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FACING HOMELESSNESS

FINDING INCLUSIONARY, COLLABORATIVE SOLUTIONS

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Chapter 6

A practical guide to providing health services to homeless persons using community-oriented primary care

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Why is health care for homeless persons important?

> Walking through the city centre and entering territories considered 'dangerous' and 'dirty' brings out that the street is not only a place of passage and circulation, it is also a place of permanence and residence, repression and resistance.[28]
>
> (Hallais & De Barros 2015:1501)

Homelessness is complex and multifactorial, as are the health issues homeless persons face. Homelessness is strongly associated with poor health. This association can be described as circular: poor health can predispose people to poor and difficult living conditions that can contribute to homelessness, and homelessness can contribute directly to poor health through physical factors such as exposure, lack of shelter or systemic and lifestyle factors and lower levels of personal safety.

Homeless persons in general have the same baseline population risk for non-communicable diseases for people their age and socio-economic status, but are at much higher risk of mental health problems, substance use disorder, physical disability and infectious diseases such as TB, HIV and hepatitis, as well as of violence and injury (Hwang & Burns 2014; Seager & Tamane 2010). These conditions are often co-morbid and have compound health effects, complicating their management.

Another significant factor contributing to poor health outcomes experienced by homeless persons is access to care.

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28. The text was translated using Google Translate.

The stigma of homelessness and the associated health-related issues (such as substance use disorder or mental health issues) lead to homeless persons being easily recognisable, often facing discrimination from the health care services. People who are homeless, consequently, often become reluctant to access care, and when they do, they receive suboptimal care without the necessary continuity and coordination of care.

As homeless persons have to spend much time and effort in meeting their most basic needs, what is normally considered appropriate help-seeking behaviour in the housed population is often a lower priority. Practically this might translate to late presentation with a complicated disease, non-adherence to treatment or appointments and loss to follow-up.

We recognise that there is no one-size-fits-all approach to addressing homelessness, as the phenomenon of homelessness is heterogeneous in terms of demographics, causes and family relations. Hwang and Burns (2014:1546) accurately state that '[h]omelessness is ultimately the result of the convergence of individual vulnerabilities and structural factors'. Therefore, an appropriate health care response recognises the individual and structural problems, and implements special care measures to include homeless persons and keep them in care.

In this chapter we describe an approach to care that makes the care of homeless persons a specific part of the health care service. Primary health care tailored to meet the needs of homeless persons might be more effective compared to standard care and is likely to achieve higher patient-rated quality of care (Hwang & Burns 2014:1543) and better health outcomes.

■ Who provides health care for the homeless?

The South African Constitution, the Bill of Rights and the *National Health Act* designate to the State the responsibility to provide access to health care services. This means that public

health services have to provide care for people who cannot afford access to private pay-for-service providers or health insurance.

Homeless persons have a higher burden of disease than the general population and hence, being some of the most disadvantaged individuals in society, an equitable approach to healthcare for homeless persons is needed. We argue that in a healthcare system that aims to provide universal health coverage using a PHC model, the state not only has the responsibility to provide access to healthcare for homeless persons, but should prioritise their care.

The experience of homeless persons with the public healthcare system is contrary to what is set out as the ideal in the relevant legislation. Homeless persons lack access to healthcare, as the healthcare system discriminates against them because they are homeless, or the treatment guidelines do not include homeless-specific interventions. To address this lack of access and the gap in the healthcare system, non-governmental organisations fill the gap by providing healthcare to homeless persons. These organisations usually fall into the following categories:

- Organisations that provide a service for which there is a health need, but the specific service is not offered in the public health system. Such services include, but are not limited to, harm-reduction services such as opioid substitution therapy, needle and syringe programmes and hepatitis C treatment programmes.
- Organisations that offer services to people who might have difficulty accessing existing health care services (even though the service may already be offered in the public health care system): pre-exposure prophylaxis, antiretroviral treatment to key populations, PHC to undocumented migrants.
- Organisations that may not deliver health care services directly, but do advocacy and linkage work for people who have difficulty in accessing the public health services. These include organisations

that provide meals, training and housing to homeless persons, linkage to care and advocate in the public sphere.
- Organisations that provide care and living space for homeless persons who are ill. These organisations may hire or depend on volunteer health care workers, but are largely dependent on the public health care services for long-term follow-up, medication and supplies.

No one service can provide all-inclusive holistic care to any patient. Homeless persons make use of all levels of the public health care system: mobile clinics when they are available, PHC clinics, district and tertiary hospital care if necessary. Therefore, all of these types of organisations need to be able to link, collaborate and use existing public health services to ensure coordination and continuity of care.

