Homeless people have poorer health outcomes and more long-term physical and mental health problems, and are more prone to alcohol and drug use, than the general population. Based on records from 2001-2009, the average age of death among homeless people is 43 years for women and 48 years for men (Thomas, 2011). In 2012-2013, a nurse-led satellite outreach sexual health service for homeless people was set up at three hostels run by St Mungo’s (Box 1) in the borough of Camden in north London. The aim of the project was to improve health outcomes for residents, and explore residents’ and staff knowledge of, and attitudes towards, sexual health.

Sexual health needs of homeless people
Risk factors for homelessness are also risk factors for poor general health, particularly sexual ill-health in women. Although women are in a minority among the homeless population, they are highly vulnerable, have multiple unmet health needs (Homeless Link, 2013; Department of Health, 2010a) and are more likely than women in the general population to become pregnant and have a sexually transmitted infection (Maguire et al, 2009). They often use drugs and alcohol to cope with their situation and then turn to selling sex to support their consumption (Hunter et al, 2004).

Sex work and use of injected drugs further increase the risk of STIs and infection with blood-borne viruses (BBVs) which, in turn, can lead to escalating mental health issues (DH, 2013; DH, 2010a).

In 2008, the Medical Foundation for AIDS and Sexual Health (MedFASH) indicated that DH policy specified that homeless people need targeted and specialist sexual health services. This article details the initiative that was undertaken.

Key points
- Risk factors for sexual ill-health among people who are homeless
- Cycle of mental, emotional and social issues experienced by many homeless people
- Outcomes of a sexual health outreach service for hostel residents

Nurse-led sexual health clinics in hostels for homeless people

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Author Fiona McGregor is specialist reproductive sexual health nurse; Rebecca Stretch is deputy director of infection prevention and control; Elissa Cannon is charge nurse in sexual health; all at Central North West London Foundation Trust. Ann Robinson is a senior teaching fellow in midwifery at the University of Surrey; Jill Shawe is professor women’s health, Institute of Health and Community, University of Plymouth.

Abstract Between May 2012 and May 2013, 161 people were seen in nurse-led sexual health clinics set up at three St Mungo’s hostels for homeless people in north London. Services included screening and treatment for sexually transmitted infections; access to contraception, pregnancy tests and cervical cytology; testing and treatment for HIV, hepatitis and other infections from blood-borne viruses; and vaccination. A mixed-methods study confirmed that homeless people are at increased risk of sexual ill-health. It also showed that their health outcomes can be improved through sexual health services provided in a convenient, familiar and friendly environment. This article details the initiative that was undertaken.

Clinical Practice

Research

services. However, their chaotic lifestyles – including drug and alcohol use and dependence – make them less able to secure permanent accommodation and, without an address, it is more difficult for them to access health and other services (Hunter et al, 2004). Homeless people are often wary of statutory organisations, while some services lack the flexibility and expertise needed to respond to their complex needs (DH, 2010b).

Factors influencing homeless women’s use of contraception and cervical screening attendance are poorly understood, and little is known about the sexual health of homeless men. We need to better understand sexual health issues affecting those people who are homeless, to inform current NHS strategies that are aimed at reducing health inequalities, as required by the 2010 Equality Act.

Objectives of the project

Our project was developed after a public and patient engagement exercise conducted at a mainstream sexual health clinic had identified a need for sexual health services among homeless women. Homeless women had been identified as being at risk of STIs, pregnancy and non-attendance for cervical screening. St Mungo’s hostel staff had also highlighted that there was a lack of health education for residents.

As a result, our objectives were to:

- Establish a weekly nurse-led satellite outreach sexual health service at three St Mungo’s hostels in Camden, north London;
- Provide appropriate sexual health care (including contraception and STI and BBV screening and treatment) and health promotion to homeless women in a familiar environment that was also non-threatening;
- Explore residents’ and staff members’ knowledge of, and attitudes towards, sexual health.

The project initially targeted only female residents, but male residents asked if they could attend the clinics and were later included.

