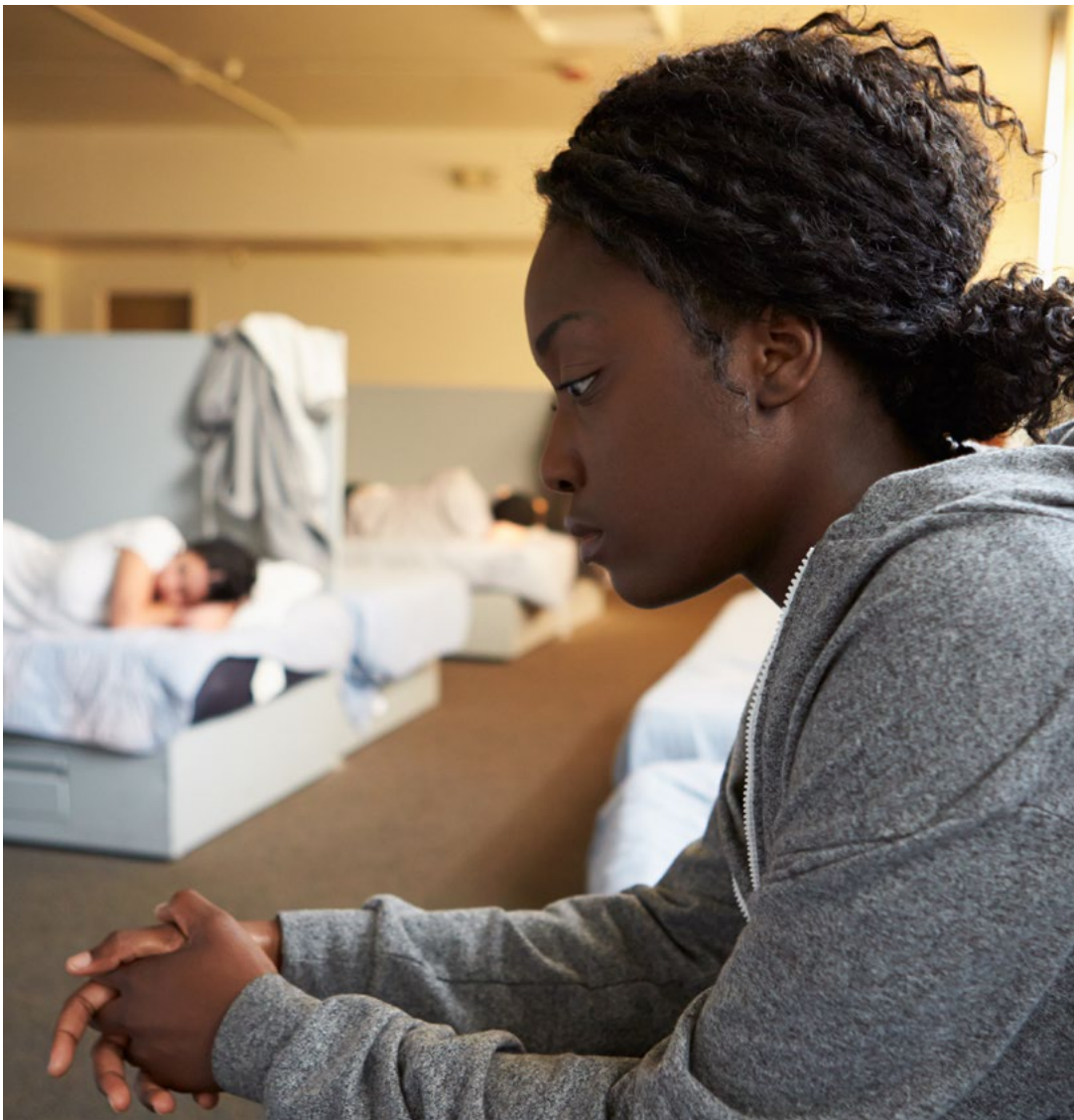
IAS

Put people first: Enabling access to quality integrated HIV services for people experiencing homelessness



International AIDS Society

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This advocacy brief developed by IAS – the International AIDS Society – explores the intersections between HIV and homelessness, social determinants of mental and physical health, and layered identities. It showcases models of good practice and culminates in recommendations for policy makers, service providers, surveillance teams, researchers and advocates to mitigate risk factors and contribute to improving the long-term quality of life of people living with and affected by HIV.

The IAS recognizes that quality healthcare for people living with and affected by HIV must integrate other health issues and be responsive to the evolving needs, priorities and preferences of each individual within their unique and shifting contexts. Through its Person-Centred Care programme, the IAS promotes healthcare that honours and respects people's identities, including factors related to their gender, age, socioeconomic and cultural contexts.

Homelessness, health and HIV

Homelessness consists of a complex set of interrelated issues, reflecting inequities in society.[1] Many driving forces that contribute to homelessness also contribute to vulnerability to HIV acquisition and poor HIV outcomes.[2] Homelessness also magnifies other vulnerabilities and social injustices linked to HIV, such as food insecurity, violence, incarceration, racism, substance use, post-traumatic stress disorder, depression and other diseases.[3] In contexts where a person's values and identities are expansive or in conflict with the law, their likelihood of experiencing homelessness, as well as exposure to HIV, increases.[4] These factors, in turn, reinforce each other to further exclude people from access to social services, including housing, employment and health.

Early identification of people vulnerable to homelessness and responses that integrate housing and HIV services across prevention and treatment are required to improve physical[2] and mental health outcomes. Such interventions also reduce the use of acute health and social services.[5] Early intervention is more cost effective, given the expanded programme and service resource implications of inaction.[6] Integrated all-of-society approaches, with meaningful engagement of people who have experienced homelessness and people living with HIV ("experts by experience"), are needed for effective responses to the multiple challenges of homelessness, HIV, co-morbidities and co-infections.[7]

Acronyms

ART	Antiretroviral therapy
BHESP	Bar Hostess and Empowerment Support Programme
COVID-19	Disease caused by the novel coronavirus SARS-CoV-2
HCV	Hepatitis C virus
HON	Health Opportunity Network
LGBTIQ+	Lesbian, gay, bisexual, trans, intersex, queer, questioning and more
NCD	Non-communicable disease
NGO	Non-governmental organization
PEP	Post-exposure prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PrEP	Pre-exposure prophylaxis
SEGT	Supportive-expressive group therapy
TB	Tuberculosis
UHC	Universal health coverage
WHO	World Health Organization

Introduction

The right to adequate shelter is enshrined in international law through the Universal Declaration of Human Rights.[8] Without a home, people are vulnerable, isolated and marginalized. Evidence from multiple countries and different contexts suggests people experiencing homelessness also experience a higher burden of HIV,[9,10] tuberculosis,[11] mental illness,[12] substance use[13] and physical and sexual violence than individuals who are stably housed. Homelessness is a predictor of poor health outcomes; morbidity and mortality rates from a wide range of causes – including infectious diseases like HIV – are significantly higher among people without a secure home.[14]

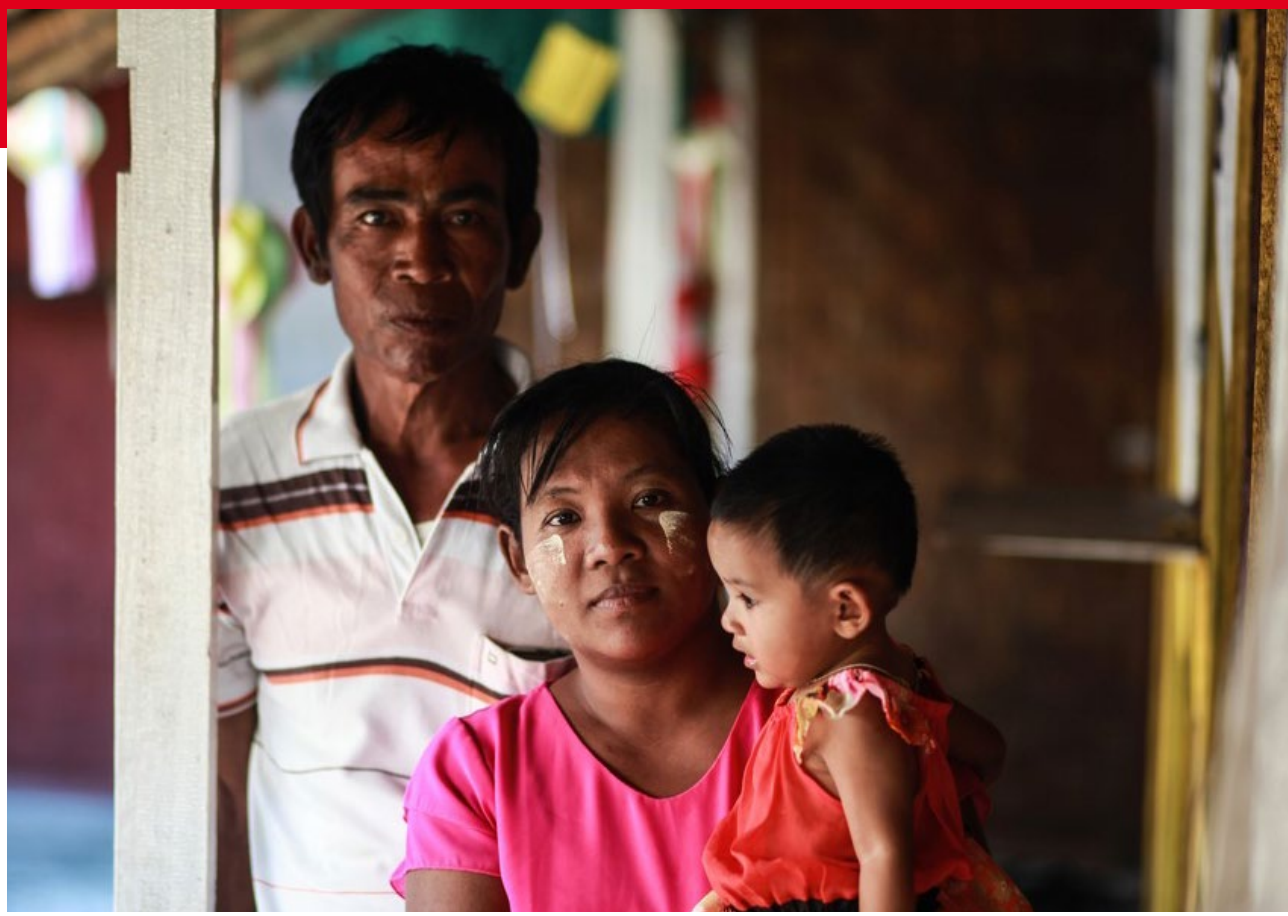
Primary homelessness: a state of being without accommodation (See Table 1) is the focus of this brief. However, the brief also recognizes that many people may live in informal or unstable housing and that the relationship between homelessness and informal or unstable housing may be fluid.[15] It explores the intersections between HIV and homelessness, social determinants of health, layered identities and social groups, and mental and physical health.

