women experiencing homelessness, compared to 45% nationally.

Deciding how to manage an unintended pregnancy looked different for different women, but what remained consistent in the data was the limitations on women's options, underpinned and exacerbated by housing precarity. For some women who decided to continue their pregnancies, it was evident that anti-abortion and essentialising motherhood narratives had a determining role in how they made this choice: namely, that abortion was not an option at all.

This was the case for Sarah (late 40's, Eng). As discussed in the previous section, none of the contraceptives she had used were effective. Despite trying several different methods, she had become pregnant three times. Sarah shared that because of the sexual abuse she had experienced as a child, she had never wanted to have her own children. However, her beliefs about abortion meant termination was not an option:

> Er obviously my past history as a child with sexual abuse, I didn't want any children in case the same thing happened to them. So…Then I ended up with two boys. I was quite happy with the two boys and then obviously found out about my daughter. So that was a bit of a shock. But… [Would you-, if you'd found out earlier about your daughter, would you have considered… Ending the pregnancy?] No. No, not at all. No, I don't, I don't agree with-. Unless it's in a case of rape or whatever like that. Or… but I don't agree with abortion at all, no. [Yeah, it doesn't align with your values...?] No, it doesn't, no. Yeah. Each-, everybody's each to their own kind of thing, but that's not-. No. They were there, so that's it, kind of things. It's like… Obviously, with ectopic, they have to take it away. It's-, there was no choice, kind of thing.

In this quote, Sarah understands abortion to be immoral and socially unacceptable. The limitations of this stance on abortion for her own reproductive choices are clear. Describing her pregnancies as 'they were there, so that's it' shows there was no other option in her mind but to go through with them. Sarah did not have a blanket anti-abortion position; in this quote, she identifies scenarios where pregnancy occurs because of rape, or in the circumstance of an ectopic pregnancy, as situations where there 'was no choice' and therefore where termination was justifiable. Having experienced an ectopic pregnancy herself, which she miscarried, Sarah empathised with the decision of terminating a pregnancy that is life-threatening to the mother. Notably, she did not view her own pregnancies as circumstances where there was no choice, despite all occurring due to contraceptive failure. Internalised abortion stigma is laced throughout her narrative:

> That is the only complaint I've got about the hospital is because… they put you on a ward with people that are… actually having abortions and all that. And are happy to have abortions. And I was miscarrying, and I didn't want to, kind of thing. So, I think hospitals need to be a bit more aware of that. Where they put people on wards. Yeah. Cos, I had a girl in the next bed to me at the time. And she was like, 'Oh, I can't wait to go out partying tonight'. And it's like, 'Oh my God'. It's like, 'Seriously?' And it's like, 'No'... But obviously there's other people that are in there that are miscarrying for other reasons. For medical reasons and all that kind of stuff. And you've got these other girls, they're totally bragging.

Sarah draws a distinction between her experience in the hospital of having a miscarriage (not a choice she has made and so one that is out of her control) and other women having an abortion (a 'wrong' choice that has actively been made). Her words conjure up a stigmatised image of the archetypal abortion seeker: young, reckless, and wanting to party. This imagined woman is positioned as irresponsible and thoughtless, clear in Sarah's description of the girls on her ward as 'totally bragging'.

Like Sarah, Nellie (62, Aus) has three children, and none of her pregnancies were planned. Nellie's contraception had failed for two of her pregnancies, as she humorously explained when discussing her decision to continue them:

> [when you found out you were pregnant um, what - how did that feel and was that…?] Oh, not again [laughs]. [Was that the reaction?] Yeah, but I wasn't going to get rid of them, you know. I don't believe in abortion. That was *way* out of my mind. If I can put up with one kid, I can put up with nine, but then another one come along and then oh,

> bloody hell! But they're mine, you know. Even my step-kids, I've got 12 step-kids, so they're all mine too.

Again, there is an air of responsibility in the way that Nellie talks about making this decision. She described having children as something to 'put up' with rather than an active choice she can make, and pregnancy is talked about as being out of her control.

Ellie (early-30's, Eng) became pregnant after her partner lied to her about having undergone a vasectomy (her experience is explored in more detail in section 6.3). Similarly to the other women, despite not having had agency over the circumstances of her pregnancy, her stance on abortion meant she did not see termination as an option:

> [How did you feel when you found out you were pregnant, after he told you that he had had the snip?] I wasn't very happy, but-. And then he asked me to get, have an abortion. I went, 'No.' I went, 'If you don't want the kid, then you go separate ways. I don't believe in that.' [You don't believe in having an abortion?] No. I don't believe in anything like that.

Choosing an abortion was not possible for Ellie, not because she wanted to have a baby, but because of stigmatising narratives which made it impossible. Abortion stigma is built from gendered norms that construct notions of idealised female sexuality and motherhood, and position those that seek abortion as morally abhorrent (Makleff et al., 2023). It creates circumstances under which obtaining an abortion is not an option for women and can never be considered as an option.

Running through all these accounts is a narrative of abortion as sexually irresponsible, in which responsibility is always located with the women. Kimport (2021) talks about this as a feminisation of responsibility, where unintended pregnancy is interpreted as the result of failing to take sexual responsibility, and so one must live with the consequences. Antiabortion narrative presents terminating a pregnancy as selfish, and in opposition to narratives of essentialised maternalism. As she argues, choosing an abortion is understood as 'a denial of women's nature and called into question their personhood. When women are understood as essentially mothers, women who have abortions are marked as deviant' (Kimport, 2021: 93).

Antiabortion stigma does not affect all women equally. As discussed in Chapter Four, the women in this study were de-valued reproductive citizens due to the stigma attached to being homeless, and so occupied a contradictory position to the gendered idealisation of women as mothers and carers (Saunders, 2021). Such stigma positions women experiencing homelessness as incapable of being 'good' mothers. However, it can also be a powerful force in preventing women from seeking an abortion due to the very same narratives that construct their behaviours as irresponsible. These women, who are already stigmatised along poverty, race and gendered lines, may feel unable to get an abortion, as it is just another way that they could be read as irresponsible.

Women experiencing homelessness are also more vulnerable to the consequences of constraints on their pregnancy decision-making (Kimport, 2021). As the findings have shown, many of the women in this research were unable to intentionally plan their families. Having an unexpected pregnancy at a young age has been shown to be a catalyst for further loss of reproductive health rights for women experiencing homelessness (Cronley et al., 2018). This has dire consequences for women with already precarious housing and financial circumstances, as unintended pregnancy can create further insecurity, deepen poverty and entrench cycles of homelessness (Galvin et al., 2023b).

It must be noted here that by spotlighting the women who did not terminate their unintended pregnancies, I am not assuming all the women would *want* to have an abortion: such assumptions reproduce harmful stereotypes about women experiencing homelessness. Indeed, some of the women spoke about their hopes to have children in the future (although always talked about securing stable housing, amongst other factors, as essential to this happening, which demonstrates again how reproductive justice is denied for this group of women). Rather, this research is concerned with centring the principles of reproductive justice which champion the right for women to choose if and when to have children. Evidently, abortion stigma was one factor that prevented some women from having children in circumstances of their choosing. Choice was an illusion.

There were also many instances where women did obtain abortions. However, even for the women that did opt to have an abortion, it was clear that abortion stigma impacted their decision-making. For Alison (40, Eng), the weight of her decision to have an abortion was evident:

> Well, like I say, if my friend hadn't kept me going with this pregnancy for so long until I realised it really weren't what I wanted, and I thought it's not fair. It's not right and I just did it. I regret it, now I regret it. Back then, I didn't, and I still feel bad that I don't. You know what I mean? And maybe... and then, you know, sometimes I think well, it's because that happened with the abortion. That's why they took my son. You know you kinda you... you make up lots of fucked up things in your head. You know what I mean? For what happens to you in life... And that’s maybe where the religious thing comes into it maybe. You know like, what goes around comes around.

The long-term impacts of abortion stigma on Alison are evident. In discussing her decision to have an abortion, she appears torn between knowing it was the right decision for her (‘it weren’t really what I wanted, and I thought it’s not fair’) and feeling punished for her choice. Alison feels that her youngest son being removed from her care is karmic retribution for obtaining the abortion.

Her experience suggests the devastating lingering consequences of stigma for how women interpreted their decision-making, and the effect this had on their future choices.

This section has delineated stigma as a significant barrier to accessing abortion, articulated by both women who had sought out an abortion and those who had continued their pregnancies. The women's experiences demonstrate the power of stigma in constraining their SRH choices, demonstrating the barriers they faced to be complex and to extend beyond solely the practical. As has been discussed, abortion was often not an option at all due to intertwined stigmas related to abortion and homelessness, which amplified notions of respectability, responsibility and the value of motherhood in the context of abortion.

