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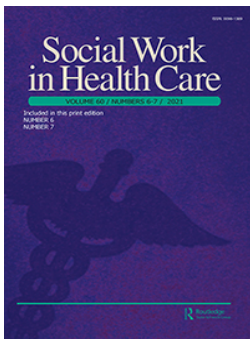
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Sharing the burden of treatment navigation: social work and the experiences of unhoused women in accessing health services in Santa Cruz

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ABSTRACT

This paper explores the challenges faced by unhoused women in accessing general and reproductive health care services in Santa Cruz, CA. Semi-structured interviews with women experiencing homelessness were conducted in Santa Cruz, CA with a focus on their narrative experiences as patients. The overwhelming majority of participants expressed appreciation for clinics that provided support through longer hours, alternative therapies, and appointment reminders. Overall, the interviews indicated that women who had access to a social worker were much more likely to report improved access to satisfactory treatment. These findings suggest that there is not a tangible lack of healthcare services for unhoused women in the local community, but rather a burden of treatment navigation caused by a dearth of information on how to access care. The interviews suggest that this burden can be reduced with social work interventions and service centers that offer health navigation support. By adapting theories of the “burden of treatment,” we argue that additional attention must be paid to overcoming the “burden of treatment navigation.” For related reasons, we suggest that increasing the availability of social workers would concretely improve health outcomes for unhoused women.

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KEYWORDS

Resilience; embodiment;
trauma-informed care;
social-workers; biological
sub-citizenship

What is Known:

- Women and families represent the largest demographic of the unhoused population in the United States.
- Women experiencing homelessness face unique health challenges, most notably reproductive health-related issues.
- Life on the street significantly increases the likelihood of sexual harassment and assault for unhoused women.
- “Burden of treatment” refers to “the workload of healthcare and how it impacts patients’ functioning and well-being”, and has been used to understand the effort healthcare necessitates from patients (Spencer-Bonilla et al., 2017).

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This article has been corrected with minor changes. These changes do not impact the academic content of the article.

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What this Paper Adds:

- It highlights the insights, experiences, and resiliency of women experiencing homelessness through a narrative based approach.
- It introduces the concept of “burden of treatment navigation”, which we theorized from “the burden of treatment”, to index the challenges of navigating complicated healthcare systems. This concept exacerbates embodied social determinants of health and reinforces forms of biological sub-citizenship.
- It introduces research on interactions of unhoused women with “alternative” health services such as acupuncture.
- It recommends social work approaches to trauma-informed care for organizations providing healthcare to unhoused women in order to minimize burdens of navigation.
- Past studies have focused on unhoused women’s interactions with health providers and focused on unhoused women as mothers. However, this paper emphasizes women experiencing homelessness as autonomous and incorporates a wide lens of how they interact with all portions of health systems.

Introduction

The COVID-19 pandemic has reinvigorated concerns surrounding the immense inequalities in health access in the US, including those surrounding unhoused populations (Abrams & Szeffler, 2020; Sparke & Anguelov, 2020). Unhoused women are often the most vulnerable and least visible of these populations, and research is urgently needed to better understand the challenges that they face in accessing health services.

This paper shares results from interview-based research into difficulties faced by unhoused women in accessing general and reproductive health care services within Santa Cruz. The meaning of homelessness remains contingent upon community and societal context, and few scholars or governments agree on an all-encompassing definition (Chamberlain & Mackenzie, 1992). For the purposes of our study, we relied on the HUD definition of homelessness, enrolling participants who fell into any of the four broad categories that HUD outlines (HUD, 2019); this included women who self-reported being unhoused or being marginally housed. This paper addresses the gaps in research surrounding unhoused women and healthcare by reflecting on direct experiences of unhoused women rather than quantitative data. To better analyze their narratives, we combined the critical epidemiological concepts of embodiment and biological sub-citizenship with close attention to women’s own descriptions of their experiences.