The vulnerabilities leading to and stemming from the lived experience of homelessness and HIV are explored in this brief, which also showcases models of good practices and culminates in recommendations. Specifically, it is designed to encourage global and local policy makers, programme implementers and advocates to meaningfully engage individuals who have experienced homelessness, "experts by experience", and commit to adopting person-centred approaches that integrate housing, HIV and related services into policy and practice. "Experts by experience" should be involved in all stages of this process, from policy formation to strategic implementation and throughout continuous impact assessment.

A range of personal stories from people experiencing homelessness and living with or affected by HIV around the world are included in the brief.[16] Their words highlight their unique cluster of challenges, as well as their courage and resilience in facing these challenges. These stories illustrate some of the different models of support currently implemented in various contexts, and the positive impacts that they can have in helping people overcome barriers related to stigma, HIV treatment, social support and other factors. They also highlight some of the unintended consequences and the challenges faced in sustaining these positive impacts. These complex yet not uncommon stories also highlight the many factors that can influence a person's experience of homelessness, health-related consequences of the experience, and opportunities to receive appropriate care and support services.

What is person-centred care?

Person-centred care refers to approaches and practices that see the person as a whole with many levels of needs and goals, with these needs coming from their own personal social determinants of health.[17] Person-centred health services consciously adopt the perspectives of individuals, families and communities who are the intended beneficiaries of these health services and see them as participants in, as well as beneficiaries of, trusted health systems that respond to their needs and preferences in humane and holistic ways.[18] Person-centred care should be focused and organized around the health needs, preferences and expectations of people and communities. For people living with and affected by HIV, person-centred care emphasizes integrated, high-quality care for HIV and related conditions over the life course.



Understanding the scale of homelessness

Globally, at least 150 million people (2% of the world's population) are experiencing homelessness. However, a further 1.6 billion people (20% of the world's population) lack adequate housing. Increasing urbanization has concentrated the increasing trend of homelessness.[19] Table 1 defines three levels of homelessness, which are useful in measuring the scale of the problem and clarifying the types of policy interventions that are necessary.

Table 1. The spectrum of homelessness

Adapted from the Institute of Global Homelessness[20] and the Australian Housing and Urban Research Institute

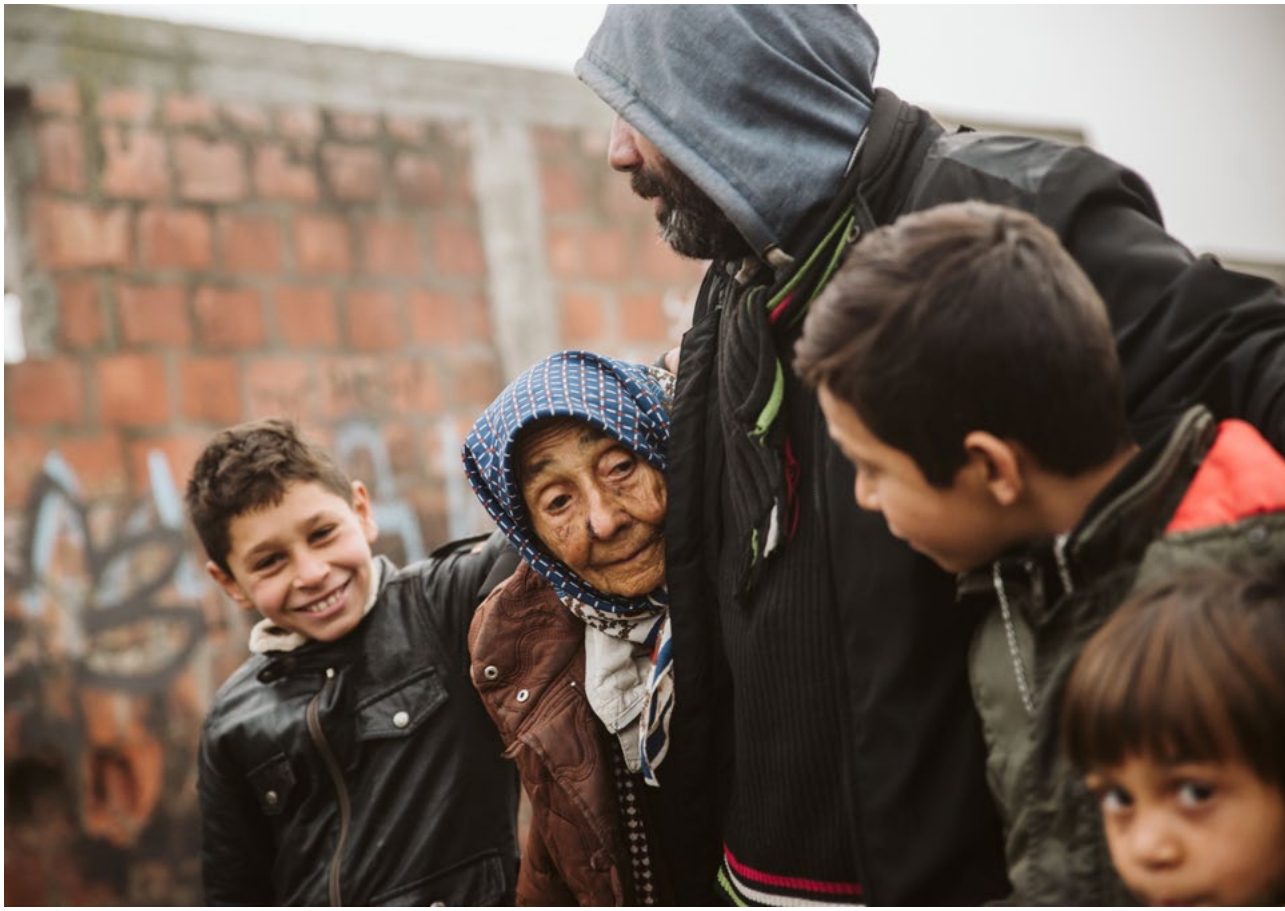
Level of homelessness	Definition	Example
Primary	A state of being without accommodation	People living on the street, in open spaces (parks, under bridges, in forests) or in roofed public spaces not intended for habitation (stations, derelict buildings) and makeshift shelters in a regular spot
Secondary	Access to temporary or crisis accommodation	People moving between temporary shelters, including houses of friends and family and emergency accommodation
Tertiary	Severely inadequate and insecure accommodation	People living with friends or relatives on a temporary basis, living under threat of violence, in cheap hostels, squatting, living in housing that is unfit for habitation, living in extremely overcrowded areas, living in slums and informal settlements, living in refugee camps, or living with threats to security of tenure

Estimating the prevalence of homelessness in a specific country is difficult given the different definitions and lack of a globally standardized method of measuring. However, available data indicates that homelessness is higher in low- and middle-income countries than in high-income countries.[21] Homelessness is also higher in failing states, countries in conflict[22] and where disasters arising from natural hazards are commonplace.[23] For example, an estimated 1.5 million people were experiencing homelessness two weeks after the series of earthquakes experienced in Turkey and Syria on 6 February 2023.[24]

People experiencing homelessness are particularly vulnerable to the effects of climate change and extreme weather events, likely leading to serious mental and physical health consequences.[25] Furthermore, the prevalence of homelessness globally may be increasing due to climate and weather vulnerabilities of marginally housed people. The climate crisis raises the price of energy, water and food, thus increasing economic burdens on people already experiencing housing instability. High energy bills can lead to utility shutoffs and, often, evictions, housing instability and homelessness.[26]

Access to housing is influenced by economic, social and cultural determinants, including poverty, income instability, criminalization, discrimination, social exclusion and rising property and living costs.[27] People experience homelessness for different lengths of time – for some, it's a matter of weeks and, for others, several years. People can also move between different states of homelessness, transitioning in and out of more stable housing depending on such factors as the suitability of services available to meet their needs and the help they receive in breaking the cycle of unstable housing.

People who experience homelessness are heterogenous, with their housing status due to a range of intersecting and complex reasons. They include people who are born on the street, living on the street (with or without their families) and forced from their homes (including through economic, social or conflict-related migration). They have a unique set of needs in addition to needs common across all people, such as nutrition, safety and health. It is imperative that their health needs be attended to in a person-centred and integrated way.



Homelessness, HIV and social determinants of health

Housing status influences a person's social and physical environment. Homelessness contributes to increased exposure to HIV vulnerability factors, as well as experiences of stigma and discrimination.[28] Across contexts, HIV prevalence is higher among people who are experiencing homelessness or have unstable housing than people who have secure housing.[29] Similarly, HIV-related premature mortality rates are significantly higher among people experiencing homelessness than those who are not, with differences most stark among young people.[30] The factors contributing to homelessness and the intersecting elements that affect people's experience of homelessness also limit their access to, and retention in, HIV prevention, treatment and care services.[9]

COVID-19 pandemic related service interruptions further exacerbated this vulnerability.[31] Housing is a modifiable risk factor; the provision of housing among people living with HIV leads to improved health outcomes.

Intersectionality is a framework for understanding how social identities (such as race, gender, class, ability, age, sexual orientation and immigration status) intersect and have impacts on a person's experiences of oppression, privilege and power.[32] Some of the intersectionality that exists between homelessness and HIV are explored below, highlighting complex interrelated layers of vulnerability, linked to other structural factors of marginalization and power differentials (such as gender, race and indigeneity). In each instance, the data around the specific group and the intersectionality between homelessness and HIV is summarized. Examples of responses and their evidence-informed recommendations are included.

