E-Journal of Humanities, Arts and Social Sciences (EHASS)
ISSN – Online 2720-7722 | Print 2821-8949
Volume 7 Issue 9 2026 pp 2583 - 2600
Available online at: https://noyam.org/journals/ehass/
DOI: https://doi.org/10.38159/ehass.2026798

Check for updates

"Beyond the Clinic Door": Examining healthcare status and access challenges of persons experiencing street homelessness in the city of Johannesburg, South Africa

Constance Matshidiso Lelaka[1], Phumuzani Mpofu [2], Johanna Deka[1] & Emmison Muleya[1]

[1] Department of Social Work, School of Community and Human Development, University of the Witwatersrand, Johannesburg, South Africa.
[2] Department of Psychology, School of Community and Human Development, University of the Witwatersrand, Johannesburg, South Africa.

ABSTRACT

This study explores the health conditions, service barriers, and coping mechanisms of people experiencing homelessness in the urban context of Johannesburg. Guided by Andersen's Behavioural Model of Health Services Use and situated within a transformative research paradigm, the study used a qualitative phenomenological design to capture the lived experiences of 10 homeless adults recruited by purposive sampling. Data were generated through in-depth interviews and thematically analysed using the Braun and Clarke (2006) framework. The findings reveal a complex interplay between poverty, illness, stigma, and systemic exclusion. Participants reported high rates of HIV/AIDS, tuberculosis, respiratory infections, and substance-related illnesses, compounded by poor sanitation and exposure to violence. Structural barriers, including a lack of identification documents, discriminatory treatment in clinics, and fragmented service delivery, significantly hindered healthcare access and continuity of care. Despite these adversities, participants displayed resilience through informal networks, support from non-profit and faith-based organisations, and personal spirituality. A recurring theme was the longing for dignity, family reconnection, and reintegration into society. The study concludes that homelessness in Johannesburg is both a health and human rights issue, necessitating coordinated, multi-sectoral interventions. Recommendations include mobile outreach health services, removal of administrative barriers, expanded mental health and addiction programs, and family reunification initiatives to promote inclusive and equitable healthcare for the city's most marginalised populations.

Keywords: Andersen's Behavioural Model, Healthcare Access, Homelessness, Johannesburg, Public Health Equity.

INTRODUCTION

Homelessness is a growing public-health and social-policy challenge in South Africa, particularly concentrated in urban centres such as Johannesburg.[1] National data and local studies indicate that

[1] Statistics South Africa, "A Profile of Homeless Persons in South Africa," 2025.

CORRESPONDENCE – Emmison Muleya **Email:** Emmi.Muleya@wits.ac.za
PUBLICATION HISTORY - Received: 8th February, 2026 | Accepted: 14th August, 2026 | Published: 28th October, 2026.
TO CITE THIS ARTICLE – Lelaka, Constance Matshidiso, Phumuzani Mpofu, Johanna Deka, and Emmison Muleya. "Beyond the Clinic Door": Examining healthcare status and access challenges of persons experiencing street homelessness in the city of Johannesburg, South Africa." *E-Journal of Humanities, Arts and Social Sciences* 7, no.9 (2026): 2583 - 2600. https://doi.org/10.38159/ehass.2026798
COPYRIGHT AND LICENSING - © 2026 The Author(s). Published and Maintained by Noyam Journals.
This is an open access article under the CCBY license (http://creativecommons.org/licenses/by/4.0/).

homelessness in South Africa is multi-factorial, rooted in unemployment, poverty, migration, housing shortages and social exclusion and that the visible street-homeless population represents only one part of a larger, fluid group of people experiencing housing instability.[2] This epidemiological and policy context is crucial because it shapes both the demand for and the practical accessibility of health services for people who are homeless.

People experiencing homelessness carry a disproportionate burden of acute and chronic health problems (infectious diseases, untreated dental problems, injuries, mental disorders, and substance-use problems) and frequently have complex social needs that intersect with their health status. South African research and clinic-based reports from Johannesburg document high levels of respiratory infections, tuberculosis (TB), HIV, skin infections and mental-health problems among street-based and shelter-based populations; These conditions are compounded by limited access to food, sanitation and safe shelter, which worsen health outcomes and complicate treatment.[3]

Despite high need, people who are homeless experience multiple interacting barriers to accessing formal healthcare. Commonly reported structural barriers include a lack of identity documents or proof of residence, clinic hours that conflict with survival activities, transport costs, long waiting times, and fragmented referral systems. Interpersonal and system-level barriers, such as stigma, discrimination from health staff, and health services not adapted to the priorities and mobility of homeless people, further reduce uptake of preventative care, continuity of chronic-disease management and adherence to medication. Collectively, these barriers create delays in care-seeking, interrupted treatments (notably for TB and HIV), and a greater dependence on emergency or outreach services.[4]

Innovations such as student-run clinics, outreach pharmacies, and integrated shelter-health programs have been implemented in Johannesburg and elsewhere to mitigate access gaps. Local qualitative work finds that when services are delivered with respect, flexibility, low administrative burden and outreach (bringing care closer to where people sleep or congregate), they are much more likely to be used and to build trust—yet such services are usually small, episodic and insufficiently integrated into the wider public-health system.[5] Systematic reviews from higher-income settings echo these findings and emphasise that person-centred outreach, harm-reduction approaches, and mechanisms to maintain continuity of medication are among the most promising interventions.[6]

From a policy perspective, city and provincial strategies increasingly recognise homelessness as an intersectoral problem requiring coordinated health, housing, social-welfare, and employment responses. However, gaps remain between policy commitments and practice: service fragmentation, weak referral pathways, limited data on health needs and service use among homeless populations, and resource constraints all undermine effective implementation.[7] For Johannesburg specifically, recent municipal policy documents and NGO reports call for improved health outreach, better tracking of service outcomes for street-based populations, and stronger links between shelter services and primary-care facilities.

Taken together, the literature indicates three broad research priorities for the proposed study "Beyond the Clinic Door": (1) accurate description of the current health needs and disease burden among people who are homeless in Johannesburg; (2) in-depth exploration of structural, interpersonal and

---

[2] Jonathan Hopkins, Jesse Laitinen, and Donald Skinner, "Understanding the Population of People Experiencing Homelessness in Cape Town and Their Service Use," *International Journal on Homelessness*, October 27, 2024, 1–18, https://doi.org/10.5206/ijoh.2023.3.16666.

[3] Deanne Johnston, Patricia McInerney, and Hilary Thurling, "Experiences of the Homeless Accessing an Inner-City Pharmacy and Medical Student-Run Clinic in Johannesburg," *Health SA Gesondheid* 21, no. 0 (April 23, 2020), https://doi.org/10.4102/hsag.v25i0.1358; T V Phiri, N Gloeck, and A Musekiwa, "Prevalence of Comorbid Disease and Associated Risk Factors among Homeless People Living in Temporary Shelters during the COVID-19 Lockdown in Tshwane, South Africa," *South African Medical Journal* 113, no. 9 (September 4, 2023): 48–52, https://doi.org/10.7196/SAMJ.2023.v113i9.668.

[4] Johnston, McInerney, and Thurling, "Experiences of the Homeless Accessing an Inner-City Pharmacy and Medical Student-Run Clinic in Johannesburg."

[5] Johnston, McInerney, and Thurling, "Experiences of the Homeless Accessing an Inner-City Pharmacy and Medical Student-Run Clinic in Johannesburg."

[6] Phiri, Gloeck, and Musekiwa, "Prevalence of Comorbid Disease and Associated Risk Factors among Homeless People Living in Temporary Shelters during the COVID-19 Lockdown in Tshwane, South Africa."

[7] Johnston, McInerney, and Thurling, "Experiences of the Homeless Accessing an Inner-City Pharmacy and Medical Student-Run Clinic in Johannesburg."

system-level barriers that shape access to care and adherence; and (3) evaluation of practice-oriented interventions (outreach clinics, pharmacy outreach, linkage mechanisms) that improve continuity, dignity and outcomes for this marginalised population. A study situated in Johannesburg will add local empirical evidence to international reviews and policy discussions, strengthen service planning, and inform a more integrated municipal response.