Our research question was: Does providing sexual healthcare within hostels improve contraceptive use and uptake of sexual health screening? Our intended measures of success were:

- Number of female clients starting contraception;
- Number of male and female clients screened and treated for STIs.

Any number of attendances above zero would be considered a success as there are too many variables – such as size of hostel, age of residents, perceived need of clients, gender and amount of sexual activity.

Outreach sexual health clinics

The on-site nurse-led outreach clinics started in May 2012. They were managed by the local sexual health service and run by specialist reproductive sexual health nurses and healthcare support workers.

Clinics took place once a week in each hostel from 12.30-3.00pm. They offered:

- STI screening and treatment;
- Contraception provision, including long-acting reversible contraception (LARC) in implants and injections;
- Cervical cytology, as well as HIV, hepatitis and other BBV testing;
- Vaccination where applicable.

Attendance at clinics was facilitated by health promotion specialists, who interacted with residents regularly as they worked with St Mungo’s to increase awareness of sexual health issues among staff and residents. Hostel residents were sign-posted for other primary or hospital healthcare as appropriate. Participant selection was purposive (made on the basis of the researchers’ judgement).

Data collection and analysis

We used a mixed methodology incorporating quantitative and qualitative methods, which included:

- Electronic collection – routine service data on contraception use and screening and treatment of STIs was collected electronically using approved software;
- A questionnaire – residents attending the clinics were asked to complete an anonymous survey with questions on demographics; knowledge of, and attitudes towards, sexual health; and clinic attendances;
- Semi-structured interviews – a total of 14 residents attending the clinics and eight hostel staff participated in qualitative semi-structured individual interviews. A topic guide was used to ensure parity in question prompts and all interviews were audio-recorded digitally.

Service and epidemiological data was analysed using approved software and summed up in descriptive statistical terms. The interviews were transcribed and analysed using computer-assisted software. Supplementary coding of the transcripts by hand increased the validity of the results (Braun and Clarke, 2006).

All participants were given an information sheet and opportunities to ask questions. Those who agreed to attend the clinics and those who agreed to be interviewed gave written informed consent.

The vulnerability of the hostel residents who participated in this study meant it was crucial to follow the correct ethical approval procedure. An application was made to the South Central – Hampshire B research ethics committee, which gave the project a “favourable ethical opinion”.

Survey data

In total, 70 questionnaires were completed. Many participants reported poor general and mental health, as well as substance use and dependence; 68% said they drank alcohol every week and 31% reported consuming more than 60 units of alcohol per week. More than 40% reported using street drugs, while 89% smoked cigarettes. Long-term conditions such as chronic obstructive pulmonary disease, diabetes, epilepsy and cardiac disease, as well as mental health conditions – for example, depression, anxiety, eating disorders, schizophrenia and addictions – were identified.

Box 1. St Mungo’s

Founded around 50 years ago, St Mungo’s (www.mungos.org) is a charity that works to alleviate and prevent homelessness. It provides hostel accommodation and personalised recovery services for homeless and excluded people in London and other cities in the south east of England. Each night it offers a bed and support to more than 2,700 people. The charity employs regional health coordinators whose job is to promote health and develop health services for residents.

With 17 outreach teams, St Mungo’s is one of the largest providers of outreach services in the country. At a national level, it manages the StreetLink referral line (www.streetlink.org.uk), as well as campaigns to bring about change on the issues that affect homeless people.

Quantitative clinic data

The clinics were attended 367 times by 161 clients between May 2012 and May 2013 (Table 1). The age range of clients was...
Four women received emergency contraception and five had pregnancy tests, of which one was positive. This is an essential aspect of the provision of sexual and contraceptive or reproductive healthcare. These women may not have otherwise taken a pregnancy test or received counselling on these issues.

Fourteen women attending the clinics reported having previously had abnormal cytology results; 12 others underwent cytology testing. Qualitative interview data revealed hostels for all residents, irrespective of clinic attendance. There was an over-reliance on condom use for contraception (as well as for STI prevention) without the backup of using a regular, reliable contraceptive. Condoms alone are not as effective to avoid pregnancy as methods such as LARC or contraceptive patches.