Embodiment, biological sub-citizenship and homelessness

Embodiment refers to “how we literally incorporate biologically, the material and social world in which we live, from in utero to death” (Krieger, 2005). This theory is useful for analyzing illness narratives and contextualizing experiences within vulnerable populations. Housing instability can be viewed as being embodied in multiple adverse effects on both physical and mental health (Burgard et al., 2012). Associated physical factors like inadequate nutrition, unsupportive shoes, and lack of a mattress often come together with everyday stress to be embodied in both acute health challenges and chronic illness. Even those living in semi-permanent shelters face job and food insecurity, and under these sorts of precarious conditions, many unhoused people turn to self-care in the form of substance dependency (Kirchner et al., 2002; Torchalla et al., 2011). Such dependencies may in turn cause physical and mental health burdens that can limit individuals’ abilities to support and care for themselves. The experience of stressful and precarious living conditions can thereby create cascades of additional problems that are embodied in poor health outcomes (Omerov et al., 2020).

Another net effect of these co-pathogenic cascades is a form of disenfranchisement from health rights which we refer to here as “biological sub-citizenship.” This term follows literature that has sought to analyze ways populations are excluded from meaningful care under regimes of neoliberalism and disease-specific treatment (Da Silva & de Ferreira, 2020; Sparke, 2017). Biological sub-citizenship highlights how the 21st century promises of precision biomedicine, personalized health investment and participatory health management have led to increased health rights for some and sub-citizenship for others (Rose & Novas, 2005; Whittle et al., 2017). Scholars have already found this a useful framework for theorizing the lack of care and health citizenship for unhoused people (Fabian, 2020). We think sub-citizenship is also a useful way to explain how such diminished rights coexist with some enduring forms of agency; in this paper, we emphasize that although unhoused women experience social marginalization and curtailed health care, they are also experts in their own experiences (Oliver & Cheff, 2014).

The intersection of homelessness and being a woman creates especially burdensome health challenges. Women experiencing homelessness face higher rates of chronic physical health issues as well as higher rates of conflict within their support networks (Winetrobe et al., 2017). Single unhoused women have also been found to have more frequent visits to the emergency department than do single unhoused men (Chambers et al., 2013). In addition, women face particular health concerns that require consistent primary care, including reproductive health, STI treatment and testing, and care surrounding pregnancy (Fact Sheet: 10 Ways STDs Impact Women.). These are also compounded with the traumatic legacies of sexual violence, severe mental health

problems, and sexist biases that have led to the systematic discounting of pain experienced by women (Hoffmann & Tarzian, 2001). These biases, paired with societal narratives of women as inherently disabled, hinder their ability to communicate their pain as valid (Hollander, 2001). The net result of all these forces and factors is that many unhoused women are cut off from adequate care services and reduced to experiences of biological sub-citizenship.

Materials and methods

Semi-structured interviews were conducted among women experiencing homelessness within Santa Cruz from December 2019 to February 2020. Participation criteria included identifying as a woman, identifying as unhoused or marginally housed, and currently residing within the Santa Cruz. Exclusion criteria included an inability to speak English and/or being under the age of eighteen. Participants were recruited with the help of the Homeless Garden Project, a nonprofit organization based in Santa Cruz county. The Homeless Garden Project provides job training and meaningful work to unhoused persons in Santa Cruz, by furthering the organization's benefits, aiding in farm harvests, and selling handmade crafts and products that are sold locally and online. Eligible women were asked to sign up for an interview time by the organization, and no prior direct contact with participants was made by the research team. Interviews generally lasted from 30–40 minutes, with the flexibility of lasting an hour. At the end of each interview, participants were given a large hygiene packet (consisting of soap, shampoo, menstrual products, and dental hygiene products), and a \$20 grocery gift card. Interviews were recorded and transcribed within a two-week time period and investigators then collaborated in coding and thematizing the results. The authors engaged in observer triangulation in order to “achieve intersubject agreement” and reduce reactivity, researcher bias, and respondent bias. Consensus was achieved by thorough group discussion and unanimous agreement on data interpretation between all three researchers (see Table A1). In addition, theory triangulation was also used in order to decrease researcher bias and boost the rigor of conclusions as suggested by *Qualitative and Mixed Methods in Public Health* (Padgett, 2011). While interview recordings have been deleted as per UCSC IRB compliance, researchers have maintained a detailed self-audit trail of data analysis procedures and discussions.