6.2.3. Resignation

As has been discussed so far, choice often appeared as a phantom in the women's narratives. It appeared that a choice was being made, but due to the constraints discussed, it was merely an illusion. This section explores one key consequence of these constraints for decision-making. That is, disengaging from the labour of navigating impossible, illusionary, SRH decisions. There were several moments where the women spoke about pregnancy, or the possibility of pregnancy, with a sense of resignation. There was an inevitability to their narratives, an acceptance that it did not matter what action they tried to take; it was likely that pregnancy would happen. Alison (49, Eng) talked about pregnancy in this way, discussing it as an event that was out of her control:

> When I got pregnant with [fourth son] I was 40. I didn't take birth control. I didn't. I didn't, you know I never took birth control. The only time I took birth control was in between [second son] and [third son]. And I had the coil put in. I didn't take birth control, because I thought

> what's the point, because I'll forget to take it anyway. And if it happens, it happens, so be it. Do you know what I mean? Sort of thing.

Although having been on long-acting reversible contraception (LARC) before, Alison said that she was no longer on any contraception because she knew she would forget to take it regularly. Her doubts concerning her self-efficacy in managing her reproduction were clear. This feeling was echoed by Beth (25, Eng), when asked whether she would be planning for her reproductive future with her partner once her LARC had been removed:

> It's my choice. I get to choose if I… if I choose the wrong decision, I choose the wrong decision. But… it's just like I said to me cousin this morning, if I choose the wrong decision, it's my decision... Like, I said to my partner if I make the wrong decision, I make the wrong decision. Get pregnant.

Beth talks about pregnancy differently to Alison; she states her ability to choose and explicitly names this as an agentic choice. However, Beth also says that she may make the 'wrong' choice and become pregnant, again suggesting doubts in her self-efficacy. Women experiencing homelessness exhibiting a lack of confidence in managing their reproduction, specifically avoiding pregnancy, has been reported elsewhere in the literature, where a narrative of 'whatever will be, will be' is prevalent (Dasari et al., 2016). For Alison and Beth, there was a sense of powerlessness in their narratives, the notion that they could not control what would happen to their bodies. The possibility of becoming pregnant elicited a neutral response, despite this not being something the women would actively plan for, rather than being perceived as either overly positive or negative.

Similarly to Alison and Beth, Ellie (early 30s, Eng) had an ambivalent attitude towards pregnancy, saying that it was not something she was planning for, but neither something that was a priority for her to manage. However, for Ellie, her ambivalence stemmed from her frustration at the lack of contraceptive options that were suitable for her, which led to inconsistent engagement with using it:

> But like as now, I've stopped taking it. Anything. [Right. Why have you done that?] Cos with the implant, and the Depo, and the pill, I was putting 10 times as much weight on. And they were thi-, the doctor's turned around and thought because I was on the implant, and the Depo, and the pill, I was putting weight on, they don't want me to come to the point where I'm gonna be diabetic. [So did they kind of advise you to come off?' Yes. I went-. And then they went, 'What about the coil?' I went, 'Not a prayer, you're putting nothing near me!' (both laugh). I use the condoms now and again, if it comes to the necessary that I don't want to be pregnant. But I can't be bothered to use 'em. I don't like the feel of it! It's a horrible feeling. I went, 'You might just as blooming well put a plastic bag on ya'.

In explaining her decision-making, it was clear that Ellie did not feel that there were genuine options to choose between, and she had to prioritise other factors, such as weight management, over fertility management.

A central concern of this thesis has been to delineate the ways that stigma de-legitimises the choices made by women experiencing homelessness as ill-considered and immoral. The resignation women exhibited in these examples of pregnancy decisions might be understood as a response to systems that deny women control over their bodies. When understood through this lens, resignation is an understandable and rational response to a system that allows for little other options. Indeed, stigma has been demonstrated to be a powerful hindrance to decision-making in research investigating the health seeking behaviours of people experiencing homelessness (e.g. Rae & Rees, 2015; O'Carroll &Wainwright, 2019; Omerov et al., 2019).

There could be multiple interpretations as to why some women exhibited ambivalence, keeping in mind the many layers of stigmatisation they experienced. A feeling that their broader life circumstances were totally unmanageable came through strongly in the data, and so a 'what will be, will be' approach could be understood as a response to an inability to control what was happening over their bodies. Additionally, Groundswell's (2020) study into women's homelessness and health reported finding that the stress of being homeless often meant women were unmotivated to engage in behaviours that would improve their health and sometimes lacked the self-esteem to do so. In the context of all the structural barriers explored throughout this thesis, it seems unsurprising that some women explained their decision-making in this way. An apathetic attitude towards SRH decision-making appeared symptomatic of the impossible situations women found themselves in, which could even be interpreted as a refusal to engage in pseudo-choices, and thus an act of resistance in itself.

6.3. Sexual violence

So far, this chapter has attended to the impossible SRH decisions that women had to make and argued that choice, when it *did* appear, was often superficial. In addition to this, violence has been shown as a frequent outcome regardless of the decision made and was a core constraint on the women's SRH autonomy. An absence of choice has appeared covertly in women's narratives: in the different decision-making processes that have been explored, an illusion of choice is still present. However, there were also moments where a total lack of choice was explicitly stated by women, where agency was not possible. In these moments, violence was front and centre:

> [Did you use, like, contraception with that partner?] No, never. That's how I got pregnant with my son. And um obviously, they've told him

> while I'm away I didn't wanna do owt. But all the time I was there on my own with him, he was asking me, 'Can I do it? Can I do it can I do it?' and I kept saying no. [Have sex with you?] Yeah. And then on my last day on the holiday... I just give up. I just said, 'Yeah, whatever'. But with the police point of view, they said that's classed as rape, because all the way through I kept saying no. But then I just give up. (Nicole, 32, Eng)

> You know it's amazing, every female on the street whose homeless get put on us for sex all the time, you know? By just you know, like, mugs. You know, who come to [place name] and picking up a girl, they'll just think that they can get, you know they can have a knock and (unclear). [Yeah, is that an experience that you've…?] Oh, over and over love. I've been raped and pillaged that many times in my life I'm just… (Maggie, 59, Aus)

Nicole and Maggie articulate experiences of violence towards their bodies at the hands of men. There is a feeling of weary expectation and exhaustion in their accounts of sexual violence; a continuous and ever-present threat of violence is clearly part of the day-to-day lives of these women. These findings reinforce a large body of research which demonstrates that homelessness exposes women to, and places them at greater risk of experiencing, sexual violence (Johnsen & Blenkinsopp, 2024; McMordie et al., 2025).

For the women, sexual violence was part of a suite of violations where their reproductive autonomy was denied. Clara and Ellie both experienced deception from men regarding contraception usage, which took away their capacity to have control over the contraception they used, and consequently their reproductive lives:

> Obviously, I've been having to use condoms when I was doing quite a bit of sex work. Sometimes clients be asking to do it without, um I've had them being a bit sly and tearing the Durex off, and lying and saying it

> had fell off when it clearly hadn't, they'd removed it unbeknown to me. I actually got pregnant to, to a client years ago. (Clara, 54, Eng)

> I was on the Depo at the time. And I thought, 'It's not run out yet'. And it did. So, I got caught. [Ahh OK. But if you, if you had known that that had run out, would you have used…?] Yes. And I did-, I thought I were covered. But he lied. He turned round and said he had the snip. [Vasectomy?] Yes. And he said, 'Don't worry, you can't get pregnant. I've had snip'. I were like, 'Okay, okay'. And then two weeks down the line, I was s'posed to be due on my period. And I were getting really bad cramps, really backache. I couldn't move now't. So, I thought-, I rang him. And I went, 'You need to come to the doctors with me.' He went, 'Why?'. I went, 'Just come to the doctors. I'm getting belly ache. I'm getting cramp. I can't eat.' (Ellie, early-30's, Eng)

Because of the violence they experienced, Ellie and Clara both became pregnant in circumstances not of their choosing. Not only had their autonomy over their bodies been taken away from them in the moment, but this continued to impact their future autonomy due to the expectations and stigma attached to them as women mothering while homeless. This finding aligns with research from the U.S. which suggests women experiencing homelessness are uniquely vulnerable to unintended pregnancy, in part due to high rates of sexual victimisation (Thompson et al., 2023; Eapen et al., 2023).

The unequal power dynamics women face in sexual relationships when experiencing homelessness which put them at greater risk to sexual exploitation and violence were acknowledged by Nisha (38, Aus):

> For me, after being put through all this experience, I'm definitely more careful because I've seen a lot of my friends falling pregnant for the survival skills who have experienced homelessness and got abused by men and got pregnant and, you know? That was a big challenge. I

> helped a lot of people. When I was homeless, I helped a lot of people too and, you know, going and fixing up their house with their kids. There was a lot that I saw and, like, when you're homeless with kids, moving with those baggage, [unclear] hotel accommodation, it's not the easiest thing. I get so angry at those men.

Nisha describes seeing the women around her become pregnant as the result of survival sex, an experience that is commonly reported in the literature (Kennedy et al., 2014; Watson, 2018).This demonstrates that reproductive justice's third principle— the right to parent in safe and sustainable communities—was absent from their lives, as survival had to be prioritised, which meant sometimes safety was not possible.