Gender, homelessness and HIV

Homelessness among women has been underestimated, partly due to inaccurate assessment and the increased efforts women take to conceal their homelessness. Gender-based social and economic inequities contribute to women's experiences of homelessness.[33] The number of women and their families experiencing homelessness is growing, due in part to women's increased likelihood of experiencing domestic violence and the impact of such violence on housing security.[34] Violence contributes towards trauma, mental illness and substance use among survivors. The fear of stigmatization surrounding homelessness prevents many women vulnerable to (or experiencing) homelessness from accessing services. Women with children face additional prejudice and stereotypes linked to parenting and other behaviours.[35]

Through these factors, people experiencing homelessness are at increased vulnerability to acquiring HIV through a combination of increased likelihood of exposure to violence and engagement in sexual practices that increase vulnerability to HIV. A study of 1,057 people experiencing homelessness in Jamaica found that HIV prevalence was twice as high among women experiencing homelessness than among males who experienced homelessness (26.7% versus 11.6%, respectively), with elevated vulnerability among women linked to sex work, multiple sexual partners and rape.[36] Pregnant women experiencing homelessness face additional challenges and health concerns. Many women vulnerable to homelessness exert their resilience through their commitment to providing for their families.[35]

A gender perspective is required for effective interventions to mitigate the effects of homelessness.[33] This often requires a philosophical and cultural shift away from views of homelessness mostly affecting men. Policy and practice must ensure that the needs of women experiencing homelessness are addressed. Trauma-informed approaches are needed to support women and their experiences of violence.[37] Safe spaces, which do not exacerbate trauma or replicate power differentials, are crucial. Access to a range of safe housing options is fundamental, particularly for survivors of domestic violence considering escape from abusive environments.

Once crises have been managed, access to prevention and treatment services that integrate mental, substance use and physical health services, including sexual and reproductive services and pregnancy and parenting services, should be provided.[34]

The diverse experiences of women must be acknowledged. A selection of options should be on offer and women's autonomy respected and their decisions supported.

Maria's story: Parenting while experiencing homelessness, drug dependency and HIV in Russia

Maria is 35 years old and lives in St Petersburg, Russia. She lived with her son in a rented apartment with a roommate and used drugs for a long time. The guardianship authorities took her son away from her and, later, she was evicted and ended up on the street. Maria first accessed services from the Humanitarian Action Fund's mobile harm reduction unit, "Little Bus". At that time, she wanted to start antiretroviral therapy (ART), access social service support and regain custody of her child. Little Bus provided her with long-term support and, in March 2020, her case was represented in the guardianship service. While her son was in an orphanage, Maria detoxed, entered rehabilitation to start ART.

She got a job and moved into a temporary residence. Six months later, Maria and her son were reunited and are living together and waiting for permanent social housing.

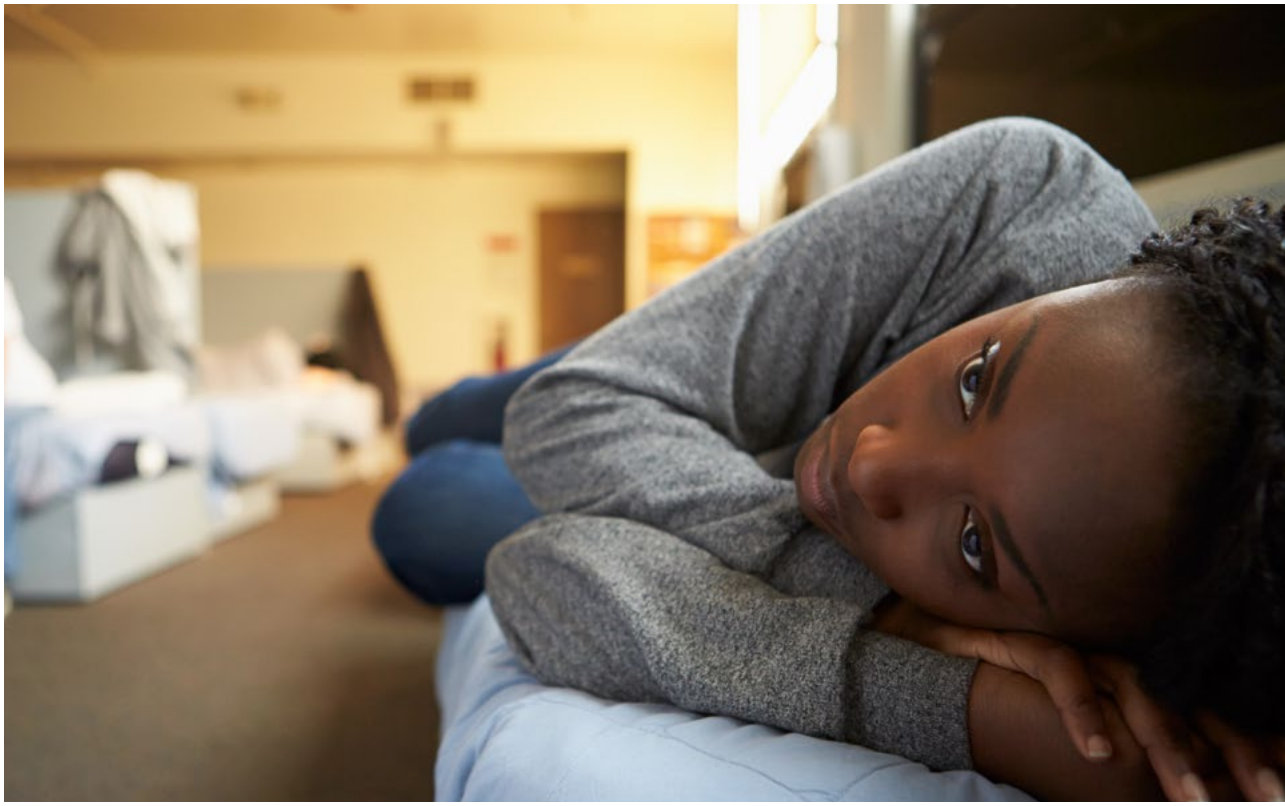
"Currently, I'm living in the Social Village (a special place for people in difficult life situations in the Leningrad region) together with my son. It became possible thanks to the help from Humanitarian Action Fund. If it were not for them, I would most likely die from alcoholism and HIV somewhere on the street. Once again, I'd like to thank the fund for their help in this regard since, at first, the child protection services told me that I won't be able to get my son back."

Maria, St Petersburg, Russia

Sex work, homelessness and HIV

Access to housing is linked to sex work in many ways. Homelessness, food insecurity and limited economic opportunities often play a part in engagement in sex work. Female sex workers experiencing homelessness are more likely to experience challenges with condom negotiation and have more clients than sex workers who are stably housed.[38]

Other sub-groups of sex workers experience additional cross-cutting issues and risks. For example, trans women and undocumented migrant sex workers are vulnerable to the consequences of law enforcement and to exploitation. One study in Baltimore in the United States found that HIV prevalence was 40% among trans women sex workers versus 5% among cis gender sex workers.[39] Over two thirds of sex workers in western Europe are migrants.[40]



Sex workers who work in contexts where their work is criminalized and their rights unprotected are more vulnerable to sexual violence, rape and exploitation.[41] The risk of criminal sanctions and entry into the criminal justice system further contributes to homelessness. Sex workers often face challenges in accessing finance and depositing savings in banks and are unable to sign rental agreements. To pool resources, sex workers may live together in crowded places, impacting their quality of life. Sex workers may also run the risk of eviction for engagement in sex work. Third-party laws can be used to target and arrest sex workers living and/or working together. All of these factors may contribute to their likelihood of experiencing homelessness.

Sex workers experiencing homelessness have elevated HIV exposure. For example, in Canada, female and trans women sex workers experiencing homelessness reported high levels of sexual violence, a high number of partners, services being offered in public spaces and daily use of crack cocaine.[42] The decriminalization of sex work and protection of sex workers' human rights are critical policy interventions.[41] Apart from access to housing, other factors are important: case management, integration of health and social services, harm reduction and sexual and reproductive health services that include family support, all provided in a non-judgemental manner.

Annie's story: Challenges to achieving viral load suppression in the hotspot in Nairobi town, Kenya

Annie, 26 years old, is a female sex worker living in Kenya. She tested positive for HIV when she was 23 during a service delivery outreach by the Bar Hostess Empowerment and Support Programme (BHESP) team at the hotspot where she lived. After months of follow up and psychosocial support, she was linked to care but had challenges in adhering to her medication due to the lack of privacy and a place to store her medication confidentially and safely within the hotspot, which was her only place of residence. This meant that her viral load was unsuppressed for a long time. After exploring the barriers to treatment adherence she was facing, the BHESP case management team were able to link her to a peer navigator in a nearby hotspot to provide treatment support. The peer navigator owned a bar and offered Annie a safe place to store and take her medication in private. Annie is now virally suppressed and works with BHESP as a peer navigator herself. She is very committed to supporting sex workers experiencing homelessness in adhering to ART. She has also minimized her alcohol intake and currently advocates for treatment as prevention within the hotspots.

"I currently work in these hotspots to bring about change, with the experience that change is possible even on the streets. Someone held my hand when I lost hope, and I got back on my feet. Now, I'm doing the same for my fellow sex workers who have nowhere to call home and restoring hope to them that even within these hotspots, we can still take our ART and attain viral suppression."

Annie, Nairobi, Kenya

Photo credit: BHESP, Kenya

Mental health, homelessness and HIV

People experiencing homelessness are more vulnerable to developing many non-communicable diseases (NCDs), including mental health, cardiovascular and respiratory conditions.[14] Experiencing homelessness for even a short time increases the risk of long-term health issues and accelerated ageing.[30] Mental health conditions are particularly relevant to the intersection of homelessness and HIV as they may contribute to homelessness, and experiencing homelessness increases the likelihood of mental health issues.[12]

Several studies among people experiencing homelessness describe significant intersections with mental health challenges. In a Canadian study of people experiencing homelessness, almost half (42%) of participants reported one or more suicide attempts and 85% had high levels of psychological distress.[12] In a Hong Kong study, 71% of participants experiencing homelessness had a lifetime history of mental health challenges, highlighting that services failed to support the most severely ill individuals who were experiencing homelessness.[43] The need to address the high prevalence of socioeconomic and mental health needs for people experiencing homelessness affirms the need for person-centred comprehensive care.[44] Alongside housing, the integration of mental health screening and care into HIV testing and treatment settings would strengthen HIV prevention and care outcomes and improve access to mental healthcare services.[45]

Tshego's story: Mental health challenges impacting retention in HIV care

Tshego is 44 years old and lives in Pretoria, South Africa. He started ART in his hometown shortly after being diagnosed with HIV when he was 41. After a failed relationship and losing his job, he became depressed. He started using heroin and defaulted on his ART. His mother then passed away. Internal stigma related to his heroin use and HIV status led him to move to Pretoria to find work. He knew the benefits of continued ART, but access to opiates and food were more pressing priorities. Hunger, long queues at the clinic and fear of health worker discrimination prevented him from accessing care. During the COVID-19 response, he was moved to a shelter where ART was reintroduced.

At that time, he was malnourished, underweight and had multiple cutaneous abscesses, chronic diarrhoea and depression. After resuming ART, his health steadily improved. He also started opioid agonist therapy and citalopram. After six months at the shelter, his well-being had improved, he was not using heroin, and his viral load was suppressed. He still experienced depressive episodes but said that he had learned healthier coping mechanisms. At the time of this testimony, Tshego was unwilling to reconnect with his family and was fearful of leaving the shelter and losing stable housing.