The overall interview process was forced to conclude early with the onset of the COVID crisis in February 2020. This meant that the total number of women interviewed was only five ($n = 5$). All 5 participants identified as homeless or transitioning out of homelessness, either to a shelter, transitional housing, or sober living communities. Despite this small sample size, we follow the arguments of qualitative researchers across the social sciences and health sciences in claiming that in-depth interviews and ethnographic encounters

with small numbers of subjects can still yield meaningful insights into health systems' successes and failings (Cohen & Crabtree, 2008; Daddow & Stanley, 2021; Farmer, 2004; Heath & Rodway, 1999; O'Carroll & Wainwright, 2019; Sands, 1990; Savage, 2000). These include insights into the embodiment of biological sub-citizenship, as a variety of compelling studies of disability (Hassouneh & Fornero, 2021), chronic disease (Bosire et al., 2018) and infectious disease (Hassan & Tucker, Hassan and Tucker, n.d.) have all recently shown. Most of all, we stress that our small sample still represents the perspectives of unhoused women who are rarely heard, and whose voices and worldviews need attention in order for care services to be more adequately informed by the embodied experience of "beating the pavement." Indeed, even a term like "beating the pavement" – a term we heard used repeatedly by the unhoused women we interviewed to describe their struggles to survive – viscerally testifies to the rough and ungiving world of everyday life on the street.

Findings

Interactions with healthcare personnel

Here we first seek to summarize all the interactions that our participants reported with both traditional and alternative healthcare providers. Interviewees reported varied experiences with healthcare personnel depending on the type of care they sought. Formal healthcare settings, such as emergency room visits and hospital walk-in appointments, produced the most negative experiences. Interviewees recounted experiences of being treated like sub-citizens subject to disregard and exclusion: "if you go into their emergency room, and they know you're homeless, you get kind of like, categorized, and not really taken seriously and [staff don't] want to go into real detail or depth with you. [They seem to], give you an antibiotic and send you on your way."

Negative experiences in these settings were also reported in managing mental health conditions. One woman shared that she's "had awful experiences," and that hospital staff in another city had once told her "your kind' [ie the unhoused] would be better off in cities like Santa Cruz. Like there are better cities for you to be homeless in and your kind should go there." Due to such interactions, she rarely goes to see a doctor.

Distrust in health professionals was a recurrent sentiment throughout every interview, and many participants connected this to experiences of feeling like sub-citizens in encounters with medical professionals. One woman recalled her negative experiences with healthcare personnel when she was seeking an abortion: "I hate going to doctors. One of the reasons I haven't been in such a long time is because when I first started experiencing homelessness . . . I had to have an abortion, and the doctors were just so, just mean to me. And just

treated me like I was less than human.” When asked to elaborate on her experience navigating abortion services, she recounted that “to be honest, it was a horrible experience. [...] the first time, there were complications, and I ended up needing a blood transfusion. And, I was just really scared. And I actually left. I first refused the transfusion, cause I just wanted to get out of there.” This strikingly traumatic interaction with healthcare personnel is illustrative of the wider experiences of sub-citizenship reported in our interviews about negative experiences with emergency care personnel.

Other challenges with healthcare personnel were tied to the particular struggles with *addiction*. One woman recounted that if staff realize you are unhoused, they “try and get you out of there as fast as possible and half the time. [They] don’t even treat what you came in there for.” Participants experiencing addiction unanimously reported avoiding hospital treatment unless absolutely necessary.