The violence described in this section further illuminates the extremely challenging and constrained circumstances in which women navigated SRH decision-making. The women's experiences demonstrate that violence could, at times, completely remove their capacity for decision-making while homeless, and be a further oppressive and compounding factor that denies their autonomy.

6.4. Conclusion

This chapter has discussed different layers of SRH decision-making, characterised by violence and a lack of control. It has explored various forms of paradoxical decision-making women engaged in, where they often had to compromise their reproductive autonomy and face violence to ensure their survival. It has demonstrated that not only were women frequently unable to enact their contraceptive preferences, but then when they fell pregnant in circumstances not of their choosing, were unable to terminate their pregnancies due to abortion stigma. This is not to say that women were without agency (they often drew on the networks and resources that they had), but rather to reify the severely constrained circumstances under which they navigated decision-making. In spotlighting this, the tensions and constraints that women encountered, and the laborious experiences of navigating choice, were revealed.

This chapter has shown that, contrary to stigmatising narratives which frame women experiencing homelessness as irresponsible, they were continuously engaged in complex decision-making processes; it is their constrained circumstances, reinforced by structures, that give the appearance of 'poor' decision-making. As evidenced throughout this thesis, women are continuously placed in contexts where they are responsibilised to navigate impossible decisions with little resources, which endangers themselves, perpetuates cycles of adversity and homelessness, and often leads to the removal of children.

The experiences discussed raise the broader question of whether it is appropriate, or even possible, to understand these women's actions within a framework of 'decision-making', when women have such limited opportunities for autonomous decision-making, and when the obligation is placed back onto women to find solutions on their own. This question will be explored in more detail in the final chapter, which provides a conclusion to this thesis.

Chapter 7: Conclusion

This thesis has explored how women experiencing homelessness in England and Australia engage in decision-making processes regarding their SRH. There is a burgeoning literature on women's homelessness, with an increasing number of academics giving attention to the gendered dimensions of homelessness for women, including in relation to motherhood (Savage, 2022; 2025; Bimpson et al., 2020; Parr, 2024; Theobald et al., 2024; Watson et al., 2025). Despite these important advances to knowledge, there remains a dearth of homelessness scholarship on the SRH of women experiencing homelessness. In particular, there has been inattention to SRH beyond a few distinct experiences, such as choosing contraceptives or having an abortion. These experiences have predominantly been explored in isolation and so are removed from the broader constellation of SRH choices that women constantly navigate. This means the intricacies of engaging in SRH decision-making have remained unexplored (Brott & Townley, 2023). As set out in the introductory chapter, the little that is known indicates the significant restraints, and multitude of adverse reproductive health outcomes, that women who experience homelessness face (Corey et al., 2020; Shah et al., 2019; Gorden et al., 2019). This thesis aimed to explore the lived experiences behind these negative outcomes, asking why they were so prevalent in this population by exploring *how* women made decisions about their SRH. In doing so, it has addressed a stark gap in the literature on the reproductive lives of women experiencing homelessness.

In this concluding chapter, the research questions are revisited and reflected on. A series of overarching conclusions will be presented that draw from evidence across all three findings chapters to offer meaningful and novel contributions for how we know and understand the SRH of women experiencing homelessness. Each of the first three conclusions delve into a major constraining force on the women's lives: stigmatised gender (and) expectations; housing precarity; and violence. The fourth concluding point considers all of these together and demonstrates their impact on how women navigated SRH decision-making and enacted many kinds of invisible labour. These conclusions will then be contextualised within the three core principles of a reproductive justice framework to clearly demonstrate the multiple ways that reproductive justice was absent from the women's lives. After this, the limitations of this research will be addressed, and suggestions for a future research agenda put forward. The chapter will end with recommendations directly from the women themselves on what they identified as most pertinent to addressing the reproductive injustices they experienced.

Three research questions were set out in the introduction to this thesis to qualitatively explore how women experiencing homelessness made decisions about their SRH. These research questions were as follows:

1. How are women experiencing homelessness engaging in SRH decision-making processes?
2. How are their choices constrained or enabled? By what/ whom?
3. How can we understand bodily autonomy in the context of survival?

The following section outlines the main conclusions that emerged from the research and demonstrates how these findings advance knowledge by providing novel contributions to the literatures on women's homelessness, homelessness and health, and reproductive justice.

7.1. Key conclusions

Despite differences in homelessness policies and approaches in England and Australia, the findings were consistent across both settings. As such, these conclusions are not distinguished according to country. This consistency may reflect similarities in the dominant ideological contexts of both countries, where the increasing retrenchment of the welfare state is taking place. Differences in the accountability of governments to provide housing to all, in accordance with the law in the respective countries, does not seem to have translated into greater protections for the women interviewed and their outcomes appear largely the same. As such, the overarching conclusions that are presented below are applicable to both England and Australia.

1. **Good/bad womanhood discourses are an injurious force that devalue women experiencing homelessness and limit their reproductive autonomy, including their reproductive futures.**

This thesis found that good/bad womanhood discourses stigmatised women along gendered and classed lines and had implications for their reproductive lives. Through stigmatising processes, women were positioned exclusively on the 'bad' side of the binary. Stigma was informed by gendered notions of respectability, and had pathologising, demonising, and devaluing effects which positioned women as incapable of 'good' decision-making. These discourses mark certain stigmatised bodies, including women experiencing homelessness, in need of regulation. The dichotomy was found to have a saturating effect on the women's SRH through constraining their reproductive presents and futures and limiting the choices they were able to make.

Stigmatising discourses barred women from the status and respectability that middle-class women can accrue through motherhood (Skeggs, 1997). The stickiness of stigma was especially evident for women who are mothers, where strong discourses around good/bad motherhood featured across their narratives. This finding adds to an emerging body of scholarship on women's homelessness and motherhood (England & Henley, 2024; Watson et al., 2025; Bimpson et al., 2020). Moreover, it aligns with the work of Saunders (2021), who highlights how working-class women's reproductive trajectories are devalued by showing that all women were subject to prevailing mothering discourses, regardless of their motherhood status. A core expectation and understanding of womanhood is through women's potential to become mothers, and so their worth is tied up in this potential.

Stigma had an all- encompassing and saturating effect on the reproductive lives of women. It appeared heavily in the women's interactions with service providers, with some reporting not seeking care due to fear of stigmatisation. It also affected their interpersonal relationships and their self-perceptions. Stigma was cyclical, compounding and paradoxical in nature (one of many paradoxes this research discovered in relation to decision-making, discussed in detail below in key finding point four). It discouraged women from engaging with services, which fuelled stigmatising images of women as uncaring or lazy due to their disengagement, and in turn further fed stigma. This cycle delineates how women were continuously marginalised by systems that removed their agency.

The impacts of stigma were stark in women's interactions with child protection services. Women described punitive environments where they felt a profound lack of empathy, particularly those whose children had been removed from their care. Women were held to a different and higher set of expectations than their partners and often held responsible for being subject to domestic violence. The frustration and hopelessness women felt towards the pervasive and inescapable 'bad mum' label was clear, and all women subject to care proceedings felt they had been dismissed before they had even had an assessment. Feelings of marginalisation were amplified in situations where women had experienced repeat child removal. Stigma not only informed assessments, but how women were treated after the removal, where they were not recognised by service providers as mothers at all, and so not seen as having legitimate claim over their grief. Across the narratives, feelings of deep injustice were evident.

In addition to impacting the present SRH circumstances of the women, good/bad womanhood discourses had consequences for the reproductive

futures of women who had children removed. For some, removal fuelled their motivation to have more children, to prove themselves as capable mothers. For others, the stigma they faced in the wake of child removal acted as a strong deterrent to having children in the future, as they knew their future actions would be under scrutiny and understood exclusively through a deficit-lens.

Together, this thesis underscores the significant, tangible, and enduring consequences of the good/bad womanhood dichotomy on the women's SRH lives. It also points to the complexity of talking about stigma, a concept that is, at times, theoretically murky and ambiguously applied. It has shown how stigma operated as a mode of governance in different ways, making it difficult to pinpoint whether stigma is generated by this binary discourse, informs the discourse, or both.

2. Women's capacity for SRH decision-making must be understood as integrally connected to housing deprivation

By focusing on the gendered dynamics of homelessness, this thesis has spotlighted the highly restrictive contexts in which women enacted decision-making. It has demonstrated a clear relationship between housing and SRH: not having stable housing has significant negative consequences for how women navigated their reproductive lives. If secure housing was not present in women's lives, all their other decisions became constrained. Their basic unmet needs meant they also lacked the resources to make agentic choices about their SRH, such as enacting their contraceptive preferences or mothering practices (for those who are mothers), as they had to prioritise securing housing and other basic needs at the expense of their SRH. This builds on scholarship by Theobald et al (2024) who found women were unable to prepare for motherhood and foster maternal identities whilst homeless, demonstrating the women could not have control over *any* part of their SRH when their housing was not secure.