We therefore argue that health care for homeless persons should be seen as a function of primary care and district care, rooted in the public health care system. In the context of South Africa's district health system, we believe that it would be prudent that each district health service approach provision of care for the homeless according to the principles of COPC, as they would for other identified at-risk populations.

The health service proposed in this chapter, and to an extent the current practice of the authors, make use of the current PHC package of care typically available throughout South Africa. While human-resources for health remain a challenge in the broader landscape in the public health care sector, the interventions described further mostly make use of existing systems and persons or organisations who additionally work towards equitable health care services for homeless persons.

Community-oriented primary care

Coordinated COPC provides a structured approach for health care in general and care for homeless persons in particular.

Bam et al. (2013) describe COPC as follows:

> Briefly, COPC is grounded in the notion that people's health is determined by their social environment. This means that individual and population level improvements in health cannot be achieved without simultaneously changing the social determinants that shape health more generally. COPC has been summarily described as 'the merger of front-line clinical medicine with public health'. As such, COPC addresses individual health needs in the collective context of family and community. COPC is characterised by local specificity that derives from the behavioural, cultural and social characteristics of people who live in particular places. (p. 1)

In COPC we are aware of problems at home and in the person's health. It is at the home where disease symptoms first show, and where care continues to happen (dressing of wounds, safe keeping of medication, adherence, rest).

In the comprehensive care of people there is a role for the clinic, the hospital and the home. Often the home and the family are the most important parts of a care plan. With people who are homeless, the home, and more often than not the family, are absent, or do not exist. That means that a significant part of caring for a patient is absent. It is like a three-legged pot with only two legs – extra attention and special resources will always be needed to produce favourable health outcomes. A major part of the difficulty of providing health care to persons who are homeless is the lack of a home.

The ideal solution for the care of homeless persons is the provision of a home or shelter. Where that is not possible, an alternative plan needs to be made through networking and collaboration. A special emphasis must be placed on substituting the home with some form of housing or shelter, accompanied by a community of care for the individual.

COPC is guided by five core principles (cf. *COPC Principles* n.d.; Marcus 2018) as shown in Table 6.1.

TABLE 6.1: Core principles of community-oriented primary care.

Principles of COPC	Explained	Specific activity related to health care for homeless persons
Local health and institutional analysis	There must be community-based assessment of the problem and the solutions in specific geographical areas. The programme takes responsibility for homeless persons in an identified geographical area in a city. Homelessness is assessed in that area by going into the community and assessing the number and nature of homeless persons as well as the network of care that is available. This assessment informs and monitors interventions.	• Each subdistrict or health catchment area should assess and quantify homelessness in its area of responsibility. This will mean a geographic representation of the number of homeless persons and where they usually sleep. • What are the health needs of homeless persons? • How do homeless persons access health care? • Which health care services do homeless persons regularly utilise, and are they at an appropriate level? • Are these needs being met (treatment for substance use, etc.)? • Where do homeless persons gather and sleep? • Where are homeless shelters and how are they managed? • Are there organisations that cater specifically to homeless persons? • Does the health care service have a relationship with these organisations?
Comprehensive care	Comprehensive care means that all the relevant conditions and factors are identified and handled in a comprehensive manner. Attention is given to the preventive and promotive care, curative care, rehabilitation and palliation.	• Health care workers should be attuned to the realities of homelessness. Delivering comprehensive care is improved when providers are aware of the abilities of their care recipients (what they can and cannot do). • One way to improve comprehensive care is to employ peers as care workers similar to community health workers. • Providing a home is the most important part of comprehensive care.

COPC, community-oriented primary care; PHC, primary health care.

Table 6.1 continues on the next page→

TABLE 6.1 (Continues...): Core principles of community-oriented primary care.

Principles of COPC	Explained	Specific activity related to health care for homeless persons
Equity	This principle in itself makes the care of homeless persons important as they are the people with the most needs and least resources in society. We also need to identify those amongst the homeless with the most needs and ensure that they have access to appropriate care.	• Care to homeless persons should not only include delivering services at existing facilities, but, as this is a population with decreased access to health care, the provision of care needs to occur as close to their lived experience as possible. We therefore recommend provision of care through a mobile clinic that routinely visits sites that have a high concentration of homeless communities to deliver PHC, with integration into the whole gamut of health care services. • 'Home visits' should be done to homeless shelters, organisations that care for homeless persons and areas where homeless persons gather and sleep.
Practice with science	This means that care should be informed by the best evidence available, delivered by a multidisciplinary and multi-sectoral team and care should be monitored and adapted. A proper information system is part of this.	• Research on homelessness and healthcare is ongoing and care providers need to be up to date with current treatment guidelines and advocate for their implementation. • The public health treatment guidelines should be updated to include the latest healthcare practices. For example, the current public health sector treatment guidelines do not cover opioid substitution therapy (OST), even though OST is considered the most effective treatment for opioid use disorder. • Reporting on the health and health care of homeless persons should be a specific element of the district health information system. • Each clinic, hospital and subdistrict or health catchment area should document, assess and adapt the care of homeless persons in its geographic area of responsibility.