In addition, 107 HIV screening tests were performed, none of which revealed positive antibody results. The uptake of HIV screening was high, in line with the current policy of increasing testing in people who may be undiagnosed (National Institute for Health and Care Excellence, 2016). The fact that there were no positive antibody results is promising, but it cannot be assumed that this infection is not present among some of the people who were not screened.

Undiagnosed and untreated STIs can have serious implications, posing a direct risk to infected individuals and an indirect risk to others – homeless people are particularly vulnerable (MedFASH, 2008). The clinics created opportunities to provide sexual health education, prevention measures, diagnosis and treatment to homeless men and women in a supportive and familiar environment, in line with the Equality Act 2010.

Hepatitis
Hepatitis testing was carried out for 96 clients (60% of a total of 161 clients who attended clinics); some were tested for more than one virus type and on more than one occasion, with the number of tests totalling 161 (Table 3). Five of those tested were positive for hepatitis B and/or C, which suggests there is sufficient past and/or current infection to justify ongoing testing and vaccination among the homeless population.

As reported in other studies (Topp et al, 2013), clients were willing to be vaccinated against hepatitis A and B (a vaccine for hepatitis C does not yet exist). However, vaccine uptake and completion of hepatitis treatment courses are poor among homeless people, due to factors including chaotic lifestyles and lack of contact with healthcare services. Many clients were unaware that they were not immune.

Table 1. Clinic attendance data

<table>
<thead>
<tr>
<th>Data</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic attendances</td>
<td>367</td>
</tr>
<tr>
<td>Clients seen in clinics</td>
<td>161</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>87</td>
</tr>
<tr>
<td>Men</td>
<td>71</td>
</tr>
<tr>
<td>Unknown</td>
<td>3</td>
</tr>
<tr>
<td>Clients who received clinical interventions</td>
<td>151</td>
</tr>
<tr>
<td>Clients who received advice only</td>
<td>10</td>
</tr>
<tr>
<td>Sexually transmitted infections diagnosed</td>
<td>59</td>
</tr>
</tbody>
</table>

Table 2. Sexually transmitted infections diagnosed

<table>
<thead>
<tr>
<th>Infection</th>
<th>Women</th>
<th>Men</th>
<th>Total, n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anogenital warts (first infection)</td>
<td>1</td>
<td>0</td>
<td>1 (1.7)</td>
</tr>
<tr>
<td>Candidiasis</td>
<td>13</td>
<td>0</td>
<td>13 (22.0)</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>8</td>
<td>2</td>
<td>10 (16.9)</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>3</td>
<td>1</td>
<td>4 (6.8)</td>
</tr>
<tr>
<td>Syphilis</td>
<td>2</td>
<td>1</td>
<td>3 (5.1)</td>
</tr>
<tr>
<td>Trichomonas vaginalis</td>
<td>2</td>
<td>0</td>
<td>2 (3.4)</td>
</tr>
<tr>
<td>Bacterial vaginosis/non-specific urethritis</td>
<td>6</td>
<td>1</td>
<td>7 (11.9)</td>
</tr>
<tr>
<td>Other (including herpes, Pediculosis pubis and Molluscum contagiosum)</td>
<td>19</td>
<td>0</td>
<td>19 (32.2)</td>
</tr>
<tr>
<td>Total</td>
<td>54</td>
<td>5</td>
<td>59 (100)</td>
</tr>
</tbody>
</table>

Table 3. Hepatitis testing

<table>
<thead>
<tr>
<th>Virus type</th>
<th>Tests, n</th>
<th>Positive results, n</th>
<th>Missing data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis A</td>
<td>27</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>88</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>46</td>
<td>5</td>
<td>7</td>
</tr>
</tbody>
</table>

Qualitative interview data
The semi-structured interviews with 14 residents and eight hostel staff revealed

19-76 years (mean 38 years); the length of time they had been homeless ranged from a few months to 10 years. Sex work was disclosed by eight of the 161 clients.

