UFSM

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REVISTA DE ENFERMAGEM DA UFSM

ISSN 2179-7692
OPEN ACCESS

Rev. Enferm. UFSM, v.16, e3, p.1-26, 2026 •
Submission: 06/28/2025 • Acceptance: 11/24/2025 • Publication: 12/18/2025

Review article

Barriers to access to healthcare services among homeless women: an integrative review*

Barreiras no acesso aos serviços de saúde por mulheres em situação de rua: revisão integrativa

Barreras de acceso a los servicios de salud para mujeres sin hogar: una revisión integradora

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* Barriers to access to healthcare for homeless women - Final Course Project

Abstract

Objective: identify the barriers to accessing health services faced by women experiencing homelessness. **Method:** this is an integrative literature review conducted in the BVS, SciELO and PubMed databases, including publications from 2015 to 2025. A total of 18 articles were selected, organized into a synoptic table, and analyzed through thematic categorization. **Results:** the analysis of the studies allowed the findings to be organized into four categories: lack of professional qualification, weaknesses in the Health Care Network, stigmatization, and violence. The identified barriers include unprepared healthcare teams, discontinuity of care, bureaucratic requirements, discriminatory behaviors, and negligent institutional practices. These factors hinder women's access to and continuity in health services, deepening their social exclusion and invisibility. **Conclusion:** the analysis of the evidence made it possible to understand that access to healthcare for women experiencing homelessness, whether cisgender, transgender or travestis, is systematically limited by a set of structural barriers that intersect across different national contexts.

Descriptors: Ill-Housed Persons; Women; Health Inequities; Health Services Accessibility; Social Vulnerability; Review

Resumo

Objetivo: identificar as barreiras no acesso aos serviços de saúde enfrentadas por mulheres em situação de rua. **Método:** revisão integrativa da literatura, nas bases BVS, SciELO e PubMed, com publicações entre 2018 e 2025. Foram selecionados 18 artigos, organizados em um quadro sinóptico e analisados por categorização temática. **Resultados:** a análise dos estudos permitiu organizar os achados em quatro categorias: ausência de qualificação profissional, fragilidades na

Rede de Atenção à Saúde, estigmatização e violência. As barreiras identificadas envolvem despreparo das equipes, descontinuidade do cuidado, exigências burocráticas, condutas discriminatórias e práticas institucionais negligentes. Esses fatores comprometem o acesso e a permanência das mulheres nos serviços, aprofundando sua exclusão e invisibilidade social. **Conclusão:** a análise das evidências permitiu compreender que o acesso à saúde por mulheres em situação de rua, sejam cis, trans ou travestis, é sistematicamente limitado por um conjunto de barreiras estruturais que se articulam em diferentes realidades nacionais.

Descritores: Pessoas Mal Alojadas; Mulheres; Desigualdades de Saúde; Acessibilidade aos Serviços de Saúde; Vulnerabilidade Social; Revisão

Resumen

Objetivo: identificar las barreras para acceder a los servicios de salud que enfrentan las mujeres en situación de calle. **Método:** se trata de una revisión integrativa de la literatura, realizada en las bases BVS, SciELO y PubMed, con publicaciones entre 2015 y 2025. Se seleccionaron 18 artículos, organizados en un cuadro sinóptico y analizados mediante categorización temática. **Resultados:** el análisis de los estudios permitió organizar los hallazgos en cuatro categorías: ausencia de calificación profesional, fragilidades en la Red de Atención a la Salud, estigmatización y violencia. Las barreras identificadas incluyen la falta de preparación de los equipos, la discontinuidad del cuidado, las exigencias burocráticas, las conductas discriminatorias y las prácticas institucionales negligentes. Estos factores comprometen el acceso y la permanencia de las mujeres en los servicios, profundizando su exclusión e invisibilidad social. **Conclusión:** el análisis de las evidencias permitió comprender que el acceso a la atención en salud para mujeres en situación de calle, ya sean cisgénero, transgénero o travestis, está sistemáticamente limitado por un conjunto de barreras estructurales que se articulan en diferentes contextos nacionales.

Descriptores: Personas con Mala Vivienda; Mujeres; Inequidades en Salud; Accesibilidad a los Servicios de Salud; Vulnerabilidad Social; Revisión

Introduction

The Unified Health System (Sistema Único de Saúde – SUS) is the healthcare model currently in force in Brazil. It was established in 1988 through the Federal Constitution and is regulated by Laws No. 8,080 and No. 8,142 of 1990.[1] The SUS is based on the principles of universality, comprehensiveness, and equity, and seeks to ensure full access to healthcare for all Brazilian citizens, regardless of social, economic, and cultural conditions.[1,2] In 2010, the Ministry of Health issued Ordinance No. 4,279, establishing the Health Care Networks (Redes de Atenção à Saúde), with the purpose of organizing care flows between levels of care and strengthening the problem-solving capacity of Primary Health Care (PHC), recognized as the main entry point to the system.[3]

With the aim of expanding access to healthcare and promoting health among the homeless population (HP), the Street Outreach Clinic (Consultório na Rua) was created in

