

**Exploring the vulnerabilities of homeless women in the Sisters' of  
Mercy Homeless Shelter during the COVID-19 pandemic in  
Johannesburg.**

Submitted in fulfilment of the requirements of the degree of Master of Health  
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*When he had received the drink, Jesus said, "It is finished." With that, he bowed his head  
and gave up his spirit.*

John 19:30

## **Abstract**

**Background:** Homelessness has multiple physical, psychological and emotional effects on those who have experienced it. In addition to directly harming public health, the lockdown measures put in place at the COVID-19 pandemic's peak to stop the virus's transmission had severe negative repercussions on the social, psychological, and economic spheres, especially for homeless women. There is a deficiency in South African literature that examines the distinct health, economic and social challenges that homeless women experienced during the COVID-19 pandemic.

**Aim:** To explore and understand the vulnerabilities of homeless women in the Sisters' of Mercy Homeless Shelter during the COVID-19 pandemic.

**Methodology:** The study was driven by a qualitative inquiry. To decide on the participants, non-probability purposive sampling was employed. One-on-one, in-depth interviews with twelve homeless women who lived in the Sisters of Mercy homeless shelter were used to gather data. Face-to-face interviews were conducted using an interview schedule that was translated to isiZulu and Sesotho to gather data, which was then thematically analysed.

To take into consideration ethics in this research, the researcher was aware that subjects were real people whose rights and dignity must always be respected, and protection of their confidentiality was significant. The researcher kept the written notes inside a lockable cabinet and the recorded data was kept in the researcher's computer under a folder that required a password, this ensured trustworthiness which is the integrity of qualitative findings.

**Findings:** Five broad themes and sixteen subthemes emerged from the data collected. Findings indicated that women who participated in this study missed hospital appointments and their healthcare needs were unmet, because of overcrowding and prioritization of those infected with Coronavirus in hospitals. This exacerbated chronic illness because they could not afford transport and administration fees linked with their health care needs. Their inability to pay these costs, was attributed to their loss of income during the pandemic. such circumstances, endured anxiety, depression and other psychological forms of distress.

The study further found that those at the Sisters of Mercy Homeless Shelter, had to vacate the shelter during the day, which resulted in little access to water which consequently affected their hygiene and sanitization of their hands. Amidst the COVID-19 pandemic, the individuals involved in this study were totally displaced from the shelter, which resulted in many having to secure alternative shelter. The findings further indicated that the participants who were employed in feminized sectors such as retail, food, hospitality and as domestic workers, suddenly lost their jobs during the pandemic. Hence, the study found that for many, their greatest fear was that of starvation as opposed to contracting coronavirus. Income losses, food insecurities and future uncertainties were coupled with greater depression, loneliness and anxiety.

Participants depended on social workers and other charitable organizations for social support, emotional support and psychological support to survive the challenges linked with homelessness. However, the study found that such support was not available during the lockdown. Lockdown regulations dictated a limited amount of physical contact and the participants were expected to communicate with social workers online which they found not helpful. A charitable organization that provided them with instrumental support such as food, clothes and toiletries was also closed, thereby exacerbating their plight.

The mitigating strategy of social distancing and self-isolation, also exacerbated gender-based violence especially amongst vulnerable homeless women, who reported that they became victims of frustrated unemployed male partners. The participants alluded that even before the pandemic as homeless women, they received limited protection and support from the police department.

**Conclusion:** The findings suggested that the unique gender experience for homeless women was exacerbated during the COVID-19 pandemic. The importance of the study was that it acknowledged that participants had feelings of uncertainty about the future, and they believed that the repercussions of the pandemic would still hit them hard even in the future. Social workers and healthcare workers should be conscientized about the vulnerabilities of homeless women, so that they may consciously remove the stigma, and take the initiative to support them. To ensure that homeless women cope with the post pandemic crisis, it is recommended that homeless women be equipped with skills and training that will make them employable or self-employed.

## **DECLARATION**

I, Sanelisiwe Portia Makabate, do hereby declare that the information reported in this dissertation entitled: *Exploring the vulnerabilities of homeless women in the Sisters of Mercy Homeless Shelter during the COVID-19 pandemic in Johannesburg* is a record of authentic research carried out by me, under the supervision of Prof. Raisuyah Bhagwan. Every reference that has been used or cited has been made clear and acknowledged in the text and reference list provided. No part of this dissertation has been presented previously for the award of any degree qualification, or other purposes at the Durban University of Technology or any other institution.

Signature:

Date: 14/11/2023

**Sanelisiwe Portia Makabate**

**Approved for final submission**

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Signature:

Date:08.12.23

Professor R. Bhagwan (PhD)

Durban University of Technology

## DEDICATION

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### *To My Parents*

Robert M. Xulu.

With all the bricks thrown at you by others, you have laid a firm foundation of education for us.

**I dedicate this dissertation to my dad.**

*and*

Thandiwe T. Xulu

Proverbs 31:15 “She rises while it is yet night and provide food for her household and portion for her maidens”.

You have channelled me to a right path of education and I will pass the baton to the future generation.

**I dedicate this dissertation to my mom.**

## ACKNOWLEDGEMENTS

---

*Give thanks for everything because it is God's will for you in Christ Jesus. 1  
Thessalonians 5: 18*

I remain indebted to the following people:

My husband: Pelane E. Makabate. Thank you for being my source of strength, inspiration and motivation. I have no doubt that even in the future you will still be there to support me to soar for excellence, because you are the wind beneath my wings.

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All my friends: Thank you for being my back up, through you I have learnt to balance my social life and my studies. Thank you for understanding when I had to be absent from some of our gatherings.

## **ACRONYMS**

CES-D	Epidemiologic Studies Depression Scale
COVID-19	Coronavirus Disease 2019
DUT	Durban University of Technology
GBV	Gender Based Violence
HIV	Human Immunodeficiency Syndrome
ILO	International Labour Organisation
IREC	Institutional Research Ethics Committee
LMIC	Low-Middle-Income Countries
PPE	Personal Protective Equipment
PTSD	Post-Traumatic Stress Disorder
PWID	People Who Inject Drugs
STD's	Sexually Transmitted Disease
SAM	Substance Abuse and Mental Health Service Administration
WASH	Water Supply, Sanitation and Hygiene
WHO	World Health Organization

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## GLOSSARY

<b>A Good Samaritan:</b>	a charitable or helpful person.
<b>Administration fees:</b>	are fees that service providers and financial institutions charge their customers for keeping and managing accounts.
<b>Amanqina:</b>	chicken feet.
<b>Chronification:</b>	describes the process of transient pain progressing into persistent pain.
<b>Coerced treatment:</b>	implicit or explicit coercion to submit to particular forms of treatment, including forced admission, isolation, and restraint.
<b>Comorbidities:</b>	the simultaneous presence of two or more diseases or medical conditions in a patient.
<b>Deinstitutionalization:</b>	is the gradual relocation of residents to regular, community-based housing
<b>Egoli:</b>	city of gold.
<b>Epidemic:</b>	a widespread occurrence of an infectious disease in a community at a particular time.
<b>Exacerbated:</b>	make a problem, bad situation, or negative feeling worse.
<b>Feminized sectors:</b>	The feminization of the workplace refers to the changing of sex and gender roles as well as the acceptance of women into social groups.

<b>Feminine hygiene:</b>	used euphemistically to discuss using sanitary products like pads, tampons, panty liners, and other items intended to treat the vulva and vagina.
<b>Feminization of poverty:</b>	refers to a pattern where there is a growing disparity between men and women's living standards as a result of the growing gender gap in poverty.
<b>Gender-Based Violence:</b>	violence committed against an individual due to that individual's gender or violence that disproportionately affects individuals of a specific gender.
<b>Hard-to-reach society:</b>	those sections of the community that are difficult to involve in public participation.
<b>Ill-equipped:</b>	not having the experience or preparation that is needed.
<b>Incarceration:</b>	the condition of being imprisoned or confined.
<b>Lockdown</b>	a state or period in which movement within or access to an area is restricted in the interests of public safety or health.
<b>Malnutrition:</b>	inadequate nutrition, brought on by a lack of food, a failure to utilise the food that is consumed, or a combination of these factors.
<b>Manoeuvre:</b>	Carefully guide or manipulate someone or something in order to achieve an end.
<b>Marginalization:</b>	treatment of a person, group, or concept as insignificant or peripheral.
<b>Non-profit organization:</b>	a group organized for purposes other than generating profit and in which no part of the organization's income is

	distributed to its members, directors, or officers.
<b>Piece jobs:</b>	work where compensation is determined by a set rate and the quantity completed, not by the time required to complete the task.
<b>Quarantine:</b>	a condition, duration, or location of seclusion used for humans or animals suspected of having come into contact with an infectious disease.
<b>Respiratory etiquette:</b>	source control measure to prevent droplet transmission of respiratory pathogens
<b>Rosebank:</b>	is a modern South African suburb that is both commercial and residential, located north of the city of Johannesburg.
<b>Sex work:</b>	is the exchange of sexual services, performances, or products for material compensation
<b>Slum dwellers:</b>	someone who lives in a slum.
<b>Social distancing:</b>	Reduce your physical contact and proximity to other people, especially if you want to prevent contracting or spreading an infectious disease.
<b>Street vendors:</b>	are an integral part of urban economies around the world, offering easy access to a wide range of goods and services in public spaces
<b>Syndemics theory:</b>	In the theory of syndemics, diseases are hypothesized to co-occur in particular temporal or geographical contexts due to harmful social

	<p>conditions and to interact at the level of populations and individuals, with mutually enhancing deleterious consequences for HIV risk.</p>
<b>Syringe:</b>	<p>a tube with a nozzle, piston, or bulb that allows liquid to be drawn in and expelled in a thin stream; it can also be equipped with a hollow needle to allow fluid injections or withdrawals.</p>
<b>Transitory populations:</b>	<p>are social groups that don't spend their days in the town or city.</p>
<b>Vulnerabilities:</b>	<p>the state or quality of being vulnerable to being attacked or harmed, either physically or emotionally.</p>
<b>Vulva contact dermatitis:</b>	<p>When the vulva becomes red, painful, and itchy, it is called vulvar dermatitis. Heat or moisture, as well as scented soaps, powders, creams, toilet paper, spermicides, or clothing, can all trigger dermatitis.</p>

# CHAPTER ONE

## OVERVIEW OF THE STUDY

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### 1.1. Introduction

Homeless people present one of the most extreme examples of poverty and social exclusion (Panader *et al.* 2018:1). Women encountering homelessness are deeply vulnerable and have different characteristics, needs, and life experiences than homeless men (Arangua *et al.* 2015:200; Matulic *et al.* 2019:45). Research on homelessness amongst women is sparse, and their unique gender issues are generally under researched, especially in low-income and middle-income countries (Vazquez *et al.* 2020:2).

The vulnerabilities of homeless women include that they experience chronic illnesses. A study by Hwang and others from Boston and Toronto, reported that women who are homeless face a five to thirty times greater risk of dying than their housed counterparts (Hwang 2015:2; Orav 2018:87; O'Connel 2015:39). Living in overcrowded shelters increases the risk of contracting infectious diseases like influenza and tuberculosis, and it also makes pre-existing conditions worse. Chronic illnesses are also common among the homeless, as they are noted to have hypertension, diabetes and respiratory difficulties (Drancourt 2018:2; Mainardi 2014:12; Vandenesch 2015:110). Tuberculosis and HIV/AIDS are endemic and the spread of the recent COVID-19 coronavirus is particularly omnipresent in homeless shelters (Harnisch *et al.* 2020:13).

Women face similar challenges to those of homeless men, such as mental illnesses and economic issues. Moreover, they are also disproportionately responsible for child-rearing and more likely to experience victimization or abuse from family members and intimate partners, thereby exacerbating the risk for poverty and homelessness (Abramovitz *et al.* 2017:13).

The gender wage gap, which causes women to receive a lower income for the same work, exacerbates the probability of women falling below the poverty line and consequently becoming homeless (Confortini 2006:30). There is a link between homelessness and violence, and programmes to address homelessness must be sensitive to the risks of gender-based violence (GBV) which are often related (Mertus

2000:45). Gender- based violence is a form of violence that affects people of a particular gender disproportionately (Enloe 2001:9). Violence against women is understood to be an act of gender-based violence that results in physical harm, sexual harm and psychological harm (Deming 2001:45).

Homeless people often have many complex health issues (Culhane et al. 2020:111). During the COVID-19 pandemic, due to their weakened immune systems, inadequate nutrition and hygiene, and long-term residence in overcrowded shelters, they were at high risk of contracting infectious diseases with a limited percentage of identification and care, implying that they are a highly vulnerable community (Albon 2020:2; Soper 2020:2; Perri 2020:1; Hwang 2020:2).

Plans of treatment that are effective for people with homes and supportive families might not be effective for those who are homeless. Even those who live in homeless shelters, bedrest may be something hard to achieve, medication is challenging to obtain and store, as using syringes is forbidden in shelters (Kertesz 2010:13). According to O'Connel (2015:52) the adherence to medication, particularly those requiring daily dosing is challenging to those in shelters and those depending on meals from soup kitchens.

The homeless shelter movement emerged in the early 1970's, as a response to the growing levels of homelessness, because of escalating unemployment, increasing housing costs, and deinstitutionalization of people who had severe mental illness (Morgan 2002:17). At the time, homelessness was seen as a temporary problem, but as the rates of homelessness increased throughout the 1980's, shelters became a permanent community fixture (Gounis 1992:15; Stark 1995:22; Morgan 2002:32).

This study was conducted at the Sisters of Mercy Homeless Shelter in Johannesburg with twelve women who voluntarily participated in the study. The mission of the shelter is to provide security, personal safety and to prevent ill health. The participants' lives were significantly impacted by the shelter, by providing them with adequate housing, so as to ensure their dignity and create the opportunity for them to lead a normal life, in order to reduce their vulnerabilities and build resilience among them.

The challenges endured by homeless women included poor nutrition, sleep deficiency, inadequate hygiene, exposure to the elements and the effects of stress and

depression (Whitzman 2010:3). Hence, the Sisters of Mercy Homeless Shelter was developed to help eradicate the challenges women faced.

Women are more likely than men to experience poverty and financial hardships for greater periods of time and more frequently (Espinoza 2022:11). The Living Wage Foundation observed that more women than men are employed in low-paying industries, which results in their earning less than the living wage. (Espinoza 2022:11).

The COVID-19 pandemic was an obvious illustration of how a global crisis can make issues worse, for a particular group of people. Therefore, the poorest people were impacted first and hardest by the rise in the cost of living. Post the COVID-19 pandemic, the increase in the cost of food and transport has negatively affected most disadvantaged members of society and due to poorer wages and minimal savings, making it harder for women to face the rise in the cost of living (Crerar 2022:40).

Therefore, there is a lack of literature on the unique challenges faced by homeless women in South Africa, as they are considered a vulnerable subpopulation amongst the homeless. Empirical research, is not gender informed and focused primarily on homelessness as a gender inclusive term. Women are underrepresented in the research on homelessness and particularly invisible in their experiences of homelessness, hence according to (McCauley & Reid, 2020) the U.S. has shifted to a quantitative assessment approach to housing allocation decisions within homeless services, whereby communities ought to consider homelessness and vulnerability through an intersectional lens in order to better account for how multiple positions of disadvantage reflect vulnerabilities differently and Without doing so, vulnerability assessments are subject to bias. In 2019, The New York Times reported that women face a heightened risk for interpersonal violence and trauma on the street compared to men, they are disproportionately represented within the homeless.

Finally, intersectionality would suggest that the intersection of minority race, female gender, and experiencing homelessness could place someone in the greatest position of vulnerability. The susceptibility of women who are homeless to abuse, exploitation, and marginalisation, as well as increased rates of poverty (Suarez *et al.* 2018:13), was further exemplified during the pandemic as they lacked the necessary resources to escape violence which was found to have increased during COVID-19. This was a

research gap and hence the need to explore vulnerabilities of homeless women during COVID-19 pandemic in South Africa.

Thus, this research sought to understand how the COVID-19 pandemic and the lockdown exacerbated the vulnerabilities of homeless women who were in the shelter. The purpose of the study's findings is to provide recommendations and ideas that can help the homeless women who took part in the study, to cope with post COVID-19 pandemic distress.

This short introduction has outlined the key dimension of this study. A discussion of the context, significance of the study and theoretical framework guiding this research study follows. Lastly an overview of the aim, objectives, methodology employed, as well as the composition of the dissertation is provided.

## **1.2. Background of the study**

People experiencing homelessness have been often marginalized and occasionally disregarded. Women are a sub-set of this group who have had particularly intense experiences with this (Bailey 2009:143). Considering the historical social construction meaning of being a woman, the history of homelessness amongst women differs from the history of homelessness amongst males (Klodawsky 2018:367). Previously, the role of a woman was only understood within the context of her relationship with a male counterpart (Casey 2008:171). Women had fewer rights, particularly the right to own property, the right to vote, to participate in making decisions regarding their bodies, their ability to divorce, and their involvement in family finances (Marshall 2009:8).

As time progresses laws evolved in many countries and women were granted rights, however there was often social and cultural resistance (Crowe *et al.* 2007:40). The notion of 'women' and 'home' were inextricably linked, and a woman experiencing homelessness was considered to be deviant, a corruption of the government and a lack of planning thereof (Goudie *et al.* 2008:20).

### ***1.2.1 The Sisters of Mercy Homeless Shelter.***

According to the Congregation of the Sisters of Mercy (2008:1) the most popular destination for job seekers was Johannesburg, also referred to as Egoli (City of Gold). However, there was sadly little employment and little access to resources to help

people develop the skills needed to find employment. Thousands were forced to join the increasing number of people sleeping on park benches, at bus shelters, under bridges, and even on pavements as hope started to fade.

For many years, the Sisters of Mercy have given those in need access to soup kitchens. Later they saw the need to give homeless people access to safe, short-term transitional housing and facilities for skill development. After seeing the Sisters of Mercy of California's outstanding work in social housing during their visit to the United States, the two Sisters from South Africa decided to look for a suitable building to use as a night shelter. Fortunately, the parish hall in Rosebank, Johannesburg, which is next to Saint Catherine's Convent, became available for purchase. Even though they had no money, they were determined to get some, and the hall was ready for use as a night shelter. *However, during the COVID-19 pandemic the outreach programmes such as daytime soup kitchens, volunteer group events, social workers daily visits at the shelter had to be put on hold, and shelter had to temporarily close due to public health and social distancing rules.*

### 1.2.2 The SARS-COV-2 virus

The SARS-COV-2 virus is the infectious agent that causes the coronavirus disease (COVID-19). Serious illness is more likely to strike the elderly and those with underlying medical conditions such as diabetes, cancer, cardiovascular disease, or chronic respiratory diseases (World Health Organisation 2020:1).

Coronavirus disease was discovered in 2019 in Wuhan, Hubei Province, in China and it became highly infectious and spread rapidly to most countries. The World Health Organisation (WHO) declared it as a global public health threat (Zhu *et al.* 2020:1; Luo *et al.* 2020:3). Singhal (2020:10) mentioned that the Coronavirus (COVID-19) which surfaced in 2019, worldwide disrupted people's health, well-being, financial security, and behaviour. The impact of the pandemic extended beyond just medical issues. *The large-scale outbreaks of the disease have varied mental health and economic implications, which outlasts the effects of the infection itself (World Health Organisation 2020:54).*

The economic downturn had a major effect on industries dominated by women since many of these sectors had to close because of lockdown regulations to control the

spread of the corona virus (Lakam 2020:56). Global data reflects that 58% (Almquist 2020:17) *of service industry employees are women, and that this group were most affected by the pandemic. As a result, their path to financial independence and, subsequently, stable housing, was hampered* (US Department of Housing & Urban Development 2019:40). Experts have also noted a sharp rise in the number of females requesting homeless shelters, which will be a trend that will likely continue post pandemic (Verity *et al.* 2020:43).

Women's subjugation is further cemented by discriminatory practises, including gender-based discrimination. The rise in the number of homeless women who experienced gender-based violence from their intimate partners and were financially dependent on them was another possible economic effect of COVID-19 (Mahlangu 2022:12). *The closure of homeless shelters during COVID-19 pandemic led them returning to their abusive partners and facing a greater risk of violence from which they had fled and sought refuge from.*

### 1.3. **Problem statement**

*The Statistic South Africa published Coronavirus (COVID-19) cases in South Africa from February 2020 to March 2022 by regions, (Cowling:2023) mentioned that as of March 06, 2022, overall coronavirus (COVID-19) cases in South Africa reached its highest at 3,684,319 infections, which was the largest volume of confirmed cases compared to other African countries. Regionally, Gauteng (Johannesburg) was hit hardest and registered 1,196,591 cases, whereas KwaZulu-Natal (Durban) and Western Cape (Cape Town) counted 653,945 and 642,153 coronavirus cases, respectively. The 2022 national census found that there were 55,719 homeless people in the country and Gauteng province had the largest number of homeless people with 25,384 recorded individuals and the Western Cape had the second largest homeless population with a total of 9,743 recorded individuals.*

*According to the City Press News (2021) paper Siyabonga Kamnqa a journalist visited shelters in Cape Town to chat to homeless people about their lives during COVID-19 and under lockdown. They alluded that they find it hard to cope with COVID-19 regulations. This is because as the homeless they needed to be in streets to keep*

*hustling and yet the lockdown regulations compelled people to stay at home and avoid overcrowded areas. This was impossible for the homeless and those who lived in overcrowded shelters.*

*Homelessness is the absence of shelter, which can be caused by various forms of poverty including inadequate food, poor health, low education, unemployment, and social exclusion (Du Toit 2010:7). Those who live in overcrowded shelters for the homeless such as the Sisters of Mercy Shelter have been exposed to these health, social and financial ills. The problem however, was that, during the COVID-19 pandemic, the lack of access to health care services, unemployment, lack of food, discrimination and gender-based violence increased dramatically for these homeless women. Interviewees in this study confirmed that throughout the pandemic their fear was not only for coronavirus infections but for fear of starvation. Homeless women are faced with unique experiences during their homelessness such as violence, victimisation, discrimination, poverty, and trauma and these were exacerbated during the pandemic. Moreover, the participants mentioned to have received poor quality health care because of the stigma that they are at high risk, and more often are carriers of the Coronavirus.*

*In 2020 during lockdown level 5, the Gauteng government worked with City metros to erect tents and use abandoned buildings to provide the homeless with sanctuary during the lockdown to stop the coronavirus from spreading, however the tents were also overcrowded. COVID-19 highlighted that little attention was provided to the homeless in South Africa, particularly vulnerable women. However, there is still limited of knowledge regarding women's unique experiences of homelessness especially during the pandemic. In order to provide services to them it is crucial that there be an understanding of their needs. This is where the research gap lies and where the value of the study lies.*

#### **1.4. Aim of the study**

The study's objective is to investigate and comprehend the vulnerabilities of homeless women in Sisters of Mercy Homeless Shelter during the COVID-19 pandemic.

### 1.5. Objectives of the study

- To comprehend how the COVID-19 outbreak and lockdown affected the economic well-being of women, living in the Sisters of Mercy Homeless Shelter.
- To explore whether these homeless women accessed medical care during the COVID-19 outbreak.
- To enquire about how these vulnerable women coped with the economic and psychological effects during the pandemic.
- To explore how social distancing and COVID-19 health protocols were affected in the shelter.
- To understand how women in the shelter supported each other during the pandemic.
- To make recommendations to the local government to better support those homeless women living in Sisters of Mercy Homeless Shelter.

### 1.6. Research questions

- How did the COVID-19 pandemic and lockdown affect the economic well-being of women, living in the Sisters of Mercy Homeless Shelter?
- *Did the homeless women have access to medical health care during COVID-19 pandemic?*
- How did vulnerable women who participated in the study, cope with economic and psychological effects of the pandemic?
- In which ways did women in the shelter support each other during the pandemic?
- Which recommendations to the local government could be made to support homeless women in the shelter?

### 1.7. Significance of the study

In addition to poverty and social isolation, gender exposure to violence was another factor that further marginalised women during the COVID-19 pandemic. Whilst the challenges of people living in homelessness has been researched, there is a paucity of local research data regarding the challenges that sheltered homeless women face on daily basis, and the ways in which the COVID-19 pandemic affected them. The

study *wanted* to close the gaps in literature by exploring the vulnerability of homeless women who lived in a homeless shelter during and after the COVID-19 pandemic.

An exploration of vulnerabilities of homeless women during COVID-19 *was aimed* at alerting policymakers about gender specific challenges, that homeless women encounter. By exploring these vulnerabilities of homeless women, more knowledge regarding their plight emerged. This raised consciousness on public service providers such as social workers, police, and medical professionals *and made them* empathic towards homeless women.

Most facets of life were profoundly impacted by COVID-19, which resulted in a decline in social support and interpersonal interaction. The virus elevated health and social problems. Therefore, the study was important because it raised questions about how to build a better and more sustainable post-pandemic future for everyone and *stresses the need for* national commitment to ending homelessness and addressing the gender vulnerabilities of homeless women.

Moreover, the research gave insight into the experiences of women who are homeless as well as factors that contribute to homelessness, which can aid in its prevention and reduction. Because they were more likely than homeless men to need services and facilities that were specific to them, the study of "female" homelessness is crucial. This study is expected to contribute to the small amount of information regarding the vulnerabilities of the experiences of homeless women. It has contributed to knowledge regarding the physical, psychological and economic effects of homelessness among women. Additionally, the study benefited those who work with the homeless community and provide services.

## **1.8. Definition of concepts**

The key concepts of this study were vulnerabilities of homeless women, homeless shelters, the Sisters of Mercy Homeless Shelter and COVID-19 pandemic. The following are definitions of these concepts.

### **1.8.1. Vulnerability**

Vulnerability is the ability to be susceptible to harm, danger, or death (Mohay & Forbes 2019:13). Sammarco (2016:48) identified vulnerable groups as those who, due to their marginalised sociocultural status, limited access to financial resources, or personal

characteristics like age and gender, have experienced a higher than average risk of developing health problems.

### **1.8.2. Homelessness**

Lack of a stable, sufficient, and regular place to live at night is the definition of homelessness (Henry *at al.* 2020:25). This covers people who are homeless, living in cars, shelters, or transitional housing. Homelessness is primarily caused by a lack of stable housing; however, it has developed into a public health crisis with compounding conditions that calls for numerous solutions in addition to housing. Individuals who are homeless have greater rates of personal disability, such as long-term medical disorders and psychological problems (Wright & Rubin 2018:22). They become even more vulnerable as a result of the potential for severe alienation from society and their support network during their time spent on the streets (Slsson 2020:2).

### **1.8.3. Women**

Mosby (2018:1) defined a woman is an adult female human. Before adulthood, a woman is referred to as a girl (a female child or adolescent). Typically, women are of the female sex and inherit a pair of X chromosomes, one from each parent

### **1.8.4. The Sisters of Mercy Homeless Shelters**



*Figure 1.1 The interior of the Sisters of Mercy Immaculate Hall.*

The Sisters of Mercy Homeless shelter was originally founded in 1831 by Catherine McAuley and it was a Religious Congregation largely involved in the care of the poor,

the sick and educationally disadvantaged. It is located at 17 Sturdee Avenue, Rosebank, Johannesburg, South Africa and they serve displaced individuals in the Rosebank area. Above providing them with shelter, they also provide skills training and assist with documentation for the city's homeless, and the work to help them get back on their feet and restore dignity.



### *1.2 Sisters Of Mercy Immaculata Hall in Rosebank map*

Ntuli (2019:1) said the Sisters of Mercy Homeless Shelter accommodates 20 women and 80 men who can sleep on the premises. They receive two meals a day, breakfast and supper. After breakfast, they normally go out to look for jobs. Most of them are domestic workers and car guards. The shelter's mission was to provide the homeless with a safe, secured place to explore counselling and personal development opportunities, help them reclaim their sense of self-worth and talent, and enable them to successfully reintegrate into their communities.

The Johannesburg Mercy Shelter provides overnight accommodations for the homeless, and as part of their outreach programme in Rosebank, they serve cooked meals every day. A full cooked meal is served to about 200 to 300 individuals who are unable to find housing, and they are also allowed to use the laundry and lavatory facilities.



*Figure 1.3 Laundry service for people living on the street*

The significant challenge the shelter had was to accommodate more people than the shelter could take, especially during the COVID-19 pandemic, when the shelter had to temporarily close to observe the lockdown protocols. The pandemic made it hard for the shelter to operate and help people, even post the pandemic fewer people could be accommodated and fewer volunteers could assist at the shelter.