Unlike formal healthcare settings, nontraditional forms of care were associated with more positive enfranchising experiences. One woman recalled that if she needs an extra day with her acupuncturist: “there’s a possibility that she might see me, and it could, you know, be really, really cheap, or you know . . . might be a free session, once a month from her. . . . if I need it she’s there, so she says, come in, if you need.” She found alternative therapy spaces to be non-judgmental and welcoming. Participants also seemed to report predominantly positive experiences with Planned Parenthood. The woman who had previously reported having traumatic experiences navigating abortion services elsewhere recalled that by contrast, “the people at Planned Parenthood have always been really nice [...]” Nearly every participant reported having positive experiences with the personnel at Planned Parenthood and felt comfortable going back to the clinic.

Interactions with health services

Here we seek next to summarize the experiences reported by participants in their search for institutional health resources including, alternative therapies, reproductive care, and mental health services. Our interviewees frequently linked their physical health with the embodied experience of lacking permanent shelter. These included dental problems, recurring urinary tract infections, and complications due to lack of podiatric support. Due to a wariness of medical professionals, many of these women chose to cope with their physical ailments on their own. Lack of hygiene was cited as a major source of communicable illness – a crucial assessment to note in the shadow of the COVID-19 pandemic. One woman cited how even the common cold could prove to be disastrous for someone who is experiencing homelessness. “When it’s cold season I try and do extra vitamin C like juices and stuff just to try and

prevent getting sick because once you get sick and you're homeless it's like the worst." She also admitted that "something has to be really seriously bad usually for me to go to the doctor."

Women shared narratives of general pain management and subsequent substance abuse. Participants noted that because they were recovering from an unhealthy relationship with substances, they wanted to find non-prescriptive ways to manage their pain. One woman shared that she felt doctors "just push more pills, you know . . . Like I'm getting off of pills, I mean, and I have to tell my doctor that I'm getting off of them." Another participant echoed this statement, saying "I'm trying to not have to rely on medication to feel happier, or to feel better. I know some people need it because of chemistry in their brains being different. But if possible, I wanna fix that through other ways." Participants' attitudes surrounding overly prescriptive mental health practices were associated with lower utilization of related services. These women often reported a high preference for alternative treatments such as counseling, yoga, acupuncture, and other non-prescriptive methods. One woman said that she enjoyed acupuncture and wanted to stick with her treatment despite her busy schedule. Another simply stated: "alternative medicine is the thing to do!"

Accessing reproductive health care did not elicit the same concerns from participants. All of the women interviewed expressed their satisfaction in, and regular access to, reproductive health services. The majority of patients received their reproductive health care from Planned Parenthood. "I think Planned Parenthood is great. You can go in there and get what you need." One woman reinforced the necessity of Planned Parenthood when on the road. Another woman admitted that she hasn't tried to access any reproductive care recently, but that she "know[s] in the past, Planned Parenthood has been great." STI testing was reported to be a positive and widely used service, both at Planned Parenthood and other clinics. One participant shared that she was able to get over her nerves and get tested because of the supportive atmosphere of the center. "They gave me like a little gift card just for taking the test which was like awesome and they went through a lot of stuff, and they were like 'well we can use this as a counseling session if you do get results that are positive or might be positive that's not like a death sentence' . . . 'if that does happen we'll take next steps and basically I will hold your hand through it' and that was pretty awesome."

Navigation of health and food systems

In this section, we seek to summarize what the unhoused women we interviewed reported about navigating wider systems of food and health provision. Interviewees reported feeling relatively confident about their food security. Nevertheless, a majority shared that there was a steep learning curve in

understanding the food access system in Santa Cruz. One woman recalled that there was a “free guide that tells you where you can get food or what days and times and places to get the hot meals . . . but there’s some things that aren’t even listed on those papers, you just kind of have to find them, or like, word of mouth.” While the free resource guide was helpful, “there are a lot more resources that it completely misses.” Difficulties in locating resource centers were major reasons for inadequate nutrition. Even when unhoused women were able to purchase food, they testified to further barriers, like “find[ing] a place to cook food. So you just have to eat, like, snacks or things that you don’t have to cook or heat up.” This participant also expressed that even if she were to barbecue, she would need coals and could only cook during park hours. She cited the physical lack of spaces to cook food as a major cause of her poor nutrition during her homelessness.