LITERATURE REVIEW

Homelessness remains a major global public-health concern, linked to a wide range of adverse health outcomes. Individuals experiencing homelessness often face multiple, intersecting health challenges that are shaped by poverty, trauma, stigma, and systemic inequalities. Empirical reviews and population studies show that people who are homeless have markedly higher rates of infectious and noncommunicable disease, poorer mental health, and increased premature mortality compared to the housed population.[8] These disparities are compounded by structural barriers to care - including difficulties in accessing primary and preventive services, documentation and insurance obstacles, stigma in health settings, and fragmented service delivery - which impede timely diagnosis and continuity of treatment.[9]

Physical and Chronic Health Conditions

Homeless individuals experience disproportionately high rates of chronic illnesses such as hypertension, diabetes, cardiovascular disease, and chronic obstructive pulmonary disease.[10] Many of these conditions are underdiagnosed or poorly managed due to difficulties in maintaining medication routines, inadequate nutrition, and exposure to harsh environmental conditions.[11] The physical burden of disease among homeless populations is further intensified by poor access to preventive care and primary health services and by high rates of multimorbidity, substance use, and mental illness.[12] These chronic health challenges contribute to accelerated aging and shorter life expectancy compared to housed populations.[13]

Infectious Diseases

Infectious diseases remain highly prevalent among people experiencing homelessness, due to overcrowded living conditions, limited sanitation, and barriers to healthcare access. Tuberculosis, hepatitis B and C, and HIV are among the most common infectious diseases reported within this population.[14] Research indicates that tuberculosis outbreaks in shelters and encampments are often exacerbated by delayed diagnosis and fragmented public health interventions.[15] Similarly, the prevalence of hepatitis C virus infection is notably high, frequently associated with injection drug use and lack of access to harm reduction programs.[16] During the COVID-19 pandemic, individuals without

---

[8] Robert W Aldridge et al., "Morbidity and Mortality in Homeless Individuals, Prisoners, Sex Workers, and Individuals with Substance Use Disorders in High-Income Countries: A Systematic Review and Meta-Analysis," *The Lancet* 391, no. 10117 (January 2018): 241–50, https://doi.org/10.1016/S0140-6736(17)31869-X; Seena Fazel, John R Geddes, and Margot Kushel, "The Health of Homeless People in High-Income Countries: Descriptive Epidemiology, Health Consequences, and Clinical and Policy Recommendations," *The Lancet* 384, no. 9953 (October 2014): 1529–40, https://doi.org/10.1016/S0140-6736(14)61132-6.

[9] Centers for Disease Control and Prevention., "Homelessness and Health- Related Outcomes," 2024; Pernilla Omerov et al., "Homeless Persons' Experiences of Health- and Social Care: A Systematic Integrative Review," *Health & Social Care in the Community* 28, no. 1 (January 16, 2020): 1–11, https://doi.org/10.1111/hsc.12857.

[10] Aldridge et al., "Morbidity and Mortality in Homeless Individuals, Prisoners, Sex Workers, and Individuals with Substance Use Disorders in High-Income Countries: A Systematic Review and Meta-Analysis"; Fazel, Geddes, and Kushel, "The Health of Homeless People in High-Income Countries: Descriptive Epidemiology, Health Consequences, and Clinical and Policy Recommendations."

[11] WHO Housing, "Health Guidelines," *Geneva: World Health Organization* 3 (2018).

[12] Stephen W Hwang, "Homelessness and Health," *Canadian Medical Association Journal* 164, no. 2 (2001): 229–33.

[13] Aldridge et al., "Morbidity and Mortality in Homeless Individuals, Prisoners, Sex Workers, and Individuals with Substance Use Disorders in High-Income Countries: A Systematic Review and Meta-Analysis."

[14] Centers for Disease Control and Prevention., "Homelessness and Health- Related Outcomes."

[15] Emily J. Tweed et al., "Health of People Experiencing Co-Occurring Homelessness, Imprisonment, Substance Use, Sex Work and/or Severe Mental Illness in High-Income Countries: A Systematic Review and Meta-Analysis," *Journal of Epidemiology and Community Health* 75, no. 10 (October 2021): 1010–18, https://doi.org/10.1136/jech-2020-215975.

[16] United Nations Office on Drugs and Crime, "Comorbidities in Drug Use Disorders" (UNODC, 2022).

stable housing were at increased risk of infection and severe outcomes due to pre-existing health conditions and the inability to isolate effectively.[17]

Barriers to Healthcare Access

Despite high health needs, homeless individuals face numerous barriers to accessing healthcare services. Shared challenges include lack of identification documents, transportation difficulties, limited awareness of available services, and experiences of stigma and discrimination within healthcare settings.[18] Additionally, survival priorities such as finding food and shelter often take precedence over health-seeking behaviors.[19] These factors contribute to delayed care, overreliance on emergency services, and poor continuity of treatment.[20] According to Evidence reviews, addressing these barriers requires a holistic, low-threshold approach that integrates medical, psychological, and social support services.[21]

Interventions and Health Service Responses

A growing body of evidence highlights that interventions that integrate housing with comprehensive health and social support services produce the most effective and sustainable outcomes for people experiencing homelessness. Among these, the Housing First model, which prioritises immediate access to permanent housing without preconditions such as sobriety or treatment compliance, has demonstrated significant success in enhancing health outcomes, reducing reliance on emergency healthcare services, and fostering social reintegration.[22] Complementary harm reduction strategies, including needle-exchange programmes, supervised consumption facilities, and opioid-agonist therapies, have also proven effective in mitigating substance-related health risks, lowering rates of overdose, and improving overall well-being among homeless populations.[23] Despite these advancements, there remains a pressing need for longitudinal, context-specific research to assess the long-term effectiveness, scalability, and adaptability of these interventions in diverse socio-economic and cultural settings.[24]

THEORETICAL FRAMEWORK

This study is guided by Andersen's Behavioral Model of Health Services Use, which offers a comprehensive framework for understanding how individual, social, and systemic determinants shape health-seeking behaviours and access to healthcare services. The model conceptualises healthcare utilisation as a function of three interrelated components: predisposing factors, enabling factors, and need factors.[25] Predisposing factors refer to inherent characteristics that influence an individual's inclination to seek care, such as demographic variables, social structures, and health beliefs. Enabling factors encompass the logistical and material resources that facilitate or hinder access to care. These include income, availability of services, transportation, and social support. The need factors represent the perceived or evaluated health status that drives individuals to seek medical attention.

In the context of homelessness in Johannesburg, Andersen's model provides a structured lens to examine how poverty, social exclusion, and urban marginality interact to constrain healthcare access. Many homeless individuals lack enabling resources such as identification documents, stable housing, or

---

[17] Centers for Disease Control and Prevention., "Homelessness and Health- Related Outcomes."
[18] Omerov et al., "Homeless Persons' Experiences of Health- and Social Care: A Systematic Integrative Review."
[19] Housing, "Health Guidelines."
[20] Centers for Disease Control and Prevention., "Homelessness and Health- Related Outcomes."
[21] Campbell Systematic Review Group, *Evidence Reviews for Effectiveness of Approaches to Improve Access to and Engagement with Health and Social Care and Joined up Approaches: Integrated Health and Social Care for People Experiencing Homelessness* (National Institute for Health and Care Excellence, 2022).
[22] Sam Tsemberis, Leyla Gulcur, and Maria Nakae, "Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis," *American Journal of Public Health* 94, no. 4 (April 2004): 651–56, https://doi.org/10.2105/AJPH.94.4.651.
[23] Olivia Magwood et al., "The Effectiveness of Substance Use Interventions for Homeless and Vulnerably Housed Persons: A Systematic Review of Systematic Reviews on Supervised Consumption Facilities, Managed Alcohol Programs, and Pharmacological Agents for Opioid Use Disorder," *PLOS ONE* 15, no. 1 (January 16, 2020): e0227298, https://doi.org/10.1371/journal.pone.0227298.
[24] Aldridge et al., "Morbidity and Mortality in Homeless Individuals, Prisoners, Sex Workers, and Individuals with Substance Use Disorders in High-Income Countries: A Systematic Review and Meta-Analysis."
[25] Ronald M. Andersen, "Revisiting the Behavioral Model and Access to Medical Care: Does It Matter?," *Journal of Health and Social Behavior* 36, no. 1 (March 1995): 1, https://doi.org/10.2307/2137284.

transportation fare, all of which are critical to navigate healthcare systems. Additionally, stigma, discrimination, and negative encounters with healthcare professionals often discourage care-seeking even when services are physically available. Therefore, the model enables this study to systematically interrogate how these interdependent factors shape the health trajectories, service utilisation patterns, and lived experiences of homeless individuals in the city. Applying Andersen's behavioral model, the research aims to generate insights that can inform targeted interventions and policies to improve healthcare access, equity and continuity of care among the homeless population of Johannesburg.

METHODOLOGY

Research Paradigm

This study was anchored within the transformative paradigm, which emphasises social justice, empowerment, and the inclusion of marginalised voices in knowledge production.[26] The transformative approach is particularly suitable for research with vulnerable populations, such as individuals experiencing homelessness, as it seeks to uncover systemic inequities and advocate for change. Through this lens, the study not only aimed to understand the challenges faced by homeless individuals in Johannesburg in accessing healthcare but also to promote awareness and policy reform to address structural barriers. The paradigm guided the research process to ensure that lived realities of participants were represented ethically, authentically, and with an emphasis on social transformation.[27]

Research Approach

A qualitative research approach was used to capture the depth and complexity of the lived experiences of participants. Qualitative research allows for an exploration of meaning, context, and interpretation, key dimensions in understanding how homeless individuals navigate healthcare systems.[28] This approach allows the participants to flexibly express their perspectives in their own words, enabling the researcher to gain nuanced insights into the interplay of individual, social, and systemic factors influencing healthcare access.

