

**Perceived barriers and facilitators to accessing and utilising sexual and reproductive healthcare for people who experience homelessness: A systematic review**

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## **Abstract**

**Introduction:** People who experience homelessness face disproportionately poor reproductive health and adverse pregnancy outcomes, including but not limited to unintended pregnancy, abortion, low birth weight, preterm birth, as well as a higher risk of sexually transmitted infections (STIs). Precarious living conditions are known to contribute to poor uptake and engagement with sexual and reproductive healthcare (SRH) for this population.

**Aim:** To identify and understand the perceived barriers and facilitators for accessing and utilising SRH for people who experience homelessness from their perspective, and the perspective of support staff/volunteers and healthcare professionals.

**Method:** Electronic databases and on-line sources were searched. Two reviewers independently carried out the screening, data extraction, critical appraisal, data synthesis and thematic analysis of findings.

**Results:** Following deduplication and screening, 23 papers/reports were considered eligible for the review. Barriers for people experiencing homeless to accessing and utilising SRH were identified within the themes of complexity, feelings, and knowledge (i.e. individual-level factors), as well as patient/provider interaction, and healthcare system (i.e. organisational factors). Facilitators were identified within all of the above themes except for complexity.

**Conclusion:** Both population characteristics and attributes of the healthcare system influence access and utilisation of SRH by people experiencing homelessness. Given the complexity of living conditions associated with homelessness, greater efforts to improve access should be placed on healthcare systems and aspects of care delivery. The systematic review highlights current gaps in the literature and provides recommendations for enhancing future research and practice to meet the needs of this vulnerable group more effectively.

## 1.0 Introduction

Currently there lacks consensus on how homelessness is defined due to its complexity, encompassing an array of living arrangements and transience.(1) A number of socio-political phenomena, many beyond an individual's control, contribute to people who experience homelessness in high-income countries facing extreme inequities across various health conditions.(2, 3) A wealth of literature shows that they are more likely to suffer from physical and mental health problems than the general population.(4-7) They face disproportionately poor reproductive health and adverse pregnancy outcomes,(8) such as unintended pregnancies, abortion and preterm births, and a higher risk of contracting STIs.(9) Compared with their housed peers, adolescents who experience homelessness are more likely to engage in high risk behaviours including initiating sexual activity at a younger age, multiple partners, inconsistent contraception use, and engaging in sex while intoxicated or for survival (e.g. trading sex for shelter).(10)

Despite these increased risks, the engagement of people who experience homelessness with SRH services is poor compared to the general population, with inadequate use of contraception.(11-13) Full understanding of the causes of these behaviours is lacking, yet is crucial to improving practices to meet the complex needs of this vulnerable population.

Systematic reviews of qualitative research are a valuable and necessary response to health service research questions, including access issues and understanding views/perceptions and experiences.(14-16) This systematic review aimed to answer the question:

- What are the perceived barriers and facilitators to accessing and utilising sexual and reproductive healthcare for people who experience homelessness from their perspective, and the perspective of support staff/volunteers and healthcare professionals?

## **2.0 Methods**

### **2.1 Research protocol**

#### *Positionality statement*

Our positionality statement can be found in Supplementary File 1.

#### *Patient and Public Involvement statement*

A community volunteer contributed to the interpretation and reporting of the review findings, as well as the research dissemination plans. She has been involved in the homelessness sector for over 10 years, and focuses on issues including sexual and reproductive health, dental health and nutrition.

#### *Protocol and registration*

The review protocol was registered a priori with PROSPERO (registration number: CRD42018104273). ENTREQ and PRISMA guidelines were followed to conduct and report the review.

#### *Theoretical framework*

The review adopted a phenomenological approach(17) to identify and understand the lived experiences and views of people experiencing homelessness, support staff, volunteers, and healthcare professionals.

#### *Eligibility criteria*

The SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research type) method (Table 1) was chosen to define the eligibility criteria and inform the search strategy,(18) being developed to specifically identify relevant studies of qualitative or mixed-methods design, which are the focus of this review.