Substance use, homelessness and HIV

The relationship between homelessness and substance use is well-documented and interdependent. Harmful, dependent substance use may contribute to homelessness, as well as affect socioeconomic status, relationships and likelihood of engagement with the criminal justice system. In turn, challenges with poverty, exclusion and physical and mental health issues may contribute to further substance use.[46] When discussing the intersection between homelessness and substance use, it is important to consider the role of trauma since substances are often used to cope with trauma and provide distraction.[47] Despite the documented link between trauma and substance use, many programmes require sobriety as a prerequisite to accessing trauma and mental health services support, which can constitute a serious barrier.[48]

Individuals who experience homelessness and inject drugs are more vulnerable to acquiring HIV and viral hepatitis and overdosing as accessing sterile injecting equipment is challenging on the street.[49] Of the 11 million people who inject drugs, half are living with hepatitis C and 1.4 million with HIV.[50] The risk of acquiring HIV is 35 times higher among people who inject drugs than adults who do not inject drugs,[51] with homelessness among people who inject drugs associated with an elevated risk for HIV acquisition.[52] The intersections of homelessness and HIV-related vulnerability factors have also been documented among women who use drugs in Southeast Asia, particularly in relation to their engagement in receptive syringe sharing, inconsistent condom use and sex work.[53] In a 2019 study from Cambodia, HIV prevalence among people who inject drugs and live on the street was 25.0% versus 11.5% among people who inject drugs and are stably housed.[54]

Engagements with people experiencing homelessness and who use substances have highlighted the need for harm reduction approaches over approaches that focus on abstinence or that criminalize substance use altogether. Substance use interventions that take place in a facilitative service environment are more likely to be effective than those provided in imposing environments. The provision of services should be provided by compassionate people, including people who use drugs, in a non-judgemental manner. A core priority for people who use drugs and have experienced homelessness is the importance of a long-term view to support them and to have choices in the services they access (that is, it must be person-centred). Having opportunities to learn how to manage life's challenges in a healthier way is important.[55]

Omar's story: Leaving life on the streets and becoming a harm reduction outreach worker

Omar works as the Program Manager at the Global Network of People Living with HIV. He was one of the first-generation harm reduction outreach workers in Jakarta, Indonesia. His use of the outreach services provided him with a pathway into both activism and employment. Omar recalls how life on the street was filled with fear. As a person who injected drugs and was also living with HIV, his safety was always at risk. He feared engaging with law enforcement. He feared local groups that would catch and assault people who use drugs and hand them to the police for arrest.

He recalls how he and his peers had their money and drugs stolen by other people who lived on the street. They were forced to sleep separately from other people.

Omar explains that few people experiencing homelessness were able to access hospitals as many did not have identity documents. At that time, none of the shelters were equipped to provide the medical services that people living with HIV required. Sadly, he remembers many of his friends who died.

"I was so grateful to be found through an outreach programme for injecting drug users. The programme allowed me to get support and to access HIV services. It has been the only support around, and really, it literally provided a lifeline for me."

Omar, Jakarta, Indonesia

Young people, homelessness and HIV

In Canada, young people (16-24 year olds) are the fastest-growing segment of the population experiencing homelessness.[56] The social consequences of the HIV pandemic are also an important contributor to homelessness among young people in Africa.[57] Other factors that push young people towards homelessness include poverty, family disruption, traumatic environments (violence, harmful substance use, criminality, emotional neglect and sexual abuse), orphanhood and family rejection.[58]

Mobility is common among young people experiencing homelessness, who are often in search of better opportunities, new environments and different communities. Young people experiencing homelessness prioritize work, linked to their need for survival and sense of purpose. Work includes informal labour, domestic work and, in some instances, sex work, selling drugs and theft.[59] The shifting nature of their accommodation influences the possibility that they will establish trusting relationships with peers and health and social service providers. Among young people living with HIV and co-infections, such as viral hepatitis or TB and/or co-morbidities, including mental health conditions, treatment continuity and retention in care is further complicated.[56]

Many young people experiencing homelessness have increased sexual health vulnerabilities, lower levels of condom use, higher levels of unplanned pregnancy and higher HIV incidence than stably housed young people.[57] Studies have shown that young people experiencing homelessness have limited if any knowledge of pre-exposure prophylaxis (PrEP), and there is a disconnect between their perception of vulnerability and their actual vulnerability to HIV acquisition.[60] Limited engagement in school, family and other services can influence a young person's vulnerability to acquiring HIV on several levels. This includes knowledge and awareness of risks and, on prevention and treatment options, condom negotiation skills and the likelihood of engaging in transactional sex.[61,62] Street-based young people have greater odds of experiencing sexual coercion[59] and being sexually assaulted (adolescent girls and young women are particularly vulnerable)[58] and experience more stigma related to homelessness than their older counterparts. Limited access to appropriate perinatal services, including prevention of vertical transmission and postnatal care, negatively affects the health outcomes of pregnant young people living with HIV who experience homelessness.[37]

The effects of social stigma, challenges in finding work, unsuitable living environment, negative interactions with criminal justice systems and alienation are risk factors for mental illness that are apparent among young people experiencing homelessness. These factors are often compounded among young people who are gender expansive[63] or identify as part of a sexual minority group.[64] Young people experiencing homelessness have been found to have high levels of substance use and high rates of depression and post-traumatic stress disorder. The mortality for young people experiencing homelessness is notably higher than for young people who are not experiencing homelessness.[65] Suicide and substance overdose are the main causes of death among young people experiencing homelessness.[66,67] The provision of mobile services, social network-based interventions and support towards adequate housing are priorities for this group.[68] Youth pathways into homelessness are often unique and thus prevention and treatment services may benefit from a tailored and flexible approach.[69]

Kabelo's story: Growing up with HIV and living on the streets as a young person in South Africa

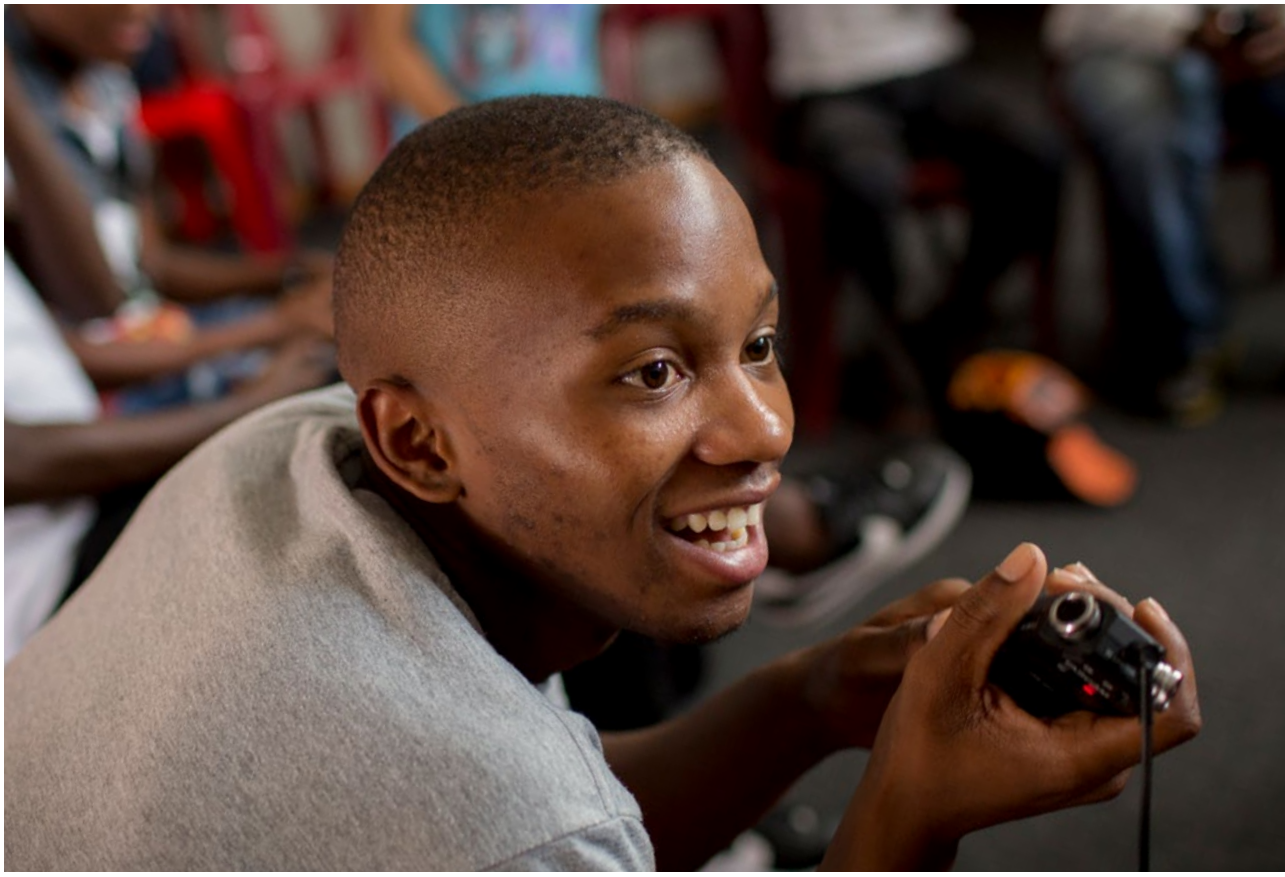
Kabelo is 24 and has lived on the streets of Pretoria for the past four years. He was born with HIV in a rural town and family members provided him with ART without his knowledge. He was orphaned at 13 and left home to live with a school friend. Kabelo started using cannabis and heroin. He did not complete high school and moved to Pretoria to look for work. In February 2020, he tested for HIV. He was informed of his positive diagnosis and restarted ART, but finds it very difficult to be adherent while on the street. Smoking heroin makes him feel good. He knows that it is harmful to his health. He also believes that people use heroin to cope with the severe deprivations while living on the street. He is finding ways to manage his heroin use and continue taking ART.

"I lost my whole bag once when the taxi drivers chased us. Another problem is eating. Even if you just get a little biscuit, it's okay. And nobody will remind you to take your tablets; you have to be sober minded. Otherwise, you will forget."