2011 through the National Primary Health Care Policy. This strategy is carried out by trained and qualified multidisciplinary teams designed to address the specific demands of the homeless population.[4] These teams are predominantly composed of nurses, social workers, psychologists, and occupational therapists, who work in articulation with multidisciplinary teams in Primary Health Care (eMulti), the Psychosocial Care Centers (CAPS), and Emergency and Urgent Care Services.[4]

The homeless population is composed of individuals who use public spaces and degraded areas as temporary or permanent housing and who experience weakened family and community bonds. This condition results from multiple factors, including extreme poverty and unemployment, domestic violence, the absence of housing policies, and the harmful use of psychoactive substances.[5] Acknowledging this reality, the National Policy for the Homeless Population was established in 2009 through Decree No. 7,053, which recognizes this group as rights holders and establishes guidelines for intersectoral care, encompassing health, social assistance, and housing policies.[6]

In recent years, the homeless population in Brazil has grown significantly as a consequence of the intensification of social inequalities and the weakening of public policies aimed at ensuring fundamental human rights.[7] According to data from the Institute for Applied Economic Research (IPEA), in 2022 there were 281,472 homeless people in the country, representing an increase of 38% compared to 2019 and 211% compared to 2012.[6] Although men represent the vast majority of this population, the contingent of homeless women, including cisgender, transgender, and travesti women, is substantial and requires specific attention.[7] These women are exposed to heightened vulnerabilities, such as gender-based violence, sexual exploitation, institutional abandonment, and precarious access to healthcare, particularly regarding sexual and reproductive rights.[8]

The presence of homeless women tends to be underestimated or rendered invisible in epidemiological surveys, especially in the case of transgender and travesti women. This invisibility stems from the frequent disregard for markers such as gender identity, sexual orientation, and race, which limits the development of integrated public policies sensitive to the specific needs of this population.[8,9] Moreover, the lack of disaggregated data on these dimensions compromises the formulation of effective strategies to guarantee access to rights and dignity.[9] Therefore, health policies addressing the homeless population must incorporate an intersectional gender perspective to recognize the social violence experienced within healthcare and social protection systems.[9]

Although formal guidelines aim to guarantee health as a universal right, everyday healthcare practice reveals persistent barriers. Homeless women face challenges ranging from inadequate physical infrastructure to the lack of professional preparedness to provide ethical and humanized care.[10,12]

Institutional violence in healthcare is described in the literature as occurring through both acts and omissions, manifesting as neglect, moral judgment, denial of care, and, in more severe cases, verbal or physical aggression.

Within this context, this review seeks to answer the following research question: What barriers hinder homeless women’s access to healthcare services? The central hypothesis is that structural, institutional, and symbolic barriers, such as stigma, violence, transphobia, and the absence of intersectional public policies, act as decisive factors in the denial of the right to health for this population. These obstacles broadly affect cisgender, transgender, and travesti homeless women, although exclusion mechanisms are intensified among those whose gender identities are systematically invisibilized.

Despite important legal advances aimed at guaranteeing the right to health and social protection, such as the National Policy for the Homeless Population (Decree No. 7,053/2009), significant gaps persist in the implementation of these guidelines in routine healthcare services. The National Policy for Comprehensive Women’s Health Care (2004, updated in 2011) ensures sexual and reproductive rights; however, it does not specifically address the needs of homeless women, who experience contexts of violence, food insecurity, and limited access to continuous care.

The Maria da Penha Law (Law No. 11,340/2006) represents a major milestone in combating gender-based violence; nevertheless, homeless women face greater obstacles in accessing protection mechanisms and specialized services. Furthermore, the National Primary Health Care Policy (Ordinance No. 2,436/2017) incorporates the Street Outreach Clinic as a strategy to expand care within primary healthcare; however, its coverage remains insufficient to meet the existing demand. In this scenario, although relevant, current public policies remain fragmented and poorly articulated, contributing to the persistence of barriers to healthcare access for homeless women.

This reality is not exclusive to the Brazilian context. At the international level, UN-Habitat estimates that more than 1.8 billion people worldwide live without adequate housing, approximately 150 million are homeless, and nearly 2 million are forcibly evicted each year, highlighting the systematic violation of the human right to housing and the interdependence between housing, health, and dignity.[13] In parallel, UN Women emphasizes that poverty is not gender-neutral: women are historically overrepresented among the poor due to systemic exploitation, unequal access to opportunities, unpaid care work, and the overlapping of multiple forms of discrimination.

Globally, 383 million women and girls live in extreme poverty, and this condition is exacerbated by violence, unequal power distribution, and lower participation in the labor market.[14] When structural poverty is combined with the lack of housing, the risk of family bond rupture, social exclusion, and exposure to violence increases significantly, pushing many women into homelessness.[14] Thus, the barriers to healthcare access faced by homeless women constitute a global, complex, and intersectional phenomenon, present across different countries and healthcare systems, requiring coordinated and equitable responses.