<p><b>Sample</b></p>	<p>Adolescents and adults experiencing homelessness, healthcare professionals and other staff working with people who experience homelessness. The European Typology of Homelessness, adopted in this review, comprises a number of living situations:</p> <ul style="list-style-type: none"> <li>• <i>rooflessness (without a shelter of any kind, sleeping rough)</i></li> <li>• <i>houselessness (with a place to sleep but temporary in institutions or shelter)</i></li> <li>• <i>living in insecure housing (threatened with severe exclusion due to insecure tenancies, eviction, domestic violence)</i></li> <li>• <i>living in inadequate housing (in caravans on illegal campsites, in unfit housing, in extreme overcrowding)</i>”.(19)</li> </ul>
<p><b>Phenomena of Interest</b></p>	<p>Access and utilisation of sexual and reproductive healthcare among people who experience homelessness. In the context of healthcare, and hence in this review <b>access</b> was considered as “Access to a service, a provider or an institution” (“the opportunity or ease with which consumers or communities are able to use appropriate services in proportion to their needs”(20)); and <b>utilisation/use</b> as a proxy of access (realised access).(20)</p> <p>The review adopted the definition by the Faculty of Sexual and Reproductive Health: <b>Sexual and reproductive health care</b> “supports all people in having a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of infection, coercion, discrimination and violence; enabling them to decide if, when and how often to have children by informing them of, and providing access to, safe, effective, affordable and acceptable methods of contraception of their choice. It also signposts women to the necessary support and care to go safely through pregnancy and childbirth, thus maximising the chance of having a healthy infant”(21)</p>
<p><b>Design</b></p>	<p>Inclusion: Empirical studies using qualitative analytic methods and mixed-methods evaluations that were conducted in countries of very high Human Development Index (HDI),(22) to improve transferability of findings and develop recommendations for policy and practice applicable to advanced SRH services.(23)</p> <p>Exclusion: Countries of high, low or medium HDI.(22)</p>
<p><b>Evaluation</b></p>	<p>Perceived barriers (factors that hinder access and or utilisation to SRH) and facilitators (factors that enhance access and or utilisation to SRH) to accessing and utilising SRH for people experiencing homelessness from their perspective, and those from support staff and volunteers and healthcare providers.</p>

<b>Research type</b>	<p>Inclusion: Qualitative research studies and mixed method evaluations with clearly distinguishable qualitative findings- as they utilise the most appropriate methodology to understand views, perceptions and experiences of accessing SRH.(23, 24)</p> <p>Exclusion: Quantitative studies, narrative reviews, letters, commentaries and editorials, conference proceedings.</p>
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**Table 1.** Eligibility criteria

There were no limitations in terms of language or date, and both peer-reviewed and grey literature were eligible.

## **2.2 Search strategy**

### *Information sources*

Searches were undertaken by an information specialist and conducted on 17 May 2018, then updated on 22 April 2020 for potential new papers.

The following databases were used: Embase, MEDLINE, CINAHL and SocINDEX, with further searches using Google, EThOS, Open Grey, the Health Foundation, Social Care Online, and the Faculty of Sexual and Reproductive Health. Following screening, bibliographies of included studies were searched.

### *Search*

The search strategy, comprising terms for homelessness including synonyms for hostels, and terms for contraceptive, sexual and reproductive care, can be found in Supplementary File 2.

## **2.3 Study selection**

### *Study selection and data collection process*

Search results were collected, deduplicated in EndNote and then screened via the Rayyan systematic review web application.(25) Two reviewers independently

screened the titles, abstracts and then full texts against the inclusion criteria (MP, JMM). When there was a disagreement, discussion was held to reach consensus. If not possible, a third reviewer (JS) was consulted. A data extraction form was pilot-tested prior to its application (MP, JMM).