Kabelo, Pretoria, South Africa

LGBTIQ+ people, homelessness and HIV

Globally, members of sexual minority groups make up between 8% and 37% of populations that are experiencing homelessness in middle- and upper-income contexts.[70] Lesbian, gay, bisexual, trans, intersex, queer and questioning (LGBTIQ+) people experiencing homelessness are affected by the factors mentioned in this brief. Yet, LGBTIQ+ people, particularly young people, are more vulnerable to homelessness linked to identity-based family rejection and exiting out of systems of care that are ill-equipped to provide supportive services, as well as factors that contribute to unique experiences of homelessness linked to their sexual orientation and gender identity.[71,72] In the United States, young LGBTIQ+ people are twice as likely to experience homelessness than their cisgender peers.[73,74] Rates of homelessness among LGBTIQ+ people of colour are even higher and they have higher chances of experiencing hardship and emotional distress than LGBTIQ+ people from white families. Young LGBTIQ+ people experiencing homelessness are also exposed to higher levels of sexual violence than their heterosexual and cisgender counterparts.[71]



LGBTIQ+ people experiencing homelessness have higher levels of substance use and violence than non-LGBTIQ+ people experiencing homelessness. Higher levels of family breakdown are a contributing factor for people to leave home, which can lead to survival sex and sex work.[75] Barriers for LGBTIQ+ people to access health services, such as HIV testing and treatment, include experiences of harassment and discrimination in shelters.[71] Additionally, people who identify as trans or gender expansive often experience systematic practices that deny them the possibility of understanding and expressing their gender.[76] Together, these factors lead to further inequality and its consequences.

Interventions that should also be part of integrated interventions for LGBTIQ+ people include: providing immediate access to safe spaces to people who are most vulnerable; addressing structural issues contributing to exclusion, homophobia, transphobia and racism; engaging with families of origin; and making efforts to affirm and support identity. [73]

Dao's story: Navigating drug dependency, HIV, TB and unstable housing as a trans woman in Thailand

Dao is a trans woman who lived under a mosquito net with her son on the streets of Pattaya in Thailand. She did odd jobs, such as hospitality work, and received care from people in the community. The team at Health Opportunity Network (HON) met Dao while surveying trans people who use drugs in Pattaya and their vulnerability to HIV and tuberculosis (TB). Dao was estranged from her parents when she was nine years old. She cannot remember details of her early life or her parents' names. She fled her abusive caregiver and came to look for work in Pattaya. While in Pattaya, she had her gender reaffirmed. Dao has never had an identification number. She fell ill and had to use someone else's identification number to receive treatment at the hospital, where she was diagnosed with TB. HON volunteered to follow up on her treatment and care for her. They last saw her when she was sent by ambulance to hospital; she had returned to using [crystal meth], hoping that drugs would give her strength and cure her illness. Soon after that, she was sent to a shelter in Bangkok despite her objections.

"In the past, everyone called me Madam Dao, the one standing first (Dao means 'star' in Thai and it is implied that she is the star of Pattaya), but now I have to stand up on my own again. 'Ice' (crystal methamphetamine) makes me [feel] strong enough to stand up right now."

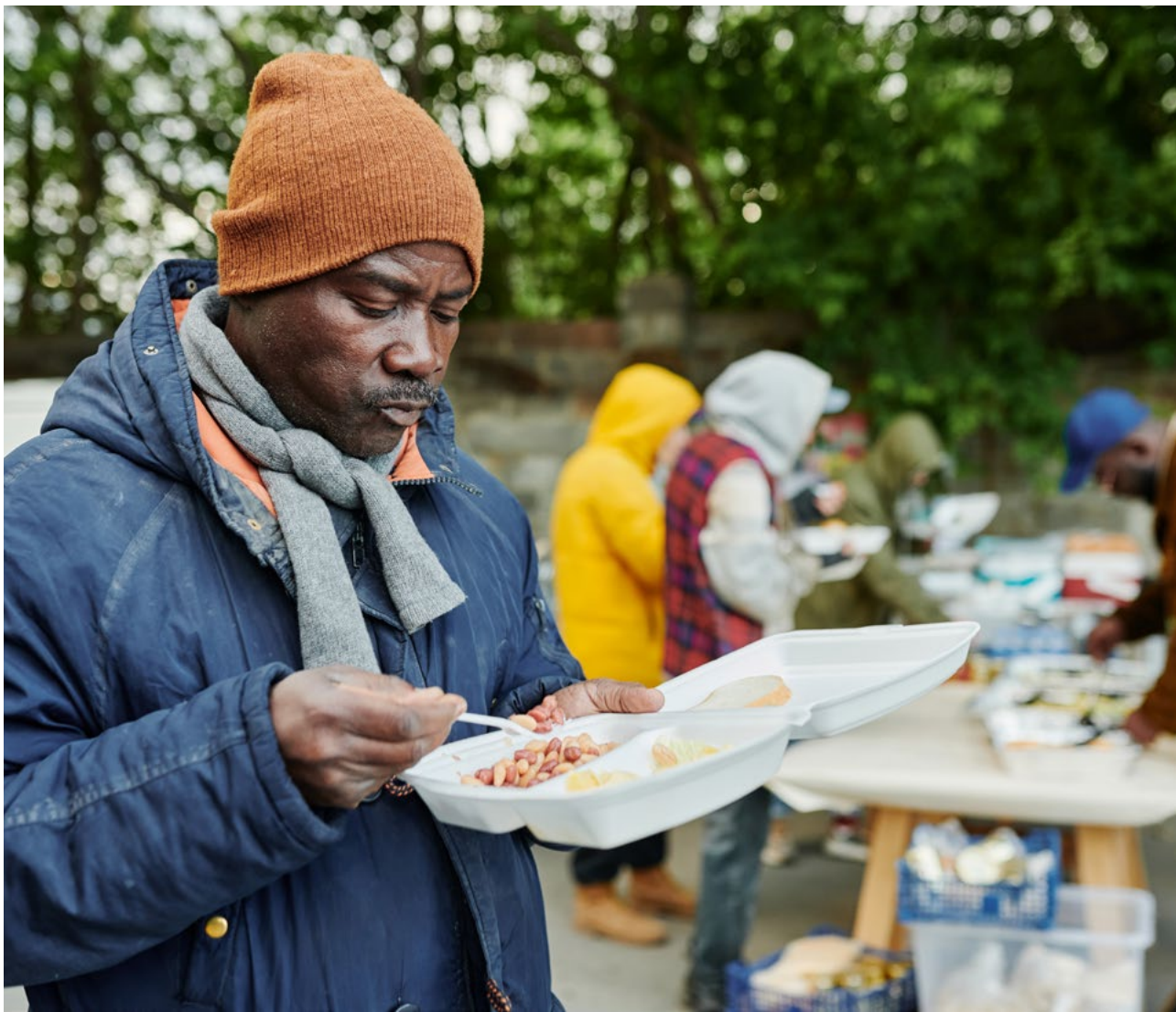
Dao, Pattaya, Thailand

Marginalized minority populations, HIV and homelessness

Marginalized or minority groups experience higher levels of homelessness than majority groups. For example, in the United States, African American and Hispanic people make up a 10th of the total population but constitute two-thirds of the population that is experiencing homelessness.[77] In a scoping review from Australia, Canada and New Zealand, Indigenous peoples were found to be consistently overrepresented in populations experiencing homelessness compared with non-native populations by a factor of five or more.[78]

One particular subset of minority populations – migrants – faces these and additional specific challenges within host countries. The current United Nations global estimate is that there were around 281 million international migrants in the world in 2020, which equates to 3.6 per cent of the global population.[79] While an estimated 60% of these people migrated for labour reasons, many people were forced to migrate due to conflict or other extreme events. For example, over 8.1 million Ukrainian refugees had been registered across Europe one year after the Russian invasion of Ukraine which began in February 2022.[80]

While public health strategies increasingly recognize the need for inclusion of migrant populations,[81] these populations bear a significant burden of HIV, TB and viral hepatitis compared with non-migrant populations. A study from Spain among people who newly started to inject drugs found a higher proportion of them were migrants who had experienced homelessness, which also correlated with elevated HIV and HCV prevalence.[82] Strengthening inclusion in housing, health and education for migrants has been shown to improve social integration,[83] although there is a lack of evidence regarding appropriate interventions for migrants living with HIV.[84]



Chan's story: Committed to managing HIV, but unable to afford transport to access methadone at the local hospital

Chan is 38 years old. He was born in a marginalized community near Phnom Penh, Cambodia. He has seven siblings and his family is poor and barely makes ends meet. Chan's father used to beat him when he was drunk. Chan attended school until his early teens and has been living on the street since he left home at 18. Chan has seen many of his friends overdose, die and be assaulted. Every day, he fears that he will get beaten up – for no reason or for the little money that he might have. He also fears harassment by the police. The community looks down on him. Chan started using drugs in 1994 through the influence of a friend he met while living on the street. He first used cannabis and "yama" (methamphetamine pills). In 1995, he started using "ice" (crystal methamphetamine), and in 2007, he switched to smoking heroin mixed with ice. Chan started methadone treatment at a local hospital in 2010.

His income comes from picking rubbish, and most of his income supports his drug use. In 2005, Chan and his wife were diagnosed with HIV. Chan believes that his wife, who was an entertainment worker at a bar for foreigners, was most likely the first of them to acquire HIV. He is currently on ART, though he stopped taking methadone in 2018 due to lack of funds for transportation to the hospital.

"I hope that in the future, the government, as well as local organizations, will have detoxification centres, training centres and shelters for drug users, as well as job opportunities."

Chan, Phnom Penh, Cambodia

Promising service delivery approaches to improve health outcomes

A range of effective, rights-affirming and person-centred care approaches have been implemented to enhance the health, HIV outcomes and well-being of people experiencing homelessness. Table 2 provides examples of institutional responses relating to intersections of housing and HIV. Illustrations of different models of care for people experiencing homelessness are provided in Table 3, reflecting models that adopted fixed or mobile services.