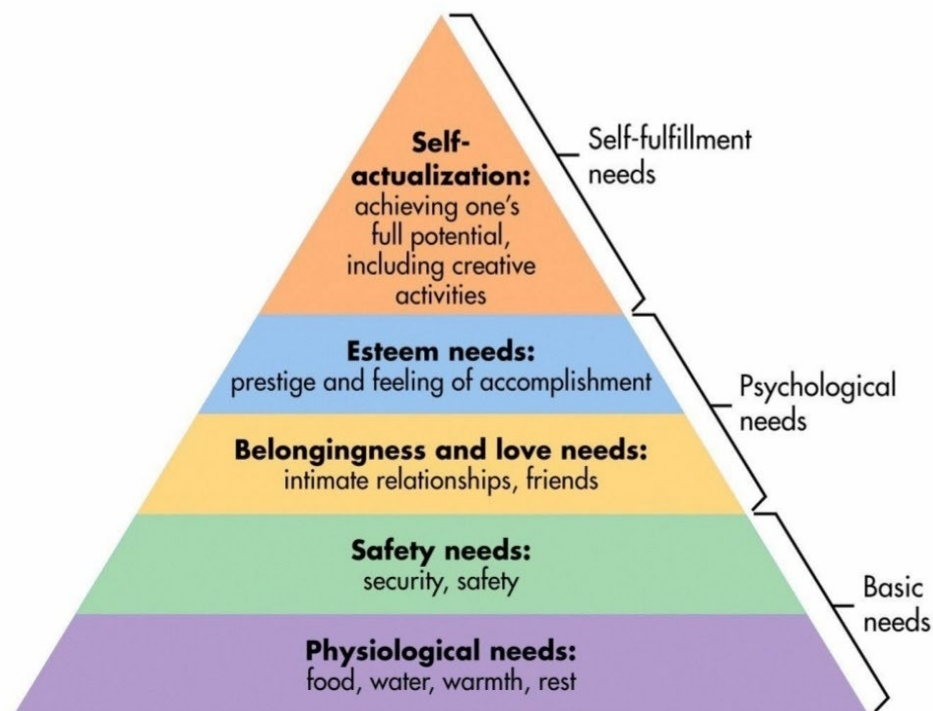
#### **1.8.5. COVID-19 pandemic**

WHO (2020:17) specified coronavirus disease (COVID-19) as an infectious disease brought on by the SARS-CoV-2 virus. When an infected person coughs, sneezes, speaks, sings, or breathes, tiny liquid particles from their mouth or nose can spread the virus. These particles can be smaller aerosols or larger respiratory droplets. The majority of virus-infected individuals will recover from mild to moderate respiratory illness without the need for additional care (Jayaweera 2020:18). Nonetheless, a small percentage will get very sick and need medical care.

### **1.9. Conceptual Framework**

A conceptual framework is a tool that makes connections between ideas to help explain how concepts relate to one another for variables in the real world (Zackoff *et al.* 2019:102). The researcher's comprehension of a hypothesis, investigation of a framework or model, or the way in which preexisting concepts are combined to inform a specific problem (Grant & Osanloo 2014:27). The reader can also see how various components work together to support research and a clear understanding of the findings thanks to the conceptual framework (Imenda 2014:8). It is crucial to remember that a conceptual framework is a written or visual product that describes the primary subjects of study, the crucial elements, concepts, or variables, and the assumed relationships between them in a narrative or graphic format (Miles & Huberman 1994:5; Robson 2011:12).

The vulnerability of homeless women was positioned at the core of this study. Therefore, the unmet hierarchy of needs of homeless women which led them to the state of vulnerability, played a critical role in determining the most accurate conceptual model to guide this study. The hierarchy of needs model as originally articulated by Maslow, illustrate hierarchy of needs below:



*Figure 1.3 Maslow's Hierarchy of Needs*

In 1943 psychologists Abraham Maslow developed the idea that human beings have a hierarchy of needs (Tay & Diener 2011:8). The theory explains how humans progress to their full potential and thrive. The hierarchy of needs help individuals to have a better understanding on how to overcome challenges. Homeless people are vulnerable and the theory provides ideas of the kind of support that homeless individuals might need to overcome in reaching great independence (Wahba & Bridwell 1976:5).

The first step is to attend to basic needs, which include physiological needs like food, water, clothing, and shelter as well as safety needs. Homeless people work hard to meet these needs on a daily basis in order to survive. Once physiological needs are satisfied the theory says the need for safety and security arises (Baumeister 2005:14). Mental and physical health challenges, lack of employment, Post Traumatic Stress Disorder (PTSD) and substance abuse, are complex issues leading people to

homelessness (Substance Abuse & Mental Health Administration (SAMHSA) 2011:61). Therefore, the ability to access long term secured and safe accommodation is crucial to overcome these challenges.

Moving up the pyramid, the last three steps of the hierarchy of needs model, is the need for love, sense of belonging and self-fulfilment. Humans are social beings and rely on each other to survive and thrive (Kremer 2013:18). Over and above the support from social workers, homeless women who live in shelters may form relationships and emotionally support for one another (Gorm 2010:56). This support both from the social worker and those they live with in shelters, help homeless individuals slowly gain self-esteem and confidence and can work on building healthy relationships with themselves and others. The gaining of confidence will lead to self-actualisation and one will realise his or her purpose in life (Villarica 2011:2). One would have a desire to become everything that one is capable of becoming, said Maslow (1943:13).

### **1.9.1. Basic needs**

The most essential needs for homeless individuals are housing, regular meals, adequate clothing, and safe drinking water. Being homeless means not only having a roof over your head, but also not being able to afford the necessities of life, such as health, safety, and cleanliness (Lingan 2018:9). Satisfaction of basic needs will also protect the individual from threatening health issues. Feminine hygiene items are also basic and fundamental needs that the homeless should use (MODA 2020:1). Homeless women may not have sufficient resources to cope with menstruation, which can be embarrassing and inconvenient.

#### **- Physical needs**

Women who are homeless are the most vulnerable segment of society, experiencing more physical health issues. (Shelter Scotland 2015:8). The majority of this population had a variety of comorbidities (Department of Health 2016:2). Although it is commonly believed that homelessness only refers to sleeping on the streets, which affects a small percentage of the population, someone can also be considered homeless if they do not have a permanent place to live (Heriot Watt University 2021:9). According to the homeless Health Audit from 2014 (Darkwah 2010:9) findings showing that 39% of homeless people reported having mental health issues and 73% of them

reported having physical health issues. According to estimates, 70% of homeless patients who were released from hospitals in 2013 had their medical needs unmet. About one-third of the medical conditions treated in homeless people's healthcare facilities are chronic illnesses (Silver & Panares 2000:1). These are chronic conditions like ulcers, diabetes, hypertension, and asthma that are frequently reported (Weinreb *et al.* 2014). Furthermore, it has been discovered that women who are homeless also report high rates of gender-specific health issues pertaining to pregnancy, gynaecological health, feminine hygiene, and STDs. Accessing appropriate health care services is difficult for homeless women due to a variety of factors, including long wait times and limited transportation (Nyamathi 2000:2).

### **1.9.2. Psychological needs**

According to Maslow (1943:3) when one need is satisfied, another one progressively takes its place. According to Patterson *et al.* (2012), those who are homeless are disproportionately likely to suffer from mental health issues and insufficient resources to address these issues. The unfulfilled mental health requirements ought to guide policy and social reform and enhance mental health (Kerman 2019:12). Personal accounts of trauma, victimisation, stigma, and a lack of basic necessities can be used to highlight unmet mental health needs (Goering *et al.* 2011:5). Mental health issues affect between 30 and 35 percent of the homeless, with the number more than doubling for women who are homeless O'Brien *et al.* (2020:9). Bipolar disorder, posttraumatic stress disorder, depression, and anxiety are frequently diagnosed in homeless people (Giesbree *et al.* 2018:17).

### **1.9.3. Self-Fulfilment needs**

The results of the study indicated that individuals using emergency shelters prioritised learning necessary skills. The ability to master the inner fortitude to endure homelessness may also fill the homeless with pride (Feigenbaum 2020:7). According to Maslow, happiness is more than just a hedonistic concept and involves striving. Examining a participant's personality and level of happiness under stressful circumstances can reveal the real outcome of a study involving homeless people (Compton 2018:55). *With the skills such as computer literacy, sewing, fabric painting and car guarding that the shelter equips them with, those who are homeless could feel proud of themselves for having the inner fortitude to endure homelessness* (Souza *et*

al.2016:19). Therefore, despite extreme material deprivation, homeless people may be able to articulate their life's purpose and develop a philosophy of life that brings them personal fulfilment.

### **1.10. Research Methodology: An overview**

A qualitative inquiry was adopted in this study. *Interviews were conducted in an exploratory manner using the one-on-one interviews method.* The qualitative method was a quick and inexpensive way to analyse and understand the experiences of homeless women which was employed to obtain comprehensive understanding of the issue and produce fresh research ideas. In the study, a non-probability sampling technique called purposive sampling was applied. Twelve homeless women who lived in the Sisters of Mercy Homeless Shelter were recruited from the shelter in Rosebank, in Johannesburg.

A semi-structured interview was scheduled with open ended questions to acquire information. The interviews were conducted face-to-face and on a one-on-one basis and all COVID-19 protocols were observed. The researcher chose these techniques in order to fully comprehend the participants' vulnerabilities as a result of their homelessness both during and after the COVID-19 pandemic. Thematic analysis was used to interpret patterns and analyse data obtained from recruited participants.

### **1.11. Structure of the Dissertation**

#### **Chapter One: Overview of Study**

This is an introductory chapter that provides a brief outline of the background of the study and the research problem. It reflects on the significance of the study, aims and objectives, including a succinct description of key concepts relating to the study. The theoretical framework by Abraham Maslow that was used to define the scope of relevant data was explained in this study. The last two aspects were the methodology that the researcher used and the structure of the dissertation.

#### **Chapter Two: Literature Review**

The research provided a detailed literature review, which engaged existing national and international literature in relation to the aims and objectives of the study. Furthermore, the paucity of literature on vulnerabilities of homeless women in South Africa during COVID-19 pandemic was discussed in this chapter.

### **Chapter Three: Research Methodology**

This chapter outlined the appropriate research methodology chosen by the researcher. It provided a clear explanation and justification of the sampling technique, participants, research design, data collection procedures and ethical considerations.

### **Chapter Four: Analysis and Discussion of Findings**

This chapter reported and discussed all findings. Qualitative presentation and analysis of findings from recruiting participants using thematic analysis were presented. The interpretation of qualitative findings integrated with existing body of literature of the topic under study, was presented.

### **Chapter Five: Conclusion and Recommendations**

In relation to the objective of the study, an overview of findings was presented in this chapter and recommendation for future studies, were discussed.

#### **Reference:**

A list of literature sources consulted during compilation of this dissertation, that allows the researcher to acknowledge the contribution of other writers and researchers.

#### **Appendices:**

a section that is placed at the end of the dissertation, and may contain materials such as tables, figures, maps, photographs, interviews questions etc., to provide a more comprehensive understanding of the research problem.

### **1.12 Conclusion**

The problem statement was presented along with the study's potential contribution to the field of women and homelessness research. This introductory chapter outlined the aims and objectives as well as the rationale for the study. The theoretical framework that guided the study was also discussed. A review of the pertinent literature is given in the following chapter.

## CHAPTER TWO

### LITERATURE REVIEW

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#### 2.1 Introduction

A literature review gives a broad overview of current knowledge so they can identify pertinent theories, approaches, and gaps in the body of research. A competent literature review assesses sources critically to give a clear picture of the state of knowledge on the subject (McCombes 2023:1). A literature review is a great tool for combining research findings to evidence at the meta-level and identifying areas that require additional study. The task of accurately building on research and relating it to existing knowledge as a building block of all academic research activities has become increasingly complex when knowledge production accelerates at a tremendous speed (Webster & Wartson 2002:67).

Conducting a literature review assists a researcher to build their knowledge in their research field (Western Sydney University Library 2016:17). Understanding the body of research that is pertinent to a given topic or field of study is the aim of a literature review, which is then presented as a written report (Labaree 2009:10). The aim of a literature review is not just to summarize each source, but should compare and contrast each source to other relevant literature on the topic, to indicate how each source contributes to the body of knowledge about the topic and lastly integrate discussion of the source into the researcher's argument about the state of knowledge on the topic (University of Melbourne 2013:14).

This chapter provides a wealth of information about the vulnerabilities faced by homeless women during the COVID-19 pandemic, with an emphasis on pertinent national and international principal theories as well as a summary of previous research findings. The literature reviewed for this chapter comes from a variety of sources, including books, websites, and online journals. It is reviewed in accordance with the research objectives of the study, beginning with a discussion of the prevalence of comorbidities related to COVID-19 and the insufficiency of healthcare for the homeless. The researcher discussed data relating to the loss of income during COVID-19 and how it exacerbated the vulnerabilities of homeless women. Furthermore,

existing knowledge about marginalization and stigmatization of homeless women during the pandemic, as well as how they have been socially excluded, has been presented in this chapter.

Many people who are homeless suffer from long-term mental and physical illnesses. (Tsai 2020:39). The prevalence of major mental disorders and other mental health issues is disproportionately high among women who are homeless. Because there are insufficient resources to address the unique needs of homeless women and a lack of awareness of mental health issues, many homeless women with severe mental illnesses do not receive the necessary care (Robertson 2015:311). They can be neglected in the allocation of healthcare services especially during the COVID-19 pandemic (Kinner *et al.*2020:40). Many nations find it difficult to support shelters with resources and infrastructure, let alone to take care of the homeless during a potential quarantine. Hence, it becomes difficult to detect and prevent the disease in transitory populations (Danias 2020:41).

## **2.2 Homeless individuals coping with mental health problems**

### 2.2.1. Lack of access to medical health care

In many *global South* countries, many homeless women who suffer from serious illnesses do not receive the necessary care. Research results frequently imply that mental health issues are the root cause of homelessness (Koegel *et al.*2017:331), even though mental health problems are not the only core principle explanation of homelessness of women, but they are an important contributing factor (Culhane 2011:332). Additional to mental illness, substances abuse is another factor influencing homelessness among women, and it demonstrates the inadequacies of the basic social systems.

### 2.2.2. Gender differences and capabilities

According to *reports in* (Lovell 2000:317), homeless women experience mental health issues at higher rates than men. It makes sense that there is a high incidence of emotional distress and demoralisation among homeless women. Moreover, Merves (2001:317) mentioned that the Centre for Epidemiologic Studies Depression Scale (CES-D) suggested that homeless women have higher levels of emotional distress or depressed mood than the general population based on an assessment using the

indicator of emotional distress and depression mood. Compared to women without children, women with children experienced greater levels of distress Susser (2014: 319).

### **2.3 Primary care for homeless**

There is a serious risk to people's physical health with homelessness. This is because of challenges such as accessing services and maintaining good health associated with homelessness (Anderson 2015:77). Aday Anderson developed The Equity of Access of Medical Care Framework. According to the framework, services should only be provided in proportion to people's needs rather than their sociodemographic traits in order to achieve equity (Aday 1974:80). The main belief of the framework is that access to health care is a human right, and that even with scarce resources, health care policy must determine how to best use them in a manner that is equitable (Donaldson 1996:84).

#### **2.3.1 Substance abuse as a setback to fighting homelessness**

Substance abuse and homelessness are strongly correlated, indicating a two-way relationship. Drug and alcohol abuse are potential coping mechanisms for those who are marginalised and lack housing (Roy *at al.*2014:3). Substance use was found to contribute to a person's health declining longing for adequate housing. This decline is in line with the connections between substance abuse and higher mortality rates among the homeless population. (UN Commission for Social development 2019:3). Mental disorder studies conducted amongst homeless women are typically associated with unmet needs, which further indicates the need for an integrated approach to treatment, in order to both directly and indirectly mitigate their effects (Williams *at al.*2018:14).

The Ministry of Housing (2021:15) *in France* mentioned that the different initiatives such as the Housing First, Assertive Community Treatments and Critical Time Intervention that address the needs for housing have been researched over the last decade. However, homeless persons now face an increased risk of infection due to the COVID-19 pandemic which further marginalizes them (Deutsche 2021:13).

#### **2.3.2 Threats that led to homelessness before COVID-19 pandemic**

A study by Stein (2000:1018) demonstrated how issues in adulthood like low self-esteem, ongoing victimisation, depression, and chronic homelessness can be directly caused by a more dysfunctional early home environment marked by abuse and substance abuse. Among the homeless women, childhood abuse, which includes verbal, physical, and sexual abuse is the most common and dangerous predictor of a variety of dysfunctional outcomes (Wenzel *et al.* 2011:1023). Moreover, parent substance abuse is also a direct predictor of drug and alcohol problems among homeless women, which led to intergenerational influence substance abuse in their progenies (Melchert 2013:1021).

A study by the Los Angeles Homeless Services Authority (2007:2) revealed that threats associated with health for homeless women, living in temporary shelters were far worse than those women in low-income houses. For example, rate of past years in victimisation, either physical or sexual (35% vs. 13%), alcoholism (16% vs. 1%), drug abuse (30% vs. 2%), and sex trading (35% vs. 2%) (Hartel 2004:13). Such sexual behaviours and substance use are additional factors and significant threats which increase the vulnerabilities of homeless women during the COVID-19 pandemic

## **2.4. Prevalence of comorbidities among homeless women**

### **2.4.1. Comorbidities that relate to COVID-19**

Tsia (2020:2) mentioned that when patients are homeless, taking COVID-19 precautions is easier said than done. When compared to women of the same age who live in houses, those who are homeless have a significantly higher prevalence of comorbidity and chronic illnesses (Story 2013:5). The largest specialist general practitioner practise in Australia in homeless healthcare, sees about 4000 active patients, of whom 13% have chronic respiratory conditions, 79% smoke, which is linked to poor lung health and associated risks, and 8% have diabetes, which means almost all of the patients have comorbidities. (Pathway 2020:1).

Homeless people are more likely to experience multiple morbidities and early mortality. Among the women who are homeless, drug and alcohol abuse, as well as mental illness, are the most common manifestations (Lenmed 2020:4). A review of literature about *sexually* transmitted diseases among homeless women concluded that they were promiscuous and had a high partner turnover rate, and more often will exchange

sex for money, which indicates that a high frequency of STDs, including HIV, exist in this population.

#### 2.4.2. Health risk implications for homeless women

Younger homeless women have a higher death risk than those living in homes. (Hwang *et al.* 1997:23). These homeless women are not only poverty stricken but they are also susceptible to complicated medical issues, substance abuse, physical and sexual abuse, and long-term mental illness (Hamisch 1989:70).

Moreover, homeless women often have risk factors that make them vulnerable for being exposed to, and being infected with mycobacterium tuberculosis TB (Loftus-Farren 2011:4). These risk factors include overcrowded living areas such as shelters, that are also poorly ventilated, comorbidities, substance abuse, HIV infection and malnutrition (Kohn 2004:129). When homeless people are diagnosed with TB, adherence to a treatment of about six months can be really difficult especially when the accommodation is overcrowded and unstable or while dealing with substance addictions, comorbidities and HIV (Tremoulet and Basset (2012:17).

#### 2.4.3 Homeless women in shelters

Women living in cramped shelters run the risk of contracting infectious illnesses like influenza and TB (O'Connel 2004:11). If someone has an underlying or chronic illness that has weakened their immune system, they are more likely to experience severe symptoms or complications from a COVID-19 infection (Lenmed 2020:1). It can be challenging to store medications safely, especially for people with diabetes, as many shelters prohibit syringe possession (Kertesz 2001:18). This may cause a delay in health care seeking, and difficulties with treatment adherence which fuels COVID-19 infections especially amongst the homeless population.

In light of the COVID-19 pandemic, mental health among the homeless population is of particular concern because research indicates a higher prevalence of depression (Fancourt *et al.* 2020:2) especially among women either living in the street or in a shelter. Possible exacerbation of depression risk factors during the health crisis, especially because this population group has been exposed with so many more illnesses such as TB, HIV even prior to COVID-19 (Rossi *et al.* 2020:5). Associated risk factors that caused depression were being a woman, having a long-term illness,

experiencing food insecurity, and the future lockdown that would limit movement to their place of work (Sigdel *et al.*2020:3).

## **2.5. Social distance and isolation**

### Psychological effects of isolation

Adherence to social distance or isolation can have a side-effect of opening a space between human beings, with regrettable effects on mental health (Abel.2020:38) A study carried out in China in January during the pandemic, found differences in the expression of emotions. Self-isolation period led to an increase in depression, anxiety cases (Xiao *et al.*2020:40). Although social interaction can still occur during the COVID-19 pandemic through the use of mobile, internet, and other technological devices, the majority of homeless people regrettably do not have access to these privileges.

The former Minister of Health Zweli Mkhize announced in early May 2020 that the most prevalent comorbidities linked to significant COVID-19 cases in South Africa are diabetes, asthma, chronic renal disease, HIV, and tuberculosis. Moreover, (Lewis *et al.*2014:15) HIV risk behaviours were linked to a lifetime diagnosis of substance abuse or dependence as well as a longer period of homelessness. The results from other homeless samples support the association between drug abuse and HIV risk behaviours (Lenning 2009:55).

According to a study in Riley *et al.* (2014:50), 74% of homeless women had anxiety disorders, 70% had mood disorders, 85% satisfied the criteria for substance abuse disorders, and 97% of them had at least one psychiatric disorder. Furthermore, research results indicated that homeless women with mental health issues had higher rates of loneliness and a lack of social support (Tsai *et al.*2015:6). This confirmed earlier research that highlighted the loneliness that homeless people experience and the challenges they face in sustaining social relationships. Phipp *et al.* (2019:11) highlighted that the social support plays a role in getting off homelessness. During the pandemic crisis, homeless women's mental health will benefit from increased quantity and quality of social relationships, which is the key to reducing feelings of loneliness. (Bower 2018:12).

Furthermore, social distancing and isolation perpetrated more domestic violence and women were victims. UN Women's analysis of the gendered effects of COVID-19 in Palestinian territory revealed a rise in gender-based violence and issued a warning that women will probably be disproportionately affected by the pandemic and that it will exacerbate already-existing gendered risks, vulnerabilities, and inequalities. (UN Women 2020:67). A global pandemic of domestic violence existed long before the COVID-19 virus spread (Caruso 2020:2).

The number of sick people, the unemployment rate, the anxiety rate, and the financial stress created a foundation for the rise in domestic violence against women, whether it be at home or on the streets where they reside. Victims of abuse have found refuge in shelters, childcare centres, medical facilities, and crisis centres for sexual assault. However, these centres are overwhelmed and understaffed (Howard 2020:5).

## **2.6. Deficient health infrastructure for the homeless**

According to Tsai (2020:8) many individuals who are homeless suffer from long-term medical and psychological conditions, and they tend to be neglected when health services are redirected to exclusively fighting the spread of COVID-19. Many countries lack infrastructure and resources to accommodate and shelter homeless people in the event of quarantine.

Many people in the Global South experience extreme poverty and food insecurity, and a sizable portion of the population is either homeless or lives in densely packed shacks (Nelson 2013:301). Living in such conditions where there is an inadequate access to clean water and electricity, the COVID-19 pandemic is proven to be more rapid (The Lancet 2020:17). Graham (2020:40) suggested that the impact of COVID-19 on poor people, especially women will likely exacerbate the already extreme social inequality that exists.

A homeless patient in poor countries described how hard management of COVID-19 and other related diseases was, without adequate accommodation, social support, and poor diet. The Low-middle-income countries (LMICs) frequently have even worse conditions. Gerrish *et. al* (2020:8) demonstrate with an example that countries in Latin America have younger populations than those of Europe and Asian countries. This is an advantage in terms of biological resistance against the coronavirus. However, most of these countries in Latin America have weaker health care systems and

socioeconomic conditions that can make consequences of the pandemic to be worse off, which increases social and health inequality. Sagbakken *et al.*(2020:10) highlights the low socioeconomic status of migrants and the homeless, which is often a result of their high risk of exposure to the environment. Their numerous demographic and psychosocial circumstances, coupled with the lack of access to timely healthcare services and accurate information, force them to live in poor health. (Hunt 2018:13).

## **2.7. Loss of income during COVID-19 pandemic**

### Increased gender inequalities

The most impoverished people are women, and they are frequently the poorest of the poor (Garikapat 2016:1). Their experiences of poverty are shaped differently from men's experiences by the social injustices and disadvantages they encounter. (Kabeer 2015:2). Their susceptibility is heightened by inequality, which also makes it more difficult for them to escape poverty. Women are often in the workforce caught in a trap of working for wages that cannot possibly bring them up and out of poverty, even if they are putting in a hard day's work (Nanda 2016:1).

Studies indicate that women are disproportionately impacted negatively by a range of global socioeconomic challenges, (Ewing-Nelson.2020:78) which COVID-19 has made worse. Johnson (2020:6) stated that, in Canada, for example, 5% of women and 2% of men in the same age range lost their jobs as a result of COVID-19. Although the pandemic is terrible for gender parity, it is even more terrible for the health of women. According to economist Alon *et al.* (2020:78), women's employment is more vulnerable to the COVID-19 pandemic due to a number of distinct factors, whereas men have lost their jobs in previous economic crises.

Almost everywhere, women's jobs, particularly in the unorganised sector, are typically given less priority. Their employment is more likely to be part-time, low-paying, and insecure than men (Floro *et al.*2012:79). It's important to note that such a population group may not have benefits including health insurance, paid time off, and other measures to shield lower-paid employees from COVID-19. It is sufficient to recognise that the COVID-19 pandemic has led to structural injustices given that women have been systematically disadvantaged in several ways. (Yancy 2020:80).

It is impossible to overlook how COVID-19 made gender inequality already present worse. While putting policies into place is important to mitigate crisis from the pandemic, but there is much more to be done (Hess, *et al.* 2020:84). Countries should use this pandemic as a chance to discuss the injustices and inequalities that women experience globally and what concrete steps institutions can take to address them. Rather than just helping women get through COVID-19, the objective should be to build an environment where they can thrive in both the formal and informal sectors Alon (2020:85).

Because COVID-19 disrupts many people's ability to live sustainably worldwide, its effects are likely to increase social and economic vulnerabilities. According to the South African Reserve Bank (2020:101) as part of social and economic mitigating strategy, South Africa is addressing the decline in economic activities by taking measures such as the R350 monthly COVID-19 Social Relief of Distress grant for the unemployed. The homeless are also seen in the queues for this relief grant (The presidency 2020:103).

In response to the health risks posed by COVID-19, many nations implemented social and economic activity bans, which left many people without a means of subsistence (ILO.2020:97). For example, South Africa restricted travel, closed off borders and entry points, outlawed large-scale gatherings, and stopped production in numerous industries. The COVID-19 pandemic is predicted to erase the social and economic advancements of the previous 30 years and result in previously unheard-of levels of unemployment and poverty, according to Sumneret et al. (2020:98).

## **2.8. Lack of resources for the vulnerable**

*According to Wisner (2002:84) vulnerability is the degree to which a population, individual, or organisation is unable to foresee, deal with, resist, and recover from the effects of disasters, according to the World Health Organisation (WHO). It is commonly known that during pandemics, vulnerable groups become even more vulnerable. Among those are homeless women who are already dealing with difficult, stressful situations are homeless women in crisis, even prior to the pandemic. The National Health Act in South Africa advocates that women, children, People with disabilities must have their rights upheld and protected National Health Act (2003:85).*

The rights to health care are also applicable to homeless and are safeguarded by the South African Constitution's section 27(1). Although the State is required to implement reasonable laws and other measures to ensure that people have access to these rights, the State's ability to do so is constrained by the resources at its disposal (Farha 2020:84).

#### 2.8.1 Lack of hygiene facilities for the homeless's workspace

The water supply, sanitation, and hygiene (WASH) has played a pivotal role in the COVID-19 response by means of promoting good hygiene, with a particular emphasis on regular and adequate handwashing (Ekumah *et al.*2020:2). Adequate water is necessary for good hand hygiene. supply and access to hand washing facilities such as soaps that ensures hygienic behaviour. However, Lack of access to soap and water supplies that encourage proper hand hygiene is especially evident in the streets where the homeless reside or work (Howard *et al.*2020:5).

An estimated 8% (627 million) of the world's population uses shared sanitation facilities as their primary sanitation location when there is not enough water or soap for hygiene needs (Caruso and freeman 2020:4). Because they use a shared facility more frequently to take care of their own needs, including menstrual hygiene, women may be more vulnerable (Groupe URD 2020:6) Furthermore, inadequate public waste management and sanitation coupled with overcrowded, claustrophobic living conditions in shelters can worsen the spread of the COVID-19 virus, which will disproportionately affect the homeless.

Out of two billion workers in the informal sector worldwide, just over 740 million are women who are exposed to working in lower- and middle-income nations in an informal capacity. Furthermore, they are more frequently *pronounced* in the most precarious circumstances, such as in dumping sites as waste pickers and in the streets as sex traders, according to a Labour Organisation study (2018:2).

### **2.9. Homelessness vulnerabilities worsened during COVID-19**

Bassier *et al* (2020:8) argues that if the government does not take any action, the rate of extreme poverty among vulnerable households, especially the homeless will triple. Given the high rate of unemployment and large percentage of work in the unorganised sector in the Global South, the COVID-19 pandemic's negative effects will undoubtedly

be even more severe there (Lancet 2020:1). Homeless people and those who found some refuge in camps are forced to go to work and might just not have the choice to stay safe (Nelson 2013:10).

In South Africa, the army and police were called in to remove thousands of homeless people from the streets and relocate them to open spaces, abandoned school buildings, and stadiums where makeshift tent shelters were set up in an attempt to reduce the risks associated with overcrowding (Lewis *et al.*2014:15). The national rates of poverty and malnutrition have sharply increased as a result of the COVID-19 national response, among other previous conditions. Throughout the lockdown homeless individuals who make their living in the unorganised sector lost their day-to-day source of livelihood.

#### Increased mortality due to poverty and exclusion

The number of deaths due to COVID-19 did not only emphasize the existence of inequalities in countries but made them worse (Rodriguez *et al.*2020:2). Pre-pandemic social group exclusion was influenced by several factors, including informal employment, access to health care and lack of social protection which perpetuated a situation of vulnerability (Dall'alba *et al.*2021:4).

