Article

Lifetime Experiences of Housing Insecurity among Gay Men Living with HIV at Midlife: An Exploratory Study Utilizing a Social Determinants of Health Perspective

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Abstract: Understanding the socioecological contexts of gay men living with HIV is critical to addressing the environmental conditions that influence their lifetime experiences of housing insecurity and homelessness. In line with the strategies of the US Center for Disease Control and Prevention to end the HIV epidemic, it is of utmost importance to recognize how the allocation of available resources impacts health inequities affecting gay men living with HIV who experience housing insecurity and homelessness. Drawing from the World Health Organization’s social determinants of health (SDoH) framework, we used an exploratory, community-based research (CBR) approach to examine the lifetime experiences and important sources of support of gay men living with HIV at midlife who have experienced housing insecurity in Southern Nevada. Thematic analysis of our semi-structured interviews with 12 gay men living with HIV at midlife revealed three overarching themes: (1) challenges to obtaining housing and related support, (2) informal support from friends, and (3) formal support from community-based sources employing diverse support strategies. In this article, we discuss the different sub-themes we identified under these overarching themes and the implications of our findings from an SDoH perspective. We conclude with a discussion on the dire need to (1) highlight the considerable value of both informal and formal sources of support for the housing insecure, and (2) generate recommendations for interventions to address housing insecurity and homelessness with greater consideration for the impacts of SDoH in the work dedicated to helping gay men living with HIV at midlife overcome housing insecurity as they age.

Keywords: gay men; HIV; homelessness; housing insecurity; midlife; social determinants of health

1. Introduction

Research has documented that the prevalence rates of lifetime experiences of housing insecurity and homelessness among sexual and gender minorities in North America are alarmingly high, particularly among gay men and those living with HIV (Buhl 2020; Colletti 2020; Statistics Canada 2018; Wilson et al. 2020). Since the turn of the 21st century, the notion that homelessness and HIV are inextricably linked has become more apparent (National Alliance to End Homelessness 2023), as empirical research has increasingly shown that homelessness is both a cause and an effect of HIV, especially among gay men and other specific subpopulations who are categorized as high-risk (Kidder et al. 2007; Melo et al.
2022; Munasighe et al. 2024; National AIDS Housing Coalition 2012). In fact, scientific investigations have underscored this bidirectional relationship between homelessness and HIV. Studies have not only reported that people experiencing housing insecurity and homelessness face a greater risk of acquiring HIV and even have higher rates of HIV infection compared to people who are housed, but they have also shown that PLWH are at increased risk of experiencing housing insecurity and homelessness (Buhl 2020; National Coalition for the Homeless 2009; Palimaru et al. 2023).

Today, homelessness has proven to be both an urgent social crisis and a strong but modifiable risk factor for HIV, especially among people experiencing housing insecurity or homelessness with a chronic history of intravenous drug use who are more likely to sustain unmanaged HIV infections (Arum et al. 2021; Buhl 2020; Flannigan and Welsh 2020; Palimaru et al. 2023; Serchen et al. 2024; Stone et al. 2022). Across many states in the US, the prevalence of housing insecurity among people experiencing housing insecurity and homelessness has soared to alarming rates in the last two and a half decades (Archibald 2018; Buhl 2020; Curry 2000; Harbarger 2019; Kidder et al. 2007; National Alliance to End Homelessness 2023; Sleet and Francescutti 2021). This substantial increase in prevalence rates of HIV among people experiencing housing insecurity and homelessness has been found to be staunchly associated with socioecological contexts such as dealing with stressful conflicts over costs of day-to-day subsistence (e.g., housing, food, healthcare); living on the streets with constant exposure to intravenous drug users and suppliers; struggling with addiction to methamphetamines and sharing needles; engaging in sex for money, drugs, or a place to stay (i.e., exchange sex); and engaging in condomless sex and/or with multiple sexual partners (Dickson-Gomez et al. 2017; Ford et al. 2023; George 2018; Kherghehpoush and McKeirnan 2023; Kidder et al. 2007; Mueller et al. 2023; National Coalition for the Homeless 2009; Stein et al. 2009).

Conversely, PLWH have historically been at increased risk for housing insecurity and homelessness for the last few decades. According to recent studies, up to as much as 50% of PLWH are at greater risk of experiencing housing insecurity not only because of the unavailability of affordable homes, limited housing options, and skyrocketing costs of rent and housing in locations where HIV care and services are more accessible (Buhl 2020; Colletti 2020; Curry 2000), but also because of competing costs of housing, healthcare, and medications; poor health that precludes stable employment, and by extension, housing; maltreatment by landlords; lack of safety in insecure housing; and lack of awareness of available housing services in the community (Ecker 2024; National Coalition for the Homeless 2009; Palimaru et al. 2023). In particular, when seeking housing, gay men living with HIV have been found to encounter distinct challenges such as homophobia and HIV discrimination, finding affordable housing where they feel safe, and locating affordable housing with adequate access to wraparound HIV services (Martinez 2023).