Table 2. Examples of institutional responses relating to intersections of housing and HIV

Name	Description
World Health Organization (WHO) guidelines and initiatives	The *WHO Guidance on community mental health services: Promoting person-centred and rights-based approaches*[85] provides a detailed description of person-centred and human rights-based approaches in mental health and examples of good practice services around the world. It describes the linkages needed with housing, education, employment and social protection sectors, and presents examples of integrated regional and national networks of community-based mental health services. The *WHO Housing and health guidelines*[86] and the *WHO Urban Health Initiative*[87] also acknowledge the determinants of health inequities, particularly in urban settings, and aim to equip health and other sectors with the data, tools and capacity to demonstrate to the public and decision makers the full range of benefits that can be achieved from creating healthy urban environments. The human right to adequate housing is recognized in international human rights laws as a component of the right to an adequate standard of living, enshrined in the Universal Declaration of Human Rights (adopted in 1948) and the International Covenant on Economic, Social and Cultural Rights (adopted in 1966).
The United Nations Political Declaration on HIV and AIDS	The 2016[88] declaration included stable housing as a priority HIV prevention and support intervention as part of social protection benefits. The 2021 declaration[89] commits to "adopting and enforcing legislation, policies and practices that prevent violence and other rights violations against people living with, at risk of and affected by HIV and protect their right to the highest attainable standard of physical and mental health, right to education and right to an adequate standard of living, including adequate food, housing, employment and social protection, and that prevent the use of laws that discriminate against them".
The Global Fund	The Global Fund to Fight AIDS, Tuberculosis and Malaria recognizes the intersectionality of homelessness and the increased vulnerability of key populations, especially people who inject drugs.[90] The *Modular Framework Handbook: Allocation Period 2023-2025*[91] specifically encourages the inclusion of activities in funding requests to create linkages with social services, such as housing for "key populations and high-risk groups",[92] as well as to conduct advocacy and mobilization of capacity for law and policy reform as it relates to HIV and TB support activities, including engagement with ministers of housing, among others. United for Global Mental Health has prepared a guidance note on planning and budgeting for the integration of mental health services into HIV programmes supported by the Global Fund.[93]
PEPFAR	The United States President's Emergency Plan for AIDS Relief (PEPFAR) acknowledges the barriers that people experiencing homelessness face that can make it harder to maintain regular clinical care and ART adherence. PEPFAR encourages HIV programmes to address these factors,[94] including creating linkages with organizations supporting people experiencing homelessness and key populations with, for example, food security and mental health support.

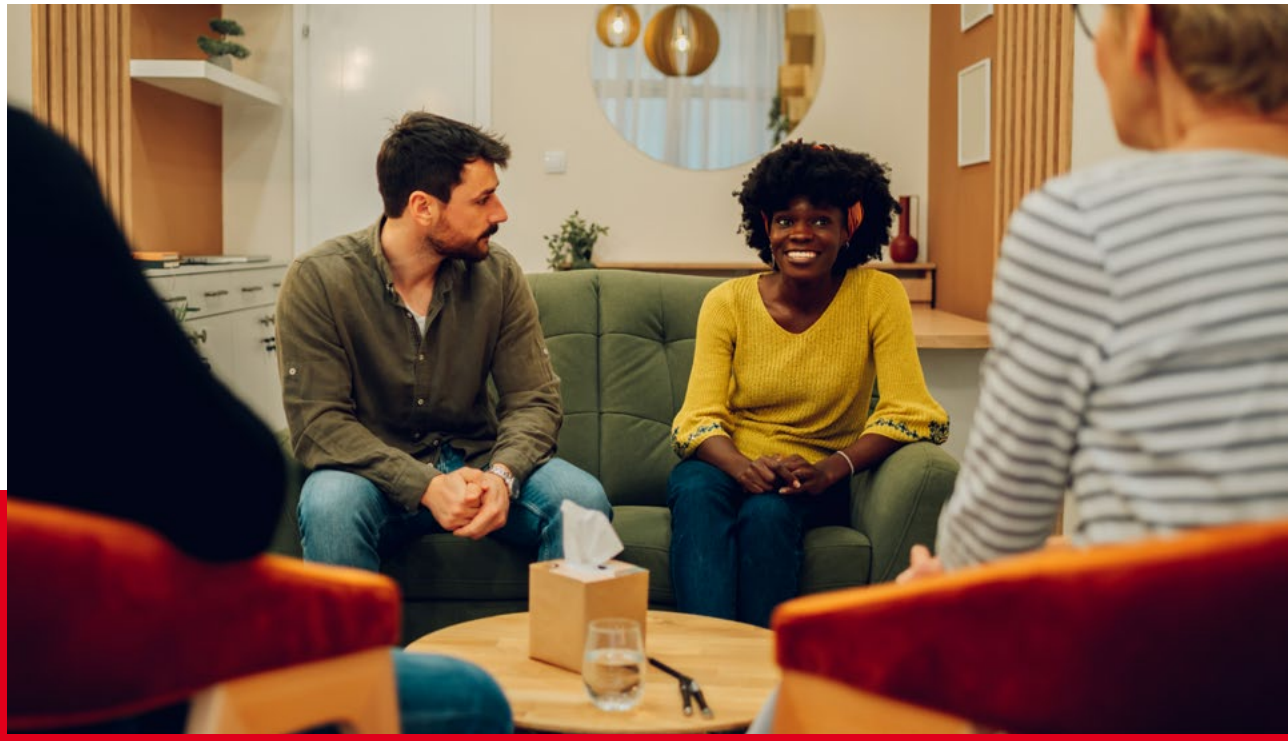
The following models have been piloted around the world in an effort to move to more person-centred and integrated care. While they recognize the ideal of moving toward sustainable housing as the gold standard goal, they also incorporate various levels of harm reduction in contexts where this ideal may not be achievable, either on the individual or community level.

Table 3. Examples of service models addressing the intersection of HIV and homelessness

Name	Description
Habitat for Humanity and the catalytic role of housing for people living with HIV in Cambodia	In Cambodia, Habitat for Humanity worked with 40 families affected by HIV to improve housing conditions. The evaluation found that the project enabled beneficiaries to improve their living situations. Improvements included protection from the elements and access to electricity and sanitation facilities. Most beneficiaries (90%) reported an increased sense of security in their home environment. The project also increased awareness around general sanitation and HIV prevention and care. The security and stability of a home and being part of a community have also seen 75% of beneficiaries report a reduction in discrimination.[95]
Medical homes	The Special Projects of National Significance Initiative: Building a Medical Home for Multiply Diagnosed HIV-Positive Homeless Populations (2012-2017) supported nine demonstration sites to integrate and coordinate HIV care, mental health and substance use services and stable housing for people experiencing homelessness across the United States.[96] The project enabled partnerships between HIV and housing providers, integrated behavioural health and HIV services, and demonstrated the benefit of a network navigator to provide individualized support. The model included tailored training, small caseloads (less than 30 people per navigator) and consistent clinical and administrative supervision, as well as the provision of emergency housing towards permanent housing. Overall, 1,338 people were provided with emergency housing, 70% achieved HIV viral suppression and 34% received permanent housing.
Community health centres focused on the needs of people experiencing homelessness	The United States National Health Care for the Homeless Council supports healthcare professionals, medical respite care providers, people with lived experience of homelessness and advocates and has over 200 organizational members. Many of these members offer Health Care for the Homeless and respite programmes, others are housing and social service organizations that provide specialized health services for people experiencing homelessness. The standard package of service includes primary care, HIV testing, PrEP, mental healthcare, substance use harm reduction support and dental care, as well as case management, support for transport and access to housing, health education and translation services. Sites are either standalone or part of a larger health centre. Trauma-informed, harm reduction-based approaches are employed, with strong investments in supportive housing programmes.[98]
Housing Works	"Stable housing is healthcare." Over 30,000 people in New York City have benefitted from the services provided by Housing Works. Following a harm reduction approach, the organization provides holistic and empowering programmes, inclusive of integrated primary care, wellness and disease prevention, meals, mental health and substance use treatment, job training and legal assistance. Integrated case management services are provided. Specialist youth services cater to young gay men of colour and young men who have sex with men, young LGBTIQ+ people, trans people and older people. HIV services include testing, PrEP, post-exposure prophylaxis (PEP) and HIV treatment. Housing support services are provided and coordinated with healthcare service access. Housing services include LGBTIQ+-friendly shelters and transitional housing, adult day healthcare and case management. The organization's mission is to end the AIDS pandemic and homelessness. A core function relates to advocacy efforts, and the business model is a social enterprise.[99]

Table 3. Examples of service models addressing the intersection of HIV and homelessness (continued)

Name	Description
Street Medicine	The concept of Street Medicine began in the United States and has grown into an international movement. The underlying principle of Street Medicine is to engage people experiencing homelessness in their environment – to "Go to the People". Healthcare services are provided to people sleeping outside through walking teams, mobile units and open-air clinics. This approach allows for flexibility, increases access and minimizes barriers to care. The Street Medicine team provides a link between health, social and housing services. The model aims to provide person-centred, longitudinal care that is comprehensive and interdisciplinary in a cost-effective manner.[100] The San Francisco, California, Department of Public Health's HIV Homeless-Health Outreach Mobile Engagement (HHOME) project is a mobile, multidisciplinary team-based intervention designed to engage and retain in care the most severely impacted persons living with HIV and experiencing homelessness. From 2014 to 2017, HHOME served 106 clients, 61 of whom were enrolled in a longitudinal study. Viral suppression increased from 23.6% to 60% 12 months after enrolment, and 73.8% of participants obtained permanent supportive housing.[101]
Integrated mobile health services for people experiencing homelessness in Russia	For 20 years, the Humanitarian Action charitable fund has been engaged in the prevention of HIV and other socially significant diseases among people who use drugs in St Petersburg, Russia. Services are based on the principle of respect for every human life. Providing medical and social services to people who do not have a place to live is challenging, and for people who are living with HIV the challenges are especially acute. Integrated services are provided for people experiencing homelessness, including: low-barrier care (needle and syringe service, contraceptives, testing for HIV and other STIs, x-ray examination, counselling, psychological assistance and consultations with doctors); case management (coordination of treatment for HIV, tuberculosis, viral hepatitis and substance use disorders, legal documentation, access to housing, and psychosocial and legal services); and online counselling by a social worker, lawyer, surgeon, narcologist and psychologist. As of November 2020, 233 people experiencing homelessness and 10 people without citizenship were receiving long-term medical and social support from the fund and had received 2,030 consultations. The work is being carried out in partnership with "Nochlezhka", the oldest non-governmental organization helping people experiencing homelessness in Russia, and the street medicine charitable project, Charity Hospital.