Participants also reported numerous navigational challenges within Santa Cruz’ health system. Insurance access and navigation seemed to be a common cause of confusion. While most participants expressed a lack of knowledge about insurance, many felt that simply being dependent on MediCal made them a target for discrimination. One woman shared that before realizing her insurance status, physicians were willing to provide her with more detailed care. She noted that in a recent dental appointment, her dentist said “oh you’re *MediCal*. Well we can pull all your teeth and give you dentures?” There was a generalized sentiment that doctors were not giving participants adequate care, and that participants were unsure how to locate it themselves.

This navigation challenge was compounded by participants often having problems with insurance transfer, or lack of insurance. One participant mentioned that a barrier to receiving treatment was going through the insurance approval process: “[. . .] things like, getting stuff approved. You know, like, it took I don’t know how many months to get an extra day with acupuncture.” Participants expressed confusion in what *MediCal* actually covers, particularly in regard to dental care. One participant summarized this idea: “there’s a lot of things that *MediCal* covers that a lot of people don’t know about that they kind of just have to somehow, someway find out about.” This was reaffirmed in that some participants shared they wished MediCal covered dental, whereas other participants explained that they were already receiving dental care through MediCal.

However, in the situations that women had access to “navigational aids,” participants reported higher usage and satisfaction with health services. They underlined the crucial role of social workers in alleviating the burden of treatment navigation. One woman shared with us how she was able to expedite processes by relying on her social worker; when she felt unsafe in a co-ed shelter, “my worker got me out of there right away.” Another woman expressed her gratitude for having a social worker to help her reunite with her family. “I do have a worker. Um, when it comes to like, the food stamps

and like, um- now I have, like, a lot of social workers because of CPS coming into my life . . . the social workers have helped me a lot, the ones that are through, like, family preservation court.” These sorts of comments testified in very visceral embodied terms – “got me out of there” – to the ways social workers could re-enfranchise unhoused women with a physical experience of agency, rights and biological citizenship.

In addition, approaches used by health services institutions were highly praised when they were able to tailor services to individual unhoused women’s personal needs. This was particularly the case for clinics that offered appointment forgiveness and continued to reach out to participants. One woman expressed her frustration with receiving mental health care in the past: “it’s like so difficult to get a new doctor and like they have so many appointments.” However, she praised the clinic that had reached out to her with reminders, letting her know that they were still available to her. She shared that she had “to give them credit for like really reaching out and that really did make a huge difference. I was like okay I feel like that door is still open. Because even like months later, like I got something in the mail a few months ago and I was like wow.” This sense of enfranchisement with health rights was also experienced in embodied forms of navigational assistance thanks to the colocation of services. Some clinics, for instance, made adjustments so women who weren’t close to the clinic could get all of their testing, checkups, and medication in one day. Participants reported the ease of getting birth control in larger batches to decrease travel and the frequency of prescription refills. In these sorts of ways, institutions with active communication and socially sensitive care adapted effectively to personal experiences of homelessness thereby mitigating the experience of biological sub-citizenship by opening pathways to resilience.

Resilience

Despite the burdens in these women’s lives, resilience remained a central theme in their narratives. Participants showcased their capacity to recover from difficulties and make strides toward personal growth. Stories of past hardship were often followed up with positive reports on recovering afterward. For example, in regard to her journey toward sobriety, one woman said that she was “doing pretty good, you know, life just keeps on getting better, little by little. It’s been . . . really slow and sometimes I feel, like, really hopeless, but then I look back, like, three months ago, six months ago, eight or nine months ago, and I see that, you know, things really are getting better.” This interviewee underlined her sense of gratitude, a crucial aspect of resilience to which many of the other women also testified. “I have a lot to be grateful for” was in fact a common refrain.