Structural barriers to the right to health among homeless populations, particularly among women, can be observed in several countries worldwide. In the United States, for example, the healthcare model is predominantly based on private insurance and restricted programs such as Medicare and Medicaid, which leads to access difficulties and fragmentation of care flows when a comprehensive vision of care is lacking.[15] A national census conducted in 2021 indicates that by 2024 more than 770,000 people experienced homelessness in the United States, representing the highest number since 2007 and a significant increase among women and gender minorities.[16] The lack of intersectoral policies and the fragility of integration between physical health, mental health, and housing conditions result in discontinuity of care and increased social vulnerabilities, especially among Black and transgender homeless women.

In Canada, although the healthcare system is public and universal, access to primary care still faces structural challenges, such as the central role of the family physician and the absence of free medication distribution.[17] A 2023 study estimates that 235,000 Canadians experienced homelessness throughout the year, and more than 40 percent of women in this condition began living on the streets after episodes of domestic violence.[18] The overlap of physical, institutional, and symbolic violence is intensified by low adherence to sexual and reproductive health services, demonstrating that system universality alone does not guarantee equity in access.

In countries with consolidated public systems, such as Sweden and the United Kingdom, barriers related to bureaucracy, stigma, and the absence of gender equity oriented policies persist. Even in contexts of broad healthcare coverage, requirements for a fixed address, lack of awareness of rights, and institutional prejudice continue to interfere with homeless women's access to basic care.[19] Mandatory residential registration and rigid service hours reinforce feelings of exclusion and indignity, distancing women from healthcare services.[19] In the United Kingdom, the predominant use of emergency services instead of primary care reveals the absence of systematized preventive strategies and the difficulty in establishing continuous bonds with healthcare teams.

In Australia, whose system combines public and private characteristics, a significant increase in the homeless population has been observed in recent years.[20] In 2023, more than 273,000 specialized healthcare visits were recorded, most of them among women.[21] The increase is even more pronounced among older women, who face additional barriers related to gender, age, and access to services.[22]

In Western Europe, studies indicate that gender inequalities and low health literacy deepen the cycle of exclusion. Homeless women with lower levels of health literacy show worse mental health indicators and higher rates of treatment interruption, reinforcing the need for gender sensitive educational strategies.[23]

In summary, international data demonstrate that, regardless of the healthcare model adopted, the barriers faced by homeless women present converging characteristics, such as stigma, social exclusion, institutional violence, and the absence of intersectional policies. This scenario reveals a global, multidimensional, and persistent phenomenon that transcends borders and governance models, reaffirming the urgent need for policies that integrate housing, health, and social protection with an emphasis on gender equity.

This research is justified by the need to expand the scientific and political debate on the multiple forms of vulnerability experienced by homeless women, to promote the production of qualified data on this population, and to contribute to the development of more effective and inclusive healthcare strategies within the context of urban exclusion.

Therefore, the present study aims to identify the barriers to healthcare access faced by homeless women.

Method

This study is an integrative literature review, which enabled the grouping and systematization of previously published articles, allowing the acquisition of information and knowledge from the analyzed studies.

To achieve the proposed objective, the integrative review followed the essential steps for its development: identification of the theme and selection of the research question; establishment of eligibility criteria; identification of studies in scientific databases; evaluation of selected studies; critical analysis and interpretation of the results; and presentation of the data within the structure of the integrative review.[24]

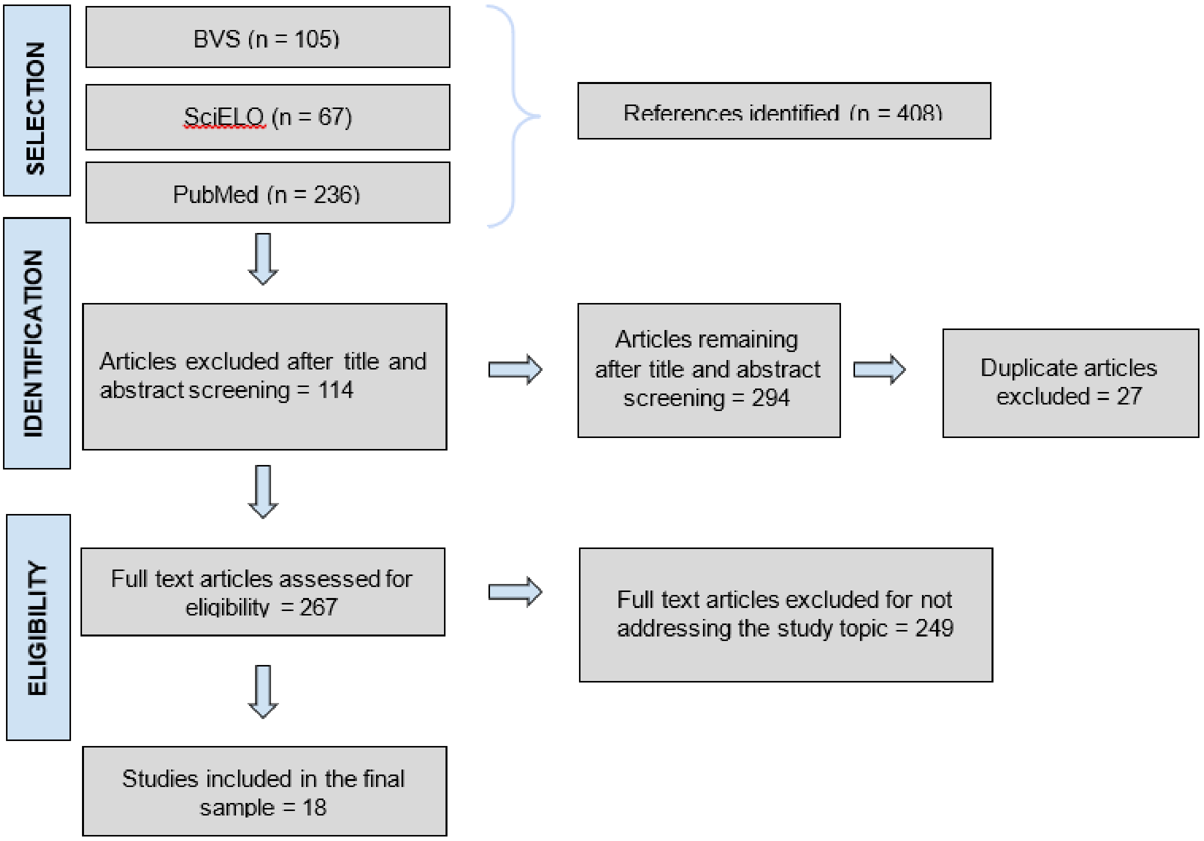
To guide the integrative review, the guiding research question was: What barriers are faced by homeless women in accessing healthcare services?