Once gay men and other PLWH experience homelessness, they become at greater risk of experiencing adverse health outcomes due to a variety of reasons. Notably, they become at increased risk of losing access to HIV care and services (Fletcher-Hildebrand et al. 2021; Graham and Plankey 2023), which may then lead to their delayed entry into HIV care and deferred antiretroviral therapy (ART) initiation (Health Resources and Services Administration Ryan White Program (HRSA RWP) n.d.; Reddon et al. 2023; Tharakar et al. 2016), poorer access to knowledge of HIV treatment options (Royal et al. 2009), disruptions in treatment and follow-ups within the HIV care continuum (George 2018), difficulties in staying with care (Land 2018), inconsistent utilization of services (Henry et al. 2008), and consequently, higher rates of unmet HIV care and service needs (Ford et al. 2023). Research has documented that homelessness among PLWH has been strongly associated with poor adherence to life-saving ART (Fletcher-Hildebrand et al. 2021; Reddon et al. 2023; Royal et al. 2009), unsatisfactory viral suppression (Berthaud et al. 2022; Land 2018; Tharakar et al. 2016), and increased intravenous drug use and clinical comorbidities (Ford et al. 2023; Madden et al. 2021). Most worryingly, research has found that housing insecurity and
homelessness among PLWH leads to greater mortality risk (Lam 2023; Montgomery et al. 2016) and is firmly linked with higher mortality rates (Harbarger 2019).

When epidemiological studies found that young gay men represented the majority of people infected with HIV annually in the US during the first decade of the 21st century (CDC 2012; Mustanski et al. 2011), a significant amount of research was conducted by scholars in response to this finding to focus on the socioecological contexts of housing insecure or unhoused, young gay men at risk of or living with HIV (Grace and Hankey 2024; Logan et al. 2013; Madden et al. 2021; Royal et al. 2009; Semborski et al. 2021; Stein et al. 2009). Most recently, it was found that not only have HIV prevalence and incidence rates in the US among young gay men markedly declined, but the corresponding rates for people 45 years of age and older have remained stable and have had no decline in the past five years prior (CDC 2023; HIV.gov 2023a). Despite the stark absence of any improvement in the latter HIV prevalence and incidence rates in recent years, only scant research has been conducted to include an examination of the plight of housing insecure, gay men living with HIV aged 40 years and older (Cummings et al. 2022; Hessol et al. 2019; Vorobyova et al. 2023). Additionally, although ample research focused on the relationship between homelessness and HIV has emphasized the value of utilizing a social determinants of health (SDoH) framework to examine this relationship (Buhl 2020; George 2018; Sleet and Francescutti 2021), to the best of our knowledge, there has been no discourse based on empirical research that has utilized an SDoH perspective for the purposes of generating recommendations and proposing interventions that could potentially help mitigate the challenges to attain sustainable housing experienced by housing insecure, gay men living with HIV, particularly those aged 40 to 65 years old, who are considered at midlife (Lachman 2015), and who had been impacted by HIV the most since the start of the HIV epidemic (CDC 2012, 2023).

In this article, it is our aim to investigate the following research questions: (1) What have been the specific challenges encountered by gay men living with HIV at midlife who have experienced housing insecurity at any point in their lifetime since their HIV diagnosis? and (2) From an SDoH perspective, which factors are the most important to consider in terms of developing and providing support to gay men living with HIV at midlife who are experiencing housing insecurity? It is also our aim to address the research gaps we have identified by sharing and elucidating the findings and lessons learned from our exploratory project, as well as presenting recommendations and possible interventions that take into great consideration the importance of crucial SDoH, which could help mitigate the challenges to overcoming housing insecurity and homelessness among gay men living with HIV as they age.

SDoH are non-medical factors in society that influence health outcomes, and are the conditions in which people are born, grow, work, live, and age, as well as the wider set of forces and systems shaping the conditions of daily life (CDC 2022; World Health Organization (WHO) n.d.). They have a significant impact on health inequities, which are avoidable inequalities in health between groups of people between countries and within countries. Socioecological contexts and their influence on people’s lives determine their risk of illness and the actions taken to prevent them from becoming sick or treat their illness when it occurs (CDC 2022).