COPC, community-oriented primary care; PHC, primary health care.

Table 6.1 continues on the next page→

TABLE 6.1 (Continues...): Core principles of community-oriented primary care.

Principles of COPC	Explained	Specific activity related to health care for homeless persons
Service integration around users	Care should be coordinated around people and families. This requires person-centred care coordinated to include the homeless person and those he or she lives with.	• Care for homeless persons needs to be integrated; from involving the patient themselves in their care, utilising services not necessarily pertaining to health care, and coordinating care with the rest of the healthcare system. Central to this needs to be a person-centred approach that considers the patient's agency and a respect for their wishes. • Coordination of care of homeless persons is a particular challenge and a clear system of coordination between the health services, social services, shelters and organisations needs to be developed and maintained.

COPC, community-oriented primary care; PHC, primary health care.

Emancipatory care

> In this decolonizing perspective, welcoming refers to an emancipating care that is based on the recognition of the diversity and autonomy of the subjects, thus allowing the transformation of the patient-passive subject into the participatory agent of their health, disease and care process. This condition also enables and enhances the approach and dialogue between health professionals and users, reconfiguring doctor-centred relationships that preserve (and even recover) the life histories and knowledge of the individuals under treatment.[29] (Hallais & De Barros 2015:1502)

Emancipatory research engages issues of social justice and power relations. It seeks to transform the power relation between the researcher and the researched, that is the research is guided by the researched and the research belongs to the researched, not the researcher (Swartz & Nyamjoh 2018:1). Using the same

29. The text was translated using Google Translate (https://translate.google.com).

principles of emancipatory research, emancipatory care seeks to transform the power relation between the patient and the healthcare system by providing support to vulnerable and oppressed groups 'to identify and act on social policies and practices that keep unequal power relations in place' (Kramer-Roy 2015:1211–1212). Furthermore, Hallais and De Barros (2015) posit that the diversity and autonomy as well as the needs of the individual must be recognised, and that people should actively participate in the process of their care. They are transformed into participatory agents of change in the health–disease process.

The autonomy of homeless persons is important. Often their homelessness is related to a sense of their own autonomy, but homelessness also makes them vulnerable and susceptible to be dominated by health care workers who often approach them as individual failures. In the process of caring for homeless persons, the actions and interventions must allow them to fully participate in the development of a care coordination plan for themselves, as this will acknowledge and respect their autonomy, and enable them to reclaim their dignity, agency and humanity.

The patient, the one cared for, actively participates in the continuum of care, participating in the decision-making process with the health care teams about their own health, and taking responsibility for their own and their community's health. The healthcare team provides the patient with multiple intervention options, and the patient has the responsibility to choose the option that they know will work for them. The individual, knowing themselves and their environment the best, will know which of the options will work.

Emancipatory care becomes political care. Political care addresses how care is conceptualised and, as Hoppania (2015:167) argues, that 'the politics of care' also consists of 'a struggle over recognition, redistribution and representation'. It challenges a

model of care that is based on hierarchy and economic factors. It seeks to break with 'biopower' (medicine's focus on the strictly biological): care must absorb the unexpected, the unplanned and the non-prescriptive, with the development of new research and innovative solutions. It also recognises the fact that the streets are the territory of the homeless communities, and that we are required to ensure care inside that ecology: Where the caregiver might slow down, and place themselves next to the recipients of care. It requires the caregiver to not only understand and view the territories of the homeless persons (i.e. the streets) as 'dangerous' and 'dirty', but to 'a place of permanence and residence, repression and resistance' (Hallais & De Barros 2015:1501).

This also means that respect and confidentiality need to be maintained. This kind of relationship-building requires more time than the healthcare provider is used to devoting to treatment, as well as requiring the provider to meet the patients where they are.

One ethical dilemma that the care provider might be faced with is that it might be more beneficial to focus on building the therapeutic relationship and forego certain interventions that the patient might not be interested in at that time.

BOX 6.1: Patient story.

A middle-aged man visited the homeless clinic seeking treatment for an eye infection. During the consultation, the health care provider realises that the patient also has a mental health disorder, with delusions and behaviour that, while not necessarily dangerous to himself or others, limits his functioning. The patient is adamant that the thoughts and behaviours are not a problem, and he only wants treatment for the eye problem. Through repeated contact and follow-up with the health care provider and other service providers, the patient was later placed in a care centre, and only then started on mental health treatment when he decided it was the correct thing to do.