Research Design

The study adopted a phenomenological design, which focuses on exploring and describing the lived experiences of participants of a phenomenon.[29] Phenomenology was appropriate as it allowed the researcher to delve deeply into the subjective experiences of homeless individuals as they seek, access, or are excluded from healthcare services in Johannesburg. The design facilitated the identification of shared meanings and patterns in participants' experiences while maintaining sensitivity to their unique contexts.

Participant Selection

Participants were selected using purposive sampling, a strategy that allows the inclusion of individuals who have direct experience with the phenomenon under study.[30] The sample comprised homeless adults residing in inner-city Johannesburg, recruited through local shelters, soup kitchens, and outreach programmes. Inclusion criteria required participants to be 18 years or older and have lived on the streets or in temporary shelters for at least six months. The targeted sample size was between 15-20; however, due to data saturation, a sample of 10 participants was sufficient for analysis. Data saturation refers to the point at which no new themes or insights emerged.[31] Some of the challenges experienced included

[26] Donna M Mertens, *Research and Evaluation in Education and Psychology: Integrating Diversity with Quantitative, Qualitative, and Mixed Methods* (Sage publications, 2019).
[27] John W Creswell and J David Creswell, *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches* (Sage publications, 2017).
[28] Norman K Denzin and Yvonna S Lincoln, *The Sage Handbook of Qualitative Research* (sage, 2011).
[29] Max Van Manen, "But Is It Phenomenology?," *Qualitative Health Research* (Sage Publications Sage CA: Los Angeles, CA, 2017).
[30] Lawrence A Palinkas et al., "Purposeful Sampling for Qualitative Data Collection and Analysis in Mixed Method Implementation Research," *Administration and Policy in Mental Health and Mental Health Services Research* 42, no. 5 (2015): 533–44.
[31] Greg Guest, Arwen Bunce, and Laura Johnson, "How Many Interviews Are Enough?," *Field Methods* 18, no. 1 (February 1, 2006): 59–82, https://doi.org/10.1177/1525822X05279903.

car and individual noise when recording, and they had to move to different quiet places to limit the noise; a language barrier as well; however, the researchers were able to speak other African languages.

Data Generation Methods

Data were generated through semi-structured, in-depth interviews that encouraged participants to share their personal experiences and perspectives on healthcare access. This method allowed for flexibility in probing emerging themes while maintaining focus on key research questions.[32] The interview questions explored the health conditions of participants, encounters with healthcare providers, perceived barriers and facilitators to care, and coping strategies. The interviews were conducted in safe, private settings chosen by participants and lasted approximately 45-60 minutes. All interviews were audio-recorded (with consent) and transcribed verbatim.

Data Analysis

The data were analysed using thematic analysis, following Braun and Clarke's six-step framework: familiarisation with data, generation of initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report.[33] NVivo software was used to assist with data organisation and coding. The analysis was iterative and reflexive, allowing the researcher to continuously engage with the data, interpret emerging meanings, and relate findings to Andersen's Behavioral Model of Health Services Use. Credibility was enhanced through member checking and peer debriefing, ensuring that interpretations accurately reflected participants' voices.[34]

Ethical Considerations

Ethical clearance was obtained from the relevant institutional ethics committee (Protocol Number: H24/10/40). Participants were informed of the study's purpose, their right to withdraw at any time, and how their data would be handled confidentially. Written or verbal informed consent was obtained before participation, depending on literacy levels. Pseudonyms were used to ensure anonymity, and all audio recordings and transcripts were securely stored. Given the vulnerability of the population, care was taken to conduct interviews with sensitivity, and participants were provided with information about available support services in case of distress.

PRESENTATION OF FINDINGS AND DISCUSSIONS

The findings of this study reveal the multifaceted and deeply entrenched challenges faced by individuals experiencing homelessness in Johannesburg. Participants' narratives depict a daily struggle for survival amid deteriorating health, unsafe environments, and systemic barriers to accessing healthcare and social support. The lived realities captured in the data highlight how health vulnerabilities such as HIV/AIDS, substance abuse, and poor hygiene intersect with structural impediments such as lack of identification, clinic exclusion, and social stigma. Despite these hardships, participants demonstrated resilience through informal support networks, sporadic aid from non-profit organisations, compassionate individuals, and faith-based practices. However, the absence of consistent institutional and governmental support perpetuated cycles of illness, marginalisation, and despair. Underpinning these findings is a recurring yearning for dignity, family reconnection, and meaningful reintegration into society, underscoring the urgent need for inclusive health and social policies that address the complex realities of homelessness beyond mere clinical intervention**.** The findings support Andersen's Behavioral Model of Health Services Use, showing that people experiencing homelessness in Johannesburg have significant healthcare needs due to chronic illnesses, infectious diseases, substance-related conditions, poor living conditions, stigma, and violence. Access to healthcare is further limited by administrative and systemic barriers, while informal support networks, faith-based organisations, and personal resilience act as enabling factors that help individuals access care and cope with challenges.

---

[32] Alan Bryman, *Social Research Methods* (Oxford university press, 2016).

[33] Virginia Braun and Victoria Clarke, "Using Thematic Analysis in Psychology," *Qualitative Research in Psychology* 3, no. 2 (2006): 77–101.

[34] Yvonna S. Lincoln and Egon G. Guba, *Naturalistic Inquiry* (Beverly Hills, CA: Sage, 1985).

Theme 1: Health Status

Sub-theme 1.1: HIV/AIDS

Participants highlighted HIV/AIDS as a major health concern among people living on the streets, often linking infection to risky practices such as needle sharing. One participant stated, *"Lots of diseases like TB and HIV. Some people are sharing needles, and I know people with HIV because of sharing needles,"* while another disclosed, "*I am also sick with HIV*." These narratives reflect the high prevalence of HIV in homeless populations, consistent with research showing that unstable living conditions, substance use, and limited access to healthcare exacerbate vulnerability to infection.[35] Despite some awareness of transmission routes, structural barriers such as stigma, lack of identification, and exclusion from healthcare services limit consistent testing and treatment adherence.[36] The co-occurrence of tuberculosis (TB) with HIV among participants underscores the syndemic nature of infectious diseases in marginalised populations.[37] Moreover, needle sharing, noted in participants' accounts, highlights the urgent need for targeted interventions, including harm reduction services, mobile HIV testing, and accessible antiretroviral therapy. [38] Collectively, these findings emphasise the intersection of behavioural, social, and structural factors in shaping HIV risk and health outcomes among the homeless in Johannesburg**.**

From Andersen's Behavioural Model of Health Services Use, homelessness and substance use can be viewed as predisposing factors that increase vulnerability to HIV infection, while stigma, poverty, and lack of identification documents act as enabling barriers that limit access to healthcare services.[39] Although participants demonstrated significant health needs, structural obstacles often hindered access to HIV testing, treatment, and ongoing care. The model therefore helps explain how social and institutional barriers contribute to poor HIV-related health outcomes among homeless individuals.

Sub-theme 1.2: Other Illnesses

Participants reported a range of health problems beyond HIV/AIDS, highlighting the vulnerability of homeless individuals to infectious diseases and injuries linked to prolonged exposure and poor living conditions. Commonly mentioned illnesses included pneumonia, diarrhoea, tuberculosis (TB), and various injuries, often exacerbated by inadequate nutrition, lack of clean water, and exposure to harsh weather. One participant explained, *"Some people are sick and stressed because we sleep in the streets; we get pneumonia and diarrhoea due to eating from dustbins and drinking dirty water."* Another reflected on the compounding effect of isolation and illness: *"I was admitted due to pneumonia but lost contact with family."* These accounts resonate with findings in the literature indicating that homelessness significantly increases susceptibility to communicable diseases, malnutrition, and stress-related health issues.[40] Living in unsanitary conditions, coupled with limited access to healthcare, perpetuates cycles of illness, hospitalisation, and social disconnection.[41] Moreover, TB, epilepsy, skin conditions, lice, and respiratory infections are reported to be prevalent among homeless people. These findings underscore the compounded health risks faced by homeless individuals and the urgent need for targeted public health interventions that address environmental exposures and improve access to preventive and curative services.

Andersen's Behavioural Model of Health Services Use provides a useful lens for understanding these findings. The participants' exposure to harsh living conditions, poor sanitation, and inadequate nutrition increases their susceptibility to illness, while limited access to healthcare and other essential

---

[35] Global HIV UNAIDS, "AIDS Statistics—Fact Sheet. 2022," *Available on: Https://Www. Unaids. Org/Sites/Default/Files/Media_asset/UNAIDS_FactSheet_en. Pdf*, 2023.