The World Health Organization (WHO) (n.d.) enumerates and discusses a list of SDoH, which could impact health equity in a variety of ways. This list includes, but is not limited to: (1) housing security; (2) social support; (3) education and employment; (4) food security; (5) transportation; and (6) access to quality health services, including HIV care and services. SDoH present as an important framework, and researchers should consider them when examining health disparities that affect the wellbeing of underserved populations and people at the margins, particularly housing insecure, gay men living with HIV at midlife. In this article, not only do we purposely examine the findings of our study utilizing an SDoH perspective, but we also offer and discuss recommendations and prospective interventions.
to support PLWH experiencing housing insecurity and homelessness, particularly from the specific SDoH framework described by the WHO.

For the purposes of our study and this article, we operationalized the definition of “housing insecurity” as the state of having difficulty acquiring housing, having minimal control over one’s housing, being at risk of losing housing, being uncertain about tenure, and/or living in housing that does not meet basic household needs (De Luca and Rosen 2022). We also operationalized the definition of “homelessness” as the most extreme variety of housing insecurity, specifically when an individual is forced to live and sleep in a place not intended for human habitation (Coleman-Jensen and Steffen 2017).

2. Materials and Method

2.1. Collaborations and Partnerships

Using a community-based research (CBR) approach (Israel et al. 1998; Minkler 2005; Wood and Zuber-Skerritt 2022), we conducted the qualitative study described in this article as part of a larger, exploratory project, in collaboration and primary research partnership with the LGBTQIA+ Community Center of Southern Nevada (The Center). The Center was instrumental in linking us with an extensive network of community health centers, clinics, community-based agencies, AIDS service organizations, and other relevant stakeholder groups from Southern Nevada, which were all committed to providing health and social services specifically to PLWH in our region, including gay men living with HIV at midlife. The Center also carried out a crucial role in the creation of our community advisory committee composed of healthcare and service providers from relevant Southern Nevada agencies such as the Southern Nevada Health District, Community Counseling Center of Southern Nevada, Golden Rainbow, and the Southern Nevada HIV Health Consortium, who were involved in our project from the start, collaborating with our research team on various research process phases such as determining our research focus, choosing our research method, recruiting our interview participants, appraising and ratifying our findings from our analysis, and sharing our study findings and lessons learned to the rest of the Southern Nevada community. Our community advisory committee members provided us with prompt and essential input and feedback during the research process, which helped our research team adjust and respond accordingly to both expected and unanticipated issues such as matters related to occasional miscommunication and participant recruitment.

2.2. Participants

We obtained ethics approval for our research protocol from the Institutional Review Board (IRB) of the Office of Research Integrity of the University of Nevada, Las Vegas prior to the conduct of our study. When we recruited participants for our study, we utilized recruitment messages that we made accessible through our community partners’ various email listservs and websites, as well as IRB-approved printed flyers and circulars that we posted on the different locations of our community partner agencies and organizations. We became heavily involved in different community outreach events that our community partners organized and sponsored, which allowed us to directly hand out IRB-approved recruitment flyers and circulars to prospective participants during these events. Working with several community partners, we recruited participants from our region, all of whom participated in our interviews. We continued to recruit and interview participants until we achieved data saturation for overarching themes (i.e., when additional interviews no longer provided value-added insights).

In order to take part in our interviews and be included in the analysis described in this article, participants needed to (1) currently reside in Southern Nevada, (2) be 40 to 65 years of age (i.e., at midlife), (3) be someone who self-identified as a gay man, (4) have lived with HIV for at least one year, and (5) be willing to describe their lifetime experiences of housing insecurity and disclose their current housing status (i.e., housing secure, housing insecure, homeless). Our inclusion criteria ensured that our participants (n = 12) were gay men living with HIV at midlife from Southern Nevada, and had enough experiences with
HIV to cultivate and establish their own perspectives and insights. Our participants’ ages ranged from 41 to 64 years old, with a mean age of 52. All of our participants identified as gay men and were taking antiretroviral therapy medications as prescribed at the time of their study participation. In terms of their race, our participants identified as Asian-Pacific Islander (8.33%, n = 1), Black (33.33%, n = 4), Middle Eastern (8.33%, n = 1), and White (50%, n = 6). Our participants described their lifetime experiences of housing insecurity and disclosed their current housing status based on our operational definitions of “housing insecurity” and “homelessness”. All 12 participants revealed that they had experienced housing insecurity at some point in their lifetime since they were diagnosed with HIV, and five of them revealed that they have experienced homelessness for a period of time. Among the 12 participants, only one disclosed that they had already achieved housing security at the time of their interview, while nine disclosed that they remained housing insecure and two reported that they were still experiencing homelessness. When our participants disclosed that they were housing insecure in the past or in the present, they meant that they were either having trouble paying rent, living with residential overcrowding, couch surfing, moving frequently, or spending the majority of their total income on housing (please see Table 1 for all 12 participant demographics).