### *Critical appraisal*

Studies were appraised by two reviewers independently (MP, JMM) using the Critical Appraisal Skills Programme,(26) a third reviewer (JS) resolving any cases of disagreement. Critical appraisal was not used to weigh or exclude any papers but to improve transparency since, currently, no consensus exists on its use in the synthesis of qualitative research.(14, 27) Similarly to other studies, our review focused on conceptual relevance rather than methodological rigour.(28) To examine whether inclusion of studies of lower quality studies influenced the results, sensitivity analysis was conducted.(14)

## **2.4 Synthesis of findings**

The full texts of included studies were uploaded to NVivo 12 software (QSR International Pty Ltd, 2020). The results were synthesised using thematic analysis,(14, 29) chosen for its flexibility and ability to aid identification and interpretation of patterns or themes in a dataset.(29) Using an inductive process and mindful of the research aim to develop an understanding of the barriers and facilitators to accessing and utilising SRH, the researcher (MP) immersed herself in the data, coded the data line-by-line, grouped the codes into themes, reviewed, defined and named them, and produced the report. Direct results were coded, plus authors' conclusions provided they were supported by the results of the respective study. To ensure rigour in the analysis, a second experienced researcher (JMM) reviewed the emergent codes and themes, and questioned the assumptions and rationale for decisions made.

## **3.0 Results**

The figure below illustrates the search results at each stage (Figure 1).

*Please insert Figure 1 here*

The searches identified 3,403 articles. After duplicates were removed, 2,513 articles were screened and 23 included.

Included studies were of qualitative or mixed-methods design, the majority conducted in the United States of America (N=17), plus the UK (N=2), Australia (N=2) and Canada (N=2). Purposive sampling was used to recruit participants predominantly from homeless shelters or clinics providing care to people experiencing homelessness. Most participants were themselves experiencing homelessness (N=22) and ranged in age from 14 to 57 years.

In some studies (N=13), the sample comprised only of females, while others (N=12) focused only on young people. Of 16 studies reporting participants' race/ethnic background (all in the USA), in five the majority of participants were White/Caucasian and in 11 they were mostly of mixed race (N=4) or Black, African-American (N=7). Sexual orientation was reported in only four studies; in each the majority of participants identifying themselves as heterosexual. No study focused exclusively on LGBTQ+ people. Although reported in only 8 studies, participants commonly had a history of pregnancy (N=8) and adverse pregnancy outcomes (e.g. miscarriage, abortion) (N=2). A few studies explored the views or experiences of healthcare providers (N=5), support workers or other stakeholders (N=5). Participant characteristics are detailed in Supplementary File 3.

Critical appraisal (results in Supplementary File 4) was frequently hindered by a lack of information and detail. Although aims and findings were clearly stated in all studies, the relationship between participants and researchers was not commonly reported; nor was it always possible to assess the rigour of data analysis. All studies informed the review to some extent. Sensitivity analysis indicated that including studies with lower quality results did not affect this review's conclusions, although studies achieving higher quality appraisal results contributed more to the findings' conceptual richness.

Based on the analysis, five themes grouped into two categories were generated (see Table 2): i) individual-level factors (i.e. characteristics of the clients): complexity, feelings, and knowledge; and ii) organisational factors (i.e. characteristics of care providers and health services): patient/provider interaction, and healthcare system.(30)



Theme	Subthemes
<p><b>Complexity:</b> refers to the precarious living conditions associated with homelessness, including but not limited to transient lifestyle, lack of routine, economic hardship, limited job opportunities, addiction and prioritisation of immediate survival needs.</p>	
<p><i>Barriers</i></p>	<p>Transient and unpredictable lifestyles</p> <p>Lack of routine</p> <p>Addiction to drugs and/or alcohol</p> <p>Prioritisation of immediate needs (accommodation, food)</p> <p>Limited income and/or lack of health insurance</p>
<p><i>Facilitators</i></p>	<p>None identified</p>
<p><b>Feelings:</b> refer to individuals' perceptions of disease risk and treatment, and how welcome individuals felt when interacting with the healthcare system.</p>	
<p><i>Barriers</i></p>	<p>Perceived stigma and lack of respect and understanding by healthcare providers</p> <p>Feelings of embarrassment about sexual behaviours and towards procedures involved</p> <p>Fear about screening process, results and disease</p> <p>Lack of personal efficacy and low self-worth</p> <p>Low perceived need of disease risk and treatment</p>
<p><i>Facilitators</i></p>	<p>Decision ownership</p> <p>Trusting relationships</p> <p>Fear of unintended consequences</p>
<p><b>Knowledge:</b> refers to health literacy, and knowledge about service and treatment availability as well as navigation.</p>	
<p><i>Barriers</i></p>	<p>Lack of knowledge on service availability (incl. access to contraceptives), navigation and location</p> <p>Limited health literacy</p> <p>Misconceptions</p> <p>Lack of knowledge on how to access health insurance</p>
<p><i>Facilitators</i></p>	<p>Improved knowledge about the range of birth control methods and availability of free services</p>