The bibliographic search was conducted in April 2025 through database searches using the following information sources: the Virtual Health Library (BVS), Scientific Electronic Library Online (SciELO), and the National Library of Medicine and National Institutes of Health (PubMed). The combinations of descriptors used for the search were Poorly Housed Persons, Women, Health Inequalities, and Accessibility to Health Services, using the Boolean operators AND and OR.

The inclusion criteria were scientific articles that addressed barriers hindering homeless women's access to healthcare services, published between 2015 and 2025 in publicly accessible electronic databases, in Portuguese, English, or Spanish. Theses, dissertations, and any type of grey literature were excluded, as well as articles not available in full text. The decision to exclude grey literature was made in order to ensure greater methodological rigor and reliability of the results.

For the extraction of publications and data organization, the Rayyan reference management software was used. Initially, 408 articles were identified. After preliminary screening through the reading of titles, abstracts, and full texts, 18 studies addressing issues related to barriers to healthcare access for homeless women were selected. This study is an integrative literature review conducted using secondary data from publicly accessible sources and did not involve primary data collection from participants; therefore, submission to the Research Ethics Committee was not required.

Figure 1 – Flowchart of article selection



Results

To present the selected articles, a synoptic table was developed with relevant information from the analyzed scientific production, including the following variables: authors, study location, source and year, and the method used. Subsequently, another synoptic table was prepared with information that allowed a better description of the manuscripts, including the following variables: title, objective, and main results of the studies (Table 1).

Table 1 – Characterization of the studies

LOCATION	METHOD	OBJECTIVE	RESULTS
Brazil [25]	Theoretical study based on secondary data.	To reflect on the citizenship status of homeless women in relation to their access to Brazilian health policy.	The study showed that the focus of health policy directed almost exclusively toward motherhood, combined with punitive and institutionalized approaches, limits comprehensive care for homeless women. It also highlights the absence of specific policies for this population, the presence of stigmatization, and the territoriality requirement imposed by the Unified Health System, which links access to services to the existence of a fixed address.
Brazil [26]	Theoretical study based on secondary data.	To discuss the expressions of coloniality in the process of social exclusion in access to healthcare among homeless Black women, based on professional experience in the Consultório na Rua (Street Outreach Clinic).	Specific barriers to healthcare access for homeless Black women were identified, including institutional racism, the dehumanization of the Black body, inequalities shaped by the intersection of race, gender, and class, as well as the marginalization of these women within spaces of care.
Brazil [27]	Descriptive cross sectional primary study.	To describe the sociodemographic profile and access to social assistance and healthcare services among transgender	Among the factors that hinder access to healthcare, the absence of personal documentation, delays in care, social and racial discrimination, and the lack of professional preparedness to