[36] Chad A. Leaver et al., "The Effects of Housing Status on Health-Related Outcomes in People Living with HIV: A Systematic Review of the Literature," *AIDS and Behavior* 11, no. S2 (November 8, 2007): 85–100, https://doi.org/10.1007/s10461-007-9246-3.

[37] Temitope Ojo et al., "HIV, Tuberculosis, and Food Insecurity in Africa—A Syndemics-Based Scoping Review," *International Journal of Environmental Research and Public Health* 19, no. 3 (January 19, 2022): 1101, https://doi.org/10.3390/ijerph19031101.

[38] Tessa S. Marcus et al., "Harm Reduction in an Emergency Response to Homelessness during South Africa's COVID-19 Lockdown," *Harm Reduction Journal* 17, no. 1 (December 24, 2020): 60, https://doi.org/10.1186/s12954-020-00404-0.

[39] Andersen, "Revisiting the Behavioral Model and Access to Medical Care: Does It Matter?"

[40] Fazel, Geddes, and Kushel, "The Health of Homeless People in High-Income Countries: Descriptive Epidemiology, Health Consequences, and Clinical and Policy Recommendations."

[41] Hwang, "Homelessness and Health."

resources constrains their ability to seek timely treatment. Although the need for healthcare is evident in reported illnesses, structural barriers often prevent effective service use, perpetuating poor health outcomes among homeless individuals.

Sub-theme 1.3: Needle Sharing and Drug Abuse

Substance abuse and needle sharing emerged as major contributors to poor health and mortality among homeless individuals in Johannesburg. Participants described witnessing overdoses and deaths linked to shared needles, while some engaged in transactional sex to obtain drugs, reflecting the intersection of addiction, poverty, and risky survival strategies. Similar patterns are reported globally, with studies showing that homelessness and drug dependency, particularly involving heroin and nyaope (street illegal drug), increase vulnerability to HIV, hepatitis, and other infections due to unsafe injection practices and limited access to sterile equipment.[42]

Within Andersen's Behavioural Model of Health Services Use, substance abuse can be understood as a predisposing factor that influences health behaviours and increases participation in high-risk practices such as needle sharing and transactional sex. At the same time, homelessness, poverty, stigma, and social exclusion act as enabling barriers that restrict access to healthcare services, addiction treatment programmes, and harm-reduction initiatives. Although participants demonstrate significant health needs arising from drug dependency and associated infections, these structural barriers often prevent timely use of healthcare. The participants' experiences therefore illustrate how risky survival behaviours are shaped not only by individual choices but also by broader social and environmental conditions that constrain access to appropriate care. Addressing these challenges requires harm-reduction interventions, such as needle-exchange programmes and integrated addiction services tailored to the homeless population.

Sub-theme 1.4: Hygiene Practices

Participants described severe challenges in maintaining personal hygiene due to limited access to sanitation facilities, which they linked to poor health and social stigma. One participant stated, *"No toiletries, as a lady, we need to bathe, but there are no free bathing places,"* while another noted, *"It is difficult to get health support in the street because we are unclean."* These accounts highlight how limited access to clean water and bathing spaces undermines both physical well-being and dignity, particularly for women facing menstrual hygiene difficulties. Research shows that inadequate access to sanitation among people experiencing homelessness contributes to poor health outcomes, social exclusion, and barriers to healthcare.[43] Studies in South Africa have also shown that homeless women face compounded challenges related to menstrual hygiene, privacy, and safety when accessing sanitation facilities.[44] Addressing hygiene deprivation thus requires inclusive and gender-sensitive public health interventions such as accessible sanitation infrastructure and mobile hygiene units to restore dignity and improve health outcomes for individuals living on the streets.

The findings can further be understood through Andersen's Behavioural Model of Health Services Use. Access to clean water, sanitation facilities, and hygiene products represents critical enabling resources that influence health outcomes and the use of healthcare. Participants' inability to maintain personal hygiene demonstrates how structural barriers can increase vulnerability to illness

---

[42] World Health Organization, *Global Status Report on Alcohol and Health and Treatment of Substance Use Disorders* (World Health Organization, 2022); Samantha Colledge-Frisby et al., "Global Coverage of Interventions to Prevent and Manage Drug-Related Harms among People Who Inject Drugs: A Systematic Review," *The Lancet Global Health* 11, no. 5 (May 2023): e673–83, https://doi.org/10.1016/S2214-109X(23)00058-X; Nirvana Morgan, William Daniels, and Ugasvaree Subramaney, "Smoking Heroin with Cannabis versus Injecting Heroin: Unexpected Impact on Treatment Outcomes," *Harm Reduction Journal* 16, no. 1 (December 5, 2019): 65, https://doi.org/10.1186/s12954-019-0337-z..

[43] Jessica Leibler et al., "Personal Hygiene Practices among Urban Homeless Persons in Boston, MA," *International Journal of Environmental Research and Public Health* 14, no. 8 (August 18, 2017): 928, https://doi.org/10.3390/ijerph14080928; Johnston, McInerney, and Thurling, "Experiences of the Homeless Accessing an Inner-City Pharmacy and Medical Student-Run Clinic in Johannesburg"; April M Ballard and Bethany A Caruso, "Public Handwashing for Basic Hygiene in People Experiencing Homelessness," *The Lancet Planetary Health* 5, no. 11 (November 2021): e763, https://doi.org/10.1016/S2542-5196(21)00283-7.

[44] Ayanda Mhlongo, "A Capability Approach to Examining the Experiences and Perceptions of Menstrual Hygiene Management (MHM) among Homeless Women in Cape Town," 2021.

while simultaneously discouraging healthcare-seeking behaviour due to stigma and social exclusion. The model highlights that even when individuals recognise their health needs, inadequate enabling resources may prevent them from achieving positive health outcomes.

Theme 2: Perceived Drawbacks in Accessing Healthcare and Support Services

Sub-theme 2.1: Ignorance of Healthcare

Some participants indicated that fellow homeless individuals often neglected seeking healthcare, either due to a lack of awareness or fatalistic attitudes. "Sometimes people do not want to go to the clinic, and the clinic is around here." This reflects a disconnect between health needs and service use. Within Andersen's Behavioural Model of Health Services Use, ignorance or fatalism acts as both a predisposing factor, shaping beliefs and attitudes that reduce care-seeking, and an enabling barrier, limiting awareness of or access to available services.[45] Among the homeless population of Johannesburg, these combined factors result in low service uptake, suggesting the need for targeted interventions that increase health literacy, shift attitudes, and improve access through outreach or peer navigation.

Sub-theme 2.2: Lack of Support from Clinics

Participants highlighted that systemic barriers and a lack of compassion from healthcare providers impeded access to care. "*I am HIV positive, and there is a clinic around, but other homeless people stole my drugs. If I go back to the clinic, they will never help me."* Such experiences reflect both structural and interpersonal barriers that discourage continued engagement with health services. Studies show that homeless individuals often face stigma, discrimination, and judgmental attitudes from healthcare staff, which reduce trust and contribute to treatment discontinuity, particularly for chronic conditions like HIV/AIDS.[46] Within Andersen's Behavioural Model, these barriers operate in the enabling domain: even when resources are nominally available, perceptions of unwelcoming or unsafe care environments limit effective access.[47] Addressing these challenges requires interventions that foster provider sensitivity, reduce stigma, and implement flexible, inclusive service models such as mobile clinics or peer-supported care, which have been shown to improve engagement among marginalised populations.[48]

These findings strongly support Andersen's Behavioural Model of Health Services Use, which identifies enabling factors as critical determinants of healthcare utilisation. Although healthcare facilities may be physically available, negative experiences with healthcare providers, stigma, and perceptions of discrimination function as barriers that reduce willingness to seek care. Andersen's model suggests that access to healthcare is influenced not only by the availability of services, but also by the extent to which individuals perceive these services as accessible, supportive, and responsive to their needs.

Sub-theme 2.3: Lack of Identification or Documentation

The absence of official identification documents emerged as a significant barrier to accessing healthcare and social support services. Participants highlighted that without IDs, they could not register for clinics or receive government grants, compounding their vulnerability and compromising their health. One participant stated, "I can't go to clinic without ID and food, and ID would help me to be healthy," while another noted, "We struggle here in the street without IDs, no grants." This finding aligns with international research showing that lack of identification limits homeless individuals' access to essential services, contributing to poorer health outcomes and social exclusion.[49] In the South African context,

---

[45] Birgit Babitsch, Daniela Gohl, and Thomas Von Lengerke, "Re-Revisiting Andersen's Behavioral Model of Health Services Use: A Systematic Review of Studies from 1998–2011," *GMS Psycho-Social-Medicine* 9 (2012): Doc11; Mareike Lederle, Jana Tempes, and Eva M Bitzer, "Application of Andersen's Behavioural Model of Health Services Use: A Scoping Review with a Focus on Qualitative Health Services Research," *BMJ Open* 11, no. 5 (May 2021): e045018, https://doi.org/10.1136/bmjopen-2020-045018.