The time and effort involved in navigating complex housing, healthcare, child protection, criminal justice and other systems associated with homelessness services was clear. Hearing the stories of women who were pregnant or caring for children whilst facing, or at risk of, homelessness, reinforced the gendered contexts in which women navigated professional services and the specific set of challenges they faced. Women shared experiences including looking after their new-born babies in precarious housing contexts, sofa surfing and moving constantly, trying to look for housing while heavily pregnant, and being penalised by child protection for not having appropriate housing. In these accounts, their ability to enact autonomous decision-making in other areas of their lives, and the attention they were able to give to mothering, was heavily impacted by systemic failures to offer secure, long-term housing support. This meant, at times, the housing, justice, and welfare services that provide various kinds of homelessness support invertedly enabled and perpetuated gendered violence, despite being intended to provide and/ or enable safety for women. Precarious housing situations exacerbated a lack of control that women already faced.

Consequently, this research adds compelling evidence to a growing body of scholarship that highlights the necessity and urgency of Housing First[12] models of support (Clarke et al., 2019; Pleace, 2018). It shows the devastating consequences of the accelerating housing crises in both research contexts on women's SRH, and how a failure to provide safe and secure housing for women led to their continued violent victimisation and inability to have reproductive autonomy.

This key finding outlines that for these women, bodily autonomy was not possible in the contexts of housing insecurity and fighting for survival. The

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[12] Housing First is 'an intensive, consumer-led (co-productive) and housing-led approach, that (gives) people experiencing homelessness with complex needs immediate independence in their own homes with a mix of support that they largely shape for themselves' (Pleace, 2023: 322).

women had no choice but to prioritise their basic needs, which in turn severely limited their SRH decisions. This demonstrates that women's capacity for SRH decision-making could not be understood in isolation from the housing deprivation they faced. This is revealed by focusing on the gendered nature of women's homelessness.

3. **Violence permeates the lives of women experiencing homelessness and is a significant repressive force on their SRH decision-making.**

This research has shown that despite differences in the women's lived experiences of homelessness, violence featured across all their stories and was a core part of their everyday realities. The links between violence and women's homelessness have been well-documented in existing literature, where violence has been shown to be a primary cause of homelessness and to be a distinguishing feature of experiencing homelessness for women (Mayock et al., 2015; Bretherton, 2020). However, this thesis contributes a novel finding to this literature through demonstrating how experiences of violence were integral to SRH (and wider) decision-making and constitutes a significant constraining force.

As outlined in Chapter Six, the pervasiveness of violence became apparent in moments where women articulated pseudo-choices, where harmful outcomes happened despite their best efforts to mitigate them. This was particularly evident in situations where women knowingly acted in ways that were detrimental to their health in the hope of avoiding other kinds of physical violence. The hope of evading violence was a driving force behind decision-making, demonstrating how an anticipation of violence removed the possibility of agentic decisions being made. For example, several women chose contraceptive methods that went against their preferences in attempts to mitigate the pro-longed effects of physical violence experienced at the hands of their partners. Enduring immediate, usually physical, violence was necessary and unavoidable for some women's survival long-term. Sexual violence was another experience in a suite of violations in which women's reproductive autonomy was denied. This finding shows that not only did women have to compromise their reproductive autonomy in the face of interpersonal violence, but they were also unable to plan for their reproductive futures.

Violence that appeared in the women's interpersonal relationships was compounded in their experiences within homelessness support services. Women described being unable to leave their provided accommodations because there were no alternatives available apart from the streets, and as a result became trapped in violent environments. This was significant as women had almost always come from histories of extensive interpersonal violence. Violent accommodations provided by housing services, and interpersonal violence experienced on the streets or at the hands of partners, meant that women were in high alert and unable to attend to their SRH needs or have control over their lives, as they had to prioritise their survival. Spaces of safety, in fact, morphed into a mirror of the violence they had experienced elsewhere. At times, child protection systems also inadvertently hampered their ability to leave violent relationships because women feared being penalised for their partner's violence, and so chose not to disclose the violence they were experiencing out of fear of having their children removed.

The finding that child protection systems unintentionally worked to keep women in violent relationships is consistent with existing literature (e.g. Gordon et al., 2019; Johnsen, 2025). However, this is an important finding in the context of understanding decision-making as spotlighting this unwinnable situation points to yet another kind of paradoxical decision-making women had to engage in.

4. **The barriers women experiencing homelessness face mean their SRH decision-making is highly complex and resourceful, and requires constant, often invisible, forms of labour.**

The three overarching conclusions presented above illuminate significant constraints on women's sexual and reproductive health (SRH) that have, to date, been under-explored in analyses of decision-making. These are: stigmatising gendered (and classed) expectations; housing precarity and homelessness; and interpersonal and systematic violence.

This final concluding point considers all of these barriers together and suggests the outcome of these compounding constraints is that women were negotiating environments in which they were left with no 'good' decisions to make. This thesis has shown that, contrary to dominant stigmatising depictions of the women as lazy, uncaring or irresponsible, they were in fact engaged in complex, and often paradoxical, decision-making. Rather than being passive, women were in fact constantly engaged in invisible labour to meet their needs in highly constrained circumstances.

A strong finding of this thesis is that choice often appeared as a phantom: seeming to exist, but in reality, absent. In Chapter Six, this appeared in relation to experiences of unintended pregnancy, where the intertwined stigmas of abortion and homelessness left women with little options. The ways in which institutions responsibilise and designate women as making 'poor' decisions is stark in a system that ultimately positions women as failures and leaves them isolated, with few resources and no 'good' decisions to make. This led to kinds of decision-making that could be read as uncaring or irresponsible through the lens of stigma, an experience that women frequently reported when describing their interactions with professional services. However, despite their lack of options, women still engaged in constant, considered decision-making. This included responses such as resignation and fatalism: choosing not to engage with services that stigmatised them and left them with no good options. Contrastingly, in many instances women fought to rebut discourses which served to disempower them. These modes of decision-making were irrefutably forms of labour that women were actively engaged in, however before being unearthed by this research they were invisible.

The primary focus of this thesis has been to understand women's SRH decision-making processes while homeless. Spotlighting decision-making has raised broader questions about how we can think about choice, and ultimately what constitutes 'free' choice, when the social conditions in which decision-making occurs are so restrictive and the barriers so great. Importantly, despite autonomy being hindered, this did not mean that decision-making was not happening. On the contrary, the many kinds of barriers encountered meant the decision-making taking place was highly complex and resourceful.

A reproductive justice framework illuminates that autonomy cannot be thought of in terms of individual rights and must be understood within the intersecting oppressions in which one is located (Ross, 2017). Reproductive justice reframes autonomy as only truly possible when equitable and socially just systems are in place to support free SRH choices. Much of the evidence presented shows that autonomous decisions were not possible for women, and they were unable to make the choices they wanted to due to an interplay of interpersonal, service provider and systemic barriers. However, this did not mean they were powerless. Rather, the appearance that the decisions they made were irresponsible or harmful to themselves or their children, was in fact the product of a system which left women with little options, and a series of impossible, paradoxical decisions to navigate. The following section situates these key conclusionary points within a reproductive justice framework to articulate how reproductive justice was continuously denied for the women in this research.

7.2. Implications of the research findings in the context of reproductive justice

Ross (2017) sets out three interconnected foundational principles of a reproductive justice framework. These are: '(1) the right to have a child under the conditions of one's choosing; (2) the right not to have a child using birth control, abortion, or abstinence; and (3) the right to parent children in safe and healthy environments free from violence by individuals or the state' (p290). Without these three principles, reproductive justice is argued to be absent.

Interrogating women's capacity for autonomous decision-making has been a central concern of this thesis. Thinking about reproductive justice is a crucial tool for addressing questions of autonomy because it interrupts notions of 'free choice' and questions how the intersecting oppressions in which a woman is situated influences her ability to have *meaningful* choices about her SRH (Eaton & Stephens, 2020). Through applying this lens, this thesis found that all three of reproductive justice's principles were denied and unreachable for the women. To illuminate how and where injustice occurred, this section will address each principle of reproductive justice and reflect on the key conclusions shared in this chapter to evidence some of the ways this denial took place.

1. The right to have a child under the conditions of one's choosing

The key findings presented have delineated that having a child under the conditions of one's choosing was not a reality for the women in this research. Women experienced intersecting oppressions of stigma, homelessness, and violence, which in turn influenced their decision-making processes and hampered their bodily autonomy.

Chapter Four discussed the impacts of the good/bad womanhood binary, the lens through which all of the women's choices were understood, and their actions interpreted. It showed some of the ways women had been labelled as incompetent, lazy, and 'bad' by stigmatising discourses, and so were written off by systems that classified them as what Saunders (2021) aptly terms 'devalued reproductive citizens'. This shows that these women did not have the same reproductive options to choose from as women living in different social and material circumstances, as they were labelled as not displaying the 'right' kinds of mothering and as failing to adhere to normative mothering standards. As such, their engagement with child protection services was defined by stigmatising discourses that devalued the women and their parenting capabilities, which often led to the removal of children from their care. These stigmatising attitudes were cemented in institutions, limiting the reproductive options that women were able to choose from. 'The right to have a child' was not present for these women, because they were so often labelled as unfit to parent in the first place. This stigma impacted decisions made around childbearing, as some women decided not to have children due to the fear of removal.