To understand the concept of necropolitics of Achille Mbembe that describe the authority to decide who ought to live and who ought to die; death becomes acceptable, but not for every individual or body. The body deemed "killable" according to racial standards is always the one that represents the poorest and Blackest people (Mbembe 2019:2). Studies have shown that many homeless people have difficulties accessing health services, especially preventative ones (Nune 2020:12). In the context of a pandemic, the barrier to promoting health care for homeless populations is even more severe because it increased the rate of premature death (Brazil Ministerial 2021:3). Homeless people in Brazil still face obstacles in getting access to services and healthcare despite the implementation of specific public health programmes and policies. These include stigma, lack of information, and discrimination based on race and gender.

It is critical and urgent that public health service providers receive specialised training in order to effectively treat homeless populations because they might not be familiar with their unique circumstances and way of life. This is because the real needs and

demands of the homeless are not met by the programmes currently in place (Freeman 2011:6). The lack of investment in special training for the treatment of vulnerable homeless populations often lead to homogenized and stigmatized practices which does not assist with the cycle of poverty and homelessness persist (Silva 2020:7).

## **2.10. Vulnerabilities of those who find work in the informal sector**

### 2.10.1 Female refugees were hit harder

Refugee women are unable to obtain employment in the formal sector due to their lack of legal status. Such economic insecurity was evident even before COVID-19 (Freedman *et al.*2020:4). Prior studies in (Crankshaw *et al.*2021:5) have demonstrated that compared to their male counterparts, female refugees face more obstacles and fewer options when it comes to finding informal work. The portion of women interviewed during study conducted on female refugees about the impact of COVID-19 on refugees, said that prior to COVID-19 they had worked as car guards, hairdressers, childminders, nail technicians, and other informal sector jobs. Which were the kinds of jobs that are already vulnerable to exploitation and unstable. However, workplaces were closed at the beginning of the lockdown, which caused people to lose their jobs and income

### 2.10.2. Sex trade became impossible and more dangerous for women

Sex trade is a source of income for several homeless women. Women in the sex trade are exposed to harmful environments for a variety of factors, including inadequate access to food, housing, and medical care, all of which raise their risk of catching COVID-19 (Shedahi & Partington 2020:2). To fully comprehend the risks that women in prostitution take, one must have a basic understanding of what it is like to be concerned about finding food and shelter (Sonavane 2020:10). According to Dutt (2020:4) an Indian woman in prostitution argued that one might survive the coronavirus, but you will not survive eating for two months. She mentioned that poverty will kill them before the coronavirus. Vulnerabilities of homeless women are shamefully exposed when the COVID-19 was regarded as less dangerous by homeless women involved in the sex trade than violence in prostitution (Avanier 2020:21).

According to Williams (2019:3) homeless women who use drugs rely on sex work to support themselves and need to seek out clients whereby social distancing is

impossible. Homeless women who are sex workers are exposed to premeditated sexual and physical violence. Such violence is thought to worsen the stressful experience of selling sex, which is frequently handled by numbing the senses with drugs and alcohol (Korobchuk 2019:3). When talking about female sex work, violence, and oppression—all of which are common experiences for street-level working women—it is impossible to avoid the topic of victimization (Wolfe 2012: 6). Sex work is where gender and sexual role inequality between men and women is most blatant, and contain victimisation of women especially during desperate times of the pandemic where social and economic movement, are limited.

Homeless women who are sex workers responded in a study by Brewis (2019:4) that they have engaged in sex trade because they needed money to satisfy their needs and some to pay for drugs (Walters *et al.*2020:2008). Social inequalities have exacerbated disparities, when communities experience job losses (Kantamneni 2020:2008) which resulted in sadness, shock, disbelief, rage, and other related emotional effects along with grief related to virus-related loss.

Sex trade is linked to homeless women who engage in commercial sex for survival (Platt *et al.*2020:2010). The theory of syndemics acknowledges that epidemics generate a compound effect that predisposes people to various health and social conditions (Singer *et al.* 2017:2008). The theory holds that social circumstances produce a set of conditions that increase people's susceptibility to various health conditions and worse health behaviours. The social disadvantages that are faced by street-based sex workers and their susceptibility to contracting and coming into contact with coronavirus can be comprehended through the lens of the syndemics theory.

The extent of COVID-19's effects on sex workers may have been unclear, but such a group experiences a disproportionate number of social factors such as trauma, poverty, homelessness and substance abuse which again led to a high mortality rate among the group as articulated by the Centres of Disease Control and Prevention (2020:2010).

When asked how COVID-19 affected their work as sex workers, some simply responded to Platt's (2020:2011) study and said that it had not affected them, since they are young and in good health, they reasoned. Some stated they had fewer

customers. Many more stated that their HIV status put them at risk for COVID-19, and they were worried that working in the sex industry during the pandemic would leave them more susceptible to illnesses.

Sex workers during COVID-19 pandemic are thus facing a dual model of risk. Apart from the possible danger of spreading COVID-19, there was also a chance of HIV/STIs transmissions because a study revealed that only half of the participants confirmed condom usage. During the examination of condom usage and personal protective equipment (PPE) usage, PPE was being used by at least three people who had not used condoms. This implied that COVID-19 might have presented a greater health risk than STIs and HIV for those people (Callander *et al.*2021:2013).

### **2.11. Marginalisation and stigmatization during COVID-19 pandemic**

Madhav (2017:8) stated that homeless shelters are a perfect setting for the severe acute respiratory syndrome coronavirus to spread. The shared living space and overcrowding makes it difficult to physically social distance (Tsai 2020:10). Leung (2008:9) drew a conclusion that epidemics and pandemics caused by infectious diseases disproportionately affect those who are marginalised, poor, stigmatised, and discriminated against.

De Venanzi (2018: 8) justified the stigmatisation of the homeless by stating that a lack of hygiene is seen by society as a rejection of custom. Such an approach misses the fact that unequal access to infrastructure frequently makes it difficult to follow hygiene regulations. During COVID-19, hospitalisation for symptoms is essential to reduce transmission and bringing positive outcomes. However, the stigma attached to being homeless and a drug user makes it less likely that homeless drug users seek medication for COVID-19 symptoms (Liang 2020:3).

The remaining 18% of the population is comprised of women who are homeless according to O'Brien (2018:7). The streets are rich environments that convey the social marginalisation brought about by homelessness. The cruel reality is that the numbers of homeless among women during social and economic crisis are expanding because of challenges in gaining access to social policies like social protection and health care (Elwell-Sutton 2016:5).

It is impossible and a challenge that has become more apparent during the COVID-19 pandemic to socially distance oneself from those who have made the streets their homes, wash one's hands for those without access to clean water, protect one's hands, mouth, nose, and eyes, and provide employment at recycling or garbage sites. The Brazilian government did not have a specific plan to protect the homeless that would have guaranteed them access to food, basic sanitary conditions, and emergency assistance (Prefeitura da Cidade do Rio de Janeiro 2020:10).

In Rio de Janeiro, restrictive measures were put into place in March 2020, which led to the closure of businesses and decreased street traffic. As a result, the meagre income streams that the homeless population had previously enjoyed from working in recycling, selling candy and candies at traffic signals, begging for cash, etc., were curtailed or outright banned. Hunger worsened and necessary hygienic conditions by the WHO were impossible (Prefeitura do Rio de Janeiro.2020:3).

## **2.12. Morbidity and mortality among the homeless**

*According to a cohort study by Burt's (2015:11), homelessness is a significant issue in the US, Canada, and the UK. The study found that, mental illness, addictions, tuberculosis, HIV infections and physical ailments account for a large portion of the high burden of illness among homeless women (Gelberg at al.1990:31). Due to these illnesses, extreme poverty, and frequently insufficient access to healthcare, the mortality rate among marginalised and discriminated-against homeless women is high (Hwang at al. 2001:19).*

Compared to the general population, homeless people have a higher death rate and are more likely to become ill. Mortality rates among homeless women have received less attention than patterns of death among homeless men, who have been extensively researched and examined (North 2018:1245). According to six studies conducted in North America and a study on death rates among homeless women in Toronto, the mortality rate among younger homeless women was approximately five to thirty times higher than predicted. This finding implies that initiatives aimed at lowering the mortality rate among homeless women should concentrate on those under 45. Considering that drug abuse and HIV/AIDS are the leading causes of death for these women, it is critical to implement programmes aimed at improving drug addiction treatment access and preventing HIV infections.

Furthermore, given the high suicide risk and high prevalence of depression among homeless women, mental health issues need to be addressed ( The World Health Organisation 2013:9). Addressing the above comorbidities as existing pre-conditions that exacerbate the spread of COVID-19 will also serve to reduce the risk of mortality among those homeless women who get infected by COVID-19.

Being homeless exacerbates ill health and puts those living in overcrowded shelters at risk for infectious diseases like influenza and tuberculosis. Additionally, it makes managing long-term conditions like diabetes and asthma more difficult (O'Connell 2018:3). This complicates the delivery of services, makes health care more difficult to obtain, and irritates healthcare professionals (Hwang *et al.*2017:16). *The uniqueness of homeless population's need*, their diversity combined with the rising number of homeless people has left academics perplexed, policymakers perplexed, and the public's compassion exhausted.

#### 2.12.1. Barriers to deliver health care for the homeless

If nurses, doctors, social workers, and psychologists are willing to leave the traditional hospital or office setting and provide care directly on the streets or in shelters where the homeless live or work, then effective primary and preventative care for the homeless can be provided (Kertesz 2001:1245). But providing care for the homeless presents a difficult moral conundrum, particularly in light of the COVID-19 pandemic, when carers can easily contract the virus. When patients lack suitable housing, efforts to prevent disease, reduce symptoms, and lessen suffering are ineffective. Cheung and Hwang (2004:12) have demonstrated the close relationship between housing and health. Men and women living in poverty who lack homes are prematurely passing away on the streets due to an excessive and acceptable burden of illness.

#### 2.12.2 Underlying medical condition exposure to COVID-19

The social stigma associated with injecting drugs (PWID) combined with the negative psychological, physical, behavioural, and economic effects of substance use renders *people who inject drugs (PWIDs)* highly susceptible to a variety of infectious diseases, including COVID-19. There is a clear connection between PWID and homeless people (Jozaghi 2020:13). People with underlying medical conditions such as chronic kidney disease, diabetes, asthma, or other lung diseases, smokers, HIV-positive individuals, or those with compromised immune systems are more likely to develop severe

COVID-19 signs and symptoms (Townsend 2020:17). Drug users' compromised immune systems make them susceptible to tuberculosis. The same factors that may facilitate COVID-19 transmission include crowded, poorly ventilated living spaces and injecting facilities, a high rate of homelessness and incarceration, heavy alcohol and tobacco use, and some common practises involving sharing cigarette or marijuana pipes (Harris *et al.*2018:14).

Furthermore, homeless women are more vulnerable to challenges such as unavailability of soaps, sanitisers, water, bathrooms in the streets where they mostly live or work (Tsai 2020:10). Withdrawal of primary care outreach services (example nurses out on the streets) due to lockdown presented more exposure for the homeless to high mortality (Story 2013:5). Lastly the withdrawal of outreach programmes such as soup kitchens mostly provided by private organisations such as churches due to lockdown and financial constraints, made the homeless to be worse off (Australian Government Department of Health 2020:19).

To stop the spread of respiratory infections, practise good personal hygiene, especially washing your hands, and have access to clean water. The population that uses drugs frequently lacks access to clean water, and the locations where drugs are used are frequently unclean. Because of their limited resources, drug users may have even fewer opportunities in many countries, particularly developing ones, to find housing and access to clean water. For instance, in an effort to preserve social distance, shelters may restrict the number of homeless individuals they accept.

### **2.13. Lack of housing increased vulnerabilities to COVID-19 pandemic**

Early maps of COVID-19 show how it spreads from person to person and community to community, exposing our interconnectedness (Kim 2020:3). But as time has gone on, the maps have shown a more sinister reality, revealing extreme inequality and deplorable divisions among societies. The risk of contracting COVID-19 is higher in cases of neglected housing vulnerabilities (The Eviction Lab 2020:3). The high risk of COVID-19 among individuals without proper housing has been acknowledged by policy makers. Nonetheless, many locations have not done enough to support the homeless. This validates the discrimination and stigmatisation of the homeless community (Artiga *et al* 2020:14).

There is a correlation between psychological distress and overcrowding. Distress is generally higher for overcrowded households such as shelters for the homeless. Data from the pandemic period seems to show this intensifying during the severe lockdown in April 2020, when 39% of people in overcrowded shelters were indicating psychological distress (Schwartz 2020:2)

Ethiopia is a developing nation in East Africa, with only 0.9 health care workers for every 1000 people according to the Occupational Safety and Health Administration (2020:7). Other issues include a lack of hospitals, a high population density and reliance on public transportation, a lack of sanitary facilities like access to water, and a dearth of personal protective equipment (PPE) for healthcare providers. It has a large number of immunocompromised people, such as those who are substance users, HIV infected, living with TB, etc, and are among the major driving factors making Ethiopia a challenging developing country when dealing with unprecedented COVID-19 spread (Zu,Zi Yue 2020:10).

According to WHO (2016:12) guidelines on health and housing, overcrowded housing conditions constitute a high-risk zone of the spread and infection for all those who live in such settlements. The percentage of Ethiopia's population that is unsheltered or homeless raises the possibility that COVID-19 will spread throughout the community. According to a survey done in 11 Ethiopian cities, there are approximately 88 thousand homeless people in total, with the majority of these people being women, children, and the elderly (EPHI 2019:13).

#### 2.13.1 Homeless shelters that are overcrowded

The financial, personal, and health risks that people who provide housing to others, such as "shelters for homeless", will probably be increased by COVID-19 (Artiga *et al.* 2020:15). More people are being released from prison due to viruses, homeless shelters are closing owing to financial difficulties during the pandemic, there are fewer or no economic and *housing opportunities* (Sun 2020:11).

Davey (2020:1) claimed that several factors, including a lack of municipal services, a dirty environment, inadequate maintenance, overcrowding, and a lack of fuel and water, could compromise health and exacerbate mental health issues that could facilitate the spread of bacterial and viral diseases. In these circumstances, as well as

in the structural flaws that affect housing security and quality globally, COVID-19 *spread* (Chain 2020:2).

Overcrowded, ill-built, and poorly ventilated buildings are breeding grounds for transmissible diseases. Bad housing affects one's health, which in turn affects one's ability to work, which reduces income, and low income leads to unstable housing (Kline 2017:3). Even in settings that are generally fair and equitable, marginalised and impoverished people never have enough safe housing. The rise in COVID-19-related morbidity and mortality in Australia and other developed nations caused focus to shift from housing and shelter in general to institutional care (Slezak *et al.*2020:5).

### 2.13.2 COVID-19's impact on female refugees in shelters

Imposing strict lockdown conditions has led to refugee's camps being shut down. These living spaces are crowded, unstable, and lack access to water for routine hand washing, which is advised to stop the spread of COVID-19. Additionally, COVID-19 has had an uneven effect on women globally. Leung (2018:10) said that for female refugees these impacts were exacerbated because of already existing vulnerabilities among women due to structural gender inequalities in the country of their origin. In the country where they seek refuge, they face structures of violence and discrimination.

When questioned, a refugee from a shelter in Durban, South Africa, explained how COVID-19 had made them feel more vulnerable by escalating their fears and promoting violence. Furthermore, it is critical to recognise that COVID-19's effects are long-term and will exacerbate the violence and insecurities that female refugees already face, who are homeless in the long term as argued by Castellow *et al.* (2015:9).

### 2.13.3 Lack of adequate housing for women increased their exposure to violence

In the context of COVID-19, social vulnerabilities are related to issues like homelessness, anxiety, depression, and gender-based violence (Bauer and Weber 2020:6). Homeless women's physical and mental health conditions make them one of the vulnerable groups more susceptible to illness or death from COVID-19 (Lima *at al.* 2020:4). Hence, Gonzalez-Sanguino (2020:1) recommended that more psychological support be provided to those who are especially vulnerable in order to prevent issues like anxiety, depression, and post-traumatic stress disorder. To some extent those who

live in shelters are at an advantage of receiving psychological help by the psychologists and social workers who frequently visit shelters.

Because they use their domestic and sexual roles as a coping mechanism to avoid shelter, such as moving in temporarily for brief sexual relationships—women's homelessness is frequently invisible (Tomas & Helga.2015:4). Homelessness has historically been associated with men in Canada; however, women and young families are the at-risk demographic groups and invisible homeless groups with the fastest rate of growth.

In addition, the value of welfare grants continues to decrease in comparison to the cost of living due to the absence of policies aimed at reducing inflation (Canadian Association of Food.2013:20). Reducing social assistance and other social programmes has affected women differently than men because women are more likely than men to be poor. The vulnerabilities faced by homeless women were made worse by the notable decline in low-income households and the economic insecurity that beset women, making it more difficult for them to find housing after they became homeless.

During the COVID-19 pandemic sexual violence against women increased in many countries, especially experiences of sexual harassment and sexual assault for women living on the street or in inadequate homeless shelters. Homelessness is a much more dangerous condition to be in for women (Griffiths 2021:130). The results of a study of homeless people in Toronto, for example demonstrated the risk of sexual violence. It was found that 43,3% of the women sampled had received unwelcome sexual advances, as compared to 14,1% of men. More than one in five women interviewed reported being raped and platforms for reporting such cases are ineffective making homeless women even more vulnerable (Crane 2020:4).

#### **2.14. Social exclusion for homeless**

In addition to living in abject poverty, homeless women also experience high levels of social and familial disengagement, which exacerbates their physical and mental health issues (Panadero 2018:7). Due to their deteriorating health, they have a mortality risk that is twice that of the general population. Previous studies by Castellow et al. (2015:8) indicate that stress and traumatic homelessness-related experiences, particularly for women, increase vulnerability and present other risks. The

chronification of homelessness is also directly impacted by stressful life events like rape, abandonment, and family violence. These experiences are also known as the "revolving door" to homelessness (Roca *et al.*2019:4).

Although there has been less research on the condition of homeless women, the information indicates that these women have important risk factors, including mental health issues, risky behaviours, and lifestyle choices (Moss 2018:25). The special needs of homeless women who experience significant social exclusion differ from those of their male counterparts. Women are victimised and encounter challenges because of the relationship between their financial status and mental health, which seems to be particularly noticeable for homeless and pregnant women (Nyamathi 2019:21).

The ecological theory states that various levels of influence, which are moulded by the social environment, have an impact on behaviour. It proposes five spheres of influence: public policy, intrapersonal, interpersonal, organisational, and community (McLeroy *et al.* 1988:4). The complexity of homelessness, which is impacted by personal circumstances, societal structures, and environmental factors, has been illustrated using the ecological theory model (Nooe *et al.*2010:6). From an ecological perspective, people who are homeless require a variety of tools and networks of support to go about their everyday lives.

The COVID-19 pandemic disproportionately affects members of underprivileged populations. It has been demonstrated that residents of shared housing, such as homeless shelters, are more likely to contract COVID-19, which has a high rate of morbidity and mortality (Ward *et al.*2020:265). Individuals who live in homeless shelters and migrants may be appropriate candidates for the COVID-19 vaccination. The vaccine's acceptability in this population is though unknown.

It is commonly known that stress and depression impair a person's immune system. People with low incomes are disproportionately more likely to experience mental health issues. Uncertainties happening across the world have exacerbated mental health issues (The Philadelphia Inquirer 2020:1). Homeless organizations have been sending alarms, a warning that in the lack of a coordinated strategy, the coronavirus could worsen the situation for homeless communities, to deal with the issues of overcrowded tents and shelters reported in The Guardian (2020:1).

## **2.15 Conclusion**

women who are homeless are becoming more and more ill. Many people lack access to primary care and have underlying medical conditions. They have trouble finding public restrooms where they can practise basic hygiene. In the event that they exhibit symptoms of self-isolation, people who reside in cramped shelters and tents are unable to maintain their distance from others (The Washington Post 2020:2). More injustices against the impoverished homeless people have been sustained by COVID-19. According to Dykeman (2011:34), all models that attempt to explain and end homelessness emphasise the necessity of providing basic services that enable people to become self-sufficient and avoid homelessness in the future.

In an American study of homeless youth, researchers looked at what motivated them to leave the streets, Raleigh-DuRoff (2004:565) emphasised that organisations that offered uplifting and skill-building programmes, along with the support of family and friends, were crucial to their rehabilitation. (Ham & High 2020:3) the statements made by world leader Barack Obama is profound 'we cannot deny that racial and socioeconomic factors are playing a role in who is being hit the hardest by the virus'. It serves as a reminder to our policy makers to prioritise the needs of our most vulnerable communities when making decisions.

## CHAPTER THREE

### RESEARCH METHODOLOGY

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#### 3.1. Introduction

Research methodology is an outline of how a given piece of research is carried out. It is the technique or procedure that is used to identify and analyse information regarding a specific topic (Thomas, 2015:4). This chapter *includes* details about the research methodology and a rationale for the approach that was selected. Additionally, the chapter outlines the various phases of the research, such as participant selection, data collection, and data analysis. The researcher's role in qualitative research and reflexivity are also covered in this chapter. The final section of the chapter discusses reliability and ethical issues regarding qualitative research.

#### 3.2. Research Approach

Qualitative research deals with the methods people use to make sense of their world, manage, and sustain a sense of order in their lives, and interact with other people (Babbie and Mouton.2001:30). Garfinkel (2000:21) pointed out that people are knowledgeable about their realities, social environment, and lives. They use their everyday wisdom and knowledge to make sense of their everyday social interactions. Grobbelaar (2000:89) added that qualitative research *emphasises* is on intuition-based knowledge, which is knowledge based on subjects' experiences of the situation, it focuses on social process and the meaning attached to the social situation by the participants. Babbie and Mouton (2001:33) states that in qualitative research, theories are taken to be in line with the knowledge, wisdom, and common sense of the subjects themselves. Hence, the data collection methods according to Creswell (2003:206) need careful consideration, and the researcher should try to see through the eyes of the participants by standing in their shoes (Babbie and Mouton 2021:28).

Interviews were conducted with women in the Sisters of Mercy Homeless Shelter, and the information based on their pre-COVID-19 and pre-pandemic life experiences was gathered by the researcher. The qualitative approach was useful and was successful in exploring their vulnerabilities and their coping mechanisms (Wellington and Szezerbinski 2007:3). The process of interactive interviews allowed the researcher to

investigate and prompt things that could not be observed, and she was able to probe participants' thoughts, values, prejudices, perceptions, views, feelings, and perspectives.

The qualitative research approach created an opportunity for the researcher to learn from the experiences of the participants and to make sense of their daily routines, choices, and experiences (Ochieng 2009:16). The researcher was able to put herself into the participant's shoes which made it possible to interpret and make sense of their realities without any judgments (Flick 2018:2).

One of the objectives of this research study is to make recommendations to the local government to better support those homeless women living in the Sisters of Mercy Homeless Shelter. Creswell (2007:4) felt that a reform action agenda for research should be included in order to potentially impact participants' lives. Indeed, the researcher has recommended to the municipality of Johannesburg through the office of the counsellor in ward 57, that the homeless women living in the Sisters of Mercy Homeless Shelter as part of the marginalized group, should be given preferences. This relates to providing social welfare relief and health care services, to care for their vulnerabilities that worsened during the COVID-19 pandemic.

### **3.3 Research Design**

Research Design refers to the overall plan, structure or strategy that guides the research project.

#### **Sampling strategy**

Both purposive and convenience sampling were used, and women from different age and ethnic backgrounds were purposefully selected (Barrios 2006:5). Purposive sampling techniques were used as a non-probability sampling strategy and women with the most information on the characteristics of interest and who were available for interview sessions successfully and willingly shared their experiences, difficulties, and how they feel different from other members of the society.

#### **- Recruitment process**

The researcher visited the shelter for the first time after being in telephonic contact with the leader. The main reason for the first visit was to issue to the leader the Ethics clearance approval letter from the Durban University of Technology as a confirmation

that the student can legitimately conduct the research. Secondly, the researcher discussed the recruitment procedure with the leader by showing her the inclusion and exclusion criteria as mentioned below. Although 12 women were initially recruited, the researcher still made sure that data was collected until saturation was reached. According to Bowen (2008:1) Saturation is generally understood to mean that additional data collection and/or analysis are not required given the information that has already been gathered and/or analysed. The point in data collection known as saturation occurs when new data ceases to provide new insights into the research questions.

**- Selection process**

The leader with the help from other staff members of the shelter recruited the 12 women who signed the consent form as an agreement to participate in the study. Among the 12 women, the selection was done based on three different age groups and on two different ethnic groups. The following tables summarised the structure of the participants.

<b>Age group</b>	<b>Number of participants</b>
Between 21 -35 Youth	5
Between 36-64 Adults	6
Between 65-more Elderly	1
Total	12

*Table 3.1: Age groupings*

<b>Non-South African</b>	<b>South African</b>
1 (Mozambican)	11

*Table 3.2: Nationalities*

The researcher grouped the participants based on different age groups. Those women between the age of 21-35 were regarded as youth and those between the age of 36-65 were regarded as adults and those above the age of 65 were regarded as the

elderly. The groups were selected and divided with the purpose of exploring the vulnerabilities based on their age groups. Economic opportunities, as well as the availability of educational opportunities for the youth, are not the same as for those above the age of 35. Health challenges and their coping mechanisms between the age groups are not the same. In a nutshell, the vulnerabilities between different age groups are not the same. and it cannot be a one size fit all, especially during the pandemic.

Furthermore, the researcher purposefully selected women based on their ethnic background so that there was a group of non-South Africans and another group of South Africans. The reason for separation was that, the welfare opportunity, and economic opportunities are not the same among these ethnic groups even though they live under the same roof. Over and above the experience of being homeless, non-South Africans experience discrimination, and xenophobia attacks and are the first to be excluded from any economic participation. They may all be living in the Sisters of Mercy Shelter but the dynamics and experiences were not the same and to achieve accuracy in the research data the researcher (with their consent) interviewed in different categories.

### **Exclusion and inclusion criteria**

When selecting a study population, the researcher must have a criterion that specifies which participants are suitable and should be included in the research study (Luborsky and Rubinstan 1995:3; Patton 1990:5). For a qualitative research study, a set of inclusion criteria or both must be specified. An attribute that a participant must have in order to be eligible for the study should be specified in the inclusion criteria, and an attribute that disqualifies a participant from the study should be specified in the exclusion criteria.

Neil (2010:1) stated that the selection or eligibility criteria used to determine whether to include or exclude the target population for a research study are made up of inclusion and exclusion criteria. The inclusion criteria for a study should be based on the scientific objective and are essential to achieving it. When inclusion criteria are chosen carefully, the study's feasibility, external and internal validity, costs, and ethical concerns are all reduced. To be more precise, sound selection criteria will guarantee

sample population homogeneity, minimise confounding, and raise the possibility of discovering a genuine relationship between exposure or intervention and results.

- **Inclusion criteria:**

- All women living in the Sisters of Mercy Homeless Shelter who were available and willing to participate.
- Women above the age of 21.
- Women from all ethnic groups.
- Women without severe mental health challenges (because of the inability to give consent)
- No one was excluded from the research because she was not willing to disclose her nationality

- **Exclusion criteria:**

- Women not living in the Sisters of Mercy Shelter
- Women younger than the age of 21.
- Women with mental health problems.

### **Data collection process**

The initial step in the research process is data collection. Typically, data collection and analysis take place at the same time. It is defined in qualitative research as the methodical collection of data for a specific goal from a variety of sources, such as focus groups, interviews, observation, pre-existing records, and electronic devices (Bowen 2009:4). Questions from interviews or observation can yield qualitative data.

The majority of the time, open-ended questions with descriptive answers that have little to no numerical value are used in qualitative data collection techniques. Using qualitative data is a great approach to learn about the attitudes and actions of your target audience (Queirós *at al* 2017:65). Qualitative data collection techniques yield information that can be utilised to identify novel concepts, opportunities, and issues, evaluate their applicability and precision, create forecasts, and delve deeper into a particular area of study.

- **Procedure for data collection**

The researcher visited the shelter to obtain gatekeeper approval (see appendix A), and gave details about the research topic and objectives thereof. The head of the shelter then provides a list of potential participants who could be interviewed based on the topic and the objectives. The interview time schedule was drawn, dates, and times were stipulated for both one-on-one and focus group interview sessions.

Three weeks after, the researcher visited the shelter to conduct face-to-face interviews on four different dates for sessions. During the first session which was one-on-one, the researcher interviewed seven women, and during the second session, five women were interviewed, and in all of these sessions, Every COVID-19 protocol was followed.

Prior to the researcher commencing interviews, potential participants were given an information letter (see appendix B) and a letter of consent (see appendix C) that were personally handed over to the participants prior to the interview. Both documents were translated to Isizulu and Sesotho as those were dominant languages used in the shelter. Participants were reassured of their anonymity in the study and that all information provided would be kept confidential. They were made aware that participation was entirely voluntary. After signing the consent form, the interview proceeded and both the researcher and participants agreed to abide by COVID-19 protocols. Masks, and hand sanitizers were available at the shelter, all participants accessed them, and data was collected until saturation.

#### **- Face-to-face interviews**

The interview process was recorded using a digital audio recorder with the participants' permission and all information was captured accurately. The researcher ensured that all required devices were present and fully charged. writing materials were available prior to the interview (Creswell 2003:23). The availability of an audio recorder assisted the researcher to pay attention to the emotions and actions of participants as they responded rather than focusing on noting down what they were saying.