[46] Travis P. Baggett et al., "The Unmet Health Care Needs of Homeless Adults: A National Study," *American Journal of Public Health* 100, no. 7 (July 2010): 1326–33, https://doi.org/10.2105/AJPH.2009.180109.

[47] Andersen, "Revisiting the Behavioral Model and Access to Medical Care: Does It Matter?"

[48] Hwang, "Homelessness and Health."

[49] Fazel, Geddes, and Kushel, "The Health of Homeless People in High-Income Countries: Descriptive Epidemiology, Health Consequences, and Clinical and Policy Recommendations"; Ulla Beijer, Achim Wolf, and Seena Fazel, "Prevalence of Tuberculosis, Hepatitis C Virus, and HIV in Homeless People: A Systematic Review and Meta-Analysis," *The Lancet Infectious Diseases* 12, no. 11 (November 2012): 859–70, https://doi.org/10.1016/S1473-3099(12)70177-9.

studies confirm that bureaucratic barriers such as ID requirements perpetuate marginalisation and impede engagement with public health systems.[50] These barriers demonstrate that structural and administrative obstacles are as critical as individual health challenges in shaping service access.

Within Andersen's Behavioural Model, identification documents can be viewed as enabling resources that facilitate access to healthcare and social support systems. The absence of these documents limits individuals' ability to use available services despite having significant healthcare needs. This finding demonstrates how administrative and bureaucratic barriers can directly influence the use of healthcare among homeless populations.

Sub-theme 2.4: Drug Use as a Barrier

Drug use has been reported as both a coping strategy for street life and as a deterrent to seeking formal healthcare. Participants noted, "People do not go to clinics because they use drugs," and *"Most don't go to the hospital even when hurt; people run away and come use drugs in the streets,"* highlighting how substance use fosters avoidance of medical services. This reflects broader evidence indicating that substance abuse among homeless populations is associated with reduced healthcare engagement, risky behaviours, and increased morbidity.[51] In South Africa, substance use, particularly *nyaope* and other opioids, has been linked to survival-driven behaviours and reluctance to access care, exacerbating vulnerability to infectious diseases and injury. These findings illustrate the complex interplay between coping mechanisms, addiction, and barriers to access to healthcare in urban homelessness. Andersen's model provides further insight into this finding by illustrating how substance use may function as both a predisposing characteristic and a barrier to healthcare utilisation. Drug dependency influences health behaviours and decision-making processes, while stigma associated with substance use may discourage engagement with formal healthcare services. Consequently, participants experience increased health needs while simultaneously facing reduced access to appropriate care.

Theme 3: Perceived Street Safety and Risk Practices

Participants consistently described the streets as perilous spaces marked by violence, theft, and pervasive fear, which significantly shaped their behaviours and psychological well-being. One participant noted, *"Although there is security around, it's not safe at all and people fight at night," while another reflected, "The streets made me become a violent person. I'm not violent by nature, but to protect myself, I am now very violent."* Others highlighted the ever-present risk of fatal incidents: "Not safe, random shootings and robbery… some homeless people would be killed." These accounts align with broader research indicating that street homelessness is closely associated with exposure to interpersonal violence, criminal victimisation, and environmental hazards, which contribute to increased stress, trauma, and the adoption of risk-laden survival strategies.[52] The normalisation of self-defensive aggression observed among participants mirrors findings from studies on urban homelessness, where continual exposure to unsafe environments fosters hyper-vigilance, defensive behaviours, and emotional dysregulation.[53] Such dynamics underscore how the physical and social dangers of street life not only compromise safety but also intensify psychological vulnerability, creating a cycle of risk and survival that shapes daily life for people experiencing homelessness**.**

---

[50] Jeremy Seekings, "Poverty and Inequality after Apartheid," 2007; Yanga Z. Zembe et al., "Intimate Partner Violence, Relationship Power Inequity and the Role of Sexual and Social Risk Factors in the Production of Violence among Young Women Who Have Multiple Sexual Partners in a Peri-Urban Setting in South Africa," *PLOS ONE* 10, no. 11 (November 23, 2015): e0139430, https://doi.org/10.1371/journal.pone.0139430.

[51] Seena Fazel et al., "The Prevalence of Mental Disorders among the Homeless in Western Countries: Systematic Review and Meta-Regression Analysis," *PLoS Medicine* 5, no. 12 (December 2, 2008): e225, https://doi.org/10.1371/journal.pmed.0050225; Les B Whitbeck, Danny R Hoyt, and Wa-Ning Bao, "Depressive Symptoms and Co-Occurring Depressive Symptoms, Substance Abuse, and Conduct Problems among Runaway and Homeless Adolescents," *Child Development* 71, no. 3 (May 1, 2000): 721–32, https://doi.org/10.1111/1467-8624.00181.

[52] Martha R Burt, Carol L Pearson, and Ann Elizabeth Montgomery, *Homelessness: Prevention Strategies and Effectiveness* (Nova Publishers, 2007); Paul A Toro, Amy Dworsky, and Patrick J Fowler, "Homeless Youth in the United States: Recent Research Findings and Intervention Approaches," in *National Symposium on Homelessness Research*, vol. 6, 2007, 2..

[53] Kevin M. Fitzpatrick, Mark E. LaGory, and Ferris J. Ritchey, "Dangerous Places: Exposure to Violence and Its Mental Health Consequences for the Homeless.," *American Journal of Orthopsychiatry* 69, no. 4 (1999): 438–47, https://doi.org/10.1037/h0080392.

The findings may also be interpreted through Andersen's Behavioural Model of Health Services Use. Unsafe living environments represent contextual barriers that influence health outcomes and healthcare-seeking behaviours. Constant exposure to violence, theft, and insecurity increases physical and psychological health needs while simultaneously limiting opportunities to access healthcare services. The model suggests that environmental conditions are important determinants of health behaviour and may contribute to ongoing vulnerability among homeless individuals.

Theme 4: Support from Others

Sub-theme 4.1: Support from Non-Profit Organisations (NPOs)

Participants described receiving "sporadic support from NPOs that provided food and basic necessities" (*"Support usually from organisations like Meals on Wheels for food, but once in a while"*). This reflects a common pattern in South African urban contexts, where homeless individuals rely on NPOs for immediate relief but rarely receive continuous or comprehensive support.[54] Although such assistance can temporarily reduce stress and provide essential resources, its unpredictability limits its impact on long-term coping and transition out of homelessness, undermining agency and stability.[55] From a Cultural-Historical Activity Theory perspective, episodic NPO interventions function as unstable mediating artefacts between the homeless person and their object of improved wellbeing, constraining potential transformative change. Structural challenges such as limited capacity, funding instability, and weak coordination among NPOs further explain the irregularity of support.[56] These findings highlight the need for sustained integrated services that move beyond immediate relief to support long-term coping, resilience, and pathways out of homelessness.

From Andersen's perspective, support provided by NPOs functions as an enabling resource that facilitates access to necessities and, in some cases, healthcare services. However, because participants described this support as sporadic and inconsistent, its effectiveness in promoting sustained wellbeing remains limited. Andersen's model highlights the importance of stable enabling resources in supporting positive health outcomes and service use.

Sub-theme 4.2: Support from Students

Participants mentioned receiving occasional assistance from university students, often in the form of food donations or necessities. One participant reflected, "I get support from students, things like food, though it's rare. Jaa, they help a lot." This support, though infrequent, was described as meaningful and humanizing, offering temporary relief and a sense of recognition. Similar findings have been reported in studies highlighting how student-led outreach initiatives contribute to providing social and material support to marginalised urban populations. For example, Johnston et al. described how student volunteers established a primary health care clinic serving homeless individuals in Johannesburg, demonstrating the social impact of student-driven community engagement.[57] Similarly, Kruger et al. found that South African oral-health students gained empathy and civic awareness through community outreach and service activities addressing vulnerable populations.[58] Although such efforts are often short-term and resource-limited, they foster social connection and mutual understanding between students and homeless individuals, bridging the gap between academic institutions and marginalised communities.

---

[54] Mosa Moshabela et al., "Development of Non-Profit Organisations Providing Health and Social Services in Rural South Africa: A Three-Year Longitudinal Study," *PLoS ONE* 8, no. 12 (December 16, 2013): e83861, https://doi.org/10.1371/journal.pone.0083861.

[55] Paramjit Singh Jamir Singh and Azlinda Azman, "System Theory and Ecological Approach in Social Work Practice: An Actual Case Illustration," *Asian Social Work Journal* 7, no. 6 (2022): 24–33.

[56] Emmison Muleya and Constance Matshidiso Lelaka, "Perceptions and Experiences of Shelter Managers in Working with the Homeless Persons during the COVID-19 Pandemic," *Discover Global Society* 3, no. 1 (May 5, 2025): 30, https://doi.org/10.1007/s44282-025-00170-z.