Effective "inclusion health" interventions for people experiencing homelessness

Adapted from Luchenski et al, Lancet, 2018 [34]

- **Housing and social determinants:** The immediate provision of stable housing and reduced engagement with the criminal justice system, combined with the provision of occupational therapy, education, employment and life skills, especially schemes providing individual placement opportunities
- **Pharmacological interventions:** Access to inclusive treatment services for HIV, TB, HCV, opioid use and mental health challenges, including antipsychotics
- **Psychosocial interventions:** Should be based on a multi-modal approach, including contingency management for people who use stimulants, motivational interviewing, cognitive behaviour therapy, mindfulness and peer support
- **Case management:** Enhanced coordination and delivery of health and social services
- **Disease prevention:** Access to prevention and screening services, including harm reduction, vaccination, overdose prevention, and targeted and integrated screening for HIV, HCV and TB (including chest x-rays)
- **Well-being:** Access to exercise, nature and complementary support services
- **For women:** On-site pregnancy services with harm reduction services, parenting skills, and integrated maternal mental health services and community empowerment programmes, especially for female sex workers
- **For young people:** Noting the value of a safe environment and caring relationships, as well as the potential for family-based therapy, cognitive behaviour therapy and brief interventions for young people

Recommendations

For policy makers

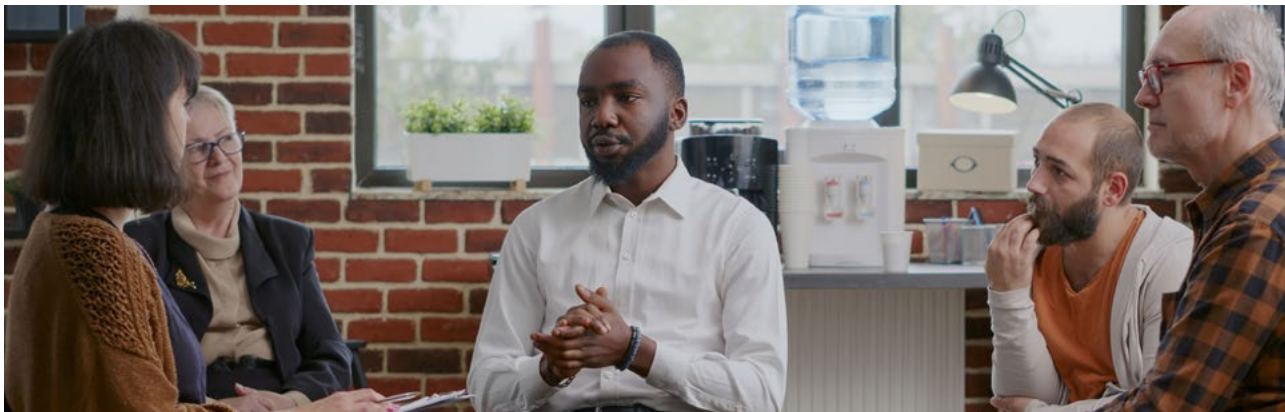
- **Work towards "inclusion health" and develop policies that enable people experiencing homelessness to easily access HIV, primary health and social services.** HIV prevention and treatment services should not be withheld, nor linked to people's stable housing situation. Policy makers at all levels and across portfolios must recognize both the right to shelter and the right to health as a central tenet that informs their decision-making processes to ensure the development and implementation of linked health and social services for overlapping marginalized groups, inclusive of disease prevention and management.

- **Collaborate with people who have experience of homelessness.** Ensure that people who have lived experience of homelessness are engaged in discussions and represented throughout all efforts to improve access to safe accommodation, including implementation and impact assessment phases. This type of ongoing partnership will allow for the design of more tailored, culturally appropriate and ultimately cost-effective interventions that consider the full range of health and social needs of people experiencing homelessness in a given context.

- **Protect and promote access to affordable, appropriate housing in urban areas.** With careful planning and legislation, it is possible to preserve areas for low-cost and appropriate housing regardless of other market forces. Affordable housing must be located in places where people can access employment, transport, health services (including free and low-cost HIV management services) and social opportunities. While working towards resolution of longer-term structural issues, such as social exclusion and inequality, municipal governments can ensure access to affordable housing as a short-term measure.

- **Provide a social security resource that allows all people access to a minimal level of individual benefits that ensure that all citizens can attain the individual right to health.** As recognized by the Sustainable Development Goals, universal health coverage (UHC) is one of the most effective upstream policies to reduce material poverty and deprivation, especially for families with children. Supporting access to healthcare through commitments to achieve UHC should not only remain a critical foundation of national health policies; it should be considered indispensable to all policies across all levels of government.

- **Address social stigma and structural issues that compound vulnerability to homelessness and HIV.** Stigma, discrimination and their structural drivers disproportionately affect the health and well-being of all people, including people at the nexus of homelessness and HIV. These drivers may include the criminalization and disproportionate arrest that further marginalizes people like drug users and sex workers, as well as challenges in continuity of healthcare and social care.



Recommendations

For service providers

- **Adopt person-centred, trauma-informed, evidence-based models of care and practice based on harm reduction principles and approaches.** A comprehensive assessment of needs should be provided when a person first accesses social or health services related to HIV; these should include physical, mental and emotional needs and coping mechanisms, substance use and behaviours. This will allow referrals to ensure that a person's basic needs, including food and housing, in addition to their HIV management needs, are being met. Where these linkages are not currently possible, providers should work to form them. People living with HIV and experiencing homelessness have often experienced trauma throughout their lives, which can discourage them from seeking health and social services that are not tailored to their needs. Further tailoring to the intersectional needs of young people, women, LGBTIQ+ people and minority and migrant populations is also of utmost importance. At the community level, evidence-based outreach harm reduction services should be easily available and located according to local drug use patterns; these services include safe spaces, drug consumption rooms, needle and syringe services and opioid agonist therapy. These interventions can significantly reduce HIV vulnerability.

- **Rethink eligibility criteria. Housing access should not require abstinence from drug use or sex work, the need to list an address or provide valid identification as a requirement to access services.** There is no evidence that making access to social services, including welfare support and housing, contingent on demonstrated abstinence from drugs or other behaviour reduces the use of drugs or engagement in behaviours that impact on vulnerability. In fact, experts believe these types of requirements could increase drug use, as well as compound stigma and discrimination. It is crucial that systems do not exclude people without a fixed address or valid identification from accessing HIV and other primary health and social services.

- **Enhance capacity for high-quality case management, focusing on peer leaders and including robust safeguarding policies and procedures.** Invest in training programmes to increase the number of qualified personnel within organizations and communities who can provide trusted and individualized, health and social case management. Training peers (that is, people who have experienced HIV and homelessness themselves) is especially important. These peers and/or trusted, respected workers should offer non-judgemental education around communicable diseases and sex and drug use practices that can increase vulnerability.

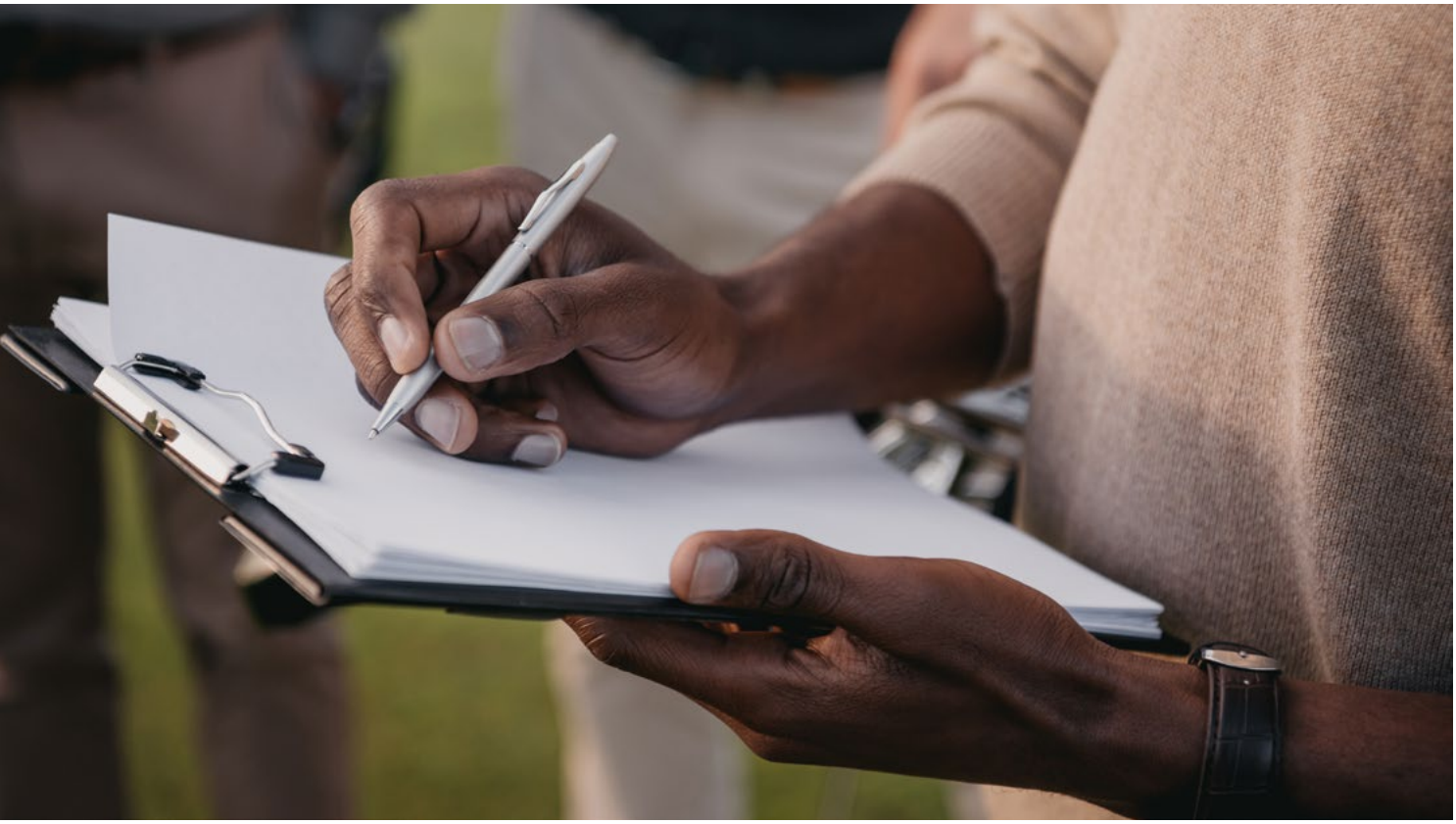
- **Nourish community linkages to integrate health, housing and social services to the greatest possible extent.** As underscored in this brief, individuals living with HIV and experiencing homelessness often experience a complex range of barriers to maintaining their physical and mental well-being. To the extent that it is possible to address the entirety of their basic needs, providers must do so, which may require them to seek out linkages to core services that they do not currently provide. Some of these services may be for non-communicable diseases, including mental health and dental care, substance use, infectious diseases, sexual and reproductive health and perinatal care.

Recommendations

For surveillance teams and researchers

- **Invest in surveillance and integration to enable evidence-based interventions.** It is important to support the collection of operational data around housing, criminal records and drug use to consistently document the problem. Evidence-based interventions will be unattainable as long as the evidence base is weak. It is equally important to capture data on community interventions and group participation – being careful to note challenges, such as stigma. Without continuously evaluating impact, it will not be possible to arrive at better, more cost-effective interventions over time.