Clinical care

Clinical care of homeless persons needs to take their specific situation and needs into consideration. Standard treatment guidelines and procedures are often inadequate and inappropriate for homeless persons. Continuity of care is often difficult and special measures need to be negotiated and put into place to provide quality care and achieve the aims of care. In practical terms, this means that completing standard courses of antibiotics or attending appointments might not be possible for homeless persons. With support from a homeless peer, this becomes a much more achievable task for the individual.

A positive interpersonal relationship with homeless persons is essential; this is effected by maintaining respect for the individual, upholding the person's dignity, building mutual trust and showing warmth and care (cf. Hwang & Burns 2014):

- We propose the following practical guidelines to transform clinical care practices that will seek to address the specific needs of the homeless communities (see Hwang & Burns 2014).
- Adapted clinical guidelines are available to help health care providers adjust their practice to better meet the physical and mental health needs of patients who are homeless.
- Physicians working with homeless individuals in emergency departments need to develop systems that ensure appropriate follow-up in the community.
- When homeless persons are admitted to a hospital, proactive two-way communication between hospital-based and community-based providers is essential to ensure smooth transition of care.
- Provision of health care should include collaboration between organisations with active outreach to homeless persons who are difficult to engage; health care teams that can provide general medical care, mental health care and addiction treatment and housing services. When care is provided to a person living with mental illness, the individual should be connected to local services rather than being matched to a specific programme.

Street medicine

'Street Medicine is a systematic approach to the provision of health care to the unsheltered homeless' (Operation Safety Net n.d.:1). According to Jim Withers, the founder of the Street Medicine Institute, Street Medicine is a 'radical attempt to create a care relationship on the terms of those who have been largely excluded from our system of organized health care' (Withers 2011:1). The Street Medicine Institute (n.d.) coordinates an international network of people involved in street medicine. The Institute also provides training, support, resources, guidelines and an annual international symposium.

The concepts of Street Medicine are not new to South Africa, as there are many overlaps between the philosophy and principles of street medicine and those of COPC. At the core of both Street Medicine and COPC is the building of a relationship with vulnerable people, and engaging them where they are and on their terms (cf. Operation Safety Net n.d.:1). Furthermore, both seek a holistic approach to providing health care to vulnerable communities using the best available evidence base.

Howe, Buck and Withers (2009:242) note that there are four best practice categories to ensure quality care in the implementation of street medicine:

1. 'use of mobile clinic vans'
2. 'development of Street Medicine-specific electronic medical records (EMRs)'
3. 'collaboration with community clinics and providers from these clinics'
4. 'provision of comprehensive social support by establishing links to resources such as housing, sources of income, and insurance'.

Important elements of Street Medicine include the fact that it involves peers, entails street outreach and street rounds and ensure effective referrals, and follow-up and coordination of care.

In South Africa the theories and practice of street medicine inform the specific health care for homeless persons as part of the district health system. Street medicine should not be regarded as something special outside of the health service, but as an integral part of the health service.

Embedding peers or community health workers

Community health workers (CHW) play an important role in ensuring that people have access to health and continue to access health care. Homeless peers play a role similar to that of CHWs (cf. Scheibe et al. 2020). Just as CHWs are recruited from the communities that they serve, so are homeless peers recruited from the communities they serve. Scholars have noted that 'peer involvement […] is widely promoted as essential to effective responses to health, social, and political challenges' (Chang et al. 2021:1) in vulnerable communities and key populations, and that peers 'have an important role as members of the health care teams for homeless person' (Hwang & Burns 2014:1545). They know the streets and bridges, the people that live there, the politics and dynamics of the communities and the realities of their lives. They are in a unique position to relate to the broader homeless communities and build trust between the health care teams and the homeless communities. The peers are able to translate the concerns, ideas, fears and expectations. Peers are also trained to participate in the assessment and care of people. During street rounds and outreach, peers lead the way. Peers play an important role in the care of the community, yet despite the recognition of their meaningful contribution, Chang et al. (2021:1) state that 'in practice there is a consistent lack of funding and political support' to ensure the full participation of peers.

Miller et al. (2020:14) propose a number of guidelines for embedding peers or CHWs in services (Table 6.2).

TABLE 6.2: Guidelines for embedding peers or community health workers.