[57] Johnston, McInerney, and Thurling, "Experiences of the Homeless Accessing an Inner-City Pharmacy and Medical Student-Run Clinic in Johannesburg."

[58] Candida Kruger, Ntombizodwa Rosemary Nkambule, and Ahmed Bhayat, "Self-Reported Experience of Outreach Activities amongst Undergraduate Oral Health Students at a University in South Africa," *South African Dental Journal* 79, no. 01 (March 6, 2024): 30–35, https://doi.org/10.17159/sadj.v79i01.16603.

Sub-theme 4.3: Support from Drivers

Some participants described receiving occasional assistance from passing motorists who offered them food or small amounts of money. One participant shared, *"People who pass with cars give us food… but the shelters they want ID, and if you don't have an ID, they will not let you in."* Such acts of kindness were viewed as spontaneous and temporary gestures of compassion that, while not consistent, provided emotional upliftment and immediate relief from hunger. Similar findings have been reported in studies showing that the public sometimes provides informal aid to people experiencing homelessness, often in the form of food, clothing, or small donations.[59] However, this support tends to be sporadic and dependent on individual goodwill rather than structured intervention.[60] Although this form of assistance contributes to meeting short-term needs, it rarely leads to sustainable change due to the lack of coordinated systems that address homelessness at a structural level.[61]

Sub-theme 4.4: Need for Government Support

Participants voiced strong concerns about the lack of structured government intervention to address homelessness, highlighting the need for policies that provide housing, healthcare, and access to essential services. One participant expressed this frustration, stating, *"No support shelters; we really need support from government."* This reflects a broader perception that the state has neglected its responsibility to protect vulnerable citizens. Similar findings have been reported in South African studies showing that government responses to homelessness are often fragmented, under-resourced, and dependent on non-profit organisations rather than coordinated public policy.[62] Research further indicates that municipalities frequently acknowledge homelessness as a pressing issue but lack comprehensive strategies to address its structural causes.[63] Internationally, effective approaches to reducing homelessness have emphasised the importance of government-led interventions that integrate housing provision, social protection, and healthcare access.[64] The participants' appeals thus underscore the urgent need for a coordinated and compassionate state response that moves beyond temporary relief toward sustainable solutions.

Sub-theme 4.5: Need for Healthcare Support

Participants emphasised that accessing healthcare while living on the streets was extremely challenging due to stigma, discrimination, and bureaucratic obstacles. One participant lamented, *"It's difficult to get health support in the street because we are unclean,"* illustrating how societal perceptions of dirtiness and moral failure often deter homeless individuals from seeking care. This aligns with findings from South African studies showing that healthcare workers sometimes display negative attitudes toward homeless patients, contributing to avoidance of health facilities and delayed treatment.[65] Moreover, the lack of identification documents and fixed addresses was cited as a significant barrier to accessing free public healthcare and social support programs.[66] Internationally, research also shows that people experiencing homelessness often experience "institutional exclusion" from health systems that are not designed to accommodate transient populations.[67] Consequently, many rely on self-medication or

[59] Kate Haddow, "'Free Food Places': Looking Beyond the Food Bank to Better Understand Alternative Models of Food Aid," *Sociological Research Online* 31, no. 1 (March 29, 2026): 111–26, https://doi.org/10.1177/13607804251345908.

[60] Catherine Cross et al., "Skeletons at the Feast: A Review of Street Homelessness in South Africa and Other World Regions," *Development Southern Africa* 27, no. 1 (March 2010): 5–20, https://doi.org/10.1080/03768350903519291.

[61] Tshilidzi Stanley Makhitha and Petro Botha, "Teenagers' Sexual Activities on School Grounds: A Need for Social Work Support," *Social Work/Maatskaplike Werk* 53, no. 4 (2017): 496–516.

[62] Cross et al., "Skeletons at the Feast: A Review of Street Homelessness in South Africa and Other World Regions."

[63] Cross et al., "Skeletons at the Feast: A Review of Street Homelessness in South Africa and Other World Regions."

[64] Graham Tipple and Suzanne Speak, "Definitions of Homelessness in Developing Countries," *Habitat International* 29, no. 2 (June 2005): 337–52, https://doi.org/10.1016/j.habitatint.2003.11.002.

[65] Johnston, McInerney, and Thurling, "Experiences of the Homeless Accessing an Inner-City Pharmacy and Medical Student-Run Clinic in Johannesburg."

[66] Kesia Reeve, "Welfare Conditionality, Benefit Sanctions and Homelessness in the UK: Ending the 'Something for Nothing Culture' or Punishing the Poor?," *Journal of Poverty and Social Justice* 25, no. 1 (February 2017): 65–78, https://doi.org/10.1332/175982717X14842281240539.

[67] Amanda Stafford and Lisa Wood, "Tackling Health Disparities for People Who Are Homeless? Start with Social Determinants," *International Journal of Environmental Research and Public Health* 14, no. 12 (December 8, 2017): 1535, https://doi.org/10.3390/ijerph14121535.

emergency services only when illness becomes severe. These findings underscore the need for inclusive, community-based healthcare interventions tailored to the realities of street homelessness.

This finding directly reflects Andersen's Behavioural Model of Health Services Use, which emphasises that healthcare utilisation depends on the availability of enabling resources. Participants clearly expressed significant health needs, yet barriers such as stigma, lack of documentation, and exclusion from healthcare systems reduced their ability to access services. The findings therefore illustrate a mismatch between healthcare needs and healthcare utilisation among homeless individuals.

Sub-theme 4.6: Faith-Based Support

Religion provided psychological and moral comfort for some participants. One stated: "*I am religious, and I am close to the Lord."* For them, faith offered hope, purpose, and resilience amid adversity. In the South African context, research shows that many homeless individuals actively engage with religiosity through prayer, belief in divine guidance, and participation in faith communities as a coping mechanism in navigating life on the margins.[68] Faith practices often provide a moral framework and emotional refuge, helping individuals maintain a sense of dignity and meaning despite their exclusion from mainstream society.[69] Moreover, faith-based organisations and churches are significant providers of relief services, such as shelters, soup kitchens, and street ministries, often stepping in when state support is limited or inconsistent. This dual role, which offers spiritual and practical aid, positions faith-based support as a vital component in understanding how street-homeless individuals construct resilience, meaning and belonging amid hardship.

Theme 5: Relationships with Families

In Sub-theme 5.1: Desire for Family Reunification.

In the desire for Family Reunification sub-theme, participants expressed a strong longing to reconnect with their families, linking reunification to healing and social reintegration. One participant noted*, "I want to be reunited with my family, but I do not know their phone numbers," while another shared, "Would like to be reunited with the family if I can bathe and have clean clothes. I don't want them to see me in this manner."* These statements reflect both hope and concern over dignity and appearance, echoing research showing that family reconnection can improve psychosocial well-being but is often constrained by barriers such as stigma, broken contact, and low self-care.[70]

Within Andersen's Behavioural Model, family support represents an important enabling resource that may facilitate healthcare access, emotional wellbeing, and social reintegration. Participants' desire to reconnect with their families suggests recognition of the role that social support can play in improving health outcomes and enhancing resilience in the face of homelessness.

Sub-theme 5.2: Strained Family Relationships

Addiction, criminality, and prolonged living on the street often fractured family bonds, leading to rejection and mistrust. One participant stated, *"They know I'm in the streets, but family doesn't want to be close to me because of my addiction and gangsterism," while another said, "I don't have relationships with my family."* Such estrangement is common among people experiencing homelessness and substance use, as familial instability and disrupted relationships reduce social support and increase isolation.[71]

---

[68] Buhle Mpofu, "A Conversation with a Stranger: Debunking Religiosity and Poverty in South Africa," *HTS Teologiese Studies / Theological Studies* 77, no. 4 (December 17, 2021), https://doi.org/10.4102/hts.v77i4.7053; Noah K. Tenai and Gloria N. Mbewu, "Street Homelessness in South Africa: A Perspective from the Methodist Church of Southern Africa," *HTS Teologiese Studies / Theological Studies* 76, no. 1 (January 23, 2020), https://doi.org/10.4102/hts.v76i1.5591.

[69] Stephan F. De Beer, "Homelessness and Covid-19 in the City of Tshwane: Doing Liberation Theology Undercover – A Conversation with Ivan Petrella," *HTS Teologiese Studies / Theological Studies* 76, no. 1 (December 1, 2020), https://doi.org/10.4102/hts.v76i1.6209.

[70] Lídia Gouveia et al., "Family Reintegration of Homeless in Maputo and Matola: A Descriptive Study," *International Journal of Mental Health Systems* 11, no. 1 (December 11, 2017): 25, https://doi.org/10.1186/s13033-017-0133-7; S. Sibanda, "A Holistic Family Reunification Services Model for Children in Alternative Care " (University of Pretoria, 2022).