		and travesti people experiencing homelessness in Salvador, Bahia.	adequately receive transgender and travesti homeless women stand out.
Brazil [28]	Qualitative, descriptive and exploratory study.	To describe the work process of the Consultório na Rua teams in providing care for homeless women.	Barriers to the care of homeless women were identified, related to difficulties in articulation with the care network, the invisibility of gender specificities, the fragility of established bonds, and the standardization of care practices that disregard the singularity of the users.
Brazil [29]	Systematic review based on secondary data.	To understand what has been investigated about the health of this group of women in both national and international contexts, considering the specificities related to gender.	The study identified as barriers to access the lack of coordination among services, the presence of discriminatory attitudes, the absence of humanized care, long waiting lines, lack of knowledge about where to seek help, and the inexistence of specific policies and integration among the areas of health, social assistance, and protection of women.
Brazil [30]	Integrative literature review based on secondary data.	To identify the approach to the health of transgender homeless women in scientific publications.	Specific barriers were identified, such as institutional exclusion, intersectional discrimination, experiences of physical and symbolic violence, the absence of qualified reception, denial of gender identity, and difficulties in access due to lack of documentation or passability, with significant impacts on the physical and mental health of these women.
Brazil [31]	Descriptive qualitative primary study.	To analyze the perception of homeless transgender women regarding the use of healthcare services.	Among the observed barriers, discriminatory care based on institutional transphobia stands out, as well as delays in access to HIV treatment, the absence of medical follow up for hormone therapy, the unsupervised use of hormones, the lack of specialized services, and the geographical and bureaucratic difficulties that compromise continuity of care.
Brazil [32]	Descriptive qualitative primary study.	To identify how social protection and the provision of care for travestis and	Barriers were identified such as institutional violence, disrespect for the chosen name, segregation within services, lack of privacy,

		transgender women experiencing homelessness are carried out within public health and social assistance policies in the municipality of Belo Horizonte, Minas Gerais, based on the perceptions of these individuals.	harassment, discrimination based on gender identity, lack of professional preparedness, and the absence of specialized services, which reinforces exclusionary practices and hinders access to comprehensive care.
Brazil [33]	Quantitative cross sectional primary study.	To identify groups of transgender women and travestis with specific patterns of discrimination based on gender identity and to analyze the factors associated with this form of discrimination.	The study, conducted in five Brazilian state capitals with transgender women and travestis, identified high levels of discrimination based on gender identity, especially among those experiencing homelessness. Barriers such as stigmatization, social exclusion, lack of recognition of the chosen name, and institutional discrimination within healthcare services were reported. The analysis indicated that factors such as the lack of legal name change, a history of physical or sexual violence, and living on the streets were associated with higher chances of experiencing discrimination in different contexts, including during healthcare encounters.
Brazil [34]	Descriptive qualitative primary study.	To understand the experience of access to oral health actions and services among homeless women in the city of Teresina, Piauí.	The study identified barriers such as delays and difficulties in scheduling appointments, requirements for documentation, rigid territorialization, institutional violence, lack of preparedness of oral health teams, absence of a dentist in the Street Outreach Clinic teams, and stigma that drives women away from services.
Brazil [35]	Literature review based on secondary data.	To identify how nursing care for homeless women is provided during the pregnancy puerperal cycle.	The study identified several difficulties faced by pregnant homeless women, including environmental and health risks, possible lack of professional preparedness among healthcare providers to offer appropriate

			reception, as well as prejudice and judgment within healthcare services.
United States [36]	Systematic narrative review based on secondary data.	To review evidence on how intersectionality affects service engagement and help seeking among women, transgender women, and non binary people experiencing homelessness or housing exclusion.	The study analyzed factors that influence access to and engagement in healthcare among women, transgender women, and non binary people experiencing homelessness. Stigma, institutional discrimination, and the lack of support experienced during the pregnancy puerperal cycle were identified as barriers, a period often marked by punitive attitudes, blame directed at pregnancy, and lack of professional preparedness to provide ethical and welcoming care to this population.
Brazil [37]	Literature review based on secondary data.	To reflect on equity for homeless women.	It discusses how homeless women face serious barriers to accessing healthcare, including violence, stigma, lack of basic hygiene, and unprepared health services. The article argues that the adoption of public policies, psychosocial support, and specific actions is necessary to ensure equity in care while respecting their needs and dignity.
United States, United Kingdom, Turkey and Iran [38]	Systematic review based on secondary data.	To explore the barriers and facilitators perceived by homeless women during pregnancy or within six weeks after childbirth in accessing prenatal and or postnatal healthcare services.	The study, a qualitative review based on data from the United States, the United Kingdom, Turkey, and Iran, identified barriers such as fragmented services, requirements for documentation and health insurance, stigma and discrimination during care, mistrust of services due to fear of losing custody of the baby, geographical barriers and lack of transportation, as well as low health literacy and competing demands that hinder access to prenatal and postnatal care.
Australia [39]	Descriptive quantitative primary study.	To explore the health needs and barriers to healthcare services among older homeless women in	The study conducted in Perth, Australia, identified barriers such as stigmatization, expressed through fear of judgment and shame when seeking care.