Additionally, women talked about wanting to be mothers but feeling that their lives were not stable enough. This was particularly relevant in discussions about not having secure housing, experiencing poverty, and being subject to domestic violence. Chapter Five detailed the myriad ways that women were unable to access professional supports, which presented another set of barriers to having children, as women existed outside of formal help and had to work hard to secure resources on their own. Motherhood was an aspiration for many women, but they were severely constrained by their material conditions and as such felt unable to raise children. Furthermore, they were unable to have children under conditions of their choosing, as housing insecurity and homelessness created environments under which their options were highly constrained, and they were subject to intensive governance by systems and institutions (including child protection services).

2. The right not to have a child using birth control, abortion, or abstinence

This research found that over half of the women in each sample had experienced at least one unintended pregnancy. Sometimes the pregnancy was welcomed, however this research found that in many instances, women felt unable to choose an abortion (even in instances of contraceptive failure or assault) due to the stigma surrounding it. This occurred despite abortions being a legal procure in both countries, although accessibility is dependent upon gestational age and the approval of two doctors (in Victoria, approval is only required after 24 weeks gestation).

In Chapter Six, it was posited that abortion stigma may be one stigma too many on top of all the other judgments that women faced. This meant some women had children they had not actively planned for and did not feel they were in a stable place in their lives to have. Continuing such pregnancies sometimes led to further precarity and exacerbated their vulnerability to homelessness.

Additionally, Chapter Six detailed that several women talked about paradoxical decision-making regarding contraception. Specifically, not choosing their preferred contraceptive method in an attempt to minimise the consequences of their partner's sexual violence. In these instances, the right not to have a child through using birth control or abstinence was not present. Not only were they unable to enact their contraceptive preferences, but were also unable to practice abstinence as they were subject to sexual violence. Sexual violence was something many women had experienced and removed their capacity for autonomous decision-making. Some of the women became pregnant after being sexually assaulted in contexts where their contraceptive preferences were denied. This, coupled with abortion stigma, meant the right not to have a child was not present.

3. The right to parent children in safe and healthy environments free from violence by individuals or the state

As has been demonstrated, violence was an ever-present reality that wove through all the women's narratives. It first emerged in their early childhood experiences, then interpersonal relationships, and then was replicated in interactions with homelessness, child protection, and domestic violence systems. For example, women often talked about remaining in violent relationships to avoid scrutiny from child protection services. This thesis contributes to a body of literature (Gordon et al., 2019; Johnsen, 2025) which shows how systems invertedly create situations where women feel unable to leave violent partners and so remain with their children in unsafe environments, for fear of blame, shame and ultimately child removal. The stories shared in this research clearly illustrate that women were not free from violence by individuals or the state. Indeed, systemic violence mirrored the interpersonal violence women experienced.

In addition to this, housing insecurity was a significant barrier to women being able to parent their children in safe and healthy environments. Chapter Five detailed how women were provided with accommodation that was not safe or suitable to raise children in and then were penalised for not having adequate housing. Women described having children removed after their housing was deemed overcrowded, whilst not being offered any other alternatives. They shared experiences of trying to secure accommodation whilst heavily pregnant or caring for young children and resorting to sofa surfing during this time. Ultimately, housing services failed to ensure that women had safe environments to raise their children in. The links between reproductive justice and housing justice are clear: safe and healthy environments are undermined by a lack of affordable and appropriate housing.

As suggested at the end of Chapter Six, the glaring absence of choice that women articulated when discussing their SRH raises a bigger question of whether we can, or indeed *should,* view women's decision-making as decision-making at all. In no way does this thesis intend to diminish the women's agency or to paint them as powerless victims. At the same time, a key and undeniable conclusion of this research, that weaves through all of the findings, is the extremely constrained and limited contexts in which choices were enacted. This poses the question: when the only choices that women had to make led to further adversity, violence, and the denial of their SRH preferences, is it appropriate to use the language of 'decision-making' at all? Again, this is not to say the women were not agentic. There were many examples of women navigating complex systems, rejecting stigma, and drawing on whatever resources they had available, in the face of little support from professional services. Even the act of calling out, naming and rendering visible the systems that had failed them was an act of resistance and a refusal to allow their adverse circumstances to be reduced to individualised blame. Reproductive justice is a powerful tool for demonstrating that choice was not truly 'free' for the women in this research, when the options they had to choose between were so limited. The next section outlines how this thesis offers multiple novel and important contributions to knowledge.

7.3. Original contributions to knowledge

So far, this chapter has provided a series of compelling insights into an area of scholarship that has been neglected: the SRH decision-making of women experiencing homelessness. In doing so, this thesis has contributed new knowledge to multiple bodies of literature. It has presented new evidence to homelessness scholarship, an area in which very little is known qualitatively about women's experiences of SRH, a gap partially stemming from inattention given to the gendered dimensions of homelessness until more recently. It has also given new evidence to the SRH literature, which has a dearth of knowledge on how women who are homeless manage their SRH beyond a few distinct experiences, such as contraception usage.

All of the contributions shared in this chapter offer novel insight into our understandings of women's homelessness. However, I want to foreground several of the ways in which I believe this thesis has the greatest impact. *Firstly*, it has provided a theoretical contribution to knowledge through the application of a reproductive justice framework to understanding the SRH of women experiencing homelessness, a framework that is currently under-utilised within homelessness research. By focusing this research on women's experiences of homelessness and interpreting these through a reproductive justice lens, the importance of the contexts of women's lives on their SRH has been revealed. Specifically, how precarious housing and homelessness removes women's capacity to make agentic choices about their SRH, and that it is impossible to understand these processes in isolation from this context of housing deprivation. Additionally, by centring experiences of stigma, the extent to which stigma— rooted in gender norms and expectations about (actual or potential) motherhood— systemically curtails women's SRH autonomy, is revealed.

Secondly, this thesis offers a novel contribution to stigma research in offering a new application of Tyler's (2020) conceptualisation of structural stigma as a tool of neoliberal governance. It has demonstrated how stigma operates in this context through good/bad womanhood discourses that position women experiencing homelessness, particularly those who are mothers, as immoral, irresponsible, and in need of control. Stigma has been shown to have tangible implications in making professional supports conditional and difficult to access. This is particularly stark in the context of child protection interventions, which have intensified and resulted in high levels of surveillance for mothers deemed 'irresponsible' by the state. These policy responses can be seen as in line with neoliberal attitudes to welfare policy that are based on individualistic logic and responsible individuals for 'bad behaviour'. This stigma is not incidental, but in fact serves a set of specific purposes: the denial of welfare support to these women and a broader retrenchment of the state by shifting responsibility onto women and holding them morally culpable for structural failures, in the process diverting attention from governmental failure to address or provide solutions to the rapidly escalating housing crises. In this way, the political mechanisms of stigma in this context are revealed.

Thirdly, this thesis has offered new contributions to the literature on women's homelessness and violence by demonstrating the impacts of violence (past, present and anticipation of future violence) on decision-making. It has shown not only the extent of the individual and systemic violence that women experience across their lives, but how these experiences inform SRH choices. The evidence presented shows that violence acts as a significant force that underpins women's capacity to enact reproductive autonomy. Consequently, violence is another contextual factor that cannot be removed when understanding women's SRH decision-making.

Fourthly, despite the evidence presented of a significant lack of reproductive justice in women's lives, it also shows that decision-making is being enacted. Indeed, women engage in highly complex and labour-intensive processes that this research has rendered visible. However, the decision-making women undertake does not lead to meaningful or positive outcomes for them, and in actual fact is often paradoxical and leaves them in situations of further danger.

7.4. Limitations

An important part of concluding this thesis is to reflect on the limitations of the research. Due to the inherent time and resource constraints of a PhD thesis, I conducted the fieldwork in a way that likely would have differed under less restricted conditions. Firstly, given more time, I would have tried to secure a larger and more diverse sample of women. Difficulties in accessing the research population, a group that is 'hidden' and hard to contact (Bretherton, 2020), meant I recruited women from services wherever the opportunity arose. This meant half of the women in the England sample ended up being recruited from a refuge. Conversely, in the Australian sample, four women were recruited through a community health organisation that offered provision for people with no other routes to access healthcare (and often in crisis), and three women were recruited through a domestic violence victim/survivor support group who all had historic experiences of homelessness. While the links between domestic violence and women's homelessness are repeatedly demonstrated in the literature, it is possible that the pervasiveness of violence in this research might have been different if I had recruited from a more diverse range of organisations.