	Timely information to young people
<b>Patient/provider interaction:</b> Service users experiences and views of healthcare consultations	
<i>Barriers</i>	<p>Lack of understanding of people experiencing homelessness</p> <p>Lack of interaction opportunities for support workers</p> <p>Difficulties engaging in health conversations (healthcare staff)</p>
<i>Facilitators</i>	<p>Staff training</p> <p>Effective communication</p> <p>Consideration of context (people's life circumstances)</p> <p>Holistic, flexible, trauma-informed care</p>
<b>Healthcare system:</b> this refers to the organisation, nature and delivery of the healthcare system, including hours of operation, resources, appointment systems, availability and accessibility.	
<i>Barriers</i>	<p>Lack of flexibility in service organisation and delivery (e.g. restricted contraceptive practices, hours of operation, appointment system)</p> <p>Affordability (availability and costs of testing and treatment for STDs)</p> <p>Location</p> <p>Discontinuity of care</p>
<i>Facilitators</i>	<p>Improved accessibility (extending clinics hours, decreasing waiting times)</p> <p>Provision of care at familiar settings (e.g. drop in centres)</p> <p>Integration of SRH with other health services</p> <p>Accessible written information</p> <p>Provision of incentives and free supplies of contraceptives</p>

	Involvement of people with lived experience of homelessness
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**Table 2.** Subthemes identified from data analysis

Selected quotations for each theme are presented in Table 3.

Individual-level factors		Quotation and reference
<b>Complexity</b>	Barrier	<p><i>“Once you’re homeless you don’t think to go to a hospital or a GP or you don’t think... Normal daily routine is missing for you. You’re like all over the place really.”</i> [Participant experiencing homelessness(31)]</p> <p><i>“And when you’re struggling for things like food and other stuff, well, um, then buying condoms is not gonna be the highest thing on the list of what you’re doing.”</i> [Participant experiencing homelessness(32)]</p> <p><i>“And so if you have to just eliminate a couple of things just to keep my mind focused - children got to school, okay, I might have to go to work, I’m trying to get this housing....you can’t stop to take care of your health sometimes.”</i> [Service user(33)]</p> <p><i>‘Our findings suggest that hormonal contraception was not conducive to homeless lifestyles characterised by transience and unpredictability.’</i> [Author(12)]</p>
<b>Feelings</b>	Barrier	<p><i>“Seriously, I was like screaming, like ‘OW’ and the lady told me that is couldn’t be that bad. She was so rude. ...It was such a terrible experience.”</i> [Service user(34)]</p> <p><i>“I felt so disrespected and judged.”</i> [Participant experiencing homelessness(32)]</p>