STIs
A total of 59 instances of STIs were diagnosed among the 161 clients (Table 2). These STIs – including three cases of syphilis, which has potentially disastrous long-term consequences – might otherwise have remained undetected and untreated.

In addition, 107 HIV screening tests were performed, none of which revealed positive antibody results. The uptake of HIV screening was high, in line with the current policy of increasing testing in people who may be undiagnosed (National Institute for Health and Care Excellence, 2016). The fact that there were no positive antibody results is promising, but it cannot be assumed that this infection is not present among some of the people who were not screened.

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harrowing stories about clients' lives. A complex mix of physical, social, psychological and emotional issues – all compounding clients' risk of sexual ill-health – emerged from the data. Three themes were identified:

- Risk to sexual health;
- Domestic abuse and violence;
- Services.

Table 4 offers a thematic overview of the findings. Participants' specific responses are outlined below; these have been coded to protect each client's confidentiality.

**Risk to sexual health**

Risks to sexual health strongly correlated with participants' chaotic lifestyles, both as causes and outcomes. Drug use and addiction were important risk factors:

> “But I did draw up from the same spoon few times, so my best guess is that the person I was with must have used a dirty needle.”

Prioritising drug use exacerbated the risks to sexual health:

> “They think more about their drugs than they do about their health.”

Stigma, poor self-esteem, abusive backgrounds and neglect of health led to a destructive cycle, in line with the findings of Oliver and Cheff (2012). As identified by Homeless Link (2009), the starting point was often childhood trauma, followed by various attempts to cope with difficulties through unhealthy means. Issues such as poverty and desperation ensued.

One woman mentioned that sex work and crime were often linked, adding to the danger for all involved:

> “If I could rob a punter I would. If I had to have sex with him or give him a blow job I would...”

The DH (2010b) indicated that street sex workers are less likely than the general population to have health checks. In line with that, one participant in our study stated that:

> “Girls that still work on the streets [...] they don’t go out to sexually transmitted disease clinics.”

It could be that clients feel unable, unwilling and/or afraid to attend.

Clients were caught in a spiral of risk affecting their mental health and a cycle of drug and alcohol use and risky sexual behaviour, leading to unstable lifestyles and entrenched homelessness. This is a cycle that has been identified by Homeless Link (2013).

**Domestic abuse and violence**

Many participants, both male and female, had experienced or were experiencing domestic abuse and violence – sometimes they had experienced it for their whole lives. It was difficult to obtain in-depth information on this while respecting participants' dignity and being mindful of our duty to prevent harm (Beauchamp et al., 2008). One woman found her experience particularly painful to talk about and was unwilling to elaborate:

> “The kid's father was very abusive … It's a long story, I don't really want to get into it.”

Domestic abuse and violence included rape, physical violence, psychological abuse and forced street sex work. In line with the findings of Johnson et al (2006), it led to a cycle of depression, anxiety, powerlessness in relationships and further abuse. Many participants were trying to come to terms with past traumas.

As one man who had experienced domestic abuse explained, mental health problems can end up becoming ingrained and chronic:

> “I've the depression as I said; I'm very numb all the time.”

**Access to services**

Barriers to accessing sexual health services revolved around the stigma of being homeless, which led to embarrassment, avoidance and resistance to going to a healthcare setting that is unfamiliar. Overall knowledge of contraception and pregnancy risk

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**Table 4. Thematical overview of qualitative findings**

<table>
<thead>
<tr>
<th>Themes</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk to sexual health</td>
<td>Street sex work</td>
</tr>
<tr>
<td></td>
<td>Fear/lack of knowledge of sexually transmitted infections</td>
</tr>
<tr>
<td></td>
<td>Risk linked with injecting drugs paraphernalia</td>
</tr>
<tr>
<td></td>
<td>Lack of knowledge of sexual health issues</td>
</tr>
<tr>
<td></td>
<td>Poor use of contraception</td>
</tr>
<tr>
<td>Domestic abuse and violence</td>
<td>Rape</td>
</tr>
<tr>
<td></td>
<td>Personal relationships marked by threat and fear</td>
</tr>
<tr>
<td></td>
<td>Depression and mental illness</td>
</tr>
<tr>
<td></td>
<td>Cycle of abuse and powerlessness</td>
</tr>
<tr>
<td>Services</td>
<td>Lack of awareness of need</td>
</tr>
<tr>
<td></td>
<td>Need of support to attend</td>
</tr>
<tr>
<td></td>
<td>On-site care provision welcome</td>
</tr>
<tr>
<td></td>
<td>Professionalism and confidentiality appreciated</td>
</tr>
</tbody>
</table>