		the metropolitan area of Perth, Western Australia.	Failures in the care network were also observed, including scarcity of services, high costs, and difficulty accessing female professionals. In addition, lack of professional preparedness to address the specific needs of this population was reported.
Canada [40]	Descriptive quantitative primary study.	(i) To provide new insights into women's decision making processes, (ii) to describe the barriers and facilitators to breast and cervical cancer screening, and (iii) to offer recommendations for future outreach, education, and screening initiatives specifically developed for marginalized under or never screened women living in urban centers.	The qualitative study conducted in Toronto, Canada, with homeless women identified barriers such as stigmatization, fear of judgment, and mistrust of professionals, especially in situations involving gynecological examinations. The absence of linkage with primary care, lack of professional preparedness, and communication failures were also reported. Poverty, instability, and a history of sexual violence appeared as aggravating factors in seeking care and in continuity of care.
Sweden [41]	Descriptive quantitative primary study.	To give voice to women with lived experiences of homelessness and to explore their perspectives on healthcare services in a European Union country with universal healthcare.	The study conducted in Sweden with homeless women highlighted barriers such as the requirement of a fixed address and documentation, rigid service hours, and the inadequacy of services to their realities. Participants reported stigmatization and discriminatory treatment in healthcare services, as well as negligence, moral judgments, and situations of abuse by healthcare professionals. The absence of bonding and lack of continuity of care reinforced feelings of exclusion and indignity.
United States [42]	Descriptive quantitative primary study.	To explore how trauma affects the experiences, behaviors, and practices of healthcare professionals	The study conducted in the United States with homeless women identified barriers such as stigmatization, fear of judgment, and intense physical and emotional reactions to preventive examinations, especially among

		regarding the Pap smear examination in the context of homelessness.	those with a history of sexual violence. Experiences of revictimization during care, lack of professional preparedness, and absence of welcoming strategies were reported. Inadequate professional training and inappropriate conduction of examinations contributed to refusal, postponement, or abandonment of screening.

Discussion

The final sample consisted of 18 studies retrieved from the BVS, SciELO, and PubMed databases, totaling 408 references initially identified. After screening by title, abstract, and removal of duplicates, 267 articles were selected for full text reading, of which 249 were excluded for not meeting the eligibility criteria, resulting in the inclusion of 18 articles. Most publications were conducted in Brazil, which favored a more contextualized understanding of the national reality. Studies from countries such as the United States, Canada, the United Kingdom, Switzerland, Turkey, Iran, and Australia were also included, expanding the perspective on the barriers faced by homeless women in different sociopolitical and healthcare contexts.

The analyzed studies revealed multiple experiences of homeless women, with emphasis on challenges in accessing sexual and reproductive health services, hormone related care and gender affirmation, as well as the presence of institutional violence and discriminatory practices. Studies addressing the specificities of Black women and older women experiencing homelessness were also identified, revealing the invisibility of their demands within healthcare services. These findings reinforce the importance of considering social markers such as gender, race, age, and gender identity as determining factors of access or denial of care.

The full text reading of the 18 articles that comprised the sample allowed the organization of findings according to thematic similarity, resulting in the construction of four analytical categories: (1) lack of professional qualification; (2) fragmentation of the Health Care Network; (3) stigmatization; and (4) violence.

Lack of Professional Qualification

The analyzed studies show that the lack of professional qualification directly compromises the care provided to homeless women. This educational gap is reflected in the inexperience of healthcare teams, the standardization of care, and the difficulty in establishing bonds, disregarding the social, emotional, and health specificities of this population.[21,28,34] The absence of qualified listening and clinical sensitivity reinforces dehumanized practices, resulting in superficial care guided by moral judgments rather than by real needs.[34,41]

This limitation is also expressed in professionals' inability to deal with the demands of transgender women and travestis experiencing homelessness, revealing technical and ethical failures in the use of chosen names, access to hormone therapy, and comprehensive physical and mental healthcare.[31–33] In oral health services, the same logic of unpreparedness is observed, as care is restricted, fragmented, and often marked by negligence, further reinforcing the exclusion of homeless women from specialized care.[34]

In the field of sexual and reproductive health, failures are observed in prenatal follow up, in the provision of contraceptives, and in the performance of preventive examinations, revealing the absence of protocols adapted to the reality of those living in conditions of extreme vulnerability.[35,38,40,42] During the pregnancy puerperal cycle, these barriers intensify, with reports of moral judgment, institutional violence, and denial of care, transforming moments that should involve care into new experiences of suffering and rights violations.[36,37]

In addition, the use of psychoactive substances and self care strategies, which are often present in the daily lives of these women, are disregarded by healthcare teams, which do not receive adequate training to understand such contexts.[25,28] The identified failures reflect structural problems, such as the absence of continuing education and the persistence of an exclusionary logic within the Unified Health System, which maintains hierarchical practices that are insufficiently sensitive to diversity.[34,37] This reality also affects older homeless women, who face the absence of sensitive listening and approaches adapted to their lived experiences, further amplifying access inequalities.[39]

In international contexts, a similar dynamic is observed. Distrust of healthcare teams, the absence of welcoming practices, and the insensitive conduct of procedures reveal that professional qualification involves ethical, relational, and human dimensions, and not only technical ones.[36,38] These findings reinforce that health training must incorporate active listening, understanding of trajectories of suffering, and commitment to the dignity of these women.