	Facilitator	<p><i>“the threat of rape as a trans man is so real that I just have to have the implant” [Participant experiencing homelessness(32)]</i></p> <p><i>“Once a year I get tested for HIV and hepatitis... you never know when you are going to have a disease ...It’s my life and I treasure it.” [25 year old participant experiencing homelessness(35)]</i></p>
<b>Knowledge</b>	Barrier	<p><i>“Many of the female participants whole-heartedly believed that herpes could not be spread unless the infected partner had visible lesions.” [Female health educator(36)]</i></p>
	Facilitator	<p><i>‘Participants’ process of selecting birth control was further facilitated by knowledge gained from other drop-in center staff members.’ [Author(37)]</i></p>
<b>Organisational factors</b>		
<b>Patient/provider interaction</b>	Barrier	<p><i>“I probably had stereotypes about homeless adolescents, viewing them as poor, unsophisticated and aimless.” [Male educator(36)]</i></p> <p><i>“Feeling like doctors just think we’re bad people, and that we don’t know what we’re talking about, you know? So some people just don’t want to go have bad experiences in hospitals and with doctors who treat them like crap. So people just don’t go then.” [Participant experiencing homelessness(32)]</i></p>
	Facilitator	<p><i>“I think that the training that we experienced was extremely helpful in allowing me to begin to examine my biases and assumptions with homeless youth.” [Male educator(36)]</i></p> <p><i>“If I went in there with my mom or an adult whatever, the doctor would talk to her in a way, now I’m going in there without her I want him to talk to me that way. I am the one grown up. I am the one in charge of my life and body.” [Service user(34)]</i></p>

<b>Healthcare system</b>	Barrier	<p><i>“They want you to go through a process...but at times I be needing it at that moment.” [Service user(33)]</i></p> <p><i>“Wait for an appointment at clinics serving homeless women was a minimum of 2 months.” [Author(38)]</i></p>
	Facilitator	<p><i>“... knowing you can get the services for free, it’s actually really useful and you feel safe.” [Participant experiencing homelessness(31)]</i></p> <p><i>‘Most useful and dignity-promoting health care services are those that account for the context of their lives.’ [Author(34)]</i></p>

**Table 3.** Illustrative quotations for each theme.

### 3.1 Individual-level factors

#### 3.1.1 Complexity

##### *Barriers*

The transient and unpredictable lifestyles that homelessness creates, can render identification and location of SRH services and adhering to timed appointments difficult irrespective of age and gender,(12, 36) as suggested by health educators and people experiencing homelessness. The latter suggest that maintaining dosing schedules or follow-up attendance for contraception (e.g. implants, intrauterine methods) can be challenging due to lack of routine.(12)

Addiction issues can negatively affect people’s sexual health decision making and exacerbate risks,(39) e.g., substance use among youth has been associated with reduced condom use.(12) Many reported using drugs or alcohol during their last sexual encounter, leading to pregnancy.(12)

Attempting to secure accommodation and meet immediate needs such as finding food, can lead people experiencing homelessness to deprioritise contraception and STI testing across the age spectrum and irrespective of gender.(31-33, 35, 40-42). Furthermore, limited income and/or lack of health insurance (where applicable), impact ability to meet contraceptive costs and travel to attend screening, treatment and pre-natal care.(8, 12, 40, 43, 44)

### *Facilitators*

None were identified.

### 3.1.2 Feelings

#### *Barriers*

People experiencing homelessness highlight a perceived lack of respect by and trust in service providers to maintain confidentiality, deterring some, particularly women, from seeking SRH.(38, 45) Others feel stigmatised or judged,(32, 39, 46) believing that they receive sub-standard, uncaring services.(33) Encountering unwelcoming, insensitive or negative staff at clinics can deter them from further visits and engagement with the healthcare system.(31, 32, 34) Shame and embarrassment can prevent many young women from speaking to adults about their sexual behaviours.(34) Those identifying as homosexual, encountered physicians holding assumptions of heteronormativity and ill-informed about their sexual health needs.(34)

Another common concerns raised by people experiencing homelessness and staff was limited privacy in shelters.(47) Fear of the screening process, results,(42, 47) and the disease itself also negatively affected take-up.(42)

Lack of personal efficacy and low self-worth were associated with low utilisation of screening, with low self-worth and a history of trauma (e.g. domestic abuse) also increasing the risk of neglect of health.(47) Low perceived need to attend services unless significant symptoms arise has been acknowledged by people experiencing

homelessness as affecting their perception of the importance of accessing services.(39)

### *Facilitators*

Service providers suggest that enabling young females experiencing homelessness to take ownership of their decisions can facilitate better sexual healthcare and contribute to increased contraceptive uptake,(10) as can establishing connection and trusting relationships with one another and with healthcare staff.(31, 37) Fear of rape while on the streets, of infection, or the consequences of unintended pregnancy, can serve as motivators resulting in regular use of preventative measures and testing, among youth, especially females.(32, 35, 37)