Table 1. Participant demographics (n = 12).

<table>
<thead>
<tr>
<th>Participant</th>
<th>Pseudonyms</th>
<th>Age</th>
<th>Race</th>
<th>Years HIV+</th>
<th>Lifetime Experience</th>
<th>Current Housing Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Roy</td>
<td>41</td>
<td>White</td>
<td>7</td>
<td>With Homelessness</td>
<td>With Housing Security</td>
</tr>
<tr>
<td>2</td>
<td>Jay</td>
<td>41</td>
<td>Black</td>
<td>12</td>
<td>With Homelessness</td>
<td>With Housing Insecurity</td>
</tr>
<tr>
<td>3</td>
<td>Gar</td>
<td>61</td>
<td>White</td>
<td>34</td>
<td>With Housing Insecurity</td>
<td>With Homelessness</td>
</tr>
<tr>
<td>4</td>
<td>Peter</td>
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<td>M. Eastern</td>
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<td>With Housing Insecurity</td>
</tr>
<tr>
<td>5</td>
<td>Kris</td>
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<td>With Homelessness</td>
</tr>
<tr>
<td>7</td>
<td>Hugh</td>
<td>56</td>
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<td>With Housing Insecurity</td>
</tr>
<tr>
<td>9</td>
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<td>With Housing Insecurity</td>
</tr>
<tr>
<td>10</td>
<td>Charles</td>
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<td>Black</td>
<td>32</td>
<td>With Homelessness</td>
<td>With Housing Insecurity</td>
</tr>
<tr>
<td>12</td>
<td>David</td>
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<td>White</td>
<td>28</td>
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<td>With Housing Insecurity</td>
</tr>
<tr>
<td>13</td>
<td>Jack</td>
<td>46</td>
<td>Asian</td>
<td>23</td>
<td>With Homelessness</td>
<td>With Homelessness</td>
</tr>
<tr>
<td>14</td>
<td>Jimmy</td>
<td>64</td>
<td>White</td>
<td>42</td>
<td>With Housing Insecurity</td>
<td>With Housing Insecurity</td>
</tr>
<tr>
<td>15</td>
<td>Tim</td>
<td>50</td>
<td>Black</td>
<td>27</td>
<td>With Housing Insecurity</td>
<td>With Housing Insecurity</td>
</tr>
</tbody>
</table>

We assigned each of our participants a pseudonym as soon as they joined our study, and we utilized their respective pseudonyms to identify them in this article. Each of our participants provided their written consent prior to joining our study, and received a USD 50 gift card as compensation for their efforts and time spent in our interviews.

2.3. Procedures and Materials

Observing our IRB-approved research protocol that allowed us to examine the lifetime experiences of gay men living with HIV at midlife in Southern Nevada, we conducted our confidential, one-on-one, semi-structured interviews remotely over Zoom from January to April 2022. Each of our interviews ranged from 40 to 60 min in duration. We tailored our interview guide questions so that we could both generally explore our participants’ perspectives and lifetime experiences since their HIV diagnosis, and more specifically, understand factors they believed helped them survive the clinical and social impacts of living with HIV, live full lives despite having a chronic illness, thrive despite the challenges they encountered as gay men living with HIV at midlife in Southern Nevada, and purposefully contribute to the goal of ending the HIV epidemic. We digitally recorded our interviews with each participant’s consent, and later, de-identified and transcribed them verbatim for our analysis. In the course of our interviews, our participants openly shared with us their rich lifetime experiences since they were diagnosed with HIV. For this article, our presentation of our findings, discussion of these findings’ implications,
and proposed recommendations for interventions utilizing an SDoH perspective are all specifically focused on the lifetime experiences of housing insecurity of our participants.