Marker	Guidelines
Role description	Clear description of role or job needed to prevent peers from assuming extra responsibilities beyond their contractual tasks, overworking and burnout.
Compensation	Transparency must be ensured in terms of compensation for the service provided so that peers can make informed choices regarding their terms of engagement. Recognition of the complexity regarding compensation and social welfare or security issues is needed. Low-waged work should be challenged especially where peer roles are demanding and complex.
Support	Support services must be available so that peers can feel emotionally supported, given the difficult nature of their roles.
Development	Training and development opportunities must be available to ensure career progression.
Value	Value and recognition of peer workers must be ensured. Peers should feel welcome and included in their workplace and by other colleagues.
Accommodation	Workplace accommodation should be in place as required by each individual's responsibilities.

Source: Miller et al. (2020:14).

Setting up care coordination for the homeless

Care coordination is defined by Lindeke et al. (2002:291) as the '[p]rocess of assessment, planning, implementation, evaluation, monitoring, support, and advocacy to facilitate timely access to services, promote continuity of care, and enhance family wellbeing'. Matlow et al. (2006:85) suggest that when there is '[p]oor coordination' of care, it 'can have severe impacts on the health of the individual and community' that can in turn lead to 'increased medical error, morbidity, and mortality'.

Coordination of care is required to work on three levels: (1) community level; (2) PHC clinic or community health centre and (3) hospital level:

- **At the community level:**
    - o *Peers and CHWs*: Peer educators who are from the community that they deliver care in have been shown to be effective at improving health outcomes and positive

behaviour change. Peers are a necessary non-judgemental link between patients and health care workers. Peers and CHWs chosen from the community can deliver topical health-promotion messages, provide basic health care, as well as liaise with professional health workers. Peers and CHWs are essential in building relationships, trust in the health care system and ensuring continuity of care. Peers need to be part of a community health team with a team leader supported by a doctor. The team leader can be a nurse or a clinical associate. A deputy team leader from amongst the peers or CHWs is necessary.

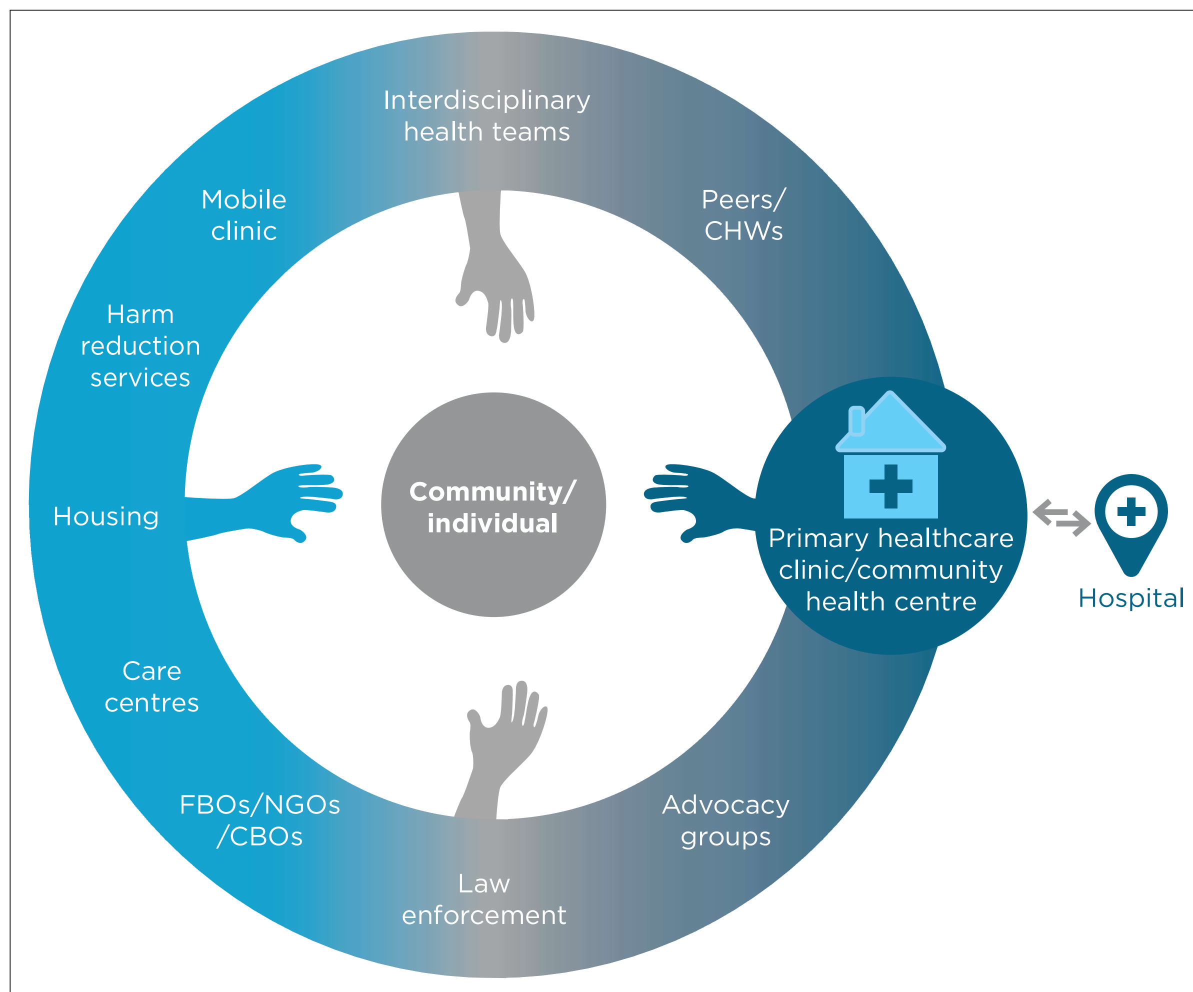
 - o *Mobile clinic*: A mobile clinic that can visit homeless persons at the site will improve access to care, improve adherence to treatment and treat minor medical problems before they escalate. The mobile clinic team should consist of peers or CHWs and a professional who can be a clinical associate, professional nurse or a doctor. This team needs to be supported by a doctor at the clinic or the hospital. The mobile clinic can be administered from a local clinic, and its supplies would be dictated by the local health analysis, specific to the community they are serving.