### 3.1.3 Knowledge

#### *Barriers*

A wide range of providers as well as people experiencing homelessness suggest that lack of knowledge of SRH service availability and location are barriers to accessing STI testing and contraceptives across the age spectrum, irrespective of gender.(36, 39, 42, 46, 48)

Being poorly informed and unaware of the asymptomatic nature of a disease (e.g. chlamydia) and respective screening may result in young people experiencing homelessness not seeking care.(40) Being uninformed about STI risks (e.g. HIV) or prospects of a cure (e.g. chlamydia) can deter testing.(40, 47) Misconceptions about specific conditions (e.g. AIDS as a disease only experienced by homosexual people) may lead to denial about the need for testing.(47) Furthermore, erroneous beliefs such as associating birth control pills with abortion or increased risk of cancer, can negatively affect use of contraception in women of any age.(38) Not knowing how to obtain and maintain health insurance can be a barrier to accessing sexual health services by youth.(42)

## *Facilitators*

People experiencing homelessness suggest that improved knowledge about the range of birth control methods and availability of free services, can help women of all ages feel safe and improve uptake.(31, 37) For young teens, it is important to obtain timely information about reproductive health and STIs.(42) Young people suggest social media platforms and text messaging as effective means of providing advice on sexual health, particularly when staff are engaging and helpful in explaining relevant concepts.(10)

### 3.2 Organisational factors

#### 3.2.1 Patient/provider interaction

## *Barriers*

A lack of cultural understanding of people experiencing homelessness, can lead to stereotypical misconceptions and biases against them.(32, 41) Lack of opportunity for support workers in shelters to have conversations about personal issues has been reported as a barrier to encouraging residents to obtain contraception.(39) Communication issues can raise barriers for healthcare service providers, including their own discomfort in talking about HIV, difficulties persuading patients to have blood tests, and in conveying the concept of self-efficacy to youth that experience homelessness.(49)

## *Facilitators*

Staff training can promote self-awareness of unconscious biases and preconceptions towards people experiencing homelessness. Both providers and clients suggest that positive staff attitudes and effective communication can influence engagement of people experiencing homelessness with SRH, especially youth.(10) Valued professional attributes highlighted by young females as well as healthcare providers included being genuine, not overwhelming, sharing own experiences, and using 'soft words' when providing advice, particularly when discussing survival sex.(10, 50) Both health educators and service users, proposed that healthcare providers, including



reception staff, needed to be respectful and non-judgemental, recognising young people as autonomous adults.(34, 36, 39, 46, 50)

Sufficient time for effective communication, allowing healthcare providers to take into account people's life circumstances is considered important.(34) Given that many experiencing homelessness have histories of trauma and sexual and/or domestic abuse, personalised, compassionate care sensitive to individuals' concerns and preferences is recommended.(39) A trauma-informed, flexible approach is considered especially beneficial when working with adolescents.(43) Young females experiencing homelessness suggest that an environment conducive to discussing sex rather than one inciting fear can reduce existing anxieties and enable them to ask questions and seek care.(34) Youth as well as programme providers suggest that adopting a holistic approach and treating the client as an equal conveys a sense of genuine care.(43)

### 3.2.2 Healthcare system

#### *Barriers*

An important barrier for women experiencing homelessness, exacerbated by precarious living conditions, is the inflexibility of service organisation and delivery, including restricted contraceptive practices (e.g. being unable to obtain contraception in one visit), limited clinic hours and long waiting times.(31, 33, 38) Other barriers perceived by people experiencing homelessness, relate to affordability such as the availability and costs of testing and treatment for STDs, the price of condoms, health insurance plans that do not cover purchase, as well proximity of clinics and discontinuity of care.(12, 32, 38, 46)