In terms of who was being thanked, the majority of participants credited social workers with helping them navigate complex food and health systems and overcome associated hardships. When speaking to their ability to strive toward personal growth, access to a social worker seems to be the key factor in maintaining that positive trajectory. A typical participant navigating healthcare and shelters in this way emphasized that “[social workers] could even advocate for you, too. I mean, you know, get a social worker, if you’re having some needs that are not being met, speak up and talk to a social worker.” When asked what she would like to see changed in the overall health system, she advocated for “[. . .] more guidance. A guidance counselor. Even if it’s not a social worker, some kind of guidance counselor.” As one participant recalled the advocacy of her social worker at a rehabilitation center, she acknowledged the crucial role that this worker played in her recovery, saying “Yeah, cause sometimes I kinda need to be nudged into taking the right steps for me.”

The positive impact of a social worker can also be illustrated through the sub-citizenship effects of not having a social worker. One participant recounted an experience with someone who was struggling to advocate for themselves: “I’ve talked to people in the shelter too, and some of them, you know, they just kind of wander around. They really need to hook up, you know, with somebody.” By having access to a social worker, this participant knew what advocacy and adequate care looked like, and could encourage her peers to do the same. Social work advocacy seemed to lead to a stronger sense of resilience and an increased likelihood that these participants could develop a personal sense of agency and enfranchisement with health rights.

Discussion

Biological sub-citizenship and the burden of treatment navigation

Within analyses of interactions between healthcare systems and patients, scholars have noted that more neoliberal systems increasingly place the burdens of disease management onto patients directly (May et al., 2014). The theory of biological sub-citizenship we are using here is a useful framework to analyze how these burdens became embodied in our interviewees’ experiences (Da Silva & de Ferreira, 2020; Sparke, 2017). Neoliberal institutions that provide health care services to unhoused populations increasingly place the burden of health care navigation on them as individuals. As our interviewees testified, being unhoused means that they often do not have the resources, networks or sense of belonging that enfranchised biological citizens have to support such personalized health care management. Instead, they experience treatment in the formal health system as sub-citizens with limited agency in finding and accessing necessary services. In the terms of scholarship on the

management of chronic illness (Eton et al., 2012), our interviewees' testimonies pointed to experiences of diminished social capital leading to higher burdens of treatment navigation and management.

Embodiment and trauma-informed care

Our interviewees traced the root cause of their health issues to their biophysical experiences of homelessness, directly reflecting Kreiger's theory of embodiment (Krieger, 2005). The resulting forms of biological sub-citizenship were mitigated by care services that took the challenges of being unhoused carefully into account. Our findings point to trauma-informed care as the necessary way to disseminate care – care that seeks to avoid re-traumatization by coming to terms with the vulnerabilities or triggers of trauma survivors (NCTI, 2012).

Relatedly, help with health care service navigation was the largest indicator of healthcare use and satisfaction highlighted by our interviews. Navigational personnel, including social workers, clinic outreach teams, and shelter liaisons clearly increased the quality and quantity of healthcare reported by the women experiencing homelessness that we interviewed. This is consistent with existing literature exploring the characteristics of satisfactory health care service and treatment, in addition to having a strong social network and “good quality of life” (Gentil et al., 2020). Additional structural methods used by health services such as “lumping” appointments, reminders, and appointment forgiveness were also important to participants (see Figure A2).