- **PHC clinic or community health centre:**
  - o Every effort should be made to create a welcoming and non-judgemental environment at the clinic. Health care workers should acknowledge the fact that patients might need more frequent follow-ups, adherence support and might not be able to meet appointment bookings. Linking up a patient with a peer or CHW could improve adherence. In areas where there are significant numbers of homeless persons, it will be best if one of the peers or CHWs is placed at the clinic permanently to facilitate access and care coordination of homeless persons. This person is the link from the community team to the clinic and vice versa.
- **Hospital services:**
  - o Being homeless is a risk factor for high-frequency emergency department use. Linking patients with local

services can prove effective in reducing high-frequency emergency department use. Homeless persons are also admitted for longer than the housed population. Evidence suggests that discharging patients to shelters or care centres or half-way houses reduces readmission rates. In areas where there are significant numbers of homeless persons, it is best if a team in the hospital is available to facilitate access and coordination of care of the homeless persons. This team can be led by a family physician or nursing manager in the hospital. Peers or CHWs and/or a team leader needs to be allocated permanently in the hospital to take care of this task. People from relevant NGOs and shelters also need to be part of this team. In the emergency unit, where homeless persons mostly come for care, a specific protocol needs to be in place which guides care and care coordination. A similar arrangement is needed for the OPD and wards. A regular ward round needs to be done by this team with the ward staff to identify and manage the care coordination of homeless patients.

Coordination of care must be a multidisciplinary team approach (Figure 6.1). The COPC principles of coordinated, collaborative care require those in the space of caring for homeless people to connect with each other and to build relationships that facilitate this kind of care coordination. This generally boils down to a referral pathway that can be used to up-refer or down-refer patients. On its own, a referral document in the hand of the patient who already has internalised stigma, poor communication skills and perhaps a substance use problem is worthless. What does work, however, is if a phone call is made or the person is accompanied by a peer or a CHW to facilitate the access and the outcome of that particular referral.

Out of the need to network and build these relationships, a multidisciplinary team and an important monthly meeting were born. Apart from the agenda items where we discuss common challenges in this sector, networking is promoted and strengthened. From peers to professors, NGOs to government hospitals, all



Source: Figure developed by the authors, designed by Robinne Renkin, published with permission from Robinne Renkin.
CBOs, community-based organisations; CHWs, community health workers; FBOs, faith-based organisations; NGOs, non-governmental organisations.

FIGURE 6.1: Coordination of care.

involved interact in this forum and many solutions have been sought together, often from the ground up. In any work involving homeless people, the most important person in the multidisciplinary team is the patient.

A social media platform also allows people to interact between meetings. Many questions and requests that have been made there were solved by the collective. The patient also benefits from this dynamic and clear feedback is then given to the referee. Of course, one needs to be respectful of the patient's identity and patient–clinician confidentiality is very important for trust to be maintained. Another tool, for example, is the Road to Linked Care book, a patient-retained record developed by UP Family Medicine

(cf. Hugo et al. 2020:4), which remains with the patient or the primary caregiver and is a patient record of all the multidisciplinary care the patient is receiving. These are merely tools to improve patient outcomes and continuity of care for homeless people.