#### *Facilitators*

People experiencing homelessness suggest that improving accessibility by extending SRH clinic hours (e.g. to evening and weekends), decreasing waiting times, testing by default and opt-out testing can improve access and uptake.(38, 49) Both they and support staff as well as programme providers suggest that SRH provision in familiar

settings such as shelters or drop-in centres providing convenient, on-site healthcare can break down barriers.(39, 43) They also recommend integrating sexual health promotion with other disciplines, in the context of promoting overall health and wellbeing.(43)

Accessible written information can increase knowledge, awareness, and uptake of services. Peer mentors (i.e. a programme provider close in age) can play a key part in providing basic information and connecting young people to healthcare providers.(43) Women experiencing homelessness suggest that free bus tokens, organised transport to SRH centres and use of mobile clinics, are all initiatives that can overcome distance and financial barriers.(38) Similarly, programme providers and users both support provision of incentives (e.g. phones, vouchers) to motivate young people experiencing homelessness to initially get involved in a sexual health programme.(10, 37, 40, 43)

Patient recommendations include a need for increased availability and distribution of condoms and lubricant supplies, with greater targeting of youth who are injecting substances.(12, 32) Actively involving individuals with current or previous experiences of homelessness in the development or delivery of a SRH programme increases its likelihood of meeting the needs of the target population.(43)

## **4.0 Discussion**

This review suggests that access to and utilisation of SRH for people who experience homelessness are influenced by both individual level and organisational barriers. Themes identified include complexity, feelings, knowledge, patient/provider interaction, and the healthcare system. Notably, every theme except for complexity has both facilitators and barriers, showing their duality.

Interpretation of the findings indicates a significant proportion of barriers mirroring conceptualisations of access to SRH for the general population.(30) However, people experiencing homelessness find themselves in living conditions marked by survival, precariousness and stigmatisation, plus external constraints that disproportionately limit their access to and utilisation of SRH.(32, 35) For example, although long waiting

times are a barrier for everyone,(38, 51) the transient nature of homelessness makes it harder for people experiencing homelessness to attend SRH services; they are forced to prioritise whether the best use of their time is to wait for treatment or to meet a basic need (e.g. find a bed for the night).(38) This highlights the need for a tailored approach that takes into account the complexity of the living conditions and the psychosocial needs of patients.

Although difficulties in accessing and utilising SRH appear similar across the whole spectrum of people experiencing homelessness, specific personal characteristics raise additional barriers. For example, there are reports that young people feel a lack of autonomy when it comes to decisions about their sexual health, which is worsened if healthcare providers treat them in a paternalistic way and/or make stereotypical assumptions.(36, 52) In addition, Begun and colleagues(32) recently found that discussion around contraception can be incomprehensible to young people who also lack knowledge on how and where to access contraceptive services.

Some evidence suggests a lack of awareness among healthcare professionals of the sexual health needs of young people of sexual orientations different from heterosexuality, creating barriers for these groups who need sexual advice the most.(34) Also, some of the SRH experiences and needs of women compared to men experiencing homelessness, may differ. For example, younger women are particularly at risk of violence and sexual assault,(53) as well as adverse pregnancy outcomes, making them particularly vulnerable to resumed substance use, which can affect decision making over SRH.(12) These findings support a need to reconfigure SRH and education in ways that are considerate of people's diverse experiences, concerns, needs and trauma history. Building meaningful and trusting relationships appears crucial to any efforts aiming to promote engagement of people who experience homelessness with SRH and to remove barriers to accessing care.(32, 43, 50)

We recognise the influence of both the characteristics of the population and the healthcare system on the utilisation of SRH by people who experience homelessness. However, although increased knowledge and awareness are needed especially among youth,(38) our findings suggest that healthcare systems and care delivery should receive greater attention to improve access.(30) Moreover, any successful

programme developed to meet the sexual health needs of people experiencing homelessness must begin with basic needs (e.g. shelter) and a better understanding of how homelessness may impact motivation to access and utilise SRH.(38) Given that people experiencing homelessness are among the most marginalised and vulnerable in high-income societies, with severe inequities across a wide range of health outcomes,(2) it is important for interventions to begin early in life with policies to address the upstream causes of exclusion.(54) In parallel, it is important to provide holistic healthcare, and intensive “cross-sectoral policy and service action to prevent exclusion and improve health outcomes in individuals who are already marginalised”.(2)