- **Research early intervention.** Moving toward the long-term goal of addressing the root causes of homelessness, such as childhood trauma and poverty, research teams must conduct additional research into early intervention and policy interventions to see how programmes can intervene and effectively interrupt cycles that precipitate homelessness.



- **Engage multidisciplinary groups as co-researchers.** To achieve wide-reaching solutions that span sectors and address interwoven clusters of life circumstances and health and social issues that people living with HIV and experiencing homelessness may face, it is necessary to engage an equally diverse range of expertise. We recommend engaging the following groups as co-researchers: people with experience of homelessness, community-led service delivery providers and policy makers.

- **Determine research gaps and promote good practices.** Identify research gaps and highlight good practices in the field of person-centred care and broadcast hopeful narratives about how to integrate health and social services to meet people where they are, building on their strengths and resilience so that they can live their fullest lives.

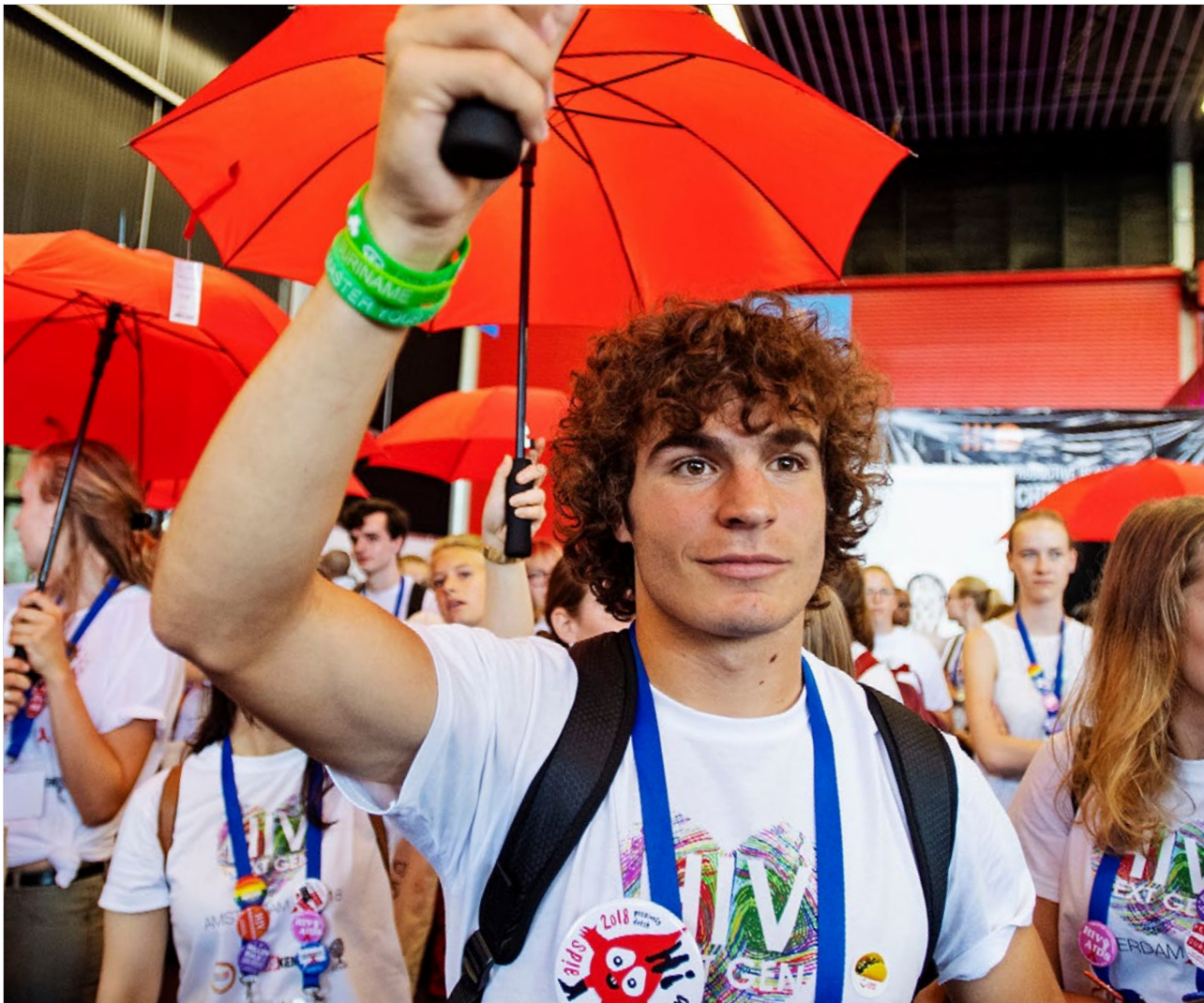
Recommendations

For advocates

- **Include "experts by experience".** Ensure that communities, especially "experts by experience", are meaningfully and comprehensively included into any discussions, planning or decision making on the topic of homelessness ("nothing about us without us").

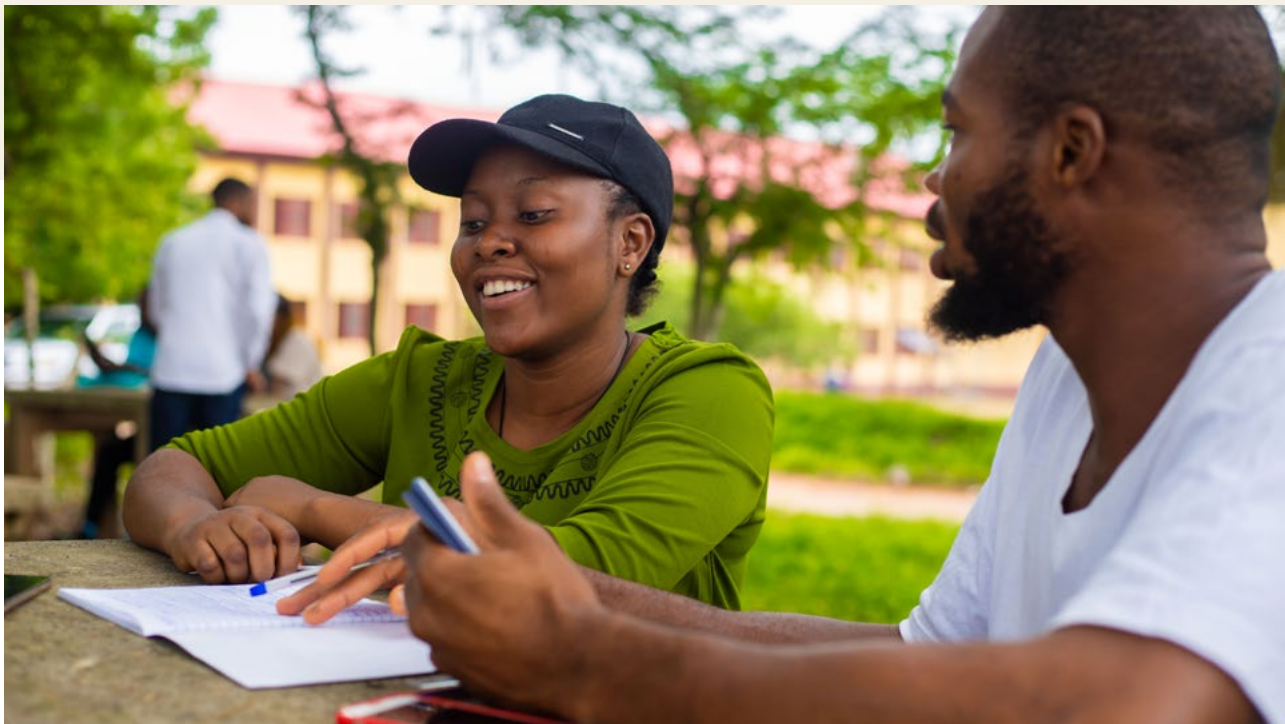
- **Facilitate demand creation and client empowerment (community level).** A first step toward achieving meaningful policy change for advocates could be to report on human rights abuses and service inadequacies that block access to stigma-free, non-discriminatory, person-centred and comprehensive care for people living with HIV and/or experiencing homelessness. Sensitivity trainings for providers, community leaders, policy makers and even media could be helpful in: 1) raising consciousness about the particular barriers that these individuals often encounter in seeking support services; 2) reducing stigma; and 3) creating demand to change discriminatory, non-inclusive laws, policies and/or services.

- **Raise awareness (local, national and global policy makers)** on the importance of the multi-faceted needs of people experiencing homelessness, particularly the most vulnerable and socially marginalized, to help ensure that they receive sufficient prioritization and resource allocation ("leave no one behind"). Advocates must hold policy makers at all levels accountable to the agreed commitments within the Universal Declaration of Human Rights and the United Nations Political Declarations on HIV and AIDS.



Resource list

- Integrated health and social care for people experiencing homelessness. London: National Institute for Health and Care Excellence (NICE); 2022 Mar 16. (NICE Guideline, No. 214.)
- Street Medicine Institute
- United States National Healthcare for the Homeless Council
- European Federation of National Organisations Working with the Homeless
- Housing First Europe
- The Institute of Global Homelessness Hub
- The Canadian Homeless Hub
- Ontario HIV Treatment Network
- At the Intersections: A Collaborative Resource on LGBTQ Youth Homelessness in the United States
- WHO. Integrated people-centred care
- WHO. Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach
- WHO. Consolidated guidelines on person-centred HIV patient monitoring and case surveillance
- WHO. Social determinants of health
- WHO. Guidance on community mental health services: Promoting person-centred and rights-based approaches



About the International AIDS Society Person-Centred Care programme

IAS recognizes that quality healthcare for people living with and affected by HIV must integrate other health issues and be responsive to the evolving needs, priorities and preferences of each individual. Established by the IAS in 2021, the Person-Centred Care programme promotes healthcare that is determined by the many components that constitute people's identities, including gender, age and socioeconomic status. The aim of the IAS Person-Centred Care programme is to advocate for a multidisciplinary, integrated and long-term focused approach to care for people living with and affected by HIV that is responsive to their evolving needs, priorities and preferences.

Find more information at
https://www.iasociety.org/ias-programme/person-centred-care

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[15] For example, in Lagos, the most populous city of Nigeria, over 70% of the population lives in informal housing.

[16] The personal stories are drawn from interviews and reflections from people who have lived experience of homelessness. Information was collected by individuals and organizations involved in the development of thisbrief. Names have been changed to protect identity and consent to tell their stories has been granted by them. Notes on file with the authors.

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