Fortunately, there was no participant who refused to be audio recorded and that was because the researcher at the beginning of the session assured them that, the information they are sharing will be kept safe and treated with integrity. The interviewer also used the reflective journal to write down responses from the

participants, reflect on the procedure for gathering data, and the researcher's new experiences.

The interview's structure is a tool for establishing a consistent process for gathering data (Richt *et al.* 2014:149). For this study, an open-ended interview schedule with some structure was employed.

#### - **Semi-structured interviews**

The purpose of semi-structured interviews (SSI) is to elicit subjective answers from people about a specific circumstance or phenomenon they have encountered and involve the use of predetermined questions, where the researcher is free to seek clarification (Holloway and Wheeler 2010:2). When there is enough objective knowledge about an experience or phenomenon but insufficient subjective knowledge, it can be utilised. It uses a fairly detailed interview guide or schedule (Merton and Kendall 1946:6; Morse and Field 1995:9; Richards and Morse 2007:67). The researcher is free to ask more questions (Corbett 2003:3) and to change the order and wording of the open-ended questions based on the direction of the interview (Power *et al.* 2010:4). Participants are free to respond to these questions however they see fit. This distinguishes it from other interview techniques in that it offers a high level of topical relevance while still being participant-responsive (Bartholomew *et al.* 2000:9).

To establish a sense of order and gather comparable data from each participant, an interview guide is created (David and Sutton 2004:10; Bridges *et al.* 2008:18; Holloway and Wheeler 2010:6). With its open-ended questions and flexible format, the interview guide gives you the opportunity to discuss topics that come up on their own (Berg 2009:22; Ryan *et al.* 2009:31). When new avenues come to light during the interview that were not initially thought of, the researcher can investigate them (Gray 2004:4). During the interview, he or she can naturally formulate questions and adopt a conversational style that centres around the subject (Patton 2002:13). Hand (2003:10) and Dearney (2005:2) discovered that the open-ended format of the questions promoted richness and life, which aided in the emergence of fresh ideas. By helping them gather rich data for analysis, this improved the study's validity. But one disadvantage is that inexperienced researchers frequently don't know where to insert

probe questions or ask leading questions, which means that some pertinent information might not be obtained.

#### **- One-on-one interviews sessions**

One-on-one interview sessions were effective during data collection (Greenfield 1996:2) as open-ended questions were used to find out what was on participants' minds which could not be directly observable. The two interview sessions were done in two days. Robson (1995:10) defined a one-on-one interview as a dialogue that is started by the interviewer with the express intent of gathering pertinent data. It focuses on specified content guided by research objectives of systematic description, prediction, and involves asking questions directly to the respondent. The researcher used a semi-structured interview and a set of certain questions (as seen in Appendix D), but they changed the order to give explanations and examples whenever needed. Because the questions were open-ended it led to even more relevant data collected, new concepts and dimensions were introduced by participants which led to data reaching saturation. Each interview lasted approximately for 20 to 24 minutes' maximum and refreshments were served after every session.

#### **Data collection tool**

##### **- Interview guide**

Speaking with people in person offers a window into their perspectives, beliefs, and emotions. Furthermore, the quality of the data collected depends on how well the interviews are conducted, so they should be done carefully. Making sure the interviewees are at ease is crucial in order to get them to open up to the interviewer and share their experiences. To create a relaxed environment where helpful information can be elicited, the interviewer should begin by restating confidentiality and anonymity (Kamen 1996:9) and outlining the purpose of the interview and his or her intentions. According to Greenfield (1996:14) the guidelines provided by, the interviewer should also be sensitive and nonjudgmental, pay attention and let people speak.

A list of interview questions was designed by the researcher in a manner that they were open-ended. The interview guide (see appendix D) was used to collect data. The researcher asked questions in IsiZulu and Sesotho to participants who did not

understand English (see Appendix D1 and D2). Bird (2016:1) defined an interview guide as a list of the high-level topics that the interviewer plans on covering in the interview with the high-level questions that he or she wants to answer under each topic. Open-ended questions are sets of questions that will assist with more detailed responses, such questions as defined by Dossetto (2018:19) cannot be answered with a simple 'yes' or 'no', but instead require the respondent to elaborate on their points.

The researcher was aware that the homeless are a vulnerable population. This is the reason the study falls under category 3 of ethics. When designing the interview guide, the researcher was sensitive and considerate. Particular consideration must be given to delicate questions that raise delicate subjects. People may avoid talking about certain subjects, withhold information, or be dishonest because they feel awkward answering certain questions. It's critical to steer clear of circumstances where interview subjects feel uncomfortable because they consider the questions to be so invasive.

One of the tools that the researcher used was an audio-tape recorder and the reflection journal to capture the responses from participants. To ensure that the analysis is founded on accurate representations of the interviews, it is helpful to have a tape recorder to capture the interviews. Taking notes and recording the interview are two methods that are frequently employed. Which one to select will depend on the amount of information required, how much the interviewee is disturbed by the recording equipment, and the interviewers' preferences. In addition to allowing the interviewer to focus on what is being said rather than simultaneously taking notes, audio recording interviews facilitates the accurate and retrievable transcription of the content.

The set of interview questions that the researcher compiled was based on exploring the experiences and challenges the homeless women faced during the pandemic. The interview process allowed women to share their feelings, social, and economic difficulties, and fears. During the interview, the researcher understood suggestions and recommendations from the women who participated on what they thought could have been done to improve their situation and were noted down in the researcher's reflection journal.

### **Data capturing and analysis**

### - **Thematic analysis**

When using qualitative data, thematic analysis is a technique for finding, analysing, and interpreting mean patterns. Thematic analysis can be applied across a range of theoretical frameworks and research paradigms. Thematic analysis is useful in a qualitative study, as it uses a systematic approach to analyse the data, develop themes, code the data according to those themes, and then interpret the data by discovering patterns, similarities, and relationships between them (Braun and Clarke.2006:71). If a thematic analysis tool is used to analyse the data, it gives a better understanding of the data collected to the researcher and other reviewers.

### - **Analysis process**

Mouton (1996:161) described analysis as breaking down a complex whole into its component parts. From this perspective, data analysis can be defined as the examination of a variety of data to produce a coherent configuration of particular variables. An 8-step process for analysing data as cited in Creswell (2009:186) was implemented.

**Step one:** To gain a comprehensive understanding of the scripts, the researcher went through all of the collected data. Using the previously mentioned data collection tool, the researcher organised the questions in a way that would facilitate guided data analysis. In accordance with the study's objectives, the analysis focused on the various sections of the questions on COVID-19, employment, social support, and healthcare.

**Step two:** The researcher went through each script one at a time, making notes in the margins about ideas that occurred to her as she read the scripts. The guided sections made it simpler to identify the recurring themes.

**Step three:** The researcher went through multiple scripts and, using one column for each script on a single sheet, created a list of all the topics that were identified. After that, all of the columns were compared to one another, and subjects that were similar were then grouped together. They were separated into columns with headings denoting important subjects, distinct subjects, and other subjects.

**Step four:** The identified topics were shortened into codes in this step. Subsequently, the investigator reviewed every script and positioned the acronyms beside the corresponding segments, such as HT for health, EM for employment, SS for social support, and CD19 for COVID-19. Furthermore, the investigator searched for novel and developing subjects that did not necessarily fall under the purview of the identified subjects being studied. These new subjects may include psycho-social problems that the researcher had not anticipated but discovered through the interviews. These newly developed subjects were jotted down as concepts and are known as analytical memos, which Tesch (1992:142) emphasised as essential.

**Step five:** In order to create categories, the researcher had to gather related descriptive words into groups. According to Tesch (1992:142), who suggested that the group should consist of between 20 and 50 categories, the researcher used the same procedure to search for subcategories.

**Step six:** The ultimate choices for abbreviations were determined for every category and arranged alphabetically to prevent repetition and spot any instances of it.

**Step seven:** Every piece of data that fit into a category was grouped together, and each category's worth of data was examined independently to perform a preliminary evaluation. Guidelines based on research questions were employed to help weed out unrelated material.

**Step eight:** To guarantee a clear analysis of the same dataset, data was recorded where the researcher thought it appropriate.

### **3.4. Study setting**

The study was carried out in South Africa at the Sisters of Mercy Homeless Shelter, which is located north of central Johannesburg. By the time Johannesburg celebrated its centenary in 1998, it was hardly South Africa's top tourist destination. Businesses had relocated to the suburbs, leaving the city centre largely abandoned. Soon after, due to a number of issues including crime, the area was frowned upon. Many individuals who had travelled to Johannesburg, also known as Egoli, or the City of

Gold, in search of work soon had their hopes dashed. Many found themselves homeless and jobless, with no way to support themselves, on the streets of Johannesburg. The Sisters of Mercy Homeless Shelter was established as part of their Centenary project after much consideration and determination that the greatest need at the time was a safe haven for the homeless. It became a registered non-profit organization and focuses on the homeless women around Rosebank.

Their primary goal is to raise standard of living for those who have been living in appalling conditions and often seem to have lost all hope. When the homeless first arrive, many experience stress, depression, and other types of brokenness. Everybody has a heartbreaking story to share, a story of their own. The new residents are greeted with love and care by the dedicated and caring staff. A fresh sense of self-worth often begins with having access to clean clothes, a hot shower, and a secure place to rest.

The shelter accommodates an average of sixty women per year who can sleep on the premises. They receive two meals a day, breakfast and supper. After breakfast, they normally go out to look for jobs. Most of them are domestic workers and car guards. Many of the women who come through the shelter are unmarried, unemployed, and have been rejected by their families due to their HIV status. On the streets of the large city, they frequently find themselves alone, afraid, and without friends.

As time passes, they start to reclaim their dignity and self-worth and feel more optimistic about the future. In addition, the shelter offers social services, including an Advice Bureau that helps both residents and non-residents apply for housing, disability pensions, child allowances, and identification documents, as well as jobs. Residents are supported and encouraged to stay in touch with their families. In addition to offering marketable skill training in computer literacy, sewing, fabric painting, and car guarding, they also collaborate with other local organisations to offer welding, bricklaying, and soft toy-making classes, which some of their residents take. It is hoped that in doing so, they will become employable and reintegrate into society.

### **3.5. Study population**

A population is the entire group about which a researcher wishes to make inferences. A sample is a particular group about which information will be gathered. The sample size is consistently smaller than the population as a whole (Bhandari 2020:1). The

selection of participants is determined by the research objectives of the study and the characteristics of the study population, including its size and diversity (Jansen 2010:7). People that we believe are most likely to have knowledge of, experience with, or insights into the research topic are the ones that are highlighted (Zaltman 2003:19).

A population is any whole group about which some information needs to be found, provided that the population is precisely defined and has inclusion and exclusion criteria that are clear (Stoltz 2004:11). The research question or study purpose will provide a suitable definition of the population to be studied, including geographic location and restriction to a specific age group, sex, or occupation. This will help in the process of choosing a population for study. In order to specify precisely who is to be included and who is not (i.e., inclusion and exclusion criteria), the population must be completely defined.) (Banerjee 2007:16).

The Sisters of Mercy Homeless Shelter provides shelter for an average of sixty women per year and about 12 women were recruited for this study. Parameters to guide sampling was set on different age groups. Through the help of the leader and different staff members of the shelter, those women from different age groups and ethnic groups were identified, sampled, and recruited to be part of the one-on-one interviews. The COVID-19 protocols such as physical distancing, wearing of masks, regular washing, or sanitizing of hands were followed with no compromise by all participants, and rooms where the interviews took place, were kept well ventilated (Simpeh 2021:9).

### **3.6. Study sample**

A sample is a group of individuals, things, or things taken for measurement from a larger population in terms of research. There are several categories of non-probability samples according to Berger (2015:220). These include (i) convenience sampling, which is the common nonprobability method used to choose units on hand; this idea largely combines with accidental, availability, opportunity, haphazard, or unrestricted sampling. (ii) Volunteer sampling is a sort of convenience sampling in which the non-individualized nature of invitations heavily influences respondents' decision to participate. (iii) Quota sampling: This is a convenience sample that can be made more representative of the population by adding sociodemographic quotas (such as those

based on age, gender, or region). (iv) Purposive sampling, also known as judgemental sampling, in which the researchers choose a sample based on their judgement or subjective ideas in an attempt to create a representative sample. Alternatively, the researchers may specifically seek out diversity (deviant case samplings). Units may occasionally be added one after the other until researchers meet certain requirements.

The purposeful selection of a participant based on their attributes is the main focus of the purposive sampling technique. Having determined what information is necessary, the researcher searches for sources willing and able to supply it based on their experience or knowledge (Bernard 2002:3). In addition to knowledge and experience the convenience sampling strategy was applied as a method that emphasises the value of being accessible, willing to engage, and having the capacity to express ideas and experiences in a clear, thoughtful, and expressive way (Walliman 2011:3).

### **3.7 Ethical consideration**

#### **- Ethics**

McCauley (2003:95) stated that the goal of social research ethics is to establish a win-win situation where participants are happy to answer honestly, valid results are obtained, and the community views the conclusions in a positive light. Salkind (2009:79) reminded researchers that while it's okay to be ecstatic about their most recent study, they should never lose sight of the fact that their subjects are real people whose rights and dignity must always be respected.

The researcher kept the written notes inside a lockable cabinet and the recorded data was kept in the researcher's computer under a folder that requires a password so that no one can access it without the researcher's permission. To back up the information the researcher saved the information, in a password-protected google drive and a hard drive to also be used as a backup in case something happened with the researcher's computer. The gathered data will be kept for five years before being erased and destroyed.

#### **- Informed consent**

Ritchie *et al.* (2014:77) claimed that opinions on the fundamentals of ethical research are in agreement. These research principles include the following requirements: the

study must be valuable and refrain from making unreasonable demands of participants; informed consent must be the basis of the study; participation must be voluntary and free from coercion; and any negative consequences to participants must be prevented.

The researcher received a gatekeeper permission letter (see Appendix A) from the leader of the shelter that served to allow the research to take place on the premises. Before interviews, potential participants were given an information letter (see appendix B) and a letter of consent (see appendix C) which were personally handed over. These documents were translated to IsiZulu and Sesotho (see appendix B1 and B2). The information letter outlined the length of the interview, the process for gathering data, how the data would be used, and how it would be stored. It also explained the goals of the study and the research methodology that would be employed.

Participants were also informed in the letter of their freedom to decline participation in the research study at any time. In addition, participants were informed that their participation in the research project would not yield any incentives or direct personal benefits; rather, their contributions would contribute to the growing body of knowledge regarding the experiences of women experiencing homelessness in Gauteng.

#### **- Anonymity and confidentiality**

Confidentiality means that while the researcher can match names with responses, no other party will be able to determine the respondent's identity. Anonymity means that the researcher will not and cannot identify the respondent (Mouton 2001:243). Participants should be informed of the potential risks of harm, and privacy and anonymity should be respected (Ritchie *et al.* 2014:77; Rubbin and Babbie 2008:82; Nnebue 2010:17).

The investigator made certain that the study adhered to these principles. The researcher also made sure that the participants suffered no negative consequences as a result of the study. Nonetheless, the investigator was cognizant that certain inquiries made to the homeless population might potentially result in emotional or psychological turmoil. In these circumstances, the researcher referred these participants to a professional counsellor linked to the shelter.

The information letter also emphasised confidentiality. Participants were made aware that the data they provided would be kept completely private and anonymous when presented. By substituting participant names with codes, the researcher hoped to uphold the principle of confidentiality. Every piece of information gathered was safely kept on a password-protected computer and was backed up on a private server that only the researcher could access.

### **3.8. Trustworthiness**

The trustworthiness criteria for qualitative research are relevant to this paper because there is a lot of discussion about the integrity of qualitative findings, and there are critics from the quantitative research community as well (Hedrick 1994:34; Ortlipp 2008:19; Sale *et al.* 2002:40; Smith and Heshusius, 1986:71). It is pertinent to address how qualitative researchers establish that the research study's findings are credible, transferable, confirmable, and dependable and trustworthiness is all about establishing these four things, as criteria to equate the traditional quantitative assessment criteria of validity and reliability (Lincoln and Guba 1985:1)

#### **- Credibility**

Credibility is the degree to which one can trust that the study's conclusions are accurate. Credibility determines if the study's conclusions accurately reflect the participants' initial opinions and are based on credible information obtained from their original data (Bond 2008:5). If people who have similar experiences can instantly identify the descriptions of human experience in a qualitative study, then it is deemed credible (Sandelowski 1986:3). The researcher spent more time in the shelter to build trust and rapport with respondents and to also understand local construction and cultural background of participants (Onwuegbuzie & Leech 2007:88). Maintaining relationships with the participants improved the credibility of the study.

#### **- Transferability**

According to Koch (2006:5), The degree to which the findings of qualitative research can be applied to different situations or contexts involving different respondents is known as transferability. Lincoln and Guba (1985:40) it is the interpretive equivalent of generalizability. The researcher facilitates the transferability judgment by a potential

user through the thick description. According to Li (2004:305) thick descriptive data, or a rich and comprehensive set of details regarding methodology and context, should be included in the research report in order to facilitate judgements about how well the research context fits with other contexts. Transferability is defined as the ability to make these judgements. The behaviour portrayed and experiences shared by the participants living in the shelter were common and meaningful to an outsider. The thick description of the study helps others researchers and are able to replicate the study using similar conditions in their contexts or settings.

**Dependability** is the data's consistency and stability under comparable circumstances (Polit and Beck 2012:5; Tobin and Begley 2004:18). A study would be considered credible if the results were repeated with comparable subjects under comparable circumstances (Koch 2006:5). To ensure dependability the interviews and group discussions were conducted face to face and after the interviews were done the researcher asked the participants to check what was said versus what was captured in the journal. Lastly, the researcher stored the tape-recorded information in their original form in a secured space.

**Confirmability** refers to the researcher's capacity to show that the data accurately reflect participant responses rather than the researcher's personal prejudices or opinions (Polit and Beck 2012:71; Tobin and Begley, 2004:2). The researcher was able to establish confirmability by describing that the conclusions and interpretations were established and derived directly from the data and that the researcher allowed the participants to view the finding and confirm that the data is accurate.

#### - **Researcher's role and reflexivity**

It is common to characterise qualitative research as impressionistic, anecdotal, and biased by the researcher (Buckner 2005:2). Reflexivity relates to a degree of influence that the researcher exerts, either intentionally or unintentionally on findings (Fontana 2004:1). In essence, the researcher engages in a process of self-evaluation to determine whether the research process is influenced by their personal experiences (Dowing 2006:3). Turning the investigative lens inward and trying to answer questions like "what do I know?" and "how do I know?" are examples of reflexivity (Caloran 2003:3).

Reflexivity is defined as the process of ongoing introspection and critical self-evaluation of the positionality of researchers, along with the explicit recognition and acknowledgement that this position may have an impact on the course and results of their research. (Bradbury-Jones 2007:2). Hence according to Burger (2018:2), researchers must pay more attention to self-awareness and sensitivity to comprehend the role that the self plays in knowledge creation. In conclusion, it is imperative for researchers to diligently observe how their personal experiences, biases, and beliefs influence their work and strike a balance between the universal and the personal.

The researcher understood her role as neutral in the research and that her personal experiences, beliefs, and morals may lead to biases and misinterpretation of the research data. Thus, to prevent bias the researcher was constantly reassessing her contributions, its impact on how inter-subjective research is shaped and how research findings are produced (Koch and Harrington 1998:6). Moreover, the researcher was aware of her attitude, values, and biases, which was a helpful tool in ensuring the research and its participants remain the main focus while also providing a deeper understanding of the study (Halcomb *et al.* 2007:5).

Following each interview, the researcher maintained a contemplative notebook. Before submitting the information to a structural analysis, she took the time to record her initial observations, ideas, and interpretations. This helped her to express her own mindset and responses to the participants she interviewed. Knowledge of reflexivity put researchers at ease because using an interactive interviewing technique was necessary to build rapport and motivate participants to divulge more personal information. The researcher remained transparent throughout the process of the study to the leaders of the shelter and participants, and the researcher was welcomed rather than looked upon with scepticism.

### **3.9. Conclusion**

The purpose of this research was to investigate how the twelve women who were chosen to live in the homeless shelter created their own realities. This chapter covered the methodology of the study, including how the participants were chosen, how the data was collected, and how the data was analysed. The chapter was able to discuss the qualitative approach to issues of ethics and trustworthiness and how it was used

in the study. The analysis procedure and research findings are described in detail in the upcoming chapter.

## **CHAPTER FOUR ANALYSIS AND DISCUSSION OF FINDINGS**

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### **4.1 INTRODUCTION**

This chapter presents the data collected from interviews with homeless women who live at the Sisters of Mercy Homeless Shelter. It provides a discussion of the findings made. The study's objective was to investigate and understand the vulnerabilities of homeless women in the shelter during the COVID-19 pandemic. There were six objectives of the study namely, to comprehend the impact of the COVID-19 pandemic and lockdown on the economic well-being of women, living at the Sisters of Mercy Homeless Shelter, to explore whether these homeless women accessed medical care during COVID-19 pandemic, to enquire how these vulnerable women coped with the economic and emotional challenges during the pandemic, to explore how social distancing and COVID-19 health protocols were affected in the shelter, to understand how women in the shelter supported each other during the pandemic, and to make recommendations to the local government to better support those homeless women living at the Sisters of Mercy Homeless Shelter

Semi-structured interviews were conducted over two days in-person using an interview schedule (Appendix D for English, Appendix D1 for IsiZulu speaking participants and Appendix D2 for Sesotho speaking participants), as a guide to collect data. Data was analysed and patterns in the data were interpreted using thematic analysis, themes and subthemes were developed to give a better understanding of data collected. In the following sub-section, the demographic profiles of the participants are presented, the process that was used to analyse data is discussed and a presentation of the findings are then made.

### **4.2 DEMOGRAPHIC PROFILES**

The demographic profiles are presented in Table 4.1, that contains the particulars of the participants.

**Table 4.1: Demographic profiles of the participants**

<b>Participants Identifier</b>	<b>Age Range</b>	<b>Gender</b>	<b>Race</b>	<b>Place of Residence</b>	<b>Hometown</b>
--------------------------------	------------------	---------------	-------------	---------------------------	-----------------

KT	50-59	Female	Black	Shelter	Free State
TS	40-49	Female	White	Shelter	Western Cape
AM	30-39	Female	Black	Shelter	Gauteng
MNH	40-49	Female	Black	Shelter	Limpopo
NX	40-49	Female	Black	Shelter	Eastern Cape
XN	30-39	Female	Black	Shelter	KwaZulu Natal
NM	40-49	Female	Black	Shelter	KwaZulu Natal
NMT	50-59	Female	Black	Shelter	Free State
DO	50-59	Female	Black	Shelter	Free State
CM	30-39	Female	Black	Shelter	Limpopo
BT	50-59	Female	Black	Shelter	Mozambique
RM	40-49	Female	Black	Shelter	Limpopo

#### **4.2.1 Summary of the demographic profiles of the participants**

Twelve women participated in the study. Three of the participants were aged between 30-39, five were aged between 40-49 and four were aged between 50-59. The racial demographics reflect that there was one white woman and the rest of the eleven were Black. All participants were females and they all stayed at the Sisters of Mercy Immaculate Hall Homeless Shelter. Only one participant indicated being originally from outside the country, which is Mozambique, whilst the rest of the participants confirmed they were South Africans. Two participants were from KwaZulu-Natal, three from Limpopo, three from Free State, one from Gauteng, one from Western Cape and one from Eastern Cape.

#### **4.3 THE PROCESS OF DATA ANALYSIS**

The researcher used thematic analysis to identify, analyse and interpret patterns and then develop the data's themes and subthemes. After developing the five themes, data was coded according to those themes to discover patterns, similarities, and relationships between them (Braun and Clarke 2006:71). All twelve interviews were recorded on a voice recorder and then transcribed verbatim. Transferring from one script to another, the investigator made a list of topics and grouped them into themes (Tesch 1992:142), and all related data from individual scripts were put under relevant themes which resulted in about 42 pages of transcription summary.

After the themes were identified and developed, it was then easy to understand a set of experiences, thoughts, or behaviours across the data set (Braun and Clarke 2012:62) that needed to be evaluated, analysed according to the research questions of the study. During the analysis process, the researcher excluded data that was irrelevant to the topic and objective of the study.

#### 4.4 DATA ANALYSIS AND FINDINGS

This section presents the analysis, discussions, and the research findings of the study. The table that follows has data that has been grouped into five themes and fifteen subthemes, each theme will be discussed below and evidenced verbatim from the interviews held with participants. These are presented in Table 2 below.

**Table 4.2: Themes and Subthemes**

<p>THEME 1: Access to health care</p>	<ol style="list-style-type: none"> <li>1. Access to health care at the shelter</li> <li>2. In-house doctors for the shelter</li> <li>3. Transport fees</li> <li>4. Lack of access to health care during the COVID-19 pandemic</li> <li>5. Increased vulnerabilities for homeless women with chronic diseases.</li> </ol>
<p>THEME 2: Access to working opportunities pre and post the COVID-19 pandemic</p>	<ol style="list-style-type: none"> <li>1. Access to economic opportunity pre- COVID,</li> <li>2. Lack of economic opportunities during lockdown,</li> <li>3. Vicious cycle of financial crisis post- COVID-19</li> <li>4. Gender inequalities among homeless people.</li> </ol>
<p>THEME 3: Availability of social support from social development organisations during and post-COVID-19</p>	<ol style="list-style-type: none"> <li>1. Emotional support from social workers</li> <li>2. Instrumental support from social workers and other organisations.</li> </ol>
<p>THEME 4: Exposure to Gender-Based Violence (GBV).</p>	<ol style="list-style-type: none"> <li>1. Increase Gender-Based Violence.</li> </ol>
<p>THEME 5: Stigma and discrimination faced by homeless women</p>	<ol style="list-style-type: none"> <li>1. Women not allowed in the shelter during the day increased vulnerabilities</li> <li>2. Unsafe working conditions on the streets</li> </ol>

	3. Stigma and discrimination faced by homeless women.
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Each theme will be discussed below and evidenced by verbatim excerpts from participants' interviews.

#### 4.4.1 THEME 1: ACCESS TO HEALTH CARE

This theme details the information collected based on access to health care, by looking specifically at how the participants accessed health care services pre - and post-COVID-19 pandemic. It includes subthemes, namely, (i) immediate access to health care at the shelter, (ii) in-house doctors for the shelter, (iii) transport fees a barrier to access health care, (iv) lack of access to health care during the COVID-19 pandemic, (v) increased vulnerabilities for homeless women with chronic diseases during the COVID-19 pandemic.

##### 4.4.1.1 Subtheme 1: Access to health care at the shelter

The first subtheme relates to availability and accessibility of health care for the participants while living in the shelter. They mentioned that whilst the clinic was a walking distance away, the hospitals were a long distance from them and that they had to catch a taxi to get there.

Those whose medication was accessible in the clinic, said the clinic was near the shelter and did not find it difficult to fetch their medication. This is evident in the excerpts that follows:

**KT:** *“The clinic is closer here, so I must go there to fetch my treatment, because it’s right here at the corner, I can walk there.”*

**AM:** *“We have the nearest clinic here down the road which is Parkhurst and the hospital we use is Joburg Gen.”*

**NX:** *“People, they go to clinics, because here there is a clinic there in Parkhurst, and you can walk maybe 30 minutes or less.”*

Participants mentioned that the clinic is a walking distance away and those who collect their medication at the clinic, are able to do so without paying any transport fee. It however, becomes a problem for those who have to collect medication or seek medical

attention at the hospital because transport is required to get there. Some of the participants mentioned that the shelter played a very important role in making sure that they seek medical attention when necessary and that the social workers make sure that those with chronic diseases take their medication as per their prescription, in the excerpt below. This means that the shelter plays an important role in providing aftercare and follow up for those living in the shelter. Gcwabe (2022:6) wrote that when many homeless people leave the shelter and go back to the streets, the limited services that are offered become unavailable to them. This is even if the treatment becomes successful while inside the public institution, when patients come out there is no aftercare.

**KT:** *“Yes, they do help as much as I’ve seen because even after my operation, I came back here and the shelter people looked after me until I recovered.”*

**NM:** *“The shelter is situated not too far from Johannesburg Gen public hospital and next to a local clinic, and you must know when you live in a shelter, leaders and social workers are always on our case when it comes to taking our health seriously. We have social workers that frequently visit us mostly for counselling and checking if we are still taking our medications. As women living in this shelter do not have problems with accessing health care even though we are always exposed to long queues but we have access.”*

As evidenced above, one participant described the importance of social workers at the shelter, who ensured that they took their medication.