## **5.0 Future research**

Existing research points to the effectiveness of community sexual health programmes for youth experiencing homelessness informed by a participatory action process and based upon holistic, trauma-informed care.(10, 43). Further research into patterns of SRH, predictors of service utilisation, and attrition of treatment could help establish services that better meet the needs of those experiencing homelessness, including triage and/or tailored services for specific subgroups. This could support commissioners and policy makers in understanding how to best direct resources towards the most vulnerable and bring about necessary structural/policy changes.

The studies included in this review lacked diversity particularly regarding people who identify as LGBTQ+. Yet transgender and gender-nonconforming people are twice at risk of experiencing homelessness compared to the general population,(55) with homophobia and other negative attitudes “often normalised in shelters, creating significant barriers to safe, accessible, and supportive services”.(56) Research into the specific SRH needs of this group are warranted as are the needs of people with disabilities and couples through exploring innovative models of SRH to meet diverse characteristics and contexts.

Future studies could also investigate: 1) mental health as a comorbidity and driver of behaviour; 2) the influence of partners on an individual’s autonomy regarding their healthcare 3) whether seeing women in a women's centre might be beneficial;

conversely, whether seeing couples could help with supporting healthy relationships and reducing cross-infection; and 4) whether past experiences of losing children to social services care affect attitudes towards and willingness to engage with healthcare services.

## **6.0 Strengths and weaknesses**

The review's systematic and methodologically robust approach has synthesised the barriers associated with low uptake of care and access to services in a transparent and detailed way, and provides recommendations on how the barriers can be overcome to facilitate better SRH outcomes for people who experience homelessness, including through changes in practice and further research.

The fact that most studies were conducted in the USA is a limitation. As the characteristics of healthcare systems and policies for the target population vary among countries, some findings may not be transferable to other countries. Transferability of findings to e.g. people with disabilities and those from LGBTQ+ communities, may also be limited. In mitigation, we have provided as many details as possible about the context and study characteristics to enable assessment of the relevance and appropriateness of the review findings to other setting and populations.

## **7.0 Conclusions**

Both individual and organisational factors influence the utilisation of and access to SRH for people experiencing homelessness. Considering the complexity and diversity of the living conditions associated with homelessness, greater emphasis in efforts to improve access could best be placed on factors related to health services and provision of care.

Robust evidence-based interventions that increase this group's access to long-term SRH as well as screening for STIs are needed, along with the engagement of people experiencing homelessness in their design and implementation.

## **Key message points:**

- Utilisation of and access to sexual and reproductive healthcare for people experiencing homelessness is influenced by both the characteristics of users and characteristics of the healthcare system.
- The precarious living conditions of homelessness amplify the barriers to accessing and utilising SRH.
- Robust evidence-based interventions to increase access to long-term contraceptive methods and family planning programmes along with screening for STIs are needed for people who experience homelessness.

## **Authors' contributions**

**MP** was responsible for the conception and design of the study, acquisition of data, data analysis and interpretation, and drafting the article.

**JMM** was responsible for the conception and design of the study, acquisition of data, data analysis and interpretation, and critically reviewing the article.

**LB** was responsible for the design of the study, acquisition of data, and critically reviewing the article.

**ESC** was responsible for the design of the study and critically reviewing the article.

**LW** was responsible for data interpretation, critically reviewing the article and advising on dissemination plans.

**JS** was responsible for the conception and design of the study and critically reviewing the article.

All authors read and approved the final manuscript.

**Competing Interests**

Prof. Jill Shawe is a member of the Faculty of Sexual and Reproductive Healthcare, Sexual and Reproductive Health Clinical Studies Group (SRH CSG).

The other authors declare no conflict of interest.

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**Data sharing**

All data generated or analysed during this study are included in this published article [and its supplementary information files].

**Patient consent**

Not applicable.

**Ethical approval**

Not applicable.

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