As multiple women were recruited from specific specialised services in each sample, it is likely that some experiences of homelessness are over/ under-represented in this research. The broad nature of the research aim and the recruitment strategy was suitable due to this being an area with little prior research, however for future research it would be interesting to understand how these findings apply across different experiences of homelessness. In particular, the experiences of women who were not accessing any professional services, and those of trans and other gender non-conforming individuals, who are likely to face additional and distinct barriers in relation to their gender identity. While this research has included six women from Black, ethnic minority, and First Nations communities, due to constraints on time and capacity to explore the many themes raised in this thesis, race has not been a focal point of analysis of this research. This is a limitation, as we know that racialisation is a key discriminatory force that shapes experiences of the world, and homelessness systems can reinforce these inequalities (Fitzpatrick et al., 2025). This is also an area that is significantly under-explored in the literature in both England and Australia.

I also would have liked to adopt a participatory, co-design approach to the entirety of the research process, however unfortunately time and resource constraints prevented me from designing the fieldwork in this way. This approach would have included consulting women before the commencement of fieldwork on the aims and questions of the research, involving them in the methodological design, and consulting with them after drawing initial findings to gather feedback. I intentionally chose unstructured interviewing and collaging in an effort to reduce the researcher/ participant power dynamics within the research, but ultimately, I think research like this would benefit from a co-design approach that allows the women to have more control over the entirety of the research process. This approach aligns with a feminist ethic of care and would allow for the co-creation of knowledge that could feel empowering to the women partaking.

The limitations outlined here are considerations that I will carry with me to inform my approach when designing future research projects. Through discussing the limitations, this section has begun to touch on potential avenues for further research. In the next section, suggestions for a future research agenda are outlined in more detail.

7.5. Proposing a future research agenda

The original guiding aim for this thesis was broad: to explore the SRH decision-making of women experiencing homelessness. It was kept broad intentionally due to a lack of research in this area, which meant that the terrain was largely unknown. As set out at the beginning of this thesis, there is currently a significant gap in knowledge on the SRH of women experiencing homelessness, with very little known about experiences outside of a U.S. context and beyond experiences of contraceptive decision-making (Brott & Townley, 2023). As such, any future research that prioritises exploring women's SRH experiences is welcomed and essential, and there are many potential avenues for further exploration. The plethora of barriers women face that have been presented in this thesis show further research on this area is urgently needed. Specifically:

- How and in what ways stigma informs the decision-making processes of women experiencing homelessness. This thesis has identified stigma as a major barrier to care-seeking for women, but *also* a barrier to how they thought about their reproductive possibilities and futures. A novel conceptualisation of stigma has been used in this thesis to show stigma as a structurally violent and oppressive force on women's ability to choose. Further research using this theoretical application of stigma as a mode of governmentality would continue to advance this nuanced conceptualisation of stigma, how it creates the conditions under which women experiencing homelessness make choices, and the effects this has on their reproductive lives. This theorisation of stigma would also be beneficial for understanding the constraints on decision-making of other marginalised groups.
- Investigating women's homelessness using a reproductive justice framework. In this thesis, reproductive justice has been proven to be a useful, yet currently under-utilised, tool that spotlights the intersectional, structural constraints on the lives of women. Applying this lens to understanding their reproductive trajectories opens up avenues to explore where injustice is occurring beyond an exclusively SRH- space. Future research that uses this lens could provide further much needed understanding of the adverse SRH outcomes of women experiencing homelessness and begin to open space for imagining novel points of intervention that target other areas of social justice.

- The impacts of interpersonal violence on how women experiencing homelessness make decisions, specifically the legacies and lasting impacts of violence on women's lives in the present. The anticipation of violence has been shown to be an important contributor to the ways women navigated their options, and to impact decision-making in sometimes unexpected ways. Further research on the gendered dynamics of violence and how these curtail women's SRH choices would contribute new understanding to the body of literature that evidences well- established links between domestic violence and women's homelessness.
- Exploring how intersectional identities impact upon how women experience homelessness and inform their SRH decision-making. For example, conducting research on the experiences of women who are racialised or transgender women. Due to the small-scale nature of this research and the recruitment strategy, there was limited diversity in the sample of women spoken to. While it is likely that many of the experiences shared would be mirrored, it is also highly likely that if this research had only included ethnic minority women, or transgender women, there would be additional sets of barriers on top of the barriers that have been laid out. Differences might include expectations regarding gender norms and presentation, and discourses around mothering practices, for these populations.

7.6. Possible avenues for future policy and practice

This thesis has presented a gloomy landscape of the SRH of women experiencing homelessness and evidenced the plethora of ways in which their reproductive justice is denied. From the women's narratives, it may appear there is little hope for improvements of their circumstances, that the barriers are too many and too great. However, the identification of such barriers highlights areas within and beyond the SRH space that could be targeted and points to possible opportunities for intervention. After some careful thought, and in keeping with the feminist principles that have been foundational to every stage of this research, I decided the most effective way to offer direction for future policy and practice is to provide suggestions directly from the women themselves. What follows is excerpts of what they identified as good practice within services: what they found was most effective for them, helped to improve their circumstances, or simply made them reflect positively on their experience of a service.

As documented throughout this thesis, women regularly felt de-humanised and marginalised in interactions with service providers. There are consistent examples of women feeling dismissed and disregarded before they had even begun to engage with a service. Their experiences demonstrate the long-lasting, material consequences of stigmatising encounters, most acutely in altogether avoiding services due to fear of stigmatisation. The women felt that compassion was missing from interactions with service providers: this was evident in frequent comments that this research's interview setting felt like one of the first times they had been able to speak without fear of negative repercussions or judgement. For instance, when asked whether she had any final comments to make at the end of her interview, Nellie (62, Aus) responded:

> Just to know that all this information you're collecting will help other females, you know, and not to be judged. Being judged is the worst part, I think. Yeah. Because not all agencies are like this, you know? Cos real life experience and education go together. You can't just have education and think, oh yes, I understand what you're going through. What a load of fucking crap.

Similarly, Becca (47, Eng) identified the judgement she faced from numerous professional services during court proceedings against her abusive ex-husband as keeping her in a traumatised state and delaying reunification with her son (as custody proceedings could not conclude until the police investigation was over). When asked how her experience of reporting domestic violence with the criminal justice system had been, Becca articulated the unfairness of the system, and explained that she would not have pressed charges knowing what she now knew:

> (I feel) Angry. At the- at the system. Like... how? How can he do all that and you go, ‘Well there’s a caution, don't do it again.’ So, the next woman like, will be like, well, I'm not going to do nowt about it. Why put myself through all that?

Beyond the injustice she faced regarding being dis-believed, a common experience of victim-survivors of domestic violence, Becca identified the stigma she experienced as underpinning her interactions with service providers and shaping her entire experience of moving through court proceedings. She described feeling systematically penalised and held accountable for the extensive violence she experienced across the interconnecting professional services involved in her case:

> It needs- it needs, the whole entire system needs re-looking at because it's all blaming the victim. Well, cos then you’re like, people saying, ‘Well, what did you do then for him to do that? What did you...’. Not actually in them words, but you feel it in the general, like, you feel it like. ‘Well you were with him for all them years.’ And, ‘You moved in with him.’ And, ‘You had a baby with him.’… Yeah, from everybody. And you're like, you just get that feeling like, like I say, they put you in certain boxes. There's no in between. You can't be an individual, you've got to fit in one of their boxes.

The women’s accounts point to the necessity of training staff across health, welfare, and justice systems involved in working with people experiencing homelessness, to provide care that is holistic, person-centred, and empathetic.

In addition to the many marginalising moments that women experienced, they shared lots of positive interactions with individual staff members or talked about an entire service that felt welcoming and safe. What united these encounters and made them positive was attentive, individualised care, delivered with compassion and non-judgement. Some of the positive experiences the women had within services are shared below:

> Oh here (they are) brilliant, just brilliant, yeah. Like today I came in, I was starving hungry as you can see [laughs]. You know, didn't have me tucker. And the first thing they do is hand me some tucker to eat, you know? [crying] Without having to beg for it, or bloody-, you can just see. You know? (Maggie, 59, Aus)

> They care, they're not judgemental, and they follow through. (Maggie, 59, Aus)

> At the same time, I get connection with [drop-in service]. I go breakfast- because I get breakfast for free there. Oh my God, that – it's an amazing place for people homeless. I never realised that people can treat you like five star. You know? Like, you go there, you sit down. 'What do you want to eat?' Serve you. Serve you with many of food like-. I feel so, like, oh my God. This kind of service I can get at hotel, to feel that safety… give people eat like– okay, what's your name? Go table, this is the food. (Scarlett, 34, Aus)

> But I changed social workers, and I got a really wicked social worker called [name]. And he was absolutely brilliant. He was really good. [When you say he was brilliant. Like, what does that mean?] It were like... you know like... he were umm... a person first and a social worker second, do you know what I mean? He'd work with you if you had a drug problem, as long as it didn't impact the child, you know? He could

> work with you, that sort of thing. He were that kind of person. (Alison, 49, Eng)

> But the one for the new one [Nicole’s youngest baby], she was alright sometimes. She was helping me. Like if I had no food, she would get me a food parcel. If I needed to talk to her, she'd be there. (Nicole, 32, Eng)

> [Do you feel like they’ve listened to you?] Always, even if I don’t talk. Sometimes I’m just going straight out, they say, ‘Ariana, come here. Come here, come here, you are not okay. Sit here, we should talk.’ You know? Insist me, they wanted me to talk. They wanted to encourage me to open my mouth and share something. Which is good, because sometimes we are guarded to share something, because we are avoiding to be judged. (Ariana, 36, Aus)

Stigmatising discourses were unequivocally identified as worsening the women’s experiences of a service. While changing societal attitudes towards homelessness is a complex and gradual process, a practice that can be immediately implemented is compulsory stigma and implicit bias training within services that support people experiencing homelessness to encourage staff to adopt anti-discriminatory and person-centred practices. This is not to say that staff intentionally enact harm on women, but rather to acknowledge the often-unconscious prejudices about homelessness that can create assumptions and inform interactions with service users.