The US General Accounting Office Report (2014:334) observed that women who were living in shelters had a higher likelihood of experiencing severe health issues or reporting worse health conditions. This is why the participants shared how they took their health seriously and how they used the spirit of togetherness as their coping mechanism. One participant said, the support they received from the social workers was important in terms of them supporting each other in hardships and encouraging one another to never default on their medication. This is also reflected in the excerpt below:

**KT:** *“I take my treatment daily with no mistakes, and this is because I am aware that my life depends on this medication, so no matter how tired I am I always make sure I take my pills, and I always encourage those that live in this shelter to do the same.”*

#### **4.4.1.2 Subtheme 2: In-house doctors for the shelter**

This second subtheme reflects the importance of the in-house doctors and the services they provide freely under an outreach programme. The following excerpts reflect evidence:

**DO:** *“There were two doctors that came here, so they told us that if anyone wishes to consult with them is welcome to come to them for free and they told us where their branch is, it seems like they are donating, but they don’t give us medicine. I went there in June and again in July, they open every second Saturday of the month.”*

**CM:** *“There are doctors who are situated not too far from the shelter called St Muttons that are volunteers for this shelter committed to helping us who live in this shelter, so we are allowed to consult with them for free for two weekends per month, but they don’t have medication.”*

**CM:** *“They just check you, test pap smear and when they see you are supposed to go to the hospital they write a referral for you.”*

The ST Mutton doctors have volunteered their services to those who live in the shelter so that when they are not feeling well, they can go and consult with them for free. However, the challenge that the participants mentioned was that they do not offer medication. After the medical examination these doctors offer a diagnosis and provide referral letters to their patients, so that they may go to the hospital for further attention and medication. This comes back to the challenge of the transport fees that the homeless participants found to be a challenge.

According to Rew (2016:14) studies have found that the homeless population have high rates of human immunodeficiency syndrome (HIV) infections, sexually transmitted disease (STD’s) depression, injuries and malnutrition. It is for these reasons that many shelters have now been equipped with in-house health care that caters for the health needs of homeless people who live in shelters. Advance Access and Delivery is another organisation according to Gcwabe (2022:2) that offers medical care to those who are homeless, drug addicts, and members of other socially

marginalised groups. Regular tests for TB, HIV, and hepatitis are among the services offered by their medical programme. They also provide free injection assessments.

In the current study the doctors from St Mutton do not provide any medication or injections. This however, only solves the problem partially, because after receiving the referral letters to the hospital, some participants still cannot afford to go to the hospital. Hence, as evidenced below we find that some participants have never consulted with those doctors and some are showing less interest. One of participants mentioned that she only consulted with doctors once, but felt she would rather go to the clinic than to go to these doctors because she says the clinic will offer her both a medical examination and medication.

**TS:** *“I was told that there is an emergency doctor on a Saturday, if there is a concern, but I have never been there.”*

**NX:** *“I have heard that there are some doctors that are here in St Mutton. It’s like they are partners with this place, so they advise that people must go there for free, and they don’t charge.”*

**DO:** *“This year around about June there were two doctors that came here, so they told us that if anyone wishes to consult with them is welcome to come to them for free and they told us where their branch is, it seems like they are donating, but they don’t give us medicine, so it still the same.”*

*“I went there only once in June, they open every second Saturday of the month. But really for me, I don’t really like going there because when I feel sick, I just go to the clinic here by Parkhurst.”*

A study by Morey and Friedman (2015:339) with regards to access to health care by homeless people, reveals that special free clinics, only 12 percent of those in shelters use shelter clinics for their regular medical needs. This implies that a large number of the homeless individuals for whom these programmes are intended may not be making use of them. There is a negative stigma attached to homelessness and victims can be discriminated against and feel excluded by the society. This is why some may have less interest in organisations that provide health care (Banks 2017:1). This

confirms that there is a very close relationship between poor health and homelessness.

#### **4.4.1.3 Transport fees**

The third subtheme reflects that there are certain fees that hospitals require upfront before they can assist them. This initial fee is for opening a file, which is evident below:

**AM:** *“In hospitals, yes, you have to pay to open a file. I think about R75 each time you are there. And remember transport to get there as well. So, if you have no money at all access to health care again is impossible.”*

**CM:** *“But again, the problem to get to the Helen Joseph hospital you need money for a taxi, and when you get there, you have to pay R75 to open a file.”*

**CM:** *“Yes, even Johannesburg Gen Hospital requires you to pay R75 for the file.”*

**CM:** *“Yes, as for me I was frequently going to Helen Joseph Hospital because I had a problem with my breasts, and every time I go there, I had to pay R75.”*

As evidenced above, participants encountered challenges receiving or raising transport fees to take them to the hospital. Participants found it difficult to access medical health care because of the transportation fees to their nearest hospital which is Johannesburg General Hospital and Helen Joseph Hospital in Johannesburg. As much as the clinic was a walking distance away and the doctors from St Muttons doctors were closer, when special treatment from the hospital was needed or in case of referral by the doctors, participants mentioned that to get to the hospital was financially impossible.

There are numerous other factors that may affect a homeless person's decision to forego seeking medical attention, despite the fact that they are at a higher risk, which has increased the need for health services (Morey and Friedman 2015:332). These include issues of confidentiality, costs for transportation and their status as homeless individuals, which may prevent them from using the available health care. This is reflected in the following excerpts:

**CM:** *“Yes, you must take the taxi and still had to pay the R75 and where would you get such an amount when you are not working.”*

**TS:** *“I could not use the hospital because you need money to be in the hospital.”*

**DO:** *And Helen Joseph hospital is for those who have special medication, but you must take two taxis to Helen Joseph so it's a bit far.”*

Hence, as evidenced above, access to health care was compromised because of costs related to accessing medical care. The government provides free access to health care. However, those who are not working and homeless still struggle to access health care because they don't have money for transport to get to their nearest hospitals. The participants in this current study have reported that they take two taxis to Helen Joseph hospital and when they get to the hospital there is a fee for opening a file they have to pay for, which is not affordable for someone who is not working and living in a shelter. Hence, they miss appointments and default with medication.

The costs of transportation lead to missed appointments and delayed medical intervention, may lead to poor management of chronic illnesses and consequently leads to poor health outcomes. Chronic diseases require clinician's visits, medical access, and changes to treatments plans, in order to receive proper care. However, Kim *et al.* (2012:370) mentioned that if the participants do not afford to pay for transport to hospitals, it may lead to a lack of appropriate medical treatment, chronic diseases exacerbations and unmet health care needs, which can accumulate and worsen health results.

Among those who are homeless, transport is frequently mentioned as a barrier to health management because of the vulnerability of those who live below the poverty line (Turnbull et al. 2007:1). It has been discovered that the expense of transportation hinders people's ability to move up the social ladder and escape homelessness by reducing their access to social services, employment opportunities, and social inclusion (Hui and Habib, 2017:56). Transportation-related barriers impede access to health care and have been linked to missed appointments and delayed medication use (Syed 2013:2).

According to Wolfe (2020:2) in 2017, 5.8 million Americans missed out on medical care due to transportation expenses. Those who are already more vulnerable to social and economic hardship, such as the impoverished and homeless, who have chronic

conditions are more likely to experience negative health consequences (Cheung and Ginde 2012:4).

#### **4.4.1.4 Lack of access to health care during the COVID-19 pandemic**

According to the data for this subtheme, those who were homeless resided in areas that were favourable to the epidemic. For instance, a large number of homeless persons resided in communal housing and may not have had regular access to basic hygiene products, which could have facilitated the spread of viruses (Zhang *et al.* 2020:1). The COVID-19 pandemic made it more difficult for people to obtain medical care, that was already burdened before the pandemic. The congestion in clinics and hospitals made it impossible for patients to receive medication and led a lot of patients to default and stay away from health care facilities. The following excerpts reflect this:

**XN:** *“The hospitals and clinics were still as full, it was so difficult to access medication, firstly because even if you were feeling sick you would be so scared to go and consult because you are just afraid of more infections and isolation processes, that comes with being positive. Secondly, in hospitals, they were prioritizing those who had severe symptoms and the rest were even going back home without help sometimes.”*

**DO:** *“Our clinic used to be full during COVID even now it still gets packed, even this one here in Parkhurst during COVID, it was not easy to access help compared to before.”*

**RM:** *“The clinic that we are using is called Parkhurst, it is a walking distance away. Apart from that we have doctors that have volunteered to help us living in this shelter. We consult with them during weekends, but they never give medication, but they check us for diabetes, HIV, TB and all.”*

As reflected in the data, most of the women were afraid of attending hospitals or clinics because of concern about catching COVID-19. According to studies, the majority of people were afraid of getting COVID-19 and presented with anxiety and stress related to the pandemic. Another participant reported that the clinic was overburdened by the vaccination drive, making it difficult to access health care. Moreover, during COVID-19 many hospitals were overburdened by a large number of patients and they had to

prioritise COVID-19 infected patients, neglecting other patients, such as those who were going to the hospital to collect to medication (Midorikawa *et al.* 2021:19).

Moreover, participants also believed that they received poor quality care because of the stigma that they are at high risk, and more often are carriers of the Coronavirus. Hence, they were neglected by clinicians, which made them reluctant to seek medical care. Such stigma and discrimination affected their access to health care, their ability to decide on a course of treatment, which could result in forced treatment. Another participant reported that she is afraid of being mistreated by clinicians because she is a homeless foreigner and hence, she ended up not seeking medical care. This is evident below:

*BT: "It's a struggle to be honest, especially when you are a foreign national, firstly even when I go there, I am always afraid that I will be mistreated because mostly they prioritise South Africans with IDs. Every time when I fall ill, I sometimes even pretend I am fine just to avoid going to the clinic or hospital. When we are there sometimes, we literally push each other to get medication."*

Thus, it's possible that stigma against homeless people has increased in various nations. It was worse for foreigners and refugees who were homeless during the COVID-19 pandemic (Akiyama *et al.* 2020:15). Chain (2020:16) described stigma as a mark of shame, disgrace, or disapproval that causes someone to be rejected, subjected to discrimination, and cut off from society. According to Kline (2019:15) this may have resulted in inadequate care or inattention from clinicians, policy makers, and other stakeholders towards people who are homeless and non-South Africans, as well as increased stigma and discrimination against them.

#### **4.4.1.5 Increased vulnerabilities for homeless women with chronic diseases.**

The vulnerability of homeless women with chronic illnesses has increased due to hospitals and clinics giving priority to COVID-19 patients. The health of homeless individuals is seriously threatened by a number of factors, both financial and nonfinancial, making it difficult for them to access necessary medical care (Wenzel 2000:11). The information in this fifth subtheme shows that the women with chronic illnesses who were staying at the shelter encountered significant obstacles when

attempting to pick up their prescription drugs at clinics and hospitals. The COVID-19 pandemic required a reorganisation and restructuring of hospital-based services. Addictions, mental health, and other illnesses affecting the homeless were neglected, these wards were repurposed into COVID-19, as evident in the excerpts below:

**NX:** *“No, where I fetch it’s always full.”*

**BT:** *“Yes, I have a chronic illness, and I take medication from the clinic after every three months., I tell you, it’s not nice. Sometimes. I come back without medication, sometimes I am there very early, but it doesn’t help.”*

**NM:** *“Majority of us here we have special sicknesses and have special medication that we always have to collect at the clinic and during COVID it was not easy to access medication, clinics and hospital were full, nurses couldn’t help all of us. For example, few years ago, I use to take medication for TB, and I finished my course but now I am taking medication for diabetes, which most of us here are suffering from.”*

**XN:** *“During COVID-19 the provision of health care services to homeless people is so difficult because of the lack of appropriate facilities and resources and their extreme poverty. Homeless people experience a high rate of health problems, such as HIV, alcohol and drug abuse, mental illness, and tuberculosis.”*

The study therefore found that the vulnerabilities of female residents in the Sisters of Mercy Shelter became worse during COVID-19, as hospital prioritised those infected with COVID-19 and little attention was given to those with other chronic diseases such as TB and diabetes. In the excerpts above, participants mentioned that hospitals and clinics were full and nurses couldn’t help them and that they were sometimes returned home without medication. Another participant mentioned that they were afraid to even go to the hospitals to seek for medications for chronic illnesses because they understood that, comorbid conditions like diabetes and tuberculosis increase the risk that COVID-19 patients will experience a more severe course and progression of the illness, and being in hospital exposes them to the virus through physical contacts.

The World Economic Forum (2021:122) verified that local clinics in some countries were quick to turn away patients in need of primary care during the COVID-19 pandemic. This led to a shift of focus to other diseases, and this is evidenced over the

years. Philips (2017:132) contends that the securitization of health issues serves to highlight a specific disease while underplaying others that may be just as or even more deadly.

A study by Morocco Ministry of Health (2018:2), provides an example that shows, prior to the COVID-19 pandemic, the National Strategy Plan for Addiction Disorder Prevention and Treatment was introduced by the Ministry of Health and other chronic diseases among the homeless in January 2018. The programme addressed many aspects of the stigmatization of people who are ill and homeless encompassing the freedoms to maintain their dignity and obtain healthcare. Nevertheless, throughout the COVID-19 pandemic there was no official plan to manage those who are homeless with chronic illnesses.

The issue of dealing with chronic diseases for the homeless is undoubtedly a very difficult task in many African countries that have a health system that is very weak, has inadequate medical supplies, understaffed hospitals, and unmotivated, underequipped medical staff (McPake *et al.* 2016:21). In the face of health emergencies like the COVID-19 pandemic or the Ebola outbreak, the state of the health system deteriorates faster because of its rapid overloading.

#### **4.4.2. THEME 2: ACCESS TO WORKING OPPORTUNITIES PRE AND POST THE COVID-19 PANDEMIC**

The third theme is related to working opportunities for homeless women, living in the Sisters of Mercy Shelter Homeless Shelter This theme explores the availability of working opportunities before COVID-19 pandemic and after the pandemic, and it is done through the following subthemes: (i) access to economic opportunity pre COVID-19, (ii) lockdown led to loss of economic opportunities, (iii) the vicious cycle of financial distress post COVID-19 and (iv) gender inequalities exacerbated among homeless people.

##### **4.4.2.1 Subtheme 1: Access to economic opportunity pre-COVID**

The first subtheme reflects data about working opportunities that were available and participants could access, before the pandemic. Most participants confirmed they had been working, or were self-employed before COVID-19 pandemic. Many indicated that

those opportunities were mainly temporary in the informal sector and paid them only enough to survive the day. This is reflected in the excerpts that follow:

**NMT:** *“It was good. I was selling food when it started for 21 days, when it was locked down that is how I lost my business.”*

**AM:** *“Before COVID I was staying at Florida, able to pay for everything*

**MNH:** *“I was selling in Joburg before COVID-19 and everything was fine at least I was making money, then everything changed, and even now nothing is better.”*

**MNH:** *“I was selling sweets in Joburg. 2013, 2014, 2015. When COVID-19 started though, that small business I was able to live a decent life, trust me, every day I would wake up, go stock, and then come back to my table. I could get R350, it depends on customers that day, life was good.”*

The participants shared that during the day they are not allowed in the shelter and that they should cater for their own meals and accommodation. This was a huge challenge for those without income. The research findings reflected that participants didn't struggle to survive when they were temporarily out of the shelter during the day before COVID-19, because their small businesses, enabled them to afford their daily needs. One participant shared how life was better before COVID-19 and that she was able to buy stock and sell at her table stand where she operated her small business.

Ross (2010:15) argued that the homeless community is often concentrated in the informal sector and that self-employed homeless people collect and process waste material, sell goods on the streets and guard parked cars (Tipple and Speak 2009:9). Such informal work requires unskilled labour and consequently the employment sector is often temporarily unsecured (Tipple and Speak 2009:6). This is the type of self-employment that participants in the current study are reported to have been engaged in.

The work that is characterised as decent work is referred to as a piece job, in kitchens, factories, restaurants or working for a contractor, (Tipple and Speak 2009:6). The advantage of this type of work is that it is regulated by labour laws which may guarantee ongoing employment and reliability of work. Some of the participants, reported having had piece jobs before COVID-19. They mentioned that they worked in restaurants and some as domestic workers. The study therefore, reveals that working

opportunities were available for participants before COVID-19 pandemic but were lost during the pandemic. This is evident in the excerpts below:

**NM:** *“ From 2010 until February 2020, I was working as a domestic worker, but I was working under an agency. The agency used to make sure that every day we had one or two houses to clean. They used to pick us up with their bakkie in Rosebank not too far from this shelter, and they would take us to the houses that we worked for that day and bring us back to the shelter. That was our daily routine. There was always work from Monday to Friday, but Saturdays and Sundays the agency never picked us up.”*

**NM:** *“They used to pay us every Friday after two weeks, they paid cash because the majority of us never had bank accounts. When it comes to payments it depends on how many houses you cleaned for those two weeks and the number of duties you performed, so roughly we will get something between R1000- to R1500 and because there were many of us, we used to accept that. Anyways we survived, considering we pay no rent here in the shelter.”*

**DO:** *“In 2019 in December, I got a piece job in a restaurant, I worked until March, because in March, COVID started and they had to stop us from working, and that was because you may remember that people were no longer allowed to buy in restaurants.”*

Pre- COVID-19, some women participating in the current study stated that they used the shelter only as a place of safety during the night and they spent most of the time working or creating work for themselves just to make money to survive during the day. One woman confirmed to have had two jobs, that during the week she is employed as a domestic worker and during weekends she is self-employed. This is evident in the excerpts below:

**NM:** *“I never rested during the weekend, one of the women I stay with here in the shelter you will maybe meet her as well, she was a full-time street vendor selling sweets, snacks, cigarettes and all. She works in part of the street in Joburg that is so busy next to a taxi rank. So, every Saturday I joined her and next to her I was selling amanqina (the chicken feet), and believe me, because that street was so busy, we never struggled to sell our products.”*

*MNH: "I was selling sweets in Joburg. 2013, 2014, 2015. Until COVID-19 started, though with that small business I was able to live a decent life, trust me, every day I would wake up, go buy stock, and then come back to my table."*

*CM: "I crochet only, I crochet skirts, bags, and baby blankets and I used to sell in the streets. It used to attract tourists and during that time, I was able to make more profit."*

By not allowing women to stay at the shelter during the day, it promotes that those who live in the shelter should be responsible for their wellbeing and that the shelter should only keep them safe for the night. One woman used her skill to crochet and make skirts and bags which she sold in the streets and in flea markets. Such income helped her to pay for transport, buy food and send some home. However, participants shared that all of that was impossible during COVID-19 and even thereafter.

In a study by Cross and Seager (2010:10) one participant said "I like working in the butchery, it was nice to get up and go to work every day, and some of us here in the shelter worked as cleaners or domestic workers before COVID-19, and we were never lazy". Women expressed other challenges that they faced when seeking employment, which was lack of suitable work clothing, the lack of a curriculum vitae and a lack of an identity document, which made it harder for them to find employment. Hence before the pandemic many homeless opted to start their own small businesses and sell products in the streets.

#### **4.4.2.2 Subtheme 2: Lockdown led to loss of economic opportunities**

The second subtheme reflects information concerning the financial vulnerabilities of homeless women living at the shelter. In this subtheme participants shared how COVID-19 exacerbated the vulnerabilities that already existed among them. They confirmed that throughout the pandemic their fear was not only for coronavirus infections but for fear of starvation. According to Cross and Seager (2018:31), job insecurities become worse during pandemics especially for the homeless population. This caused a strain on existing resources for homeless shelters, and some shelters had to reduce their services or had to close due to public health and social distancing rules. This is reflected in the excerpts hereunder:

**NM:** *“COVID-19 is one pandemic that really brought hardship in most of our lives and took away our daily bread, almost all of us here in the shelter. The shelter itself struggled with donors as the world had a shutdown, it was so hard.”*

**CM:** *“I think it becomes difficult to just sit at home when you are old and have kids without a job, and during COVID-19 we were forced to go home and we had no money, because when I am home, as I am from Limpopo I live in a village and there are no opportunities that I could make some money.”*

**MNH:** *“Yes, it affected us and there is no money, and we want money and at home there is nothing, no money and no job, there is nothing, which is the reason we are here trying so hard to survive”.?*

**KT:** *“In March 2020, we were asked to leave. Only male occupants were left here at the shelter which I’m not sure about when they left or even left the shelter. From there I had to go back home, and that was a problem because I was not going to receive any income. I was not going to access any piece job opportunities.”*

Some participants shared that they were street vendors (selling goods in the streets) before COVID-19. This is an important source of income for many poor sectors in urban areas in developing countries (Lucas 2020:2). With that income they reported that they were self-reliant and they were able to survive during the day when they were out of the shelter. However, during COVID-19, the shelter closed down and they had to leave the shelter. Majority of the participants mentioned that they went back to their home lands, which meant they had no access to those piece jobs and therefore will not receive income. They mentioned that it was devastating for them to be forced to go back to their homes with no money and they had no means to make money because their homes are mostly situated in remote areas where job opportunities are very scarce.

During COVID-19 pandemic, the Sisters of Mercy Shelter did not allow participants to continue staying at the shelter, hence many of them were displaced or had to go back to their homelands (Auerswald 2020:349). In Los Angeles for example, the displaced women were forced to choose between living in unsheltered conditions or moving into congregate shelter, both of which may feel like dangerous options because of the

increased risk for COVID-19 exposure. Reid and Roseberg (2021:1) points out that those shelters that remained open during the lockdown had gone to great lengths to continue serving people's needs but clusters of COVID-19 infections forced many shelters to close at least temporarily, as a result, those who usually sleep in shelters can no longer access them and had nowhere else to go.

The study found that the COVID-19 pandemic left participants devastated and helpless because they lost their jobs as domestic workers due to lockdown rules that prohibited movements, closed down restaurants and forced everyone to stay indoors. According to the findings, participants suffered during COVID-19, as they reported that charitable organisations and churches, where they could get food during the day were closed. These centres not only had previously provided food, clothes and hygiene items but they also provided social support and housing. This is evident in the excerpts below

**BT:** *“There was a church that was open for community service, and they were feeding us during the day, they were giving us clothes, and accommodation but during COVID it was closed.”*

**XN:** *“The shelter does not encourage us to sit in the shelter the whole day and do nothing, but we are encouraged to go out and hassle for money, but during COVID all of that was impossible, the day you meet someone who will give you food, you will be very lucky, and during that time people feared being in the streets.”*

The lockdown limited the movement of people in the streets, and other charitable organisations had to close down, because they wanted to avoid spreading the corona virus and some, because they were financially unable to keep their charitable organisations operating. Participants who relied on these organisations to be fed and accommodated during the day struggled to cope when they were closed. One woman shared that before COVID-19 it was easy to meet a good Samaritan in the street who can give you food, but during lockdown people were not allowed on the streets.

Rosenbaum (2020:12) concluded that increased loneliness was also seen in 37% of participants since the start of lockdown, alongside a higher level of worry surrounding

isolation amongst depressed participants. Such findings confirm that not only health inequalities arise in the context of COVID-19, but also how other similar circumstances may affect the mental health of future populations with comparable disadvantages.

The threats of COVID-19 on the labour market have been interpreted as more than 22 million people prone to poverty, as mentioned by the International Labour Organisation (2020:17). The approach to mitigate the effects of the virus, like movement restrictions or physical distance, challenged the livelihood of poverty-stricken individuals, resulting in food insecurities and malnutrition (Union 2020:3).

Homeless women often have many complex health issues such as the co-existence of physical, mental and addiction problems, implying that they are a highly vulnerable community. COVID-19 pandemic has exacerbated these issues (Tsai and Wilson 2020:4). The loss of jobs and food insecurities were linked positively to symptoms of depression, alongside greater levels of loneliness and anxiety. Being uncertain about where one will find food the following day was a major cause of stress among participants in the current study.

Participants reported job loss related to the COVID-19 pandemic, others a decrease in hours and rest reported inability to find work since the start other pandemic, and when they were out of the shelter they had no food. This is reflected in the excerpts that follow:

**MNH:** *“I was selling, and life was better than now. There is no more business, no money and you cannot sell and get more than R200, now you get R80. Things have changed, we experienced a lot of things since COVID-19 happened and it has ruined our lives.”*

**XN:** *“During the pandemic, I was barely coping financially because before I was employed by a security company that retrenched most of us during COVID-19 since there were fewer shops that needed securities. If it were not for the food that was provided by the shelter many of us would not have survived.”*

**NX:** *“It affected me a lot.”*

**NX:** *“You know because during that time I had just got a job, and the company had to immediately close, so financially it cost me a lot because now I had to go to the families*

*and ask for help because there were a lot of things I could not do because of the money.”*

**TS:** *“Mmm I did not cope very well, and I was struggling to find employment, and that because everybody was downsizing their businesses.”*

**NM:** *“I must say. As for me, my job as a domestic worker finished during COVID-19, the agency vanished they never fetched us they only communicated with the leaders of the shelter that they will not be working during the lockdown because of limitations in social movements. Did we have other alternatives to make money no, because business in the streets was also not allowed, this was the hardest months and years of our lives.”*

Participants shared how they lost everything during the COVID-19 Pandemic. The piece jobs they had, the small businesses they ran and charitable organisations they relied on to survive during the day, was all shutdown during the lockdown. They mentioned that it is very difficult to find a job even after the pandemic, because many businesses are downsizing. One participant who worked for a security company said, the company never called them for work because many companies closed down during the lockdown. Even though some companies opened after lockdown the demand for securities extremely decreased, she said even till date she hasn't found a job.

Those who worked as domestic workers also shared their problem, that during lockdown many house owners were no longer looking for domestic workers because they had fear of contracting the virus and the government also put in some limitations in hiring domestic workers. The most difficult part that participants mentioned is that even after the lockdown the demand for domestic workers decreased, because those who used to hire them also lost their jobs. One participant said the pandemic brought them back to poverty, because financially they were not coping and they had to start begging for money from their family members all over again.

It takes strong determination to survive as a homeless person and a lot of hard work to rise above homelessness, as hunger and mental breakdown are some of the evil

enemies of civilization, hunger and poverty can destroy a person's ethics and turn society upside down (Dong *et al.* 2020:536). The impact of COVID-19 is such that it turned many stable people into becoming homeless and it was a setback in solving the problem of homelessness. When participants were asked, they said they are losing everything all over again.

#### **4.4.2.3 Subtheme 3: The vicious cycle of financial distress post COVID-19**

The third subtheme discusses information about the financial distress that has been caused by the COVID-19 pandemic. The pandemic that emerged in 2019 has caused global destruction related to human health, well-being, financial security and behaviour and its repercussions will be felt well into the future. Participants emphasised that such damage is too much, and it will take years to repair especially amongst the vulnerable groups such homeless women. This is evident in the excerpts below:

**TS:** *“It going to take a long of time for the market to recover, employment has really dropped and so for the economy to rebuild itself it takes years so we have lost huge progress that we had already made, you know South Africa was coming back strong and business was getting bigger and property booms and now we have lost momentum, so it will take a few years to build ourselves up.”*

**MNH:** *“We will live like this I don't know until when. I don't see the changes beyond. Basically, it's a bridge that keeps fluctuating as you climb it.”*

**RM:** *“There was no money, I even think even the shelter was struggling with securing food for us because some days some of us will not be fed. The sad part is that even now it's still just so difficult and the struggle will carry on for long.”*

**NX:** *“And I do not want to lie, during COVID it was quiet clients were not there, but now clients are back and we are working, and we feel that the business has picked up because starting from last week Wednesday we have been fully booked So, but they are still saying to us they are still trying to balance, and that is the reason they hardly pay us, and at the same time we are suffering as employees, and some of us are renting flats and those people they stay in Sandton and they are going with their cars and they are not using taxis like us and they stay around their business, and the*

*rest of us have to use taxes and buses and we have to pay rent, and yet up until today we haven't been paid."*

The findings from the current study show that participants who were self-employed were still struggling even after COVID-19, their small informal businesses that closed during COVID-19 are struggling to reopen. Another participant who has gone back to selling in the streets, complained that the number of customers has drastically decreased and the income she makes daily can only pay for the taxi back to the shelter. The participants alluded that, the pandemic has taken them back, and to recover from the damage will take years. One participant was fortunate to have been called back to work said she feels very lucky she got her job back at a salon. However, she says for months that she has worked she hasn't been paid and the employers keep saying the business is still picking up, which again puts her to a state where she doesn't have money for transport from the shelter to her work place. This is reflected in the excerpts below:

**CM:** *"Right now, it is the same, I usually go to Rosebank every Sunday at the flea market and sell there, but still the business is so slow maybe a day I only one or two products are bought, and I use that money again just to take a taxi back to the shelter."*

**DO:** *"It's the same, there are no opportunities at all, the only way you find something is when someone comes and pick you up here at the shelter and takes you where there is work, other than that, in the street you walk around the whole day and you find nothing."*

**DO:** *"NO it is no longer the same at all, and that is because businesses closed down during COVID-19 and even now they haven't opened."*

**DO:** *"They are also not hiring as much because they also lost jobs, they don't have money, only maybe after 2023 we will be fine, but for now we are struggling, things have just moved back to square one."*

The participants believed that the strategies to respond to crises did little to assist the homeless who depended on the informal sector to survive, and who depended on movement of people in the streets to gain income. The participants depended on other people to hire them as domestic workers, but it was impossible for employers to call

them in because of the economic downfall during the pandemic. The streets were a source of work for many homeless before COVID-19, but when streets were quiet during the lockdown it meant no money and no food for them during the time they were out of the shelter.

The crisis caused by pandemics such as COVID-19 can hit the weakest members of society hard, particularly the poor, homeless and women, who are not well-equipped to cope with the consequences of rising prices, loss of jobs and reduction in core public services, such as social welfare, health care, and education. The mitigating strategies that the private and public sector adopts such as the national lockdown, in response to crisis can have a negative long-term development implication.

Financial systems can contribute to economic development by providing people with useful tools for risk management such as during the pandemic, but when they fail to manage the risks, it can create a severe continuous financial crisis with devastating social and economic effects (Brown 2018:56). Hence some of the participants in this current study indicated that they feel like they have economically and socially moved back to square one.