[71] H. Ngwambe, *Ripple Effects – The Impact of Substance Abuse on the Family* (South African Medical Research Council, 2024); Gabriele Schäfer, "Family Functioning In Families With Alcohol And Other Drug Addiction," *Social Policy Journal of New Zealand*, no. 37 (2011): 135.

These broken bonds exacerbate vulnerability, hindering identity formation and pathways out of homelessness, highlighting the need for interventions that restore both relational and structural support. Andersen's model suggests that weakened family relationships reduce access to important enabling resources such as emotional support, financial assistance, and guidance in navigating healthcare systems. Consequently, the absence of family support may increase vulnerability and further limit the use of healthcare among homeless individuals.

Discussion Summary

This study underscores the fact that homelessness in Johannesburg is marked by a complex interplay of health, social, and structural challenges that trap individuals in cycles of vulnerability and exclusion. Poor health outcomes, particularly the prevalence of HIV/AIDS, tuberculosis, and substance-related illnesses, are aggravated by unsanitary living conditions, lack of hygiene facilities, and inadequate access to medical care. Systemic barriers such as a lack of identification documents, discriminatory treatment in clinics, and the absence of sustained government intervention further restrict access to essential services. The unsafe and violent conditions on the streets not only compromise physical well-being but also deepen psychological distress and normalise aggression as a survival mechanism. Despite these adversities, participants exhibited remarkable resilience, relying on informal social networks, sporadic assistance from non-profit organisations, compassionate individuals, and faith for emotional sustenance. A recurring theme throughout the findings was the yearning for dignity, family reconnection, and reintegration into society, suggesting that homelessness extends beyond material deprivation to encompass profound social and emotional dislocation. The findings underscore the urgent need for multidimensional interventions that address both the health and human aspects of homelessness in South Africa's urban contexts.

RECOMMENDATIONS

Based on these findings, the study recommends a holistic, multi-sectoral response to homelessness that integrates healthcare, social welfare, and community development. First, the government should establish inclusive health policies that remove identification barriers and ensure that homeless individuals can access free or low-cost medical services without bureaucratic restrictions. Mobile health clinics and outreach programs that target HIV testing, tuberculosis screening, and substance abuse rehabilitation should be expanded to street populations. Second, collaborative partnerships between government departments, non-profit organisations, and faith-based institutions are essential to provide consistent food, shelter, and psychosocial support. Third, interventions should prioritise mental health and addiction recovery as key components of rehabilitation, accompanied by skills training and employment opportunities to facilitate reintegration. Fourth, policies should include family tracing and reunification programs to restore social connections and reduce long-term street dependency. Lastly, public awareness campaigns should be implemented to combat stigma and promote empathy toward homeless populations. By adopting these measures, Johannesburg can move toward a more compassionate and sustainable model of urban health and social inclusion.

CONCLUSION

The study explored the health conditions, service barriers, and coping mechanisms of people experiencing homelessness within Johannesburg's urban context and was guided by Andersen's Behavioral Model of Health Services Use. The study found that people experiencing homelessness in Johannesburg face severe health and social challenges, including chronic illnesses, infectious diseases, substance-related conditions, poor living conditions, stigma, and violence. Structural barriers such as lack of identification documents, discrimination in healthcare facilities, and fragmented service delivery often hinder access to healthcare. Despite these difficulties, many individuals demonstrate resilience through informal support networks, assistance from non-profit and faith-based organisations, and personal spirituality. The findings highlight a strong desire for dignity, family reconnection, and social reintegration. The study concludes that homelessness is both a public health and human rights concern, requiring coordinated multi-sectoral responses. Key recommendations include mobile healthcare

outreach, reducing administrative barriers to care, expanding mental health and addiction services, and strengthening family reunification programs to promote equitable and inclusive healthcare access.

ACKNOWLEDGEMENTS

The authors acknowledge all persons experiencing homelessness who voluntarily participated in this study.

BIBLIOGRAPHY

Aldridge, Robert W, Alistair Story, Stephen W Hwang, Merete Nordentoft, Serena A Luchenski, Greg Hartwell, Emily J Tweed, Dan Lewer, Srinivasa Vittal Katikireddi, and Andrew C Hayward. "Morbidity and Mortality in Homeless Individuals, Prisoners, Sex Workers, and Individuals with Substance Use Disorders in High-Income Countries: A Systematic Review and Meta-Analysis." *The Lancet* 391, no. 10117 (January 2018): 241–50. https://doi.org/10.1016/S0140-6736(17)31869-X.

Andersen, Ronald M. "Revisiting the Behavioral Model and Access to Medical Care: Does It Matter?" *Journal of Health and Social Behavior* 36, no. 1 (March 1995): 1. https://doi.org/10.2307/2137284.

Babitsch, Birgit, Daniela Gohl, and Thomas Von Lengerke. "Re-Revisiting Andersen's Behavioral Model of Health Services Use: A Systematic Review of Studies from 1998–2011." *GMS Psycho-Social-Medicine* 9 (2012): Doc11.

Ballard, April M, and Bethany A Caruso. "Public Handwashing for Basic Hygiene in People Experiencing Homelessness." *The Lancet Planetary Health* 5, no. 11 (November 2021): e763. https://doi.org/10.1016/S2542-5196(21)00283-7.

Beer, Stephan F. De. "Homelessness and Covid-19 in the City of Tshwane: Doing Liberation Theology Undercover – A Conversation with Ivan Petrella." *HTS Teologiese Studies / Theological Studies* 76, no. 1 (December 1, 2020). https://doi.org/10.4102/hts.v76i1.6209.

Beijer, Ulla, Achim Wolf, and Seena Fazel. "Prevalence of Tuberculosis, Hepatitis C Virus, and HIV in Homeless People: A Systematic Review and Meta-Analysis." *The Lancet Infectious Diseases* 12, no. 11 (November 2012): 859–70. https://doi.org/10.1016/S1473-3099(12)70177-9.

Braun, Virginia, and Victoria Clarke. "Using Thematic Analysis in Psychology." *Qualitative Research in Psychology* 3, no. 2 (2006): 77–101.

Bryman, Alan. *Social Research Methods*. Oxford University Press, 2016.

Burt, Martha R., Carol L. Pearson, and Ann Elizabeth Montgomery. *Homelessness: Prevention Strategies and Effectiveness*. Nova Publishers, 2007.

Campbell Systematic Review Group. *Evidence Reviews for Effectiveness of Approaches to Improve Access to and Engagement with Health and Social Care and Joined-up Approaches: Integrated Health and Social Care for People Experiencing Homelessness*. National Institute for Health and Care Excellence, 2022.

Centers for Disease Control and Prevention. "Homelessness and Health- Related Outcomes," 2024.

Creswell, John W., and J. David Creswell. *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*. Sage Publications, 2017.

Cross, Catherine, John Seager, Johan Erasmus, Cathy Ward, and Michael O'Donovan. "Skeletons at the Feast: A Review of Street Homelessness in South Africa and Other World Regions." *Development Southern Africa* 27, no. 1 (March 2010): 5–20. https://doi.org/10.1080/03768350903519291.

Denzin, Norman K., and Yvonna S. Lincoln. *The Sage Handbook of Qualitative Research*. Sage, 2011.

Fazel, Seena, John R. Geddes, and Margot Kushel. "The Health of Homeless People in High-Income Countries: Descriptive Epidemiology, Health Consequences, and Clinical and Policy Recommendations." *The Lancet* 384, no. 9953 (October 2014): 1529–40. https://doi.org/10.1016/S0140-6736(14)61132-6.

Fazel, Seena, Vivek Khosla, Helen Doll, and John Geddes. "The Prevalence of Mental Disorders

among the Homeless in Western Countries: Systematic Review and Meta-Regression Analysis." *PLoS Medicine* 5, no. 12 (December 2, 2008): e225. https://doi.org/10.1371/journal.pmed.0050225.

Fitzpatrick, Kevin M., Mark E. LaGory, and Ferris J. Ritchey. "Dangerous Places: Exposure to Violence and Its Mental Health Consequences for the Homeless." *American Journal of Orthopsychiatry* 69, no. 4 (1999): 438–47. https://doi.org/10.1037/h0080392.

Gouveia, Lídia, Honório Massanganhe, Flávio Mandlate, Dirceu Mabunda, Wilza Fumo, Ana Olga Mocumbi, and Jair de Jesus Mari. "Family Reintegration of Homeless in Maputo and Matola: A Descriptive Study." *International Journal of Mental Health Systems* 11, no. 1 (December 11, 2017): 25. https://doi.org/10.1186/s13033-017-0133-7.

Haddow, Kate. "'Free Food Places': Looking Beyond the Food Bank to Better Understand Alternative Models of Food Aid." *Sociological Research Online* 31, no. 1 (March 29, 2026): 111–26. https://doi.org/10.1177/13607804251345908.