People who are homeless often find it difficult to access healthcare services.
was lacking, which compounded the risk to sexual health. A further deterrent was wariness of meeting new staff who, as noted by Oliver and Cheff (2012), may not be aware of the complex needs of homeless people: “I think it’s embarrassment … they may be even scared of what they may find out.”

Staff raised the issue of the lack opportunity to talk to residents about personal issues, thereby recognising that communication is key. For example, encouraging residents to obtain emergency contraception could enhance uptake: “If we did have that conversation [with residents] about where to get the morning-after pill ... but we don’t have that conversation ....”

Participants did not see the need to attend services unless they had significant symptoms but staff, as well as residents, noted the benefits of on-site care provision: “He had syphilis … it means we need the care right here. It’s easier for them when the care comes to them rather than them going to get the care.”

Homeless people are often unable to conform to the rigid access times and conditions of mainstream clinics (St Mungo’s, 2008). Convenient, anonymous on-site services reduce barriers and help them access sexual healthcare within familiar surroundings. Anonymous comments pointed out the advantages: “It’s good that now they’re doing it [screening] in the hostels.”

“If they have diarrhoea and they said ‘I have diarrhoea’ and they left the military hospital, I didn’t want them to come to the hostel because they were often caught because they were there before the meeting. Your journal club activity counts as participatory CPD hours or can be used as the basis for reflective accounts in your revalidation activities.

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“The way they greet you, they keep everything confidential.”

Study limitations
On the whole, the demographic data collected was poor, so the researchers were unable to make a meaningful description of the population investigated.

Maintaining confidentiality was a challenge and some residents feared others noticing that they were attending the clinic, which could exacerbate stigma. This may have deterred residents from attending.

The study was small in scale and the participants had varied and complex needs, in addition to being difficult to engage due partly to their vulnerability and chaotic lifestyles. Qualitative information may have been biased in favour of those confident enough to share their experiences for research purposes. Also, the issue of the safety of researchers while gathering data undermined a genuine purposive sampling strategy.

Conclusion
The project was developed in response to the need of homeless people living in hostels to receive individualised sexual and reproductive/contraceptive care. The clinics have enabled health professionals to reach men and women who would not usually attend mainstream services. Positive outcomes include clients:

- Being diagnosed with, and treated for, STIs and infections with BBVs;
- Receiving hepatitis vaccination;
- Starting to use reliable methods of contraception;
- Receiving health promotion advice.

The service was evaluated extremely positively by clients, who emphasised that they wanted more collaborative working with other screening services (for example, for tuberculosis) and mental health.

Past and current infection with BBVs, STIs and susceptibility to unplanned pregnancy were evident, confirming that hostel residents and the homeless are at-risk groups for sexual ill-health. The project has provided data to inform the public health strategies of the NHS and local authorities (Local Government Association, 2013).

The project has shown that nurse-led sexual health clinics for residents of homeless hostels are feasible and acceptable to this vulnerable group of clients. The partnership with St Mungo’s enabled nurses to use their skills to provide homeless people with convenient, accessible, appropriate and sensitive care. The service will continue as regular visiting clinics moving between St Mungo’s hostels.

Future research will examine adherence of residents of homeless hostels to a three-dose hepatitis B vaccine schedule. A project is under way to improve the sexual health of homeless young people aged 16-21 years residing in young people’s hostels.

References
Department of Health (2010b) Inclusion Health: Improving Primary Care for Socially Excluded People. Bit.ly/DHInclusionHealth


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