The COVID-19 pandemic according to Feyen (2020:37) has transformed the lives of many individuals and families, even in advanced countries, where millions of people fell into poverty and exclusion. This derailed the progress to meet Millennium Development Goals and countries hardest hit by crisis, lost more than a decade of economic development time. This is evident in the excerpts below:

**XN:** *“I think it will be just, the lack of job opportunities, companies used to hire and pay decent salaries, but now they have retrenched several people, a lot is sitting at home with no jobs. We are worse here in the shelter when we are expected to be in the street the whole day and we have nothing to do; no jobs, no food. It’s a trauma that I think will take time to recover from.”*

**RM:** - *“Before COVID-19 I honesty never struggled to find a piece job somewhere, -The shelter had several donors, and the access to food was not an issue, but now we have lost so many donors that the shelter is struggling to survive, we are always eating one and the same type of food, but back than it was not the case.*

*Before the outbreak people use to come look for us to go and work for them, but they no longer come.”*

**MNH:** *“It’s worse when it comes to getting job opportunities.”*

**RM:** *“There was no money, I even think even the shelter was struggling with securing food for us because some days some of us will not be fed. The sad part is that even now it is still just so difficult, and the struggle will carry on for long.”*

Participants were found to be vulnerable due to their unfortunate circumstances. The financial crisis caused by COVID-19 hit them disproportionately because they are poor and homeless and, they have limited capacity and instruments to survive the shock and recover from impact of the crisis. One women pointed out that at some point during and after COVID-19, the shelter had suffered losses of donors, that the number of donors they had before was more than what they had after COVID-19 and at some point, they were not fed. She believes that the situation they see in the shelter will last longer even after COVID-19.

The failure to manage financial risks effectively, before and after the pandemic, can undermine the resilience of the poor to withstand adverse consequences of the future as well as their ability to take advantages of development opportunities even long after the pandemic (O’Brien 2021:234). According to the International Labour Organisation (2019:4), past experiences with financial crisis indicate that on average unemployment increases by 10.4% during a crisis and it takes 4 to 5 years for employment to return to its pre-crisis levels after the economic recovery starts. For example, in Mexico and in Argentina unemployment and wages took a serious hit in the aftermath of the financial crisis in 1994 to 1995 and 2001 to 2002 respectively.

#### **4.4.2.4 Subtheme 4: Gender inequalities among homeless people.**

Subtheme 4 reflects data regarding the exacerbated gender inequalities due to COVID-19 pandemic. Evidence in this subtheme reflects that the financial crises that the pandemic created affected homeless women harder than their male counterparts. Women were not allowed to be in the Sisters of Mercy Shelter during the lockdown, whereas men remained and could still access work opportunities that were available around the City of Johannesburg.

This means women living at the Sisters of Mercy Homeless Shelter were disproportionately impacted by COVID-19, because they were less likely to receive

income or work than men. The excerpts below show that these women were displaced and many had to go back to their homelands away from the city, where there are no opportunities for employment, and they had to ask money from family members to survive. This reflected in the excerpts below:

**CM:** *“I was in Polokwane, because shelters were closed here.”*

**CM:** *“At some point I was stuck in Polokwane with no money, and I wanted to come back this side and just hustle, it is difficult to just sit at home when you are old and have kids without a job.”*

**NX:** *“You know because during that time I had just got a job, and the company had to immediately close, so financially it cost me a lot because now I had to go to the families and ask for help because there were a lot of things I could not do because of the money.”*

**NX:** *“At some point I was at my relatives in Rustenburg, and I had to travel back after two months because I was not coping. At some point I went to stay in Alexandra for about a month with my other relatives, it was hard for me to find a stable place to stay when the shelter closed.”*

**KT:** *“In March, we were asked to leave, only male occupants were left here at the shelter whom never even left the shelter. From there I had to go back home, and that was a problem because I was not going to receive any income, I was not going to access any piece job opportunities.”*

During the lockdown all women were ordered to vacate the shelter, and a majority of the participants reported that they went back to their homelands. As a participant said the shelter still allowed men to remain. Being in the homelands for women, meant being stuck in a remote area with no job and no money. Some participants mentioned the feeling of being displaced and having no stable place to stay. One said she kept on moving from one relative to another. On the other hand, men remaining at the shelter, they were better off, because as much as the country was on lockdown, they were still in the city, where job opportunities were better than in the homelands.

Policymakers, scholars, and community leaders can agree on one thing that COVID-19 pandemic has exacerbated pre-existing inequalities (Thulien *et al.* 2020:152). The global discourse recognises that adequate housing is foundational to survival during

a pandemic (Farha and Schwan 2020:7). There is limited analysis of how gendered access to adequate housing shapes women's experiences of COVID-19. This gap in the public and scholarly debate is significant, given the evidence that gender inequalities were heightening during the global lockdown, including the high rate of job losses. One participant confirmed this in the following excerpts:

**TS:** *“Women are often the most least educated and they mostly stay home to look after their children, so economically when things turn bad women are affected worse and because they earn lower salaries. I think what will really help is that women earn equal pay with their male counter parts.”*

**TS:** *“Some of the people living here do have jobs and they are busy building themselves back up again and some of them are having it really difficult. I think the life of a man and a woman are just the same in the shelter except that women must be back here in the shelter early which means man get more time to work for money and less time for women, because women are not allowed to walk around the streets at night. Salaries I think for men, are also higher.”*

Participants in the study pointed out that, as women they faced unique experiences during their homelessness such as violence, victimisation, discrimination, poverty, and trauma and that such inequalities are typically treated for the homeless. There remains, however a dearth of knowledge regarding women's unique experiences of homelessness especially during the pandemic. The study found that because as women were the victims of violence, discrimination and trauma, the shelter made a rule that women should be back at the shelter early and that they may not be allowed to walk around the streets at night. The latter was not the same with men living in the shelter. This is why one participant pointed out that their male counterparts had more time to work and make more money than they do.

The data reflected on the exclusive experiences of women while they live at the shelter and their feelings of not being safe while they were on the streets looking for work. They have alluded to the fact that as women they were vulnerable to street victimization while their male counterparts did not have the same experiences. Homeless women are often vulnerable to other homeless men and other ordinary men in the community. This is because being a homeless woman and having no money to

survive means that they end up asking for money from men who then take advantage of their state of vulnerability. One participant shared that one woman was raped by a taxi driver, because she didn't have the taxi fare. This vulnerability is reflected in the excerpts that follow:

**CM:** *“At that moment if you had a bag as a woman, and you had a phone you will be the victim of crime because they will take those from you, especially because we were also vulnerable in the streets.”*

**CM:** *“Yes, just because we are also so desperate for money we are faced with those dangers in the streets.”*

**TS:** *“Working and walking in the street is always difficult for women, because not all men are respectful, so if they get to know you and get to know where you come from and they get to know that you are coming from the shelter, they will harass you. I heard of a girl who had no money for transport who got raped in a taxi.”*

**TS:** *“With homeless women, you see there are a lot of taxis that will let you in without taxi fare or they do something for you but some of them will ask unreasonable things of you.”*

There are good reasons to argue that the pandemic was devastating for gender equality and particularly devastating for women's well-being. Although Alon *et al* (2020:6) argued that for example in Canada, in previous economic crises men's employment had been more at risk, several unique factors of this pandemic made women's employment more vulnerable in practice. It has thus far been the case that women have lost most jobs due to COVID-19 (IWPR 2020:78). Women whose employment was affected by economic crises returned to their pre-crisis work levels more slowly than men (ILO 2010) and had a longer duration of unemployment associated with increased negative emotions and poorer wellbeing.

The feminization of poverty, linked to de-valuing of women's labour both in the formal and informal sector, suggests that many lower-income women may have entered the pandemic with less savings and greater employment uncertainty (Buchnea and Mckitterick 2020:156). Statistics shows that low-wage workers have been hardest hit

by job losses in Canada, during the pandemic, and many of these workers were women employed in sectors that were forced to close because of COVID-19, including retail, food, and hospitality (MacDonald 2020:156).

**CM:** *“Yes when you are a woman who is homeless and not working, you end up asking for R10 from males who live on the streets, and those who give you they never give you with a clean heart, they do it knowing that they stand to benefit from you as well.”*

**CM:** *“When you are not working as a woman and you are living in a man’s space, they tend to take advantage of you as a woman because they want you to give them something in return. I help you with this and you also give me this.”*

**NX:** *“Yes women are vulnerable sometimes you can even join something that you didn’t even know, women end up falling under the trap of man, because they are desperate for money.”*

**NX:** *“You can maybe start to be involved in drugs, something maybe you never think you will do, you can be in prostitution to get money from males.”*

**NX:** *“Yes, just to survive, and some man promise you love, they start pulling in by giving you money, food and everything and just because you are in the situation you just end up agreeing or understanding in order to survive, but outside there when it is at night, especially for women I think they are in danger, because where they stay, they can be raped and they can be killed.”*

Men rebounded twice as quickly as women from job losses experiences during the pandemic. In the current study, most of the participants have indicated that since COVID-19, they have not found jobs and when they compare themselves with the males who live at their shelter, they realise that males are already having some jobs which gives them power over vulnerable women who are homeless. In the above excerpts the participants shared that financial inequalities forced women to rely on men, live in their space and depend on them to survive in difficult times. Participants said, that most men never give vulnerable women money without expectations. They always want something from women in return. As a result, some women end up being prostitutes and become engaged in drug abuse.

Therefore, to build equity and evidence-based policy responses to the pandemic and beyond, gender research studies and data is critical for understanding the cause trajectory, and consequences of COVID-19 on women who are homeless (Ibrahim and Jamil 2020:32). Most importantly, there is a need for research on which interventions are effective and can be used to ensure stable housing for women who are homeless, so as to prevent violence, eviction and poverty and to do away with the policies such as that of the Sisters of Mercy Shelter of evicting women from the shelter during the crisis of the pandemic.

#### **4.4.3. THEME 3. AVAILABILITY OF SOCIAL SUPPORT FROM SOCIAL DEVELOPMENT ORGANISATIONS DURING AND POST COVID-19**

This theme is related to all the evidence of social support given to the participants during and after COVID-19. The data reported in this theme shows evidence of both emotional support, whereby the participants were offered weekly counselling and the instrumental support whereby the participants were offered clothes and toiletries by the social workers and other organisations at the shelter. The following two subthemes reflect: (i) emotional support from social workers and (ii) instrumental support from social workers and other organisations.

##### **4.4.3.1 Subtheme 1: Emotional support from social workers**

The 1st subtheme reflects data on how the participants' accessed emotional support from the social workers during and post- COVID-19. This sub-theme also emphasizes the importance of the role played by social workers during COVID-19 crisis, by covering the most urgent social needs of vulnerable groups such as the homeless. Participants in the study shared their understanding of social support as something that create positive effective states, supportive relationships and can provide individuals with access to positive social influence that can encourage healthy behaviour. This is confirmed in the following excerpt:

***XN:** "Those two ladies who are social workers allocated in our shelter gave me an opportunity to find my purpose in life. I was able to identify what I am passionate about, and I also received counselling from those sessions. I gained back my confidence and I was able to face the world. I could even put my CV to apply for jobs."*

**RM:** *“They offer counselling sessions, which helped many of us especially those of us who suffered from depression.”*

**RM:** *“To be honest I do feel better, and I am one who always consult with them every now and then because it sets me free to speak to someone who has been there for me since the beginning. Social workers have really showed support to me and other women living in this shelter.”*

**MNH:** *“Yes, we have them, there is two of them, you talk to them about anything, and you get that great feeling, that you have just released something that was just so heavy. So, it’s like offloading sessions. I always think of them like that.”*

**XN:** *“They gave me one on one counselling sessions and educated me on how I should perceive life and make the most of my current situation. Knowing that somebody was going to listen to your long depressing life story was everything to me because leaving a home to be homeless was the most difficult decision I took but I always thank God I got to live in the Mercy shelter.”*

The participants in the study mentioned that emotional support of counselling they received from in-house social workers, is what has kept them emotionally and psychologically strong, especially during unemployment crisis. The participants shared that the counselling sessions revived them and they regained their confidence that they were able to apply for jobs after the devastations of losing everything during the pandemic. According to them, those counselling sessions gave them a platform to share their emotions, release and off load the emotional and psychological burdens they carried.

Wenzel *et al.* (2020:2) argued that the social vulnerabilities, in the COVID-19 context relates to social problems, such as unemployment, gender violence, anxiety and depression or homelessness. Lima *et al.* (2020:2) pointed out that the increase in unemployment has been associated with the increase in depression and anxiety especially among homeless women, and there is a need for an increase in psychological support, to prevent post-traumatic stress disorder.

Unlike office-based healthcare professionals, many social workers practiced in the community and worked face-to-face with the most vulnerable in society. Social workers in institutions such as hospitals, nursing homes and shelters for homeless persons, faced risks when interacting with at-risk people in closed settings (Beddoe 2020:68). However, research confirms that social workers, from the beginning of their training, are steeped in the importance of everyone's unique dignity and worth. Even in the hardest time, dedicated social workers focus on the needs of the client and advocate for their welfare and well-being (Smith 2020:68).

However, during the peak of the COVID-19 pandemic, many social work offices, centres and services closed their premises. Some services were withdrawn completely, in some cases social workers work from home, contacting service users by phone or internet. Over and above the fact that those who needed the social work services did not have access to technology or were not able to use it, social workers also noted the difficulties of building trusting relationships remotely (Smith 2020:52). In the excerpt below, some participants confirmed that after the closure of the shelter due to lockdown, they could not access the services of the social workers and were unable to be in contact with them.

**DO:** *“The only problem was that, during COVID-19 we could not see them face to face, but they gave us numbers we could call to receive counselling when we needed, but most of us felt it was not helping that much when the conversations were on the phones.”*

**BT:** *“During COVID-19 social workers were not available most of the time as the shelter had to close during some of the levels of lockdown.”*

**MNH:** *“We just lost touch with them during COVID-19, because we had to leave the shelter during tense lockdowns, at some point they changed the workers and brought new ones, which disturbed some of us who had been in consultation with them all the time.”*

The closure of the shelter and the inability to see the social workers face to face disturbed women who relied on the social workers for their mental health. They were expected to communicate with social workers telephonically, but women said it was impossible because they had no access to adequate means to communicate with social workers, such as cell phones and airtime, and they felt that face to face counselling only was more suited for them. Participants mentioned that during COVID-19 they lost touch with social workers due to strict lockdowns and when they went back to the shelter, the Department of Social Development had assigned some new social workers, which made it difficult to rebuild trust and there was no continuity.

Moreover, despite the fact that the women staying at the Sisters of Mercy Homeless Shelter had experienced marginalization and emotional or psychological injuries, findings from the current study suggest that these homeless women supported each other by constructing their own friend and family-like networks within the shelter. Furthermore, they provided each other with instrumental support such as food, emotional support such as listening ears, information support such as where to find a job and where to get free meals. Lastly, they socially supported each other by providing a basic sense of protection and safety. The following excerpt reflects this.

**NM:** *“They also provide us with continuous counselling, and they ask us questions and when we have things to share, they call us in groups sometimes and they teach us maybe about certain diseases symptoms and preventions. When we are in those group meetings that normally take place in the afternoon, we get to sit together as women of the shelter and share our daily challenges. We get to sympathize and support one another because we have lived together for years now, and we have become one big family.”*

**BT:** *“They constantly ask us what we do during the day while we are out of the shelter, they always follow up on us in terms of our financial standing and that to me means a lot because they are trying to see if being in this shelter is helping us to achieve what we want to achieve, because we don’t want and we can’t live in the shelter for the rest of our lives.”*

Social work practice contains many disciplines that impact underserved or vulnerable populations, including the homeless. Social workers can't bear the weight of ending homelessness altogether (Lee *et al.* 2017:45). However, these professional's services are critical for the homeless population. They can connect homeless individuals with assistance through partnerships and outreach. Through outreach social workers work around the clock to engage with both sheltered and unsheltered homeless people, connecting them to resources to help transition them off homeless encampments, with an aim to bring them closer to stability or permanent housing (Golden *et al.* 2009:12)

*BT: "Yes, they also help us to support each other, they teach us during group sessions how to share information, and because of such group meetings, as women living in the shelter, we are very united, and we assist each other in many ways possible."*

The concept of being compassionate to one another include a number of other virtues, such as empathy, sympathy, kindness, respect, and perhaps most importantly, actually taking some kind of action (Limebury 2015:81). The social and emotional support that homeless people who live in shelters give to each other brings a sense of belonging, trust, assistance with daily living, help to re-build their lives (Shea 2017:90). Homeless people represent a vulnerable group in society, hence social workers and other organisations have created an environment intended to enable happiness and independence of the vulnerable person in the longer term (Limebury 2015:81). This may further include providing a sense of direction and them recognising the importance of long-term permanent housing.

#### **4.4.3.2. Instrumental support from social workers and other organisations.**

In addition to social workers, other community-based organisations provided support in feeding the homeless community. In the study one participant mentioned that before the pandemic, she assisted a church that was near the shelter with cooking food for the homeless who were in the streets of Rosebank. According to findings from Freeman *at al.* study (2021:7), when participants were asked what kind of extra help they were receiving during the pandemic, 83,2% said they were receiving food from NGOs and 10.2% said they received basic food parcels, and these were considered

more appropriate to them due to difficulties in cooking in the streets during the pandemic (Rodriguez 2020:8).

***NX:*** “Yes, they do, but also if you say you do not have clothes, they can give you clothes and cosmetics., Yah so if you have problems with such things you go to them and you tell your story and they give.”

***DO:*** “Sometimes I go to a church and I assist them with cooking for the homeless people who live on the street, but during COVID-19 churches were closed.”

***TS:*** “We do have ladies who come during the week and they do help with clothing and toiletries.”

***BT:*** “Social workers are available here at the shelter. They are two ladies, they come every week, they assist us mainly with counselling and sometimes with clothes and toiletries that we need at that time.”

Community-based organizations (CBOs) also play a critical role in the challenge of homelessness. They identify and address issues that mostly affect the members of the community, and being at grassroots level, gives them a right that organisations coming from outside the community, may lack (Tyler 2021:1). Community-based organizations are public or a private non-profit organization that has demonstrated effectiveness in representing the most vulnerable segments of the community such as the homeless. These CBOs are such as day centres, churches, and youth centres. They provide essential needs such as food parcels, cooked food, toiletries, clothes and other educational related services to specified individuals in the community (Mukwevho 2017:2).

From the data collected the impact of the COVID-19 pandemic has hit hardest the people with whom social workers usually work with, those who already are vulnerable, marginalized, living in poverty and homeless. The closure of other social based organisations such as face-to-face social work services, community-based day centres, churches, and youth centres, that were assisting the poor as a strategy to curb the spread of COVID-19, made it difficult for the participants for this study to get

the tangible support such as cooked food, food parcels, toiletries and clothes they need. This is reflected in the following excerpt:

**BT:** *“Unfortunately, this was good as it lasted, because during COVID-19 we could not access such stuff such as toiletries because social workers were no longer coming to shelter.”*

**NM:** *“Some of the organisations that used to stop by in the streets during the day and hand out blankets, food parcels and sometimes offered cooked food, stopped during lockdown. We were honestly stranded during the day with no food. We had no choice but to go back to our homelands, and the money to travel back home was a problem for most of us. That is when the government had to put some of us in tents.”*

The study found that the charitable organisations that used to stop by during the day to sometimes hand out blankets, food parcels and offer cooked food, were no longer available during lockdown, and the participants could not access stuff such as clothes and toiletries because the pandemic limited the flow of social workers at the shelter. This left homeless women even more helpless and these exclusionary aspects of the pandemic negatively influenced the provision of the basic needs of the homeless. This requires dedication from social workers to assist, support and exclusively deal with homeless women’s vulnerabilities.

#### **4.4.4 THEME 4: EXPOSURE TO GENDER BASED VIOLENCE (GBV).**

The fourth theme relates to information regarding the exposure to gender-based violence (GBV) by the participants and how it was exacerbated during COVID-19 pandemic. Interagency Standing Committee (2005:2207) defined GBV as violence that includes rape, sexual assault, as well as physical, psychological, or emotional violence and denial of resources opportunities, services, and freedom of movement based on socially ascribed gender roles and norms.

This theme reflected data shared by participants on their exposure to GBV as well as their observations on how it was exacerbated during the COVID-19 pandemic within the homeless community. This will be unpacked under one subtheme which will show

evidence from other studies that confirms that during the pandemic vulnerabilities created by GBV became a crisis. The subtheme is: Gender Based Violence (GBV) accelerated during COVID-19 pandemic.

#### **4.4.4.1. Subtheme 1: Increased Gender Based Violence**

This subtheme reflects data on experiences and how they were exposed to GBV during the lockdown. The subtheme will make reference to other studies with evidence that confirms that during COVID-19, GBV cases increased and vulnerable women (such as the homeless) were mostly victims. The following excerpts attest to this:

**BT:** *“Protection against GBV when you are homeless is very limited and when you are a foreigner it’s even worse. It is bad because we are weaker than our male counterparts, so they take advantage of that. During the COVID pandemic, abuse became too much because of stress and hunger, and we as women then become victims at all times.”*

**RM:** *“Because during any instabilities, it could be a pandemic, women suffer the most, they never had jobs, looking after kids is their primary responsibility at the same time and males are said to take advantage of their vulnerability.”*

**CM:** *“Gender-based violence is all over and caused by family members, but I believe during lockdown it was much more because women were locked in shelters with males the whole day, with nothing to do, as the country didn’t allow movements.”*

**NX:** *“I think so because people were in the same space almost every time and the frustration of not having money and not working, I will say during that time of COVID-19 gender-based violence was worse.”*

Participants said violence against them as women increased amidst changes in the financial structure during COVID-19 even within the homeless community. The frustration among men of not having jobs during COVID-19, led them to being more violent towards women. Women had nowhere to turn to because lockdown rules limited their movements. One woman alluded to the fact that homeless women received limited protection from the police under normal circumstances even before

the pandemic. During the pandemic it became worse, hence women are said to be the victims of circumstances and males are said to take advantage of their vulnerability said another participant.

The experts have described an “invisible pandemic” of GBV during the COVID-19 crisis as a ticking bomb (Lopez 2020:3). An analysis by the UN Women (2020:1) of the gendered impact of COVID-19 in the pandemic will disproportionately affect women, exacerbates pre-existing gendered risks and vulnerabilities. Meanwhile social, health, and legal services providers such as shelter, legal aid offices, healthcare facilities and rape crisis centres, are overwhelmed and understaffed. Some shelters are full, others have been converted into health facilities, said Lopez (2020:4).

The advent of pandemic conditions and particularly the intensified abandonment by the state’s servants such as police officers, increased the risk of physical violence. An example in Liberia, was of many GBV survivors who were denied access to basic public health services out of fear that health workers would get infected. Police and justice systems were overwhelmed, which could have led to a further increase in GBV, as an atmosphere of impunity was created. Social service providers raised concerns that GBV survivors locked in with perpetrators would lose the social and psychological resilience gained through the therapeutic work they had been provided with, prior to lockdown (Roupetz 2020:2208).

**NMT:** *“The reason I say this is because men take advantage of vulnerable women who live in a shelter or in the street, they take advantage because they know we tend to be desperate because we are hungry, women get forced into doing things without concern, and such cases are never reported.”*

**KT:** *“I think under normal circumstances police are not so visible in protecting homeless women, during COVID it got worse because also the violence was happening inside closed doors and homeless women hardly report cases of abuse.”*

**XN:** *“With gender-based violence, I think it got worse, I don’t even think police paid so much attention to the protection of homeless women. Even though before COVID it*

*was just the same, it got worse, and even men took advantage because they knew that homeless women never report abuse cases, and they are so vulnerable.”*

**NM:** *“We are usually exposed to gender-based violence when we work in the street because there it is the survival of the fittest, there are no police in the street protecting women who are street traders.”*

Public health measures in a pandemic such as rechanneling resources towards emergency service provision and the inefficiency of the policing department exposed realities of inequalities. The participants said even before the pandemic homeless women received limited protection from police. Weaknesses and vulnerabilities of homeless women is the reason they never report cases of abuse. The spike in violence against women during the pandemic is a manifestation of the inequalities and their vulnerabilities (Anyango *et al.* 2019:65). The exposure to violence increases as perpetrators might lash out due to economic strain caused by the pandemic, while the chances of victims leaving their abusive relationship, decreases (Fraser 2020:66).

**CM:** *“It was worse because, before COVID-19 in the streets you will find that there used to be organizations that will give homeless people food, but during COVID they were not there, which raised more frustrations to men, and they vented on women.”*

**TS:** *“Gender-based violence is something that is there whether there is a pandemic or not. But then again it could be that when there is unemployed people who drink more, violence does increase with alcohol and maybe more people were home and under more stress as the market was under more stress, that sort of thing.”*

**RM:** *“Gender based violence was there before COVID, but I tell you during COVID it became worse, in the streets and even in normal homes set up, and the reason was lack of money, being stacked with each other with no food frustrated a lot of women who were victims of those circumstance.”*

**KT:** *“I think women are always victims, especially those who are like us who are vulnerable. Our partners and any other male counterparts they just take advantage of our vulnerability, we are abused physically and even emotionally. During COVID it was*

*worse since males were also so frustrated by lack of income and took out their frustration on women and children.”*

Moreover, participants mentioned that the number of emotional violence cases against unemployed women by their unemployed male partners increased during the pandemic. This is because when men are unable to work and earn income to provide food, triggers them to become violent and they vent their frustration on women. Women participating in the study said being stacked with their partners be it in the shelter or in the streets with no food, frustrated men so much and women were victims of circumstances.

Findings from Peate (2020:531) study argues that during the COVID-19 pandemic a wide variety of recommendations were endorsed by the World Health Organization (WHO) which includes social distancing and quarantine, mass testing and isolation of confirmed cases to curb the spread of the disease. However, these measures are hard to meet in certain settings such as the streets and homeless shelters. Prevention of the spread of these settings was nearly impossible due to lack of space and adequate infrastructure and the high occupation of some homeless shelters (Silveira *et al.* 2020:535). This is the reason most participants in shelters confirmed that during the strict lockdown GBV increased, which also led to worse posttraumatic stress effects after the lockdown (Senses *et al.* 2020:2205).

#### **4.4.5. THEME 5: STIGMA AND DISCRIMINATION FACED BY HOMELESS WOMEN.**

This theme reports on the challenges that disproportionately affect homeless women (not men) that therefore made them more vulnerable to the rest of the community, than their male counterparts. The lack of safety and security for homeless women while they are looking for jobs in the streets, the stigma and discrimination that they are exposed to on a daily basis from ordinary people of society, has worsened during the pandemic. The discussion will be presented in three subthemes: (i) Compulsory vacation from the shelter during daytime (ii) the unsafe working conditions in the streets (iii) the stigma and discrimination faced by homeless women pre and post COVID-19.

#### **4.4.5.1. Subtheme 1: Compulsory vacation from the shelter during daytime**

Like many other shelters, the Sisters of Mercy Homeless Shelter has a policy that does not allow residents to remain on the premises of the shelter, during the daytime hours. The policy is described informally as an approach aimed at encouraging people to engage in job-seeking efforts. However, women participating in this study shared that this rule is so difficult for them, because even when they are sick they cannot decide to sleep in, without a letter from the doctor or clinic that confirms that they are sick. This is evident in the following excerpt:

**NX:** *“You know when you are in the street, and you have no money it is tough. Here in the shelter, you are not allowed to stay during the day, all of us must be out to the street and look for work.”*

**CM:** *“Here you don’t live yourself, you live under the rules you know by 7:00 am it is time that I must go.”*

**CM:** *“And there is no way you can say today I am not feeling well and I want to sleep, the only way, when you are sick you are required to go to the clinic and you get a letter that indeed you are sick and they give you maybe two days of rest, only then the shelter will allow you to rest and sleep in the shelter the whole day.”*

Participants in the study spoke about a broader sense of displacement that they felt when they were out of the shelter. They alluded to the ongoing closure which exacerbated their vulnerability and reduced access to other healthcare and social support. They became desperate for food, money and a place to live in during the time because they are temporarily out of the shelter. The women in the study shared that they become so desperate that they end up engaging themselves with men they don’t even know, which puts them in danger. The follow excerpt reflects this:

**NX:** *“So those with no work find that they meet a man in the street during the day who offers them a place to stay and food for during the day, because also remember here in the shelter we eat breakfast at 6: 00 am in the morning and we will only eat supper when we are back at 7:00 pm. So, you can imagine during the day you become so*

*hungry, and you end up putting yourself in that danger because of going with a man you don't know because you are hungry.”*

The policy of vacating the premises during the day creates challenges for participants particularly because they are women, as they are unable to access their adequate bathroom facilities for many hours during the day. Substitute facilities proved difficult to find, especially given the limited availability and poor quality of public toilet facilities which may exacerbate their chronic illness related to womanhood.

**CM:** *“Sometimes when you are in the street walking around looking for work, you get tired and some of us end up going to the park and sleeping there, think about it in the park there is hardly functioning toilets, and when they are not functioning the municipality close them, you can imagine when we have to use such environment on daily basis as a woman, we are exposed to so many diseases.”*

**TS:** *“We are very safe here in the shelter, we have running water to shower, but during the day we are literally street people, especially some of us who walk around the whole day trying to find jobs, we sweat, we get tired and where there is shade, we sometimes nap, we are never safe, our hygiene is even worse, which kills our confidence as we continue looking for work.”*

Wenzel *et al.* (2019:1) study argued that, while they were on the streets, several women reported to have ended up urinating in a corner of the subway and changed sanitary towels. This undermined their dignity and jeopardize their safety. The constant threat of feeling “dirty” or unclean as they spend hours in the street took a toll on their self-esteem, their confidence, and the sense that they can be respected in the community (Kuhlmann *et al* 2019:6). Participants confirmed this in the above excerpts.