Fragmentation of the Health Care Network

The fragmentation and lack of articulation of the Health Care Network are identified as recurring structural barriers in homeless women's access to healthcare services. The hegemonic model of care, based on territorial fixation and continuity of follow up, does not align with the dynamics of life on the streets. Studies show that discontinuity of care and the absence of longitudinal follow up compromise the problem solving capacity of healthcare services.[25,28,34,41] In addition, there is a lack of articulation between health and social assistance services, as well as the absence of consistent intersectoral care flows.[28,29,37]

These weaknesses are also expressed in the scarcity of specialized services, geographical and bureaucratic barriers, and difficulties in accessing care that addresses the specific needs of homeless women.[34,42] Furthermore, the distant location of health units, long waiting times, and the perception that services do not meet their concrete needs reinforce distancing from healthcare.[34,41]

The discontinuity of primary care also negatively affects sexual and reproductive health, with failures in prenatal follow up, contraceptive provision, and the performance of preventive examinations.[35,38,40,42] During the pregnancy puerperal cycle, institutional abandonment is observed, marked by the absence of welcoming practices, moral judgment, and interruption of care.[36,37] This scenario reveals that the structure of the care network is not responsive to the demands of homeless women, especially during periods of greater vulnerability.

Bureaucracy within the healthcare system also emerges as an important marker of exclusion. Requirements for a fixed address, personal documentation, and territoriality criteria make access to healthcare services unfeasible for this population.[25,28,37,42] The existing literature shows that lack of documentation, misinformation about services, and bureaucratic rigidity significantly compromise access to the right to health.[25,28,39] This bureaucratic logic is also observed in international contexts, configuring a global and systemic pattern of exclusion.[36–38]

In countries such as Australia and Canada, even within systems with greater funding and organization, serious failures in care for homeless women are observed, including scarcity of services, high costs, lack of linkage with primary care, and difficulties in continuity of care.[36,38] In countries with consolidated public systems, such as Sweden, barriers such as documentation requirements, fixed address demands, and rigid service hours continue to exclude women in situations of social vulnerability.[37] These findings demonstrate that regardless of the healthcare model, network fragmentation weakens comprehensive care.

Although the analyzed publications address relevant aspects of network fragmentation, most studies focus on isolated experiences or specific services, which reveals the complexity of articulation among different levels of care.[25,28,34] These findings indicate that discontinuity of care and the absence of integration among health, social assistance, and other sectors increase access inequalities, highlighting the need for strategies that consider the reality of homeless women in a broad and intersectoral manner.[28,37]

By bringing together national and international evidence, this category shows that overcoming fragmentation of the Health Care Network requires coordinated actions, reduction of bureaucratic barriers, and strengthening of bonds among services in order to ensure continuous, equitable, and needs oriented care for these women.[25,28,34,36]

Stigmatization

The stigmatization of homeless women constitutes a structural and institutionalized process, shaped by multiple social markers of inequality, such as gender, race, class, and gender identity. It is not a matter of isolated attitudes, but rather an exclusionary logic that is reproduced within healthcare services themselves, compromising the quality of care and distancing these women from spaces of assistance.[25,28,41] Studies show that stigma associated with homelessness is intertwined with gender inequalities, resulting in practices that subordinate and silence these women within healthcare services.[25,28] Complementarily, other investigations highlight the effects of institutional racism and social discrimination in the denial of care, reinforcing the intersectional nature of these barriers.[26,36]

Discriminatory practices within healthcare services include moral judgments, blame, embarrassment, and the delegitimization of the demands presented by users.[28,41,42] These behaviors are not isolated, but rather express an institutional culture that naturalizes exclusion and hinders the construction of therapeutic bonds. Such practices not only legitimize the marginalization of these women within the healthcare system, but also create a symbolic barrier that prevents full access to care.[34,41]

The absence of adequate reception compromises access to hormone therapy and mental healthcare, in addition to exposing these women to institutional and symbolic forms of violence.[32,33–36] In some cases, stigma is associated with HIV seropositivity and stereotypes of hypersexualization, which further deepen social exclusion and hinder the construction of bonds with healthcare services.[32,42]

In different national and international contexts, fear of judgment, shame, and embarrassment when accessing services are frequent feelings among homeless women.[36,38] These subjective experiences, combined with material difficulties, contribute to the progressive distancing from healthcare services. Other studies reveal that stigmatization is expressed through moralizing practices, negligence, and attitudes that delegitimize the presence of these women within spaces of care.[41,42] The sense of indignity experienced in the face of institutional rigidity and lack of empathy reinforces the cycle of invisibility and abandonment.[37] This scenario is even more sensitive in gynecological examinations, in which fear of judgment and insensitive conduct generate suffering and distancing from preventive care.[36,42]

Overall, the studies demonstrate that stigma and institutional discrimination are not exceptions, but rather structuring elements of the functioning of healthcare services. By naturalizing inequality, these practices reinforce the historical exclusion of homeless women and perpetuate the denial of their rights. Understanding stigmatization as an intersectional and institutional phenomenon is essential for the construction of care strategies that promote recognition, dignity, and equity in access to healthcare.