Women also spoke about the importance of community in the services they attended, and the positive experiences they had from being surrounded by other women who had been through a similar set of circumstances:

> They've been very helpful and welcoming like, you know, the [organisation] community, the women's group. I can go there from Monday to Friday, for breakfast… When I go there, I don't feel

> judgement - judged because there are a lot of women, all age groups, there's sex workers, there's Aboriginal seniors, there's like er… born and raised er Australian women. So, when you listen to all their - and there's immigrants and all type of multi-cultural, all type of religious backgrounds. So, when I listen to their stories, I feel like ahh I'm not the only one… It gives me a little bit of mm… ah it puts me at ease. Cos I feel they're not judging. (Nisha, 38, Aus)

Again, being in judgement- free environments was identified as crucial to having a positive experience. Judgement- free, person- centred approaches that promote women's autonomy and the building of community are all foundational pillars of intersectional, trauma-informed feminist practice, which the women of this research have clearly named as crucial to good care.

The importance of judgement- free care was particularly salient in relation to the women who are mothers and had experienced child removal. This thesis has contributed to a growing body of literature that points to the harms of misrecognition for such mothers (Broadhurst & Mason 2013; 2020; Parr, 2024), which demonstrates a sole focus on the wellbeing of the child(ren) often means the wellbeing of mothers is neglected and obscured. The deep loneliness and isolation that women felt in the wake of child removal, and how this led to further adversity, is captured in this quote from Alison (49, Eng):

> It's only when that happened. It's only when they took him. That's when my drug use spiralled out of control. That's when I had a problem. That's when it become an issue. And looking back at it that is when it became an issue. That's when it was a problem. Because I didn't have no one to ground me. I didn't have no one to stop me. I didn't have no one to hold me back. I didn't have no one to stop for. I didn't have no one to stop for… It just... just to block it all out.

This thesis echoes the urgings of other research to address the often-catastrophic consequences of child removal, particularly repeat removals, on mothers. It appeals to policymakers and service providers to offer holistic support to mothers after child removal, which starts with the simple recognition of women *as mothers* in professional service environments. This kind of support holds the potential to break cycles of addiction, adversity, and homelessness known to stem from child removal, where women may decide to have another child to alleviate the pain of the removal. This intervention has the power to prevent homelessness, and to support women to make truly agentic decisions about their reproductive lives.

Additionally, as has been underscored throughout this thesis, women often had little control over their circumstances and felt disempowered by their lack of options. As such, giving women autonomy wherever possible within service environments is crucial. In particular, the findings point to the need for specialist services that are women- only. This was particularly important for women who had been in violent relationships (most of the women in this research), who reported that women's- only accommodation was essential for them to feel settled and safe. It is important here to recognise the extent to which homelessness services are underfunded and overstretched: they do not want to deny women housing or keep them in situations of danger, yet are severely constrained by limited resources, and in many cases are doing their best despite these challenges. Services in both countries are also working within contexts of intensifying housing crises which mean there are drastic housing shortages and a huge lack of affordable and social housing.

Acknowledgement of these housing crises leads onto the most impactful and effective changes that can be made: the prioritisation of creating more affordable and appropriate housing in government policy, alongside more funding to be allocated to homelessness services (especially specialist and women-specific services). While this certainly represents a significant and sizeable systemic shift, it is ultimately the only long-term, sustainable solution to addressing homelessness on a structural level.

The women's experiences shared in this section provide some direction for future policy and practice agendas that centre around delivering care that is holistic, individually tailored and compassionate. Implementing these values would be a crucial step towards creating environments in which women experiencing homelessness can make autonomous decisions about their SRH and act with dignity.

7.7. Final reflections

Nearing the end of writing this thesis, I came across a blog post by sex work activist and founding member of the Women's Inclusion Health Collective, Grace Sumner, that brought into question the notion of 'complex needs'. In the blog, the term was critiqued for individualising the oppressions that women face and designating them to be the result of personal failures (graceyoutreach, 2025). Grace posits that rather than labelling individual women as having 'complex needs', we need to turn our attention to the complexity of systems that are extremely difficult to navigate and designed to be exclusionary. Grace reminds us that women's needs are not 'complex', but in fact should be recognised as basic and essential. As this thesis has shown, these needs remaining unmet renders choice illusionary.

This thesis has produced many novel and important findings, and they all point towards one crucial takeaway: men's violence, coupled with continuing to de-prioritise housing, underfund and cut services, and blame women for their circumstances with stigmatising rhetoric, means women will continue to be placed in unwinnable situations. This thesis is a call to arms: women experiencing homelessness are being systematically failed, and in order to enact true reproductive justice for this group, urgent systems change is needed now.

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Appendix 1: Recruitment Poster

Would you like to take part in a research study about homeless women's reproductive and sexual health decision-making?

What does taking part involve?

You would be asked your experiences of sexual and reproductive health. This may include talking about managing your periods, contraception, pregnancy, or decisions about having children.

Taking part would involve an informal interview and / or a collaging session in a location where you feel comfortable. The interview would take about 45 mins- 1 hour and the collage would take about 1/ 1.5 hours.

You will not have to talk about anything that you do not want to and can stop the session at any time.

Everything you say will be kept confidential, and your name and any other personal details will not be shared with anyone else.

As a thank you for giving your time to the research, you will receive a $50 shopping voucher.

Why is this study being done?

Very little is known about decision-making among women who have experienced homelessness. This research hopes to improve understanding of the needs and experiences of homeless women.

Are you eligible to take part?

- 18 years and over
- Are a cis-gender woman
- Have experienced homelessness

If you'd like to take part or find out more please contact:

- Student researcher: Molly Turrell
- Email address: m.turrell@latrobe.edu.au
- Phone number: 0493773868

This study is for a joint PhD at La Trobe and Sheffield Hallam Universities

Sheffield Hallam University | Centre for Regional Economic and Social Research

LA TROBE UNIVERSITY

Appendix 2: Interview Guide

Sexual and Reproductive Health (SRH) and Homelessness: Interview Guide

***The interviews will follow a life histories/ biographical approach. They will start broad; women will be asked to share their pathways into homelessness, then asked specifically about their sexual and reproductive health experiences and their decision-making processes surrounding these. ***

Warm up questions

To start with, can you tell me a little bit about yourself?

Can you tell me a bit about how you became homeless?

(This may include women's living arrangements, education status, relationship status, whether they have children, etc.)

Research question

"Can you tell me about your experiences of sexual and/or reproductive decision-making whilst you have been homeless? By this, I mean anything related to your sexual wellbeing and/or reproductive system during any period of your life. This may include access to contraception, menstruation management, sexual activity and consent, your decision to have children and how many children to have, or experiences of childcare."

Potential prompts (themes)

- Service usage and interactions
    - Barriers and facilitators
- Relationships and support networks
- Childhood and early life experiences
- Stigma
- Identity

- Gender norms and expectations
- Motherhood

Potential probes

- You mentioned X, can you tell me a bit more about that?
- You've talked a lot about X, do you think you could tell me a bit about (*insert theme here*)?
- You stated that… how did that make you feel?
- At that point in your life, how did you feel about X?
- Are there any particular examples of that experience/ feeling that stand out in your mind?
- Why did you decide to do that? How did you manage that situation?
- What did X mean to you? Why was that important to you?
- You mentioned X… what was the outcome of that decision?
- How much control did you feel you had during that time?
- Have you ever sought support for X?
- Did anyone help you make that decision?
- XX is really interesting. How did that influence your decision?
- You mentioned X… do you think that experience has influenced the way that you've made decisions/ acted since?

Appendix 3: Photographs of Collages Not Included in Analysis

Nellie's collage

Fatima's collage

Appendix 4: Photographs of Collaging Materials

Appendix 5: Participant Information Sheet

Note: This participation information sheet was used for the fieldwork conducted in England. The participant information sheet for the fieldwork conducted in Australia has not been included, as the only details that differ are the monetary value of the voucher provided to participants, the phone number of the student investigator, and the contact details of the head of research ethics.