#### **4.4.5.2. Subtheme 2: Unsafe working conditions on the streets**

The second subtheme reveals data about the criminal activities and health hazards that participants in this study were exposed to on a daily basis as they are on the streets during the day looking for work opportunities. The closure of the shelters whether temporarily or permanently for the duration of COVID-19 lockdowns, left the

residents of the shelter displaced and hence were vulnerable and victims to criminals on the streets. This is evident in the following excerpts:

**NMT:** *“ We are safe here in the shelter, that is why you see us here. We have never found ourselves in cases of crime or any other danger. We are okay but except now when we have to be in the streets because some of us are looking for work, which is really not safe, and some women become so desperate that they fall in the trap of prostitution, so just they receive money and get some security.”*

**XN:** *“Homeless women may be exposed to the risk of getting trafficked, also be exposed to rape, and contracting HIV/AIDS.”*

**NX:** *“The danger is on those who stay outside on the streets, maybe a person can be raped because they sleep in the streets. They are mixed there, having both women and men, and some men are violent, and they can do whatever to you that they want to do so because you are a woman.”*

The participants confirmed that they felt safe when they were inside the shelter. However, and whenever they were in the streets working or looking for work, they were exposed to many uncertainties and other dangers. Women discussed that they are victims of criminal cases which are perpetrated by their male counterparts, who take advantage of their vulnerabilities. They said on the streets women are at high risk of being raped, trafficked and falling for the trap of prostitution to receive some money. Kumar (2020:6) confirmed that the wider literature demonstrates that those who are homeless, or at risk of homelessness, have typically experienced much trauma including violence and severe hardship, and thus struggle to form trusting relationships. This is evident in the following excerpts:

**NM:** *“As women we have male partners that we also meet in the streets, and it is never safe with these relationships because in the street there is no honest love, and because of that women always find themselves being victims and are beaten by their boyfriends and even raped. But such, are hardly even reported, because these people are arrested for a few days and after few days are back in the streets. So ,if you report such, it makes the situation worse.”*

**RM:** *“Most of the time homeless women are victims of rape and forced drug dealers and are used as prostitutes in exchange for drugs and alcohol.”*

**RM:** *“I mean other women especially those who are drug addicts, most of the time they can’t afford to buy drugs, so the pimps use them as sex slaves, and in exchange they give them drugs and alcohol. It happens all the time in the streets here in Joburg.”*

**DO:** *“You know while you are in the street looking for work, and a person maybe a male tells you that there is some work at a certain place, you end up going with him. Such things one must avoid doing because males take advantage of homeless women because they know they are stranded.”*

Even though violence is distributed across all income categories, compared to other women, poor homeless women are more likely to become victims D’Ercole and Struening (2016:14). Poverty can undermine women’s ability to improve their environments or live safely, and can bring stress to women and their male partners (Polusny and Follette 2005:9). Extremely poor families have more and more intense economic, housing, and psychosocial needs and if these are not satisfied it leads to homelessness (Koss 2018:45). According to the American Department of Public Health (2017:3) trauma among the homeless, sexual assault against homeless women occurs more than twenty times more frequently than it does in the general population. The role that violence plays in the dynamics of homelessness among women is vital (Wenzel 2021:8), as it may exacerbate their vulnerabilities and bring anxiety among women who continue looking for work in the streets.

Women who are homeless are more susceptible to illness due to poor personal hygiene, which is exacerbated by other risk factors such as living on the streets. (McNamara 2019:6). In the current study, even before the pandemic participants confirmed they had to vacate the shelter during the day. One of their health concerns was the difficulties in managing personal hygiene while they were in the streets. This is evident in the excerpts below:

**NM:** “ When you are working in the streets, there is not enough running water, no safe toilets that you can use, those that are there they are in a bad condition for us women to use. Worse during COVID-19 we were at high risks of contracting Corona because we did not have most of the facilities such as sanitizers, sufficient water for regular washing of hands and the toilet facilities in the streets were totally not close to hygienic.”

**NX:** “People are vulnerable, during COVID-19. Streets were not a good place to be for everyone, because it was easy to be in interaction with a COVID-19 infected individual, because in the streets honestly there is no social distancing there, and we can’t access enough water for hygiene.”

The study found that homeless women who permanently or temporarily living in the streets because of COVID-19 pandemic had no access to a consistent water source, hand sanitizer or soap to practice hand hygiene, which was the one of the very important precautions to avoid contracting COVID-19. Frank (2020:4) observed that women who were homeless had a higher likelihood of visiting nearby health clinics for gynecological issues like urinary tract infections (UTIs), yeast infections and vulva contact dermatitis because they are unable to maintain genital hygiene during the day while away from the shelter.

Some of the participants in findings from Haston *et al.* (2020:1) study mentioned that the financial barriers to practicing hygiene while on the streets, they hinted that not having a place to simply go to the toilet is another challenging aspect of homelessness. These health barriers are made worse by the inability to access city shelters for the homeless, which were closed to stop the spread of COVID-19. This prevents many participants from using public spaces and supplies. (Frank 2020:5).

#### **4.4.5.3. Subtheme 3: Stigma and discrimination faced by homeless women.**

Goffman (1963: 5) defined stigma as a visible characteristic feature of an individual that make the society devalue and consider him or her unfit for their inclusion in the mainstream. Participants in this study discussed the discrimination and stigma they faced as homeless women from the community. In this subtheme they explained that, even before the community members can get to understand who they are and where

they are coming from, they already have certain stigmas, that they are mentally ill and that they cannot be normal citizens of the society. The follow excerpts reflect this:

**NMT:** *“People out there say, you stay at a shelter where mentally disturbed people stay, but I’m happy because those people have no idea the struggles I face, so whatever stigma they attach to me, I remain happy because I know what I want to achieve for being here.”*

**KT:** *“But maybe in general terms there are some stigmas attached to being homeless people think you are not mentally stable.”*

**MNH:** *“Lots of women do get it, especially from men. They treat you as if you’re less of a human or stupid. We see them, when they talk to us, they act as if you’re stupid, but I don’t care.”*

**MNH:** *“They would ask you where you stay and if you say at the shelter, they would look at you funny, one will feel uncomfortable and undermined.”*

Before the COVID-19 pandemic women in the above excerpt shared that the community always attached a negative stigma to them as homeless, that they could be mentally unstable, stupid or not human enough. During the COVID-19 pandemic this stigma was worsened, and they were perceived as high-risk carriers of the coronavirus. One participant said:

**NM:** *“During COVID as a homeless person when they see you, they saw COVID, and they never wanted us near them. Even the government had to move homeless people from the streets to temporary houses which were tents so that they make sure they don’t spread the virus to the ordinary members of society. But it was okay that the homeless were congested in those tents and they infected each other. There is serious discrimination that we saw during COVID-19 toward the homeless.”*

People who are homeless face additional challenges when using public health facilities because they often don't wear nice clothes, may smell, and are perceived as unclean when they enter government clinics (Sommer 2019:5). The mistreatment of homeless people and medical professionals' refusal to treat them because they are “dirty” is a serious problem, as it exacerbates their existing anxiety. A subset of the study's

participants reported having encountered discrimination to the extent that community members thought of them as prostitutes with no morals, just because they were homeless. The excerpts below reflect this:

***NX:*** “*If you are staying in such a place, they start thinking otherwise and others call you names., Like if you are a woman who is staying in such a place, they take you like you are coming from the streets or maybe you are a prostitute like you are not taken to be a normal person. Discrimination is too much for women, even where I used to stay at the first shelter in Hillbrow because it was a flat, so when they see you going there, they will think that maybe you are a prostitute.*”

***NX:*** “*But they still had that mentality that if you are staying in such a place, you are in your low level of life, so that was the discrimination, so they cannot take you really like a normal person.*”

***XN:*** “*I think when you are homeless women you are associated with someone with no value, no morals, and that you have nothing to offer to society.*”

Women who live in the streets whether during the day only (like current study participants) or permanently, face significant challenges in maintaining appearance, and as a result, they are generally observed to choose public facilities that are under maintained and scarce. Access to private sector restrooms, like those found in fast food restaurants, is contingent upon patrons' capacity to make purchases from their business (Phillips-Howard 2018:6). This indicates that many restaurants have a policy prohibiting you from using their lavatory if you are not a customer.

In addition, a disproportionate number of individuals who are homeless have underlying medical conditions and substance use disorders. They also face stigma and discrimination, which frequently prevents them from accessing social services, health care, and housing, increasing their risk of infection and negatively impacting their COVID-19 outcome (Culhane and Tregilia 2021:2). The participants in the current study shared how they are excluded by the society when it comes to service delivery. They mentioned how they are mistreated by nurses in hospitals when they get to know that they are homeless. They said:

**NM:** *“A lot of people especially nurses think of homeless people as being sick mentally and unclean, and when you go to the clinics or hospital they sometimes don’t even assist you, or they don’t pay much attention to you because you are homeless.”*

**XN:** *“We struggle just to be accepted, we are discriminated against even when we go to clinics, we are scared that the nurses will see and know that we are homeless and they will start judging us.”*

**RM:** *“They are seen as filthy, unhealthy, thieves. Homeless people mostly face discrimination during COVID-19, when they got to hospital for help, they would be asked questions such as “how are they supposed to be healthy while they live in the street”, they are even threatened to receive medication only if they go back home and live in the street. The difficulty of stigma is all over, when we are looking for job opportunities, even when we go look for help in home affairs.”*

The study found that homeless women felt discriminated against by service providers when they went looking for help at the Home Affairs Department or in hospitals. One participant shared that one nurse once asked her how she expected to get better while she lives in the streets. They shared that at some point they were threatened that they would only receive medication if they go back home. They mentioned that it is very difficult to even look for a job because the community is sceptical to employ a homeless person as they are perceived as filthy, unhealthy and thieves.

Moreover, in trying to curb the spread of COVID-19, the government put in urgent mitigating policies which imposed economic discrimination to those who are homeless. COVID-19, according to Subbataman *et al.* (2020:83) resulted in the largest lockdown in the history of civilization, that could severely enhance the miseries of the homeless and slum dwellers in the world, because the closure of towns and cities, meant no daily income for these members of the society. This is evident in the following excerpt:

**DO:** *“I feel like also we are discriminated against because we are not working, especially during the COVID-19, when they set those conditions of lockdown. They never took into consideration us who survive as street venders.”*

**CM:** *“I have been working and selling in the street for long, but the COVID rules that closed everything, including our small businesses, made our situations worse because we couldn’t even afford our basic things and depended on the shelter, which also continued closing and opening, as the lockdown levels kept changing.”*

**XN:** *“I think when you are homeless women you are associated with someone with no value, no morals, and that you have nothing to offer to society. Everybody takes advantage of your vulnerability. When it comes to us looking for a job, it is really terrible. Immediately you mention you live in a shelter that stigma might get you missing that job, and because of these reasons many of us have opted to sell in the streets. But COVID-19 rules prohibited our businesses from working and made our situations even worse.”*

There was a lot of stigma attached to being homeless. They are perceived as dirty and mentally unstable, which made it difficult for the homeless to find jobs. The participants felt discriminated by the policies of the government that enforced the lockdown which restricted the movement of people in the streets. No one could recycle, sell products in the streets, provide their cleaning services, beg in front of restaurants for food and cash, which are the only means of survival for the homeless when they are out of the shelter. They said because they are homeless and living in a shelter, their chances of finding employment is always less than other ordinary people. Hence a majority of them opt to start their businesses in the streets and sell whatever they could, that may bring some income, but it was all prohibited during the lockdown and they remained with no source of income.

When the lockdown was announced the first step to curb the spread of COVID-19, it was biased in favour of the privileged. When it was assumed that people could live while incarcerated in their homes, without taking into account how daily wagers, housekeepers, street vendors, barbers, and waste-pickers—jobs that the homeless typically perform—could make ends meet even if they were unemployed for a single day (Beswas 2020:5).

According to Rio de Janeiro (2020: 3) Rio de Janeiro implemented restrictive measures in March 2020 to combat the contagion, which led to the closure of

businesses and decreased pedestrian traffic. As a result, the homeless population had limited options for income, including working with recycling and selling candy and candies at traffic signals. Among other things, begging for money decreased. But hunger never stops, and it became impossible to maintain the hygienic conditions needed for preventive measures, as advised by the World Health Organisation.

Due to this population group's lack of visibility, a survey was conducted in Rio de Janeiro from August to October 2020 in an effort to map the social and health conditions that the pandemic had exacerbated (Nunes 2021:12). According to Nunes et al. (2020:3), the government did not have a specific plan in place to protect this particular population group that would have guaranteed their access to health and social care services, emergency assistance, basic sanitary conditions, and food security.

#### **4.5 CONCLUSION**

This chapter presented the themes and sub-themes from an analysis of data from twelve interviews that took place at the Sisters of Mercy Shelter Homeless Shelter. The themes and subthemes are presented in table 2 and were discussed in the chapter. The results demonstrate that while the global population was impacted by the coronavirus disease (COVID-19 pandemic), not all populations were equally affected. Pre-existing challenges that were experienced by participants such as health, and socioeconomic inequalities pre- COVID-19, exacerbated their vulnerabilities and inequalities in society. The following chapter will provide recommendations based on these findings and will form the conclusion to the study.

## **CHAPTER 5**

### **CONCLUSION AND RECOMMENDATIONS**

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#### **5.1 Introduction**

In this chapter, the researcher presents key findings in the context of the aim and objectives of the study. The importance and contribution of these findings is discussed. The limitations of the current study are also presented and recommendations that suggests new policy implementation and future research are offered. The concluding chapter is an integral aspect of the dissertation as it states the main findings, output, implications and significance of the study (Gastel 2010:2). A conclusion is an opportunity for the researcher to tell the world about their lasting legacy results from their study (Booth 2009:13).

##### **5.1.2. Key findings of the study**

The study aimed at exploring and understanding the vulnerabilities of homeless women in the Sisters of Mercy Homeless Shelter during the COVID-19 pandemic. The findings indicated that the main challenges experienced by participants were a lack of access to healthcare services, unemployment, discrimination and gender-based violence all of which exacerbated during COVID-19. While the Gauteng government worked with the metros to erect tents and used abandoned buildings to provide the homeless with a place of sanctuary, many shelters closed down during the lockdown. There was a general consensus that this caused more harm than good particularly for homeless women. The following objectives of the study provide a structure within which the fundamental findings are summarised.

###### **5.1.2.1. The access to health care and COVID-19 mitigation strategy adherence**

Access to adequate health care is one of the fundamental rights according to the South African Constitution. The study found that medical centres nearest to the participants, were the Parkhurst clinic, the St Muttons doctors, the Johannesburg General Hospital and Helen Joseph hospital. The challenge with St Muttons doctors is that they offered medical screening services only, not medication. The two nearest hospitals were two taxi rides away and required an administration fee upfront. The consequences of the

transportation fees and administration fee which led to missed appointments and unmet healthcare needs, which exacerbated chronic illnesses.

The COVID-19 pandemic categorised women with chronic illnesses as those with comorbidities. A particular strength of the study was that it was gender specific and it captured the vulnerabilities of homeless women that were exacerbated by the pandemic. In addition to the fear of being in medical centres, with physical contact with others which may exacerbate their chronic illnesses, and progress to other diseases, the pandemic brought anxiety, depression and psychological instabilities to homeless women.

The financial status of participants allowed them to afford only public health care to treat their chronic diseases and collect medication. But the study found that hospitals were overcrowded and they prioritised those infected with Coronavirus and little attention was given to them, the homeless. Hence, at some point participants returned back without medication and this exacerbated their chronic illnesses.

Social distancing, hand hygiene and sanitization were important precautions to avoid contracting COVID-19. This however was impossible to practice for homeless women. According to the study, women were not allowed in the shelter during the day (because the Sisters of Mercy Homeless Shelter is a night shelter) and those unemployed reported that they had to linger around the streets because they had nowhere to go. In the streets there is no access to clean water sources to maintain their genital hygiene let alone hand hygiene. In the beginning of COVID-19, the shelter removed women from the shelter and only males were left in order to maintain social distance. The inability to access shelter facilities whether for the day or for duration of the lockdown was challenging for the homeless women.

#### **5.1.2.2. The perpetual negative economic distress caused by lockdown**

The study's goal was to determine how much the COVID-19 pandemic affected the participants' financial situation. The findings indicated that participants believed that the damage caused by the pandemic would take years to recover, and they were devastated, because all efforts to better themselves over the years were in vain and they felt that they were back to square one. The study indicated that participants were

employed, and some were self-employed and were engaged in collecting waste material and selling products in the streets, before COVID-19. They mentioned that even though the opportunities were informal and temporary, it was enough that they were self-reliant when they were out of the shelter.

During COVID-19, their greatest fear was starvation more than the fear of Coronavirus infections. The findings from the interviews revealed that all participants lost their jobs and small businesses that operated in the streets were prohibited during the lockdown. The charitable organisation like churches that they relied on to get some food and accommodation during the day, were also closed. This meant no income, no food, no items to practice personal hygiene and no social support for the homeless during the lockdown. These problems of income losses and food insecurities created greater depression, loneliness and anxiety.

The participants also alluded that the repercussions of the pandemic would be felt well into the future. Participants classified themselves as the most marginalised group and the government had failed to manage the risks associated with womanhood amongst the homeless. Hence, they are facing severe financial crisis, reduction in core public services such as social welfare and health care, that will continue even after the pandemic. The demand for labour especially domestic workers drastically decreased since the beginning of the pandemic and the informal businesses in the streets ceased to survive.

The study significantly recorded that the COVID-19 pandemic exacerbated the pre-existing gender inequalities even among the homeless. The Sisters of Mercy Homeless Shelter evicted women and not men from the shelter for the duration of the lockdown. Men could still manoeuvre their way around the city and exploit the few opportunities that were there during the levels of lockdown that kept on fluctuating. On the other hand, women who went back to their homelands struggled to make ends meet, and some were totally displaced, seeking shelter from one relative to another.

In comparison with homeless men, homeless women face unique experiences such as violence, victimization, discrimination, poverty and trauma when they are homeless. This limits their opportunity to find piece jobs on the streets, while they are out of the shelter. Participants were employed in feminized sectors such as the retail, food

hospitality and as domestic workers, were closed down during the pandemic. Post the lockdown, the findings from interviews confirmed that men have rebounded twice as quickly as them because majority of men who stayed in the shelter had jobs to sustain them themselves during the day and women were struggling to find opportunities and means to be self-employed.

### **5.1.2.3. The type of support that was received during and after the COVID-19 pandemic**

Additionally, this study aimed to comprehend the types of assistance that participants obtained throughout the pandemic. Findings indicate that participants received limited social support from the social workers, and the support for one another was limited by the social distancing enforcement that left them to be isolated. The lockdown regulations dictated that there must be no physical contacts. Even the homeless were expected to communicate with social workers online. This was not possible according to the data, because homeless women did not have electronic means to communicate with social workers. This was devastating for those homeless women who relied on social workers for their emotional and psychological health.

Apart from social workers' services, other charitable organisations such as community-based day centres, churches, youth centres that provided instrumental support to the homeless women such as food, toiletries clothes were also closed during the pandemic. The social distancing and self-isolation regulations that came as a mitigating strategy, exacerbated the gender-based violence cases especially among most vulnerable homeless women. The study found that women became victims of their frustrated unemployed male partners who vented out their frustration on them. The pandemic exposed the realities of gender inequalities and the inefficiency of the police department. Participants alluded that even before the pandemic as homeless women, they receive limited protection from police and this was worse during the pandemic.

## **5.2. Limitations**

This study presented important data regarding the vulnerabilities of sheltered homeless women that were exacerbated during COVID-19, but the following were the limitations:

- The current study was focused only on challenges faced by sheltered homeless women and neglected the ones by unsheltered homeless women. Further research should explore the reasonable assumption that unsheltered homeless do not have organised living space and close contact with other people, and consequently they may experience malnourishment, poor hygiene, poor health and victimisation.
- Unlike sheltered homeless women, unsheltered homeless women are more distressed, more likely to engage in risky behaviour and have the higher rates of physical morbidity and yet they are not as likely to seek medical attention. Further research will provide insights on comprehensive services such as medical and social care, violence prevention and behavioural risk reduction which may be particularly available for homeless women during and after the pandemic.

### **5.3. Recommendations**

Homelessness and the COVID-19 pandemic can be seen as two intertwined crises, and the combined experiences of women, including social isolation, poverty, and gender-based violence, were more than the sum of their homelessness and exposure to the virus. Throughout the pandemic, this further marginalised women. Little research has been done in South Africa, despite the fact that these experiences have been studied internationally. The following suggestions ought to be taken into consideration in light of the findings.

#### **5.3.1. Further research on the vulnerabilities of unsheltered homeless women**

The vulnerabilities of unsheltered homeless women are still not well explored in South African literature, particularly in the context of the COVID-19 pandemic. Homelessness is a phenomenon that is associated with men, and little attention given into studying the unique challenges faced by unsheltered homeless women. If their unique

challenges are studied and understood, it will be possible to design tailored policies to deal with their vulnerabilities.

### **5.3.2. The partnership between social services and health services**

There is a close relationship between unmet medical needs and demographic variables such as a place to stay, source of health care and the ability to pay for medical care. A significant discovery in the present investigation indicates that there were two matters that made health difficult to access for homeless women. These were the transportation and hospital administration fees, and the discrimination and stigmatisation that they received from health care service providers.

The recommendation is that the local government and other entities that serves the homeless may initiate a system called “the ticket to adequate healthcare”. In this initiative homeless women who live in the shelters may be given a booklet with official stamps and a letterhead of the shelter. This booklet should be authorised by both the leader of the shelter and social workers and it must confirm the identity of the owner. Those who possess the booklet will be exempted from paying both transport fees and hospital administration fees when seeking for medical care.

A strong partnership between health care providers and social workers will close the gap, because health care providers will provide medical care to the homeless women and social workers will follow up to ensure consistency and adherence. It is necessary to increase health care providers' awareness so that they are more aware of the vulnerabilities of homeless women, because the study finds that the discriminative remarks from health care providers causes anxiety and keeps homeless women away from medical centres. It is recommended that healthcare providers may:

- Treat homeless women with compassion when providing medical care, and refrain from discontinuing care because you fear they won't follow through.
- Actively seek out and advise patients who are homeless about available community resources, such as social agencies, domestic violence services, and drug rehab centres.

### **5.3.3. Emergency cash relief grants**

The social department needs to ensure that the emergency cash relief grants that is meant to assist people with economic impact of COVID-19 crises are also made available and reach the homeless. This could be done through distribution by shelter outreach workers in social service sites and other sites serving homeless people. Moreover, an outreach programme informing homeless people of the availability of cash relief grants and location where it can be received. Considering the gender related challenges and feminised poverty that has been highlighted in this study, it is recommended that the social department may revisit this mitigating strategy and consider increasing the cash relief grant for female beneficiaries because COVID-19 exacerbated the vulnerabilities of homeless women.

#### **5.3.4. Equipping homeless women with skills and training**

One of the participants mentioned that she dislikes being served on a silver platter at all times. She believes, to beg for food, clothes and toiletries all the time undermines their dignity. She therefore suggested a skills and training programme, that will equip them with skills. For example, she mentioned that if they can be equipped with baking skills, they may bake cakes in large quantities and sell them for a profit and the skill gained will also make them employable in restaurants.

According to the literature, one of the primary reasons for homelessness is the lack of income and unemployment due to lack of education and skills. Hence, it is fundamental that shelters strive to find organisations or individuals with expertise and knowledge that is relevant to assist women of the shelter to gain financial independence, and will cope with post pandemic crises.

#### **5.3.5. Tailor made policies for identified needs**

It is further postulated that homeless women are more vulnerable during pandemics. Gender-based violence escalated dramatically during the COVID-19 pandemic as social and economic strain increased and social isolation policies were implemented, while health care and social services drastically declined. During pandemic crisis policy makers should design policies that will disproportionately favour homeless women and protect them against gender-based violence.

When making preparedness and response policies, visibility and availability of police to attend and deal specifically with issues of violence against women must be prioritised. Under no circumstances that women should be penalized for seeking support when experiencing violence.

Shelters are dedicated to assisting those who are homeless in obtaining basic social services that uphold public values, preserve their dignity, and respect diversity. However, participants are still displaced and unsafe when they involuntarily leave the shelter, hence for future reference, the study recommends that just like hospitals which never closed during lockdown, the shelters and other institutions serving the homeless may not be closed. Moreover, the number of day shelters should be increased. The overnight shelters should work in partnership with day shelters so that those who wish to stay in the shelter because they don't have jobs and have nowhere to go during the day may produce an affidavit to confirm unemployment to the day shelter, to keep them safe.

Special exemptions should be given to homeless women during a pandemic crisis that they remain in shelter for their safety against gender-based violence, and when they are in the shelter, access to health care will still be possible. The participants believed that there was no logic behind closure of homeless shelters. Furthermore, erecting tents to be used as emergency shelters, brought overcrowding, with no social distancing and no adequate hygiene was practiced. Hence, the study recommends that vacation of shelters be on a voluntary basis.

#### **5.4 Conclusion**

Service provision needs to be gender-specific in order to guarantee that homeless women can receive the necessary services because they are less visible in their particular experiences of homelessness. The study found that homeless women are more likely to be in local clinics for gynaecological infections, vulva contact dermatitis because they are unable to maintain genital hygiene when they are out of the shelter. These health issues make them more vulnerable to Coronavirus infections. The mitigating policies that restricted movement of people in the streets were devastating for homeless women who couldn't recycle or sell products and their cleaning services were less significant during the pandemic. Further intervention policies should address

the unique needs of homeless women because of their exposure to violence, exploitation, marginalisation and high rates of poverty makes them unique and more vulnerable.

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## Appendix A1: Request for Permission

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26 April 2022  
17 Sturdee Ave  
Rosebank  
Johannesburg,2109

### **Request for Permission to Conduct Research**

Dear Administrator

My name is Sanelisiwe Makabate, I am registered at Durban University of Technology for Masters in Health Sciences. The title of my study is:

Exploring the vulnerabilities of homeless women in the Sisters of Mercy Shelter during the COVID-19 pandemic.

I am hereby seeking your consent to conduct research with the women who live in the shelter. I will require your help in recruiting the participants and using the shelter to conduct the interviews. I will be looking to recruit women from different age and ethnic groupings.

I have provided you with a copy of my proposal which includes copies of the data collection tools and consent and/ or assent forms to be used in the research process. The copy of the provisional approval letter which I received from the Institutional Research Ethics Committee (IREC) is attached.

If you require any further information, please do not hesitate to contact me 0679486174 or email. [Sanelisiwep.makabate@gmail.com](mailto:Sanelisiwep.makabate@gmail.com). Thank you for your time and consideration in this matter.

Yours sincerely,

Sanelisiwe Makabate  
Durban University of Technology

## Appendix A2: Gatekeepers Permission

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# Immaculata Hall Night Shelter and Day Care Centre MERCY SHELTERS FOR THE HOMELESS

NPO #030-485

17 Sturdee Avenue, Rosebank - Phone 073 629 5698/073 321 0968

Email: [bridgetenright@telkomsa.net](mailto:bridgetenright@telkomsa.net) - [ntuli.mmuso@gmail.com](mailto:ntuli.mmuso@gmail.com)

6<sup>th</sup> May 2022

### Approval to Sanelisiwe Makabate

This is to confirm that the Board of Management of Mercy Shelters is happy to facilitate your research as indicated on your Proposal. The research can take place at the three Mercy Shelters in Johannesburg:

Immaculata Hall, 17 Sturdee Avenue, Rosebank  
Strabane Mercy Centre, 98 Kerk Street, CBD  
Primedia Mercy Centre, 85 Tudhope Avenue, Berea

We look forward to meeting you and engaging with you.

Yours sincerely

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Sr St John Enright  
Director Mercy Shelters  
Mobile 073 629 5698

## Appendix A3: IREC Ethics Clearance



Institutional Research Ethics Committee  
Research and Postgraduate Support Directorate  
2<sup>nd</sup> Floor, Berwyn Court  
Gate 1, Steve Biko Campus  
Durban University of Technology

P O Box 1334, Durban, South Africa, 4001

Tel: 031 373 2375

Email: [lavishad@dut.ac.za](mailto:lavishad@dut.ac.za)

[http://www.dut.ac.za/research/institutional\\_research\\_ethics](http://www.dut.ac.za/research/institutional_research_ethics)

[www.dut.ac.za](http://www.dut.ac.za)

11 May 2022

Ms S P Makabate  
21693 Persimmon Street  
Ext 29  
Protea Glen  
1818

Dear Ms Makabate

**Exploring the vulnerabilities of homeless women in the Sisters of Mercy shelter in Johannesburg during the COVID-19 pandemic.**  
**Ethical Clearance number IREC 273/21**

The Institutional Research Ethics Committee acknowledges receipt of your gatekeeper permission letter.

Please note that FULL APPROVAL is granted to your research proposal. You may proceed with data collection.

Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the IREC according to the IREC Standard Operating Procedures (SOP's).