Alternative care

In general, interviewees had overwhelmingly negative experiences seeking out healthcare services in traditional care settings, especially emergency care settings (see Figure A1). Negative experiences with personnel in these systems seemed to taint their expectations of healthcare, making them wary to seek out traditional care, thereby replicating cycles of stigmatization, exclusion and health sub-citizenship (Purkey & MacKenzie, Purkey and MacKenzie, 2019). On the other hand, women reported having an overwhelmingly positive experience with alternative and reproductive services such as Planned Parenthood. These services were delivered with a trauma-informed approach that our interviewees especially appreciated. Participants consistently returned to service providers who listened to them, tried to give them care tailored to their needs, and which centered participants as re-enfranchised agents of their own care.

The women we interviewed felt better able to incorporate more alternative therapies into maintaining and managing both their physical and mental health care. Our interviews indicated that when access to health services was destigmatized and safe, participants were willing to invest more time into their

health. When participants reported facing judgment, bias, and a severe lack of empathy, they understandably were not willing to continue treatment. In other words, when providers shared the burden of treatment navigation with social workers, unhoused women were able to build social trust and knowledge, and confidence in their own resilience. With better attention to the “*burden of treatment navigation*” through the use of social workers and social work knowledge, care systems can do much more to enfranchise unhoused women as resilient subjects with meaningful forms of agency and biological citizenship.

Conclusion

Limitations for this study include a small sample size ($n = 5$), participants who were relatively stable in their situation, and a geographically homogenous sample. Despite these limitations, researchers feel that findings are generalizable to larger health care systems within Santa Cruz and other communities with large unhoused populations. Further comparative research between different communities would better help elucidate the degree to which variations in social work support account for variations in the burden of treatment navigation.

This study sought to relay the experiences and narratives of unhoused women in accessing healthcare options within Santa Cruz. Findings suggest that lack of navigation assistance was a key barrier to health enfranchisement, and navigational personnel are crucial to unhoused women’s ability to advocate for their own health needs. As such, we argue for increased financial investment in social workers, case managers, and health liaisons within homeless shelters. In addition, we champion for increased access to education on benefits provided through government insurance and food services, as well as an increased funding for Planned Parenthood and alternative therapies such as acupuncture. Moreover, to decrease the embodied ill effects of homelessness we advocate for an increase of public restrooms and a more dynamic method for delivering food and health information to homeless communities. Our findings also encourage health care providers to adopt appointment forgiveness and lumping of appointments. Additionally, we encourage service providers to make an explicit effort to construct teams of doctors, nurses, and specialists that create “social networks” of care that this population can rely on. As our findings indicate, when these women had strong social networks and capital, they were more likely to invest in their long-term health care. Future studies should use narrative based qualitative research to further understand the relationship unhoused women have with alternative therapies.

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Appendix

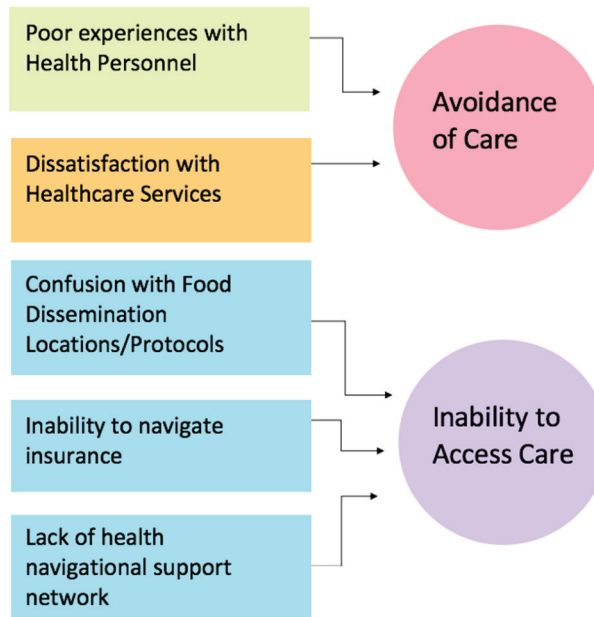


Figure A1. An illustration of factors that contribute to the avoidance of, and inability to access, care.