Understanding the sexual and reproductive experiences and decision-making of women who have experienced homelessness The research is being carried out in partial fulfilment of a Doctor of Philosophy under the supervision of Melissa Graham, Kesia Reeve, Sadie Parr and Jacqui Theobald. The following researchers will be conducting the study:		
Role	**Name**	**Organisation**
Principal Investigator	Melissa Graham	Department of Public Health, La Trobe University
Student Investigator	Molly Turrell	Centre for Regional and Economic Social Research, Sheffield Hallam University and La Trobe University
Principal Investigator	Kesia Reeve	Centre for Regional and Economic Social Research, Sheffield Hallam University
Co-Investigator	Sadie Parr	Centre for Regional and Economic Social Research, Sheffield Hallam University
Co-Investigator	Jacqui Theobald	Rural Health School, La Trobe University
Research funder	This research is supported by La Trobe University and Sheffield Hallam University	

PARTICIPANT INFORMATION SHEET

1. What is the study about?

You are invited to take part in a study about women's experiences of homelessness. This study is about how women make decisions about their sexual and reproductive health whilst homeless. This may include talking about access to contraception, menstruation management, sexual activity and consent, your decision to have children and how many children to have, or experiences of childcare.

We hope to learn about how women make decisions about their sexual and reproductive healthcare and access different kinds of support, and how being homeless affects this.

The study is being conducted by La Trobe University and The Centre for Regional Economic and Social Research at Sheffield Hallam University.

2. **Do I have to participate?**
   Being part of this study is completely voluntary. If you want to be part of the study, we ask that you read the information below carefully and ask us any questions by contacting us via phone or email.

   You can read the information below and decide at the end if you do not want to participate. If you would prefer not to take part, you do not have to give an explanation. If you decide not to participate, this won't affect your relationship with La Trobe University or Sheffield Hallam University.

3. **Who is being asked to participate?**
   You have been asked to participate because you are a woman who has experienced homelessness, and you are aged 18+.

4. **What will I be asked to do?**
   If you want to take part in this study, we will ask you to participate in a one-to-one interview about your experiences of homelessness, how and in what ways this has affected your sexual and reproductive health, and what kinds of support you have received. Interviews should last approximately 45 minutes to 1 hour and will take place in a location that you feel comfortable in.

   We will also be hosting a group collaging session that explores these themes; these will be completely optional, and you do not have to take part in them if you have done an interview. This will involve creating a cut-and-stick collage with a range of materials provided to you. After you have made your collage, you will have the option of taking part in a short discussion about how you went through the process of making it; you will be given the option of doing this in the group setting or discussing it in a one-to-one setting with the researcher. At the end of the session, you will have the option of taking your collage home. If you decide not to, it will be shredded after the session. If you give consent for your collage to be included in the research, we will take a photograph of it before shredding it. This is completely optional, and you can decide at the end of the session that you do not want to include it in the research. The collaging sessions should last approximately 1-1.5 hours and will take place in a location that you feel comfortable in.

5. **What are the benefits?**
   It is hoped that the stories gathered through this research will provide an in-depth understanding of homeless women's experiences and improve understanding into the needs of homeless populations.

   Collaging sessions are offered to explore experiences in a creative way and allow people to share stories that may not always be shared verbally. Arts-based research recognises and values different ways of knowing and sharing experiences.

   You will receive a £15 voucher as a thank you for giving your time to the study. You will still receive the voucher even if you decide to withdraw from the research.

6. **What are the risks?**
   With any study there are (1) risks we know about, (2) risks we don't know about and (3) risks we don't expect. If you experience something that you aren't sure about, please contact us immediately so we can discuss the best way to manage your concerns.

   A possible risk of emotional discomfort relates to discussing your experiences, which may be positive, negative or neutral. As a result, there is a small possibility you may become concerned or upset during or after interviews. If you do become upset, you are free to not answer particular questions if you don't want to, take a break and finish the interview later, or cease the interview at any time. You will also be provided with contact details of support organisations for advice on who you can talk to.

7. **What will happen to information about me?**

   We will **collect** and **store** information about you in ways that will not reveal who you are. With your consent, interviews will be recorded and will be transcribed (written down), with any names or identifying information removed. If you decide to take part in the collaging activity, we will ask you not to include any identifying information in your collage. If you consent to having your collage included in the research, it will be photographed after the session. All photos and interview data will be stored online in a secure Research Drive, which will only be able to be accessed by the research team. Confidentiality will only be broken in an instance where there is a risk of harm to yourself or to someone else. In this instance the researcher must report the safeguarding concern to the University Ethics Lead and/or relevant agencies where appropriate.

We will **publish** information about you in ways that will not be identified in any type of publication from this study. Your interview data and collage may be used within the PhD thesis and may be published in journal articles and/ or presentations. Any direct quotes used in the PhD thesis/ any journal articles will be anonymised.

We will **keep** your information for up to 10 years after the project is completed. After this time, we will destroy all your data. All data will be stored online in secure La Trobe University and Sheffield Hallam University research drives. No one will have access to the data outside of the research team. The only personal data that we keep will be your signed consent forms.

The storage, transfer and destruction of your data will be undertaken in accordance with the Sheffield Hallam University Research Data Management Policy and the La Trobe University Research Data Management Policy. Both can be viewed online by using the following links:

La Trobe- Research Data Management Policy
https://policies.latrobe.edu.au/document/view.php?id=106/.

The personal information you provide will be handled in accordance with the Privacy and Data Protection Act 2014 (Victoria, Australia) and the Data Protection Act 2018 (UK). Subject to any exceptions in relevant laws, you have the right to access and correct your personal information by contacting the research team.

8. **Will I hear about the results of the study?**
   If you indicate that you are interested in hearing the final results of the study, these will be shared with you once the research is complete. Access to the final thesis will also be made available online via the La Trobe and Sheffield Hallam University research websites.

9. **What if I change my mind?**

You will be able to withdraw from the interviews and collaging at any point during the sessions without an explanation. You can also choose to no longer be part of the study at any time until 2 weeks following the collection of your data. You can let us know by calling or emailing us.

Your decision to withdraw at any point will **not** affect your relationship with La Trobe University, Sheffield Hallam University or any other organisation listed.

When you withdraw we will stop asking you for information. Any identifiable information about you will be withdrawn from the research study. However, once the results have been analysed we can only withdraw information, such as your name and contact details. If results haven't been analysed, you can choose if we use those results or not.

Once the collages have been photographed, we will be unable to withdraw individual contributions, as these will contain no identifying information.

10. Who can I contact for questions or want more information?

If you would like to speak to us, please use the contact details below:

Name/Organisation	Position	Telephone	Email
Molly Turrell	Student Investigator	07443 346358	Molly.P.Turrell @student.shu.ac.uk
Melissa Graham	Principal Investigator- La Trobe University	09479 3792	
Kesia Reeve	Principal Investigator- Sheffield Hallam University	(+44) 7471327280	M.Graham3@latrobe.edu.au K.Reeve.shu.ac.uk

11. What if I have a complaint?

If you have a complaint about any part of this study, please contact:

Position	Telephone	Email
Head of Research Ethics	Dr Mayur Ranchordas	ethicssupport@shu.ac.uk

Appendix 6: Participant Consent Form

Consent Form – Declaration by Participant

☐I (the participant) have read (or, where appropriate, have had read to me) and understood the participant information statement, and any questions have been answered to my satisfaction.

☐ I know I can withdraw at any time until two weeks following the collection of my data without giving a reason. If I withdraw after this point, I understand that my data may still be used as part of the study.

☐ I understand that I can pause or stop the interview and collaging sessions at any time and choose not to answer any questions, without giving an explanation.

☐I understand that my personal details will not be shared outside of this project, and that all data will be anonymised.

☐I agree that information provided by me or with my permission during the project may be included in a thesis, presentation and published in journals on the condition that I cannot be identified.

☐I understand that all information collected will remain confidential unless there is a concern that there is a risk of harm to myself or to someone else. In these instances, I understand that the researcher must report this to a relevant person so that they can provide assistance.

☐ I agree to take part in the interview for this research.

☐ I agree to have my interview audio recorded for the purpose of being used in the research.

☐ I agree to take part in the collaging activity for this research.

☐ I agree to have my collage photographed for the purpose of being used in the research, any future publications, or presentations.

☐ I understand once my collage is photographed, I will be unable to withdraw my contribution, as there will be no identifying information included in the collage.

☐ I understand that the data collected for this research may be retained by Sheffield Hallam University and La Trobe University for up to 10 years after the study has finished but will be anonymised to protect my identity.

Declaration by Researcher

☐ I have given a verbal explanation of the study, what it involves, and the risks and I believe the participant has understood;

☐ I am a person qualified to explain the study, the risks and answer questions

Researcher's printed name	
Researcher's signature	
Date	