Please note that any deviations from the approved proposal require the approval of the IREC as outlined in the IREC SOP's.

Yours Sincerely

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Prof J K Adam  
Chairperson: IREC

## Appendix B: Letter of Information

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### LETTER OF INFORMATION

**Title of the Research Study:** Exploring the vulnerabilities of homeless women in the Sisters of Mercy Shelter in Johannesburg during the COVID-19 pandemic.

**Principal Investigator/s/researcher:** Sanelisiwe Makabate

**Co-Investigator/s/supervisor/s:** Professor Raisuyah Bhagwan (PhD)

**Invitation to the potential participant:**

Thank you for taking time to consider participating in this research study  
Warm greetings to you!

I am currently registered for a master's degree at Durban University of technology. The study aims to explore the challenges that homeless women are facing during the COVID-19 pandemic.

Your participation, is crucial to helping make valuable recommendations with regards to homeless women.

**A brief introduction and Purpose of the study**

There is limited research that has been done on the experiences and perceptions of homeless women regarding the services rendered to them. The problem of homeless is an important area of study in a country like South Africa, in which many people have left rural areas to make a living in the city with hopes of better working opportunities and have ended up in the streets.

The purpose of this study is to understand how the COVID-19 pandemic and lockdown affected the well-being of women living in a homeless shelter.

**Outline of the Procedures:**

- interviews will be conducted, and they will last approximately for 1 hour 30 minutes per session. A voice recorder and or journal book will be used to capture information from the participants

- The researcher will draw an interview time schedule with potential participants and set dates and time for interview sessions. Where necessary depending on the lockdown regulations and levels, WhatsApp video calls sessions will be scheduled.
- During the face-to-face interviews the researcher will meet women at the shelter and ensure that the room used is safe and well ventilated

The following women may participate in the study:

- All women who are homeless living in the Sisters of Mercy Shelter Homeless Shelter
- Stakeholders of the Sisters of Mercy Shelter Homeless Shelter

**Risks or Discomforts to the Participant:**

- The researcher doesn't intend to impose any risk to the participants, however, should some questions cause discomfort on the participants, a social worker will assist with counselling.
- No one will be compelled to participate in the study.

**Explain to the participant the reasons he/she may be withdraw from the Study:**

- At any time, the participant may wish to withdraw from the study they will be allowed to do so.
- Participation is on voluntary bases.

**Benefits:**

- Throughout the study participants will get an opportunity to speak out about issues that suppresses them during the difficult times of COVID-19 pandemic.
- Participants will gain cohesion during focus groups discussions and will be able to engage with other women about issues that commonly affect them

**Remuneration:**

Participants will not be given any money for participating, but the researcher will bring some refreshments that can be consumed post the interview.

**Costs of the Study:**

The study will not require participants to pay for anything.

**Confidentiality:**

- Confidentiality of all participants will be ensured in the study
- Real names of participants will only be known by the researcher and the in the study the participants will remain anonymous

**Results:**

-The summary of the research results will be made available through publication and accredited journals.

-The summary of results will be made available to the Sisters of mercy shelter, governmental and non-governmental organisations that may have interest in the study.

**Research-related Injury:**

There are no anticipated research related injuries

**Storage of all electronic and hard copies including tape recordings:**

- Handwritten notes that will be taken during interviews will be written in the researcher's journal and the journal will be kept in a lockable cabinet in the researcher's home.
- The data that will be collected digitally will be stored in the researcher's laptop under a folder that will require password to access.
- For backup purposes data will be stored on google drive and in the researchers hard-drive
- The data will be stored for five years and after five years it will be deleted and destroyed.

**Persons to contact in the Event of Any Problems or Queries:**

- Please contact the researcher (WhatsApp /calls 0679486174)
- My supervisor (Professor Raisuyah Bhagwanaz 031 373 2197)
- The Institutional Research Ethics Administrator on 031 373 2375.
- Complaints can be reported to the Director: Research and Postgraduate Support Dr L Linganiso on 031 373 2577 or [researchdirector@dut.ac.za](mailto:researchdirector@dut.ac.za).

**Thank you**

Sanelisiwe Makabate

## Appendix B1: Letter of information (IsiZulu)

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### INCWADI YOLWAZI

**Isihloko Sesifundo Sokucwaninga:** Ukuhlola ukuba sengozini kwabesifazane abangenamakhaya endaweni yokukhosela iSisters of Mercy eJohannesburg ngesikhathi sobhadanelwe-COVID-19.

**Umphenyi / sikhulu / umcwaningi:** Sanelisiwe Makabate

**Umphenyi / umphathi :** Professor Raisuyah Bhagwan (PhD)

**Isimemo kulowo ongaba umhlanganyeli:**

Siyabonga ngokuthatha isikhathi sakho ukubheka ukubamba iqhaza kulolu cwaningo

Imikhonzo efudumele kuwe!

Njengamanje ngibhaliselwe iziqu ze-masters eDurban University of technology. Lolu cwaningo luhlose ukuhlola izinselelo abesifazane ababhekene namakhaya ababhekene nazo ngesikhathi sobhadane lwe-COVID-19.

Ukubamba kwakho iqhaza kubalulekile ekusizeni ekwenzeni izincomo ezibalulekile maqondana nabesifazane abangenamakhaya.

**Isingeniso esifushane neNhloso yocwaningo**

Kunocwaningo olunqunyelwe olwenziwe kokuhlangenwe nakho kanye nemibono yabesifazane abangenamakhaya mayelana nezinsizakalo ezinikezwe bona. Inkinga yabangenamakhaya iyindawo ebalulekile yokufunda ezweni elifana neNingizimu Afrika, lapho abantu abaningi sebeshiye izindawo zasemakhaya beyoziphilisa edolobheni benethemba lokuthi bazothola amathuba angcono okusebenza futhi bagcine sebesemigwaqweni.

Inhloso yalolu cwaningo ukuqonda ukuthi ubhadane lwe-COVID-19 kanye nokuvalelwa phansi kube nomthelela onjani enhlalakahleni yabesifazane abahlala emakhaya angenakhaya.

**Uhlaka Lwezinqubo:**

- Kuzokwenziwa inhlolokhono futhi bazohlala cishe ihora eli-1 imizuzu engama-30 ngeseshini ngayinye. Irekhoda yezwi izosetshenziselwa ukuthatha imininingwane kubabambiqhaza
- Umcwaningi uzodweba uhlelo lwesikhathi sokuxoxisana nababambe iqhaza futhi abeke nezinsuku nesikhathi sezingxoxo. Lapho kunesidingo kuye ngemithetho namazinga wokuvala, izikhathi ze-WhatsApp video call zizohlelwa.
- Ngesikhathi sokuxoxisana ubuso nobuso umcwaningi uzohlangana nabesifazane endaweni yokukhosela futhi aqinisekise ukuthi igumbi elisetshenzisiwe liphephile futhi linomoya omuhle.

**Abesifazane abalandelayo bangabamba iqhaza ocwaningweni:**

- Bonke abesifazane abangenamakhaya abahlala ezindlini zoSister of Mercy.
- Ababambiqhaza beSisters of Mercy abangenamakhaya.

**Izingozi noma ukungahambisani nombambiqhaza:**

- Umcwaningi akahlosile ukubeka ingozi kubabambiqhaza, kodwa-ke, uma imibuzo ethile ingadala kabi kubabambiqhaza, usonhlalohlale uzosiza ngokwelulekwa.
- Akekho ozophoqeleka ukuthi abambe iqhaza ocwaningweni.

**Chazele umhlanganyeli izizathu zokuthi angahoxa kanjani ocwaningweni:**

- Nganoma yisiphi isikhathi umbambiqhaza angafisa ukuhoxa ocwaningweni uzovunyelwa ukwenza kanjalo.
- Ukubamba iqhaza kusekelwe ezisekelweni zokuzithandela.

**Izinzuzo:**

- Kuwo wonke umcwaningi ababambiqhaza bazothola ithuba lokukhuluma ngezinkinga ezibacindezelayo ngezikhathi ezinzima zobhadane lwe-COVID-19.
- Ababambiqhaza bazothola ubumbano phakathi kwezingxoxo zamaqembu okugxila futhi bazokwazi ukuhlangana nabanye besifazane ngezinkinga ezijwayele ukubathinta.

**Umholo:**

Abahlanganyeli ngeke banikezwe imali ngokubamba iqhaza, kepha umcwaningi uzoletha ezinye iziphuzo ezingadliwa ngemuva kwengxoxo.

Izindleko Zesifundo:

Ucwaningo aludingi ukuthi ababambiqhaza bakhokhele noma yini.

**Imfihlo:**

- Ukugcinwa kuyimfihlo yabo bonke ababambiqhaza kuzoqinisekiswa ocwaningweni
- Amagama angempela abahlanganyeli azokwaziwa kuphela ngumcwaningi kanti esifundweni ababambiqhaza bazohlala bengaziwa

**Imiphumela:**

-Isifinyezo semiphumela yocwaningo sizotholakala ngokushicilelwa nangamaphephabhuku avunyelwe.

-Isifinyezo semiphumela sizotholakala kuSisters of shelter mercy, izinhlango zikahulumeni kanye nezinhlango ezingekho ngaphansi kukahulumeni ezingaba nentshisekelo kulolu cwano.

**Ukulimala okuhlobene nocwaningo:**

Akukho ukulimala okuhlobene nocwaningo okulindelekile

**Ukugcinwa kwawo wonke amakhophi kagesi nawamakhompiyutha ahlanganisa okuqoshiwe**

- Amanothi abhalwe ngesandla azothathwa ngesikhathi senhlokhono azobhalwa ephephabhukwini lomcwaningi bese leli phephandaba ligcinwa kwikhabhinethi elingakhiqiza emzini womcwaningi.
- Idatha ezoqoqwa ngokwedijithali izogcinwa kwi-laptop yomcwaningi ngaphansi kwefolda ezodinga ukuthi iphasiwedi ifinyelele kuyo.
- Ngezinhloso zokulondoloza imininingwane izogcinwa ku-google drive naku-hard-drive yabacwaningi
- Imininingwane izogcinwa iminyaka emihlanu bese kuthi ngemuva kweminyaka emihlanu isuswe bese icekelwa phansi.

**Abantu abangathintana nabo ku-Isehlakalo Sanoma Iziphi Izinkinga noma Imibuzo:**

- **Sicela uxhumane nomcwaningi:** (WhatsApp /calls 0679486174 calls)

**.Umphathi wami:** (Professor Raisuyah Bhagwanaz **031 373 2197** )

- **Umphathi Wezimiso Zokuziphatha Zocwaningo:** 031 373 2375

- **Izikhhalazo zingabikwa kuMqondisi: Wocwaningo Nokwesekwa Kwabafundi Abathola Iziqu** uDr L  
Linganiso on 031 373 2577 or [researchdirector@dut.ac.za](mailto:researchdirector@dut.ac.za).

### **Ozithobayo**

Sanelisiwe Makabate

## Appendix B2: Letter of information (SeSotho)

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LETS'ELISO LETS'OANE

**Sehlooho sa Thuto ea Lipatlisiso:** Ho hlahloba bofokoli ba basali ba se nang bolulo sebakeng sa bolulo sa Sisters of Mercy Johannesburg nakong ea seoa sa COVID-19.

**Mofuputsi e Moholo/bafuputsi:** Sanelisiwe Makabate

**Mofuputsi-mmoho/ba/mookamedi/basebetsi:** Moprofesara Raisuyah Bhagwan (PhD)

**Memo ho ea ka bang teng ea nkang karolo:** Kea leboha ka ho ipha nako ea ho nahana ho nka karolo boithutong bona ba lipatlisiso

Litumeliso tse mofuthu ho uena!

Hajoale ke ngolisitse lengolo la masters Univesithing ea thekenoloji ea Durban. Boithuto bona bo ikemiselitse ho hlahloba mathata ao basali ba hlokanang mahae ba tobaneng le ona nakong ea seoa sa COVID-19.

Ho nka karolo ha hau ho bohlokoa ho thusa ho etsa likhonthaletso tsa bohlokoa mabapi le basali ba hlokanang mahae.

Kenyelletso e khutšoane le Morero oa thuto

Ho na le liphuputso tse fokolang tse entsoeng mabapi le liphihlelo le maikutlo a basali ba hlokanang mahae mabapi le litšebeliso tseo ba li fuoang. Bothata ba ho hloka bolulo ke sebaka sa bohlokoa sa thuto naheng e kang Afrika Boroa, moo batho ba bangata ba tlohileng libakeng tsa mahaeng ho ea phela teropong ka tšepo ea menyetla e metle ea ho sebetsa 'me ba qetelle ba le literateng.

Sepheo sa phuputso ena ke ho utloisisa hore na seoa sa COVID-19 le lockdown li amme bophelo bo botle ba basali ba lulang matlong a se nang bolulo joang.

**Kemiso ea Mekhoa ea Ts'ebetso:**

- Ho tla etsoa lipuisano 'me li tla nka hora e le 1 le metsotso e 30 thutong e 'ngoe le e 'ngoe. Sehatisi sa lentsoe se tla sebelisoa ho hapa litaba ho tsoa ho barupeluo
- Mofuputsi o tla etsa kemiso ea nako ea lipuisano le bao e ka bang barupeluo le ho beha matsatsi le nako ea lipuisano. Ha ho hlokahala ho ipapisitse le melaoana le maemo a koalo, ho tla hlophisoa linako tsa mehala ea video ea WhatsApp.
- Nakong ea lipuisano tsa lifahleho li talimane mofuputsi o tla kopana le basali matlong a bakhachane le ho etsa bonnete ba hore phaposi e sebelisoang e bolokehile ebile e na le moea o hloekileng.

Basali ba latelang ba ka nka karolo phuputsong ena:

- Basali bohle ba se nang bolulo ba lulang matlong a Sisters of Mercy a hlohang bolulo.
- Bankakarolo ba Setsi sa bolulo sa Sisters of Mercy.

#### **Likotsi kapa Mathata ho Monkakarolo:**

- Mofuputsi ha a rera ho beha kotsi ho barupeluo, leha ho le joalo, haeba lipotso tse ling li ka bakela barupeluo bohloko, mosebeletsi oa boiketlo ba sechaba o tla thusa ka tlhabollo.
- Ha ho motho ea tla qobelleha ho nka karolo thutong.

#### **Hlalosetsa monkakarolo mabaka a hore a ikhule Thutong:**

- Ka nako efe kapa efe, morupeluo a ka lakatsa ho ikhula boithutong ba tla lumelloa ho etsa joalo.
- Ho nka karolo ho ipapisitsoe le boithaopo.

#### **Melemo:**

- Nakong eohle ea boithuto ba barupeluo ba tla fumana monyetla oa ho bua ka litaba tse ba hatellang linakong tse thata tsa seoa sa COVID-19.
- Barupeluo ba tla fumana bonngoe nakong ea lipuisano tsa lihlopha, 'me ba tla khona ho buisana le basali ba bang ka litaba tse ba amang.

#### **Moputso:**

Barupeluo ba ke ke ba fuoa chelete bakeng sa ho nka karolo, empa mofuputsi o tla tlisa lijo tse ka jeoang kamora lipuisano.

#### **Litšenyehelo tsa Thuto:**

Phuputso e ke ke ea hloka hore bankakarolo ba lefelle letho.

#### **Lekunutu:**

- Lekunutu la bankakarolo bohle le tla netefatsoa thutong
- Mabitso a sebele a barupeluo a tla tsejoa feela ke mofuputsi 'me phuputsong, barupeluo ba tla lula ba sa tsejoe.

### **Liphetho:**

-Kakaretso ea liphetho tsa lipatlisiso e tla fumaneha ka phatlalatso le likoranta tse ngolisitsoeng ka molao.

-Kakaretso ea liphetho e tla fumaneha ho Sisters of mercy shelter, mekhatlo ea mmuso le e seng ea mmuso e ka bang le thahasello thutong.

### **Kotsi e Amanang le Lipatlisiso:**

Ha ho na likotsi tse amanang le lipatlisiso tse lebelletsoeng

Ho boloka likopi tsohle tsa elektroniki le tse thata ho kenyelletsa le lirekoto tsa theipi:

- Lintlha tse ngotsoeng ka letsoho tse tla nkuoa nakong ea lipuisano li tla ngoloa koranteng ea mofuputsi 'me koranta e tla bolokoa ka khabineteng e notlehang lapeng la mofuputsi.
- Lintlha tse tla bokelloa ka mokhoa oa digital li tla bolokoa ka har'a laptop ea mofuputsi tlas'a foldara e tla hloka password ho fihlella.
- Bakeng sa merero ea bekapo, data e tla bolokoa ho google drive le ho hard drive ea bafuputsi
- Lintlha li tla bolokoa lilemo tse hlano 'me ka mor'a lilemo tse hlano li tla hlakoloa le ho senngoa.

### **Batho bao u ka ikopanyang le bona ha ho na le Mathata kapa Lipotso:**

- **Ka kopo ikopanye le mofuputsi** (082 6896061 WhatsApp / 0679486174 call)
- **Mookamedi wa ka** (Moprofesa Raisuyah Bhagwanaz 031 373 2197)
- **Mookameli oa Setheo sa Boitšoaro ba Lipatlisiso ho** 031 373 2375.
- **Litlelebo li ka tlalehela Mookameli:** Tšehetso ea Liphuputso le Liithuti tsa Kalo-kalo Dr L Langaniso ho 031 373 2577 kapa [researchdirector@dut.ac.za](mailto:researchdirector@dut.ac.za).

kea leboha

Sanelisiwe Makabate

## Appendix C: Consent Form



**Full Title of the Study:** Exploring the vulnerabilities of homeless women in the Sisters of Mercy Shelter during the COVID-19 pandemic

**Names of Researcher/s:** Sanelisiwe Makabate

**Statement of Agreement to Participate in the Research Study:**

- I hereby confirm that I have been informed by the researcher: Sanelisiwe Makabate about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: .....
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

Full Name of Participant	Date	Time	Signature/Right Thumbprint

I, SANELISIVE MAKABATE (name of researcher) herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

<b>Full Name of Researcher</b>	<b>Date</b>	<b>Signature</b>
<b>Full Name of Witness (If applicable)</b>	<b>Date</b>	<b>Signature</b>
<b>Full Name of Legal Guardian (If applicable)</b>	<b>Date</b>	<b>Signature</b>

## Appendix C1: Consent Form (IsiZulu)



### IMVUME

**Isihloko Esigcwele Sesifundo:** Ukuhlola ukuba sengozini kwabesifazane abangenamakhaya endaweni yokukhosela iSisters of Mercy ngesikhathi sobhadane lwe-COVID-19

**Amagama woMcwani:** Sanelisiwe Makabate

**Isitatimende Sesivumelwano Sokubamba iqhaza Esifundweni Sokucwaninga:**

- Ngiyaqinisekisa ukuthi ngazisiwe ngumcwani: Sanelisiwe Makabate ngohlobo, ukuziphatha, izinzu kanye nobungozi balolu cwani - Inombolo Yokucaciswa Kwezimiso Zokuziphatha:...
- Sengithole, ngafunda futhi ngalugqonda ulwazi olubhaliwe olungenhla (Incwadi Yomhlanganyeli Yemininingwane) mayelana nesifundo.
- Ngiyazi ukuthi imiphumela yocwani, kubandakanya imininingwane yomuntu mayelana nobulili bami, iminyaka, usuku lokuzalwa, ama-initials kanye nokuxilongwa kuzocutshungulwa kungaziwa kube wumbiko wocwani.
- Ngenxa yezidingo zocwani, ngiyavuma ukuthi idatha eqoqwe phakathi nalolu cwani ingacutshungulwa ngohlelo lwekhompyutha ngumcwani.
- Ngingahle, noma ngasiphi isigaba, ngaphandle kokubandlulula, ngihoxise imvume yami futhi ngibambe iqhaza ocwani.
- Ngibe nethuba elanele lokubuza imibuzo futhi (ngentando yami) ngizibonakalise ngikulungele ukubamba iqhaza ocwani.
- Ngiyakuqonda ukuthi okutholakele okusha okuphawulekayo okwenziwe phakathi nalolu cwani okungenzeka kuhambisane nokubamba kwami iqhaza kuzonikezwa kimi.

Igama eligcwele lombambiqhaza	Usuku	Isikhathi	Isignesha/Isithonjana Sesokudla

Mina SANELISIWE MAKABATE (igama lomcwani) ngilokhu ngiqinisekisa ukuthi umhlanganyeli ongenhla waziswe ngokugcwele ngohlobo, ukuziphatha kanye nobungozi besifundo esingehla.

Igama eligcwele loMcwani	Usuku	Isignesha
Igama Eligcwele LoFakazi (Uma likhona)	Usuku	Isignesha

<b>Igama Eliphelele Lombheki Wezomthetho (Uma kudingeka)</b>	<b>Usuku</b>	<b>Isiginesha</b>
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## Appendix C2: Consent Form (SeSotho)



### TUMELO

**Sehlooho se Feletseng sa Thuto:** Ho hlahloba bofokoli ba basali ba se nang mahae sebakeng sa bolulo sa Sisters of Mercy nakong ea seoa sa COVID-19.

**Mabitso a Mofuputsi:** Sanelisiwe Makabate

**Polelo ea Tumellano ea ho Kenela Boithuto ba Lipatlisiso:**

- Ka hona ke tiisa hore ke tsebisitsoe ke mofuputsi: Sanelisiwe Makabate ka mofuta, boitšoaro, melemo le likotsi tsa phuputso ena - Research Ethics Clearance Number: .....
- Hape ke amohetse, ka bala le ho utloisisa lintlha tse ngotsoeng tse ka holimo (Lengolo la Morupeluo la Boitsebiso) mabapi le thuto.
- Kea tseba hore liphetho tsa phuputso, ho kenyeletsoa lintlha tsa botho mabapi le bong ba ka, lilemo, letsatsi la tsoalo, li-initials le tlhahlobo li tla sebetsoa ka mokhoa o sa tsejoeng hore e be tlaleho ea boithuto.
- Ka lebaka la litlhoko tsa lipatlisiso, ke lumela hore lintlha tse bokeletsoeng nakong ea phuputso ena li ka sebetsoa ka mokhoa oa khomphutha ke mofuputsi.
- Nka, boemong bofe kapa bofe, ntle le leeme, nka hula tumello ea ka le ho kenya letsoho thutong.
- Ke bile le monyetla o lekaneng oa ho botsa lipotso le (ka boithatelo ba ka) ho bolela hore ke itokiselitse ho nka karolo thutong.
- Ke utloisisa hore liphetho tsa bohlokoa tse ncha tse entsoeng nakong ea lipatlisiso tse amanang le ho nka karolo ha ka li tla fumanaha ho 'na.

Ke, (lebitso la mofuputsi)	Letsatsi	Nako	Saena

Ke SANELISIWE MAKABATE (lebitso la mofuputsi) ke tsoela pele ho etsa bonnete ba hore monkarolo ea ka holimo o tsebisoa ka botlalo ka sebopeho, boitšoaro le likotsi tsa thuto e ka holimo.

Lebitso le Feletseng la Mofuputsi oa	Letsatsi	Saena
Lebitso le Feletseng la Paki (Haeba ho hloka)	Letsatsi	Saena

<b>Lebitso le Feletseng la Mohlokomeli oa Semolao (Haeba ho hlokahala)</b>	<b>Letsatsi</b>	<b>Saena</b>

## Appendix D: Interview Guide



## Interview questions

The researcher will warmly welcome participants and give a brief self-introduction as well as a summary of the study at hand.

1. Can you explain what it means to be homeless?
2. What were the reasons that brought you to the shelter?
3. Are there any reasons other than violence that can make people choose the streets over their home?
  - Please elaborate on each one of them
4. What are the dangers that homeless women face in their daily lives
5. Describe how you have coped financially during the COVID-19 pandemic?
6. Please share how access to health care was experienced during whilst living in the shelter?
  - Explain what special medication for special sicknesses?
  - Can you share what about the support you get from the social development department such as visits by social workers?
  - If so, what help do they offer?
  - How have you experienced the COVID-19 pandemic and lockdown?
7. Describe your way of living before COVID-19
  - In your explanation include, access to health care facilities, protection against gender-based violence, access to working opportunities
8. Explain how COVID-19 has affected you:
  - Access to health care facilities, protection against gender-based violence, access to working opportunities
9. What are other challenges that were not there before COVID-19 outbreak that you are facing now?
10. What support is required by women at the shelter to cope with the COVID-19 pandemic?
11. Do you think that homeless people experience stigma or discrimination during the COVID-19 pandemic? Please share your thoughts?

## Appendix D1: Interview Guide (IsiZulu)

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**Imibuzo yokuxoxisana**

Umcwaningi uzokwamukela ngemfudumalo ababambiqhaza futhi azethule kafushane kanye nesifinyeto socwaningo oluseduze.

1. Ungachaza ukuthi kusho ukuthini ukungabi nakhaya?
2. Yiziphi izizathu ezakuletha endaweni yokukhosela?
3. Ngabe zikhona ezinye izizathu ngaphandle kodlame ezingenza abantu bakhethe imigwaqo ngaphezu kwamakhaya abo?
  - Sicela ucacise ngamunye wabo
4. Ziyini izingozi abesifazane abangenamakhaya ababhekana nazo ezimpilweni zabo zansuku zonke
5. Chaza ukuthi ubhekane kanjani nezimali phakathi nobhadane lwe-COVID-19?
6. Ngicela nihlanganyele ukuthi ukutholwa kwezempilo kwenzeka kanjani ngenkathi nihlala endaweni yokukhosela?
  - Chaza ukuthi imuphi umuthi okhethekile wezifo ezikhethekile?
  - Ungabelana ngani ngosizo oluthola emnyangweni wezenhlalakahle njengokuvakashelwa ngabasebenzi bezenhlalakahle?
  - Uma kunjalo, yiluphi usizo abalunikezayo?
  - Usizwe kanjani isifo esiwumshayabhuqe se-COVID-19 nokuvaleka kwaso?
7. Chaza indlela yakho yokuphila ngaphambi kwe-COVID-19
  - Encazelweni yakho faka, ukufinyelela ezikhungweni zokunakekelwa kwezempilo, ukuvikelwa ebudloveni obusekelwe ebulilini, ukufinyelela emathubeni okusebenza
8. Chaza ukuthi i-COVID-19 ikuthinte kanjani kwakho:
  - Ukutholakala kwezindawo zokunakekelwa kwezempilo, ukuvikelwa ebudloveni obusekelwe ebulilini, ukufinyelela emathubeni okusebenza
9. Yiziphi ezinye izinselelo ezazingekho ngaphambi kokuqubuka kwe-COVID-19 obhekene nazo manje?
10. Kuphi ukwesekwa okudingekayo kwabesifazane endaweni yokukhosela ukuze babhekane nobhadane lwe-COVID-19?
11. Ngabe ucabanga ukuthi abantu abangenamakhaya bathola ukucwaswa noma ukucwaswa phakathi nobhadane lwe-COVID-19? Sicela wabelane ngemicabango yakho?

## Appendix D2: Interview Guide (SeSotho)

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### Lipotso tsa lipuisano

Mofuputsi o tla amohela barupeluo ka mofuthu 'me a itlhalose ka bokhutšoanyane hammoho le kakaretso ea thuto e teng.

1. Na u ka hlalosa se boleloang ke ho hloka bolulo?
2. Mabaka a entseng hore u fihle sebakeng sa bolulo ke afe?
3. Na ho na le mabaka a mang ntle le pefo a ka etsang hore batho ba khethe literata ho e-na le mahae a bona?
  - Ka kopo hlalosa e 'ngoe le e 'ngoe ea tsona
4. Ke likotsi life tseo basali ba hlokang bolulo ba tobanang le tsona bophelong ba bona ba letsatsi le letsatsi
5. Hlalosa hore na u sebetsane joang le lichelete nakong ea seoa sa COVID-19?
6. Ka kopo, arolelana hore na phihlello ea bophelo bo botle e bile teng joang nakong eo u neng u lula sebakeng sa bolulo?
  - Hlalosa hore na ke meriana efe e khethehileng ea mafu a khethehileng?
  - Na u ka arolelana eng ka tšehetso eo u e fumanang ho tsoa lekaleng la ntlafatso ea sechaba joalo ka maeto a basebeletsi ba sechaba?
    - Haeba ho joalo, ba fana ka thuso efe?
    - U bile le koluoa ea COVID-19 joang le ho koaloa ha mosebetsi?
7. Hlalosa tsela eo u phelang ka eona pele ho COVID-19
  - Tlhalosong ea hau kenyeletsa, phihlello litsing tsa tlhokomelo ea bophelo, ts'ireletso khahlano le tlhekefetso ea bong, phihlello ea menyetla ea ho sebetsa
8. Hlalosa hore na COVID-19 e u amme joang:
  - Ho fihlella litsing tsa tlhokomelo ea bophelo, tshireletso kgahlanong le tlhekefetso ya bong, phihlello ya menyetla ya ho sebetsa
9. Ke liqholotso life tse ling tse neng li le sieo pele ho seoa sa COVID-19 tseo u tobaneng le tsona hona joale?
10. Ke ts'ehetso efe e hlokoang ke basali libakeng tsa bolulo ho sebetsana le seoa sa COVID-19?

11. Na u nahana hore batho ba hlokang bolulo ba ba le sekhubo kapa khethollo nakong ea seoa sa COVID-19? Ka kopo arolelana maikutlo a hau?