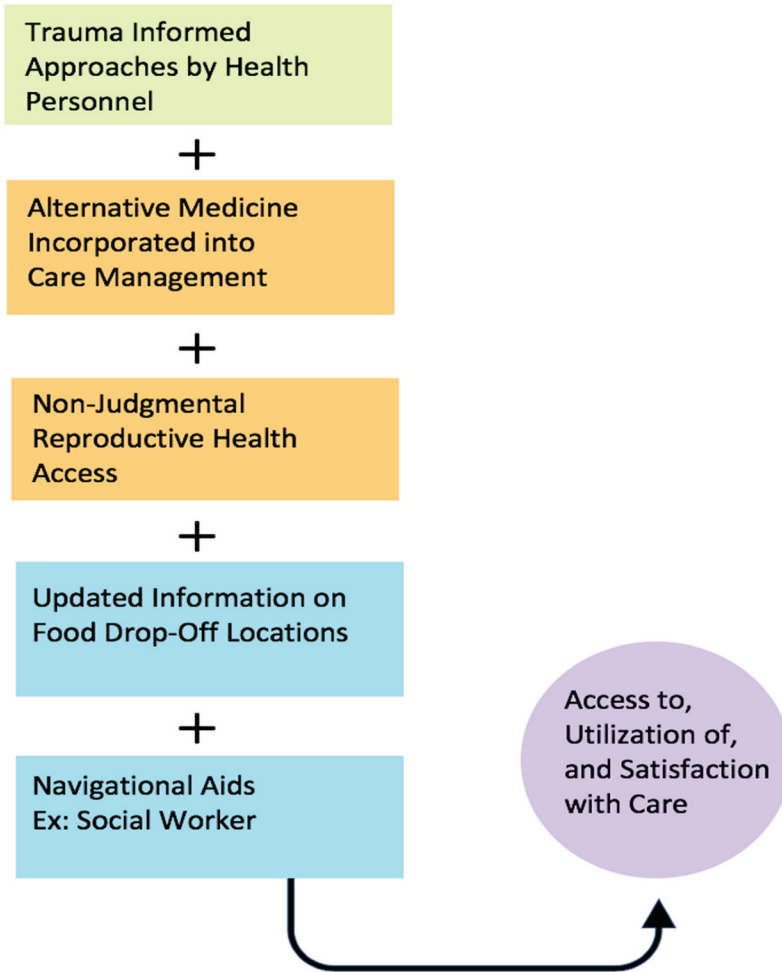


Figure A2. An illustration of factors that contribute to the access to, utilization of, and satisfaction with care.

Table A.1. List of research codes and definitions.

Theme	Code	Definition of Code
Interaction with Health Systems	Physical ailments produced by being on the street	Participant accounts of physical discomfort, pain, and/or injury that can be attributed to living on the street.
	Alternative therapy	Participant experiences with any range of medical therapies that are not regarded as orthodox by the medical profession, including meditation, acupuncture, fire cupping, etc.
	Reproductive health care	Participant experiences in accessing reproductive health care services.
Interactions with Healthcare Personnel	Mental health challenges	Participant experience with psychological and behavioral health.
	Addiction	Participant experiences surrounding and managing substance dependence
	Stigmatization of homelessness	Participant experiences surrounding various forms of discrimination, prejudice, and intolerance directed toward homeless people.
Navigation of Healthcare/Food Systems	Interaction with Health Personnel	Participant experience in interacting with nurses, doctors, mental health professionals, and any other personnel within their traditional healthcare “team.”
	Healthcare system navigation	Participant experiences in understanding and accessing various health care services.
	Food access/navigation	Participant experiences in understanding and accessing various food services.
	Caseworker/social worker	Participant experiences, or lack of experiences, with a caseworker or social worker.
Resilience	Resilience	Participants showcasing their capacity to recover from difficulties and make strides toward personal growth.