■ The role of local organisations in providing healthcare for homeless persons

Although the primary responsibility of providing health care to people (including housing and social security) and especially vulnerable communities lies with the government, the Bill of Rights (Republic of South Africa 1996:ch. 2) that sets out these responsibilities 'doesn't only apply vertically (from the state downwards, to its citizens) – it also applies, where applicable, horizontally (between one citizen or private body and another)' (Constitutional Court of South Africa n.d.). Therefore, there is also a responsibility that rests on other institutions, organisations and individuals. The responsibility in care for the homeless community takes the form of collaboration and partnerships. It is not only a vertical process, but also a horizontal one.

Grassroots organisations (NGOs, FBOs, CBOs) play an important role in the continuum of care for the homeless. Within the COPC approach, grassroots organisations have been used to host health posts and ward-based outreach teams. This has been deliberate, as they (Bam et al. 2013):

> [*H*]ave historically established structures and links in the communities. Their familiarity with local people and practices provides a base for COPC and shortens the time it takes to develop acceptability and mutual trust. In addition, their knowledge of the communities makes a significant contribution to planning and intervention. (p. 2)

In the next section we will outline practical guidelines for local organisations and communities in terms of the collaboration in providing care to the homeless, with a specific attention to health care.

Understanding the context

As homelessness is a complex issue, there cannot be a one-size-fits-all approach and solution. What is required is a context-, individual- and community-specific response to address the issues of homelessness. Therefore, it is important to know and understand the context of homeless communities and individuals within the organisations' context. Models such as asset-based community development (cf. Mathie & Cunningham 2002; McKnight 2017), local institutional support assessment (LISA) (cf. Honiball & Marcus 2020; Marcus, Reji & Ngcobo 2020), pastoral or praxis cycle or cycle of praxis (cf. Cochrane, De Gruchy & Petersen 1991; Holland & Henriot 1983; Peterson 2018; Torres-Sánchez 2016) or community mapping (eds. Coghlan & Brydon-Miller 2014:146) can be used to gain a holistic understanding of the community and the context. The above models work within the principle of including the homeless community as active participants, and acknowledging their agency in the development of pathways out of homelessness.

The individual is often the victim and blamed for being homeless. Yet the mere existence of homelessness today is the consequence of structural and institutional failures. Without an adequate understanding of the context of the community and individual, the claim that the individual is responsible for their homelessness can be perpetuated. The solutions to homelessness must thus be both systemic and individual, that is the solutions need to address the systemic issues that perpetuate homelessness, but it must also address the needs of the individual.

Outreach and building relationships

Homeless communities are continuously being excluded from mainstream life and pushed to the margins and fringes of society. Homeless communities are, as Cross et al. (2010) state, the:

> [*P*]roverbial skeletons at the feast, the excluded poorest who enter unobserved and stand by gaunt and starved, terrifying to the invited guests but deprived of any capacity to join the party. (p. 18)

It is therefore important to understand their context, acknowledge their own agency and build meaningful, long-term trust relationships (cf. Operation Safety Net n.d.; Torres-Sánchez 2017). We should not be waiting for people from the margins to come to the centre of cities to know them. We should go and meet them where they are and within their own contexts.

Local organisations are immersed in the context of homeless communities, and this means that for many homeless communities the local organisations will be the first point of contact and introduction into the continuum of care. Therefore, the outreach- and relationship-building work of local organisations play a critical role.

As health care will be one aspect of the continuum of care, grassroots organisations with a long-term trust relationship with the homeless communities will be either connecting them to other stakeholders that feed into the continuum of care, or providing care themselves.

Know people by name

For the solutions to be person-centred, it is important to understand that although homelessness is a systemic failure, the burden of homelessness falls on the individual. There is no one-size-fits-all approach, and therefore each homeless community member must be known by name (Community Solutions 2018:9). A by-name list allows for person-specific data and information that would enable tailored approaches in terms of pathways out of homelessness for each person.

Developing communities of care

A part of COPC principles is coordinating care around the families. Many people who are homeless struggle with a breakdown of their networks, families and communities. They either become part of a transient community with other people who are homeless, or find themselves alone. A new community of care

needs to be developed where a person can find a sense of belonging, care and support, and participate in communal life. Communities of care are important in the continuum of care process.

Building a continuum of care

To address the complexity of homelessness holistically, a continuum of care is required. Roux (2007:326) states that 'a continuum of empowering care for destitute people will undoubtedly call for continued and combined efforts by many role-players' and that it requires various stakeholders and role-players, including the 'destitute themselves' (Roux 2007:217).