Hopkins, Jonathan, Jesse Laitinen, and Donald Skinner. "Understanding the Population of People Experiencing Homelessness in Cape Town and Their Service Use." *International Journal on Homelessness*, October 27, 2024, 1–18. https://doi.org/10.5206/ijoh.2023.3.16666.

Hwang, Stephen W. "Homelessness and Health." *Canadian Medical Association Journal* 164, no. 2 (2001): 229–33.

Johnston, Deanne, Patricia McInerney, and Hilary Thurling. "Experiences of the Homeless Accessing an Inner-City Pharmacy and Medical Student-Run Clinic in Johannesburg." *Health SA Gesondheid* 21, no. 0 (April 23, 2020). https://doi.org/10.4102/hsag.v25i0.1358.

Kruger, Candida, Ntombizodwa Rosemary Nkambule, and Ahmed Bhayat. "Self-Reported Experience of Outreach Activities amongst Undergraduate Oral Health Students at a University in South Africa." *South African Dental Journal* 79, no. 01 (March 6, 2024): 30–35. https://doi.org/10.17159/sadj.v79i01.16603.

Leaver, Chad A., Gordon Bargh, James R. Dunn, and Stephen W. Hwang. "The Effects of Housing Status on Health-Related Outcomes in People Living with HIV: A Systematic Review of the Literature." *AIDS and Behavior* 11, no. S2 (November 8, 2007): 85–100. https://doi.org/10.1007/s10461-007-9246-3.

Lederle, Mareike, Jana Tempes, and Eva M Bitzer. "Application of Andersen's Behavioural Model of Health Services Use: A Scoping Review with a Focus on Qualitative Health Services Research." *BMJ Open* 11, no. 5 (May 2021): e045018. https://doi.org/10.1136/bmjopen-2020-045018.

Leibler, Jessica, Daniel Nguyen, Casey León, Jessie Gaeta, and Debora Perez. "Personal Hygiene Practices among Urban Homeless Persons in Boston, MA." *International Journal of Environmental Research and Public Health* 14, no. 8 (August 18, 2017): 928. https://doi.org/10.3390/ijerph14080928.

Lincoln, Yvonna S., and Egon G. Guba. *Naturalistic Inquiry*. Beverly Hills, CA: Sage, 1985.

Makhitha, Tshilidzi Stanley, and Petro Botha. "Teenagers' Sexual Activities on School Grounds: A Need for Social Work Support." *Social Work/Maatskaplike Werk* 53, no. 4 (2017): 496–516.

Manen, Max Van. "But Is It Phenomenology?" *Qualitative Health Research*. Sage Publications, Sage CA: Los Angeles, CA, 2017.

Marcus, Tessa S., Jan Heese, Andrew Scheibe, Shaun Shelly, Sasha X. Lalla, and Jannie F. Hugo. "Harm Reduction in an Emergency Response to Homelessness during South Africa's COVID-19 Lockdown." *Harm Reduction Journal* 17, no. 1 (December 24, 2020): 60. https://doi.org/10.1186/s12954-020-00404-0.

Mertens, Donna M. *Research and Evaluation in Education and Psychology: Integrating Diversity with Quantitative, Qualitative, and Mixed Methods*. Sage Publications, 2019.

Mhlongo, Ayanda. "A Capability Approach to Examining the Experiences and Perceptions of Menstrual Hygiene Management (MHM) among Homeless Women in Cape Town," 2021.

Moshabela, Mosa, Shira Gitomer, Bongiwe Qhibi, and Helen Schneider. "Development of Non-Profit Organisations Providing Health and Social Services in Rural South Africa: A Three-Year Longitudinal Study." *PLoS ONE* 8, no. 12 (December 16, 2013): e83861.

https://doi.org/10.1371/journal.pone.0083861.
Mpofu, Buhle. "A Conversation with a Stranger: Debunking Religiosity and Poverty in South Africa." *HTS Teologiese Studies / Theological Studies* 77, no. 4 (December 17, 2021). https://doi.org/10.4102/hts.v77i4.7053.
Ngwambe, H. *Ripple Effects – The Impact of Substance Abuse on the Family*. South African Medical Research Council, 2024.
Ojo, Temitope, Christina Ruan, Tania Hameed, Carly Malburg, Sukruthi Thunga, Jaimie Smith, Dorice Vieira, et al. "HIV, Tuberculosis, and Food Insecurity in Africa—A Syndemics-Based Scoping Review." *International Journal of Environmental Research and Public Health* 19, no. 3 (January 19, 2022): 1101. https://doi.org/10.3390/ijerph19031101.
Omerov, Pernilla, Åsa G. Craftman, Elisabet Mattsson, and Anna Klarare. "Homeless Persons' Experiences of Health- and Social Care: A Systematic Integrative Review." *Health & Social Care in the Community* 28, no. 1 (January 16, 2020): 1–11. https://doi.org/10.1111/hsc.12857.
Organization, World Health. *Global Status Report on Alcohol and Health and Treatment of Substance Use Disorders*. World Health Organization, 2024.
Phiri, T V, N Gloeck, and A Musekiwa. "Prevalence of Comorbid Disease and Associated Risk Factors among Homeless People Living in Temporary Shelters during the COVID-19 Lockdown in Tshwane, South Africa." *South African Medical Journal* 113, no. 9 (September 4, 2023): 48–52. https://doi.org/10.7196/SAMJ.2023.v113i9.668.
Schäfer, Gabriele. "Family Functioning In Families With Alcohol And Other Drug Addiction." *Social Policy Journal of New Zealand*, no. 37 (2011): 135.
Seekings, Jeremy. "Poverty and Inequality after Apartheid," 2007.
Sibanda, S. "A Holistic Family Reunification Services Model for Children in Alternative Care ." University of Pretoria, 2022.
Singh, Paramjit Singh Jamir, and Azlinda Azman. "System Theory and Ecological Approach in Social Work Practice: An Actual Case Illustration." *Asian Social Work Journal* 7, no. 6 (2022): 24–33.
Stafford, Amanda, and Lisa Wood. "Tackling Health Disparities for People Who Are Homeless? Start with Social Determinants." *International Journal of Environmental Research and Public Health* 14, no. 12 (December 8, 2017): 1535. https://doi.org/10.3390/ijerph14121535.
Tenai, Noah K., and Gloria N. Mbewu. "Street Homelessness in South Africa: A Perspective from the Methodist Church of Southern Africa." *HTS Teologiese Studies / Theological Studies* 76, no. 1 (January 23, 2020). https://doi.org/10.4102/hts.v76i1.5591.
Toro, Paul A., Amy Dworsky, and Patrick J. Fowler. "Homeless Youth in the United States: Recent Research Findings and Intervention Approaches." In *National Symposium on Homelessness Research*, 6:2, 2007.
Tsemberis, Sam, Leyla Gulcur, and Maria Nakae. "Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis." *American Journal of Public Health* 94, no. 4 (April 2004): 651–56. https://doi.org/10.2105/AJPH.94.4.651.
UNAIDS, Global HIV. "AIDS Statistics—Fact Sheet. 2022." *Available on: Https://Www. Unaids. Org/Sites/Default/Files/Media_asset/UNAIDS_FactSheet_en. PDF*, 2023.
United Nations Office on Drugs and Crime. "Comorbidities in Drug Use Disorders." UNODC, 2022.
Whitbeck, Les B, Danny R Hoyt, and Wa-Ning Bao. "Depressive Symptoms and Co-Occurring Depressive Symptoms, Substance Abuse, and Conduct Problems among Runaway and Homeless Adolescents." *Child Development* 71, no. 3 (May 1, 2000): 721–32. https://doi.org/10.1111/1467-8624.00181.
WHO Housing, "Health Guidelines." *Geneva: World Health Organization* 3 (2018).
Zembe, Yanga Z., Loraine Townsend, Anna Thorson, Margrethe Silberschmidt, and Anna Mia Ekstrom. "Intimate Partner Violence, Relationship Power Inequity and the Role of Sexual and Social Risk Factors in the Production of Violence among Young Women Who Have Multiple Sexual Partners in a Peri-Urban Setting in South Africa." *PLOS ONE* 10, no. 11 (November 23, 2015): e0139430. https://doi.org/10.1371/journal.pone.0139430.

ABOUT AUTHORS

Dr. Tshidi Lelaka is a Lecturer in Social Work at the University of the Witwatersrand with research interests in Public Health and working with vulnerable groups.

Dr. Phumuzani Mpofu is a Post-doctoral Fellow, Department of Psychology, School of Community and Human Development, University of the Witwatersrand, with research interests in parenting, families and working with vulnerable groups.

Dr. Johanna Deka is a Lecturer in Social Work at the University of the Witwatersrand with research interests in Occupational Social work.

Dr. Emmison Muleya Lecturer in Social Work at University of Witwatersrand with research interests in Social policy, social development and persons experiencing homelessness.