Violence

Violence constitutes a central element in the experiences of homeless women with healthcare services. It is not limited to physical aggression, but also manifests institutionally through neglect, omission, embarrassment, and abusive practices that occur within care settings themselves.[33,37] Thus, access to healthcare, which should represent protection, often becomes an environment of suffering, insecurity, and distrust.[38]

The reported forms of violence are not isolated episodes, but expressions of an exclusionary system that denies rights and naturalizes inequality.[33,34] Several studies describe situations of verbal abuse, dehumanized care, denial of services, and humiliating exposure, showing that healthcare services may reproduce indignity and reinforce marginalization.[37,41] Under these conditions, health ceases to be a guaranteed right and becomes another form of oppression.

The racial dimension also intersects these experiences. Homeless Black women report dehumanization, hypersexualization, and moral judgment, demonstrating how institutional racism operates in a silent yet persistent manner.[26,36] Neglect of their demands, combined with the naturalization of suffering, reveals the presence of symbolic violence sustained by hierarchies of race, gender, and class.[42]

In the case of transgender women and travestis, violence assumes even deeper dimensions. Studies point to constant episodes of transphobia within healthcare services, manifested through disrespect for the chosen name, non validation of gender identity, and attitudes that pathologize their bodies.[31,33] The absence of adequate reception compromises access to hormone therapy, mental healthcare, and HIV prevention, resulting in rupture of bonds and abandonment of care.[32,36] When HIV seropositivity is present, stigma intensifies, further amplifying social and institutional exclusion.[42]

Beyond explicit forms of violence, more subtle practices also cause significant harm. The insensitive conduction of gynecological examinations, the imposition of bureaucratic procedures without justification, and the absence of trauma centered approaches transform care into a source of suffering.[38,42] In these contexts, moments that should promote reception become new experiences of suffering and rights violations, leading many women to avoid or abandon services.[36]

A limitation identified is the scarcity of studies that analyze, in an integrated manner, the multiple factors that structure violence in homeless women's access to healthcare. Most studies focus on isolated aspects, such as discrimination, network fragmentation, or lack of professional qualification, which hinders a systemic understanding of exclusion processes.[25,28,34] Many investigations also present local scopes or small samples, limiting the generalization of findings and the formulation of strategies applicable to different contexts.[28,37] There is also a lack of studies that simultaneously consider markers such as gender, gender identity, race, class, territory, and life cycle, indicating the need for more robust intersectional approaches.

Despite these limitations, this study offers a critical and updated synthesis of the structural barriers that permeate homeless women's access to healthcare, demonstrating that violence is an institutional and intersectional phenomenon. By organizing the findings into four categories, namely lack of professional qualification, fragmentation of the Health Care Network, stigmatization, and violence, it becomes possible to understand the complexity of the challenges faced by this population.[14,23,34] The results point to the need for continuous training strategies for healthcare professionals,[15,24] for intersectoral articulation among health, social assistance, and justice sectors,[16,23] and for humanized care practices based on trauma sensitive approaches.[36,38] It is recommended that future research develop care models that promote bonding, consider intersectionality, and guarantee the right to health with dignity for homeless women in different contexts.

Conclusion

The analysis of the evidence made it possible to understand that access to healthcare for homeless women, whether cisgender, transgender, or travestis, is systematically limited by a set of structural barriers that are articulated across different national realities. Based on the four categories discussed, namely lack of professional qualification, fragmentation of the Health Care Network, stigmatization, and violence, it becomes evident that the difficulties experienced by these women are not restricted to the Brazilian context. They are also present in different healthcare systems, such as those of Australia, Sweden, and the United States, showing that exclusion is a transnational phenomenon.

The lack of technical and ethical preparedness of healthcare teams contributes to practices that fail to recognize the singularities of homeless women, especially when intersected by race, gender, and gender identity. Likewise, the rigidity of care networks, whether due to documentation requirements, territoriality criteria, or discontinuity of care, disregards the dynamics of life on the streets and weakens care bonds.

Institutional stigmatization, sustained by moralism, racism, and transphobia, constitutes one of the central obstacles to healthcare access. These processes not only shape interactions within healthcare services, but also directly affect how these women are either welcomed into or excluded from care spaces. When associated with neglect, revictimization, and disrespect, these elements are configured as expressions of institutional violence, reiterating the social exclusion to which these women are already subjected.

In view of this scenario, there is an urgent need to rethink public policies and care strategies that incorporate an intersectional, anti discriminatory, and context sensitive approach adapted to the specificities of the homeless population. Continuous professional training, strengthening of articulated care networks, and recognition of the multiple vulnerabilities experienced by these women are fundamental actions so that healthcare does not reinforce inequalities, but instead becomes an accessible, dignified, and emancipatory right.

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Editor in Chief: Cristiane Cardoso de Paula
Scientific Editor: Eliane Tastch Neves

How to cite this article

Sestrem BA, Grizoste KG, Escolástico GC, Henrique ML, Freitas GL, Gontijo TG. Barriers to access to healthcare services among homeless women: an integrative review. Rev. Enferm. UFSM. 2026 [Access at: Year Month Day]; vol.16, e3:1-26. DOI: https://doi.org/10.5902/2179769292672