A continuum of care process must not be developed in such a way that it creates unnecessary hurdles, too complicated or cumbersome that it no longer serves the intended purposes. It enables access to healthcare, ensuring that it is also geographically accessible. The continuum of care includes the coordination of health care, as the continuum of care goes beyond health care.

Housing

For as long as people remain homeless and cannot access adequate, secure housing, their health and quality of life will constantly decline and dissipate. In COPC we are aware of the importance of the home and the household in healthcare. A major part of the difficulty in providing healthcare to the homeless communities is that the 'home' or 'house' is absent. It is in the home where one rests, dresses wounds, keeps medication safe and, with the support of others, adherence is observed. This deficiency needs to be addressed specifically and that is why special care is needed. One important leg of healthcare will be addressed if the home can be replaced by either re-integration, communities of care or housing.

A model such as the Housing First model is required to make a significant difference in the long-term health care for vulnerable populations, and specifically homeless persons. The Housing First model 'gives homeless persons "housing first" before it does anything else' (Pleace 2012:3). Ensuring homeless persons have access to secure housing would not only improve their health and general quality of life, but will enable them to reclaim their dignity, and humanity (Operation Safety Net n.d.:13).

Networking and participating in local structures

Collaboration is integral in providing holistic care to vulnerable and marginalised communities. Collaboration has to be based on common goals, sharing of information, transparency, trust and commitment. It has to be an intentional process, as many organisations and institutions work in isolation and sometimes compete for the same funding.

If no local networks or structures that promote collaboration, coordination and integration of care exist, such structures need to be developed. These structures must ensure they include all relevant stakeholders (such as clinics, hospitals, community development workers, health workers, NGOs and FBOs) as well as representatives from the community itself. The participation of stakeholders must be on an asset-based principle: not what you can take from the collaboration but what you can contribute to the collaboration. Collaboration works on trust and trust is built over a long, sustained period of time.

In Table 6.3 we set out practical examples of how NGOs and/or CBOs can build partnerships with health services and participate in care.

TABLE 6.3: How the NGOs or CBOs build partnerships with health services and participate in care.

Examples	**Building partnerships**
Understand the context	Do sensitivity training for health care workers on the needs and ways to working with homeless persons Provide training and support peers or CHWs
Outreach and building relationships	Be the liaison between the patients or community and health care team, and organise time and place for street consultations or appointments Provide a place and time for health workers to do home visits in the shelters or institutions Provide structure for peers or CHWs who work with the health services
Know people by name	Be available 24/7 to assist health workers in the placement and caring of homeless persons
Developing communities of care	Participate in the care of homeless persons: keep medication, supervise treatment, assist with dressings, support and counselling, safe-keeping of patient-retained records Keep phone contact with the health care team in terms of caring for specific patients or people
Building a continuum of care	Participate in coordination of care between the different services and facilities, for example attend coordination of care ward rounds, act as a contact for health services to reach homeless persons Accompany homeless persons to health care facilities and provide transport Provide a structure for the homeless community to participate in the planning, implementation and evaluation of health care to the homeless persons
Housing	Provide accommodation to peers or CHWs
Networking and participating in local structures	Develop and maintain a database of services and resources that can be accessed for the care of homeless persons Advocacy: Engage health and other authorities, managers and clinicians to ensure that homeless persons have access to care and quality of care at facilities Involve health care services in the planning and implementation of projects and institutions Provide remuneration for peers or CHWs if this is not done through the state

CBOs, community-based organisations; CHWs, Community health workers.

Conclusion

The health of homeless persons can be both a cause and consequence of homelessness. Poor access (because of individual and systemic factors) to health care often leads to disease that is complex with high rates of morbidity and mortality. Homelessness is projected to increase, especially in larger urban centres, and this should be a cause for concern for those managing and planning health services. As homelessness is a result of systemic failures that affect individuals in the most unjust and often irreparable ways, great urgency is needed in using evidence-based interventions that are equitable, effective and executable.

Homeless persons therefore need to be identified as an at-risk population that requires specialised care and interventions.

As we propose in this chapter, this can be in the form of housing provision and specialised health care services targeted at homeless persons using the principles of COPC.

While one might consider such targeted primary care as an expensive endeavour, it should be noted that the economic case for providing primary care has the following advantages (cf. Anderson et al. 2018):

- Primary care improves health outcomes, not just increasing life expectancy, but also improving mental health outcomes.
- It makes for a more efficient health system as it reduces hospital admissions and other expenses.
- It makes the health system more equitable, as it provides access to care to more people, closer to where they are situated.

Providing PHC to homeless communities should be the responsibility of the government, but it will be hard to execute without the assistance and collaboration of other organisations. These types of collaborations have been shown to transform into communities of care that are able to make a marked difference in people's lives.

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