2.4. Analysis of Data

We analyzed our de-identified transcriptions using the thematic analysis phases that have been previously described by Braun and Clarke (2006). We chose thematic analysis as our method to analyze our interview data due to its inherent flexibility to interrogate complex data. We recognized it as an ideal approach to fulfill our study’s aim because its epistemological and theoretical freedom allowed for a flexible assessment of the different perspectives we derived from our participants. Braun and Clarke’s thematic analysis (2006) is an iterative process that consists of six consecutive phases: (1) becoming familiar with the data, (2) generating codes, (3) generating themes, (4) reviewing themes, (5) defining and naming themes, and (6) locating exemplars. To implement the first phase of our analysis, we used the first half of our data set of 12 interviews to develop our preliminary thematic codebook. Reviewing the first six transcriptions of our data set granted the more seasoned coders of our research team an excellent opportunity to familiarize themselves with our interview data. Our research project coordinator and two of this article’s authors separately read and re-read our first six transcriptions to carefully familiarize themselves with the interview data, and then later gathered together as initial coders to discuss possible common codes and themes during every other week meetings. Upon reaching a consensus based on the review and coding of our first six interviews, our initial coders established our preliminary codebook with overarching themes and sub-themes to accomplish the second to fifth phases of our thematic analysis. Our initial coders then shared the codebook with three other members of our research team, who served as fresh, new coders. All six coders proceeded with analyzing our remaining six transcriptions using the preliminary codebook as a guide during the remainder of our analytic process. For the final phase of our analysis, all our coders continued with bi-weekly meetings throughout the analytic process until they reached an agreement on our interview data’s overarching themes, sub-themes, and representative codes and quotes.

3. Results

After completing the thematic analysis of our interviews, we identified three overarching themes and five sub-themes from our interview data, all within the specific context of the Southern Nevada region. The three overarching themes we identified included: (1) challenges to obtaining housing and related support, (2) informal support from friends, and (3) formal support from community-based sources employing diverse support strategies. Under the first overarching theme, challenges to obtaining housing and related support, we identified two sub-themes: (1) navigating multiple steps to secure support, and (2) impacts of hostile structural forces on internal perceptions. Under the third overarching theme, formal support from community-based sources employing diverse support strategies, we identified three sub-themes: (1) AIDS service organizations, (2) religious or faith-based charitable organizations, and (3) competent and caring healthcare and service providers. We have already presented and discussed the rest of the findings and lessons learned we gained from our larger CBR project on resilience to HIV that are outside of the specific scope of housing insecurity and homelessness among gay men living with HIV at midlife in our previously published peer-reviewed journal articles (Bell et al. 2023; Ranuschio et al. 2023).

3.1. Challenges to Obtaining Housing and Related Support

Our study interviews revealed that 75% of our larger CBR project’s participants (i.e., \(n = 12\) of the 16) have experienced housing insecurity or homelessness at some point in their lifetime since they were diagnosed with HIV. Among these participants, only one revealed that they were no longer experiencing any challenges related to maintaining housing security at the time of their interview, while the remaining 11 participants shared
that they were still experiencing issues in terms of completely securing stable housing. Our participants candidly reported the challenges they encountered to obtaining housing and related support, particularly their difficulties with navigating multiple steps to secure support from available community sources, as well as the impacts of hostile structural forces on their internal perceptions of self and life itself.

3.1.1. Navigating Multiple Steps to Secure Support

Our participants described their experiences as they recognized and sought the housing and SDoH-related support they needed. They reported that they encountered challenges in terms of navigating multiple steps to secure the support they sought. Already lacking the most basic resources, they found out that they still needed to go through multiple steps to gain support and that the processes they were going to encounter were not going to be easy. Charles (52 years old, Black, 32 years HIV-positive) explained, “The homeless services are kind of wacky here in Las Vegas. I’m not sure why that’s the case. But I know a lot of clients like me feel they’re always getting the runaround when trying to get those services.” Jay (41 years old, Black, 12 years HIV-positive) expounded further:

I’ve come across situations where I’ve been homeless before, and when I tried to get help, you know, here’s the first step. Then a lot of times, you got two or three more hoops you got to jump through in order to get to your final destination. But no one explains to you all these other steps.

Jack (46 years old, Asian, 23 years HIV-positive) echoed these sentiments with similar frustration:

They’ll tell you one step that you need to take, and then, the next step you need to take. But they won’t tell you any step after that. They’ll just tell you, “Well, you got to do this.” So, you do that, and then they’re like, “Well now, you got to do this.” It’s just really time consuming for those who don’t have a car or are taking the bus. To take the bus to do anything, it takes almost the entire day to get one chore done.

Even after receiving some financial and other kinds of support, participants revealed that there were still several other steps to go through to avail of different support services since these services were not always connected or offered at the same place. On occasion, there would also be instances of misinformation, miscommunication, or lack of organization that led to repeating redundant steps or loss of precious time. Jack (46 years old, Asian, 23 years HIV-positive) reported:

So, it was nice to receive financial help, but I had to jump through so many hoops to get the cash [assistance for rent]. It’s insane the number of steps and paperwork one has to go through to get that money. It’s like, you don’t have a job, so your full-time job is to juggle paperwork around the city to get that money. Once, to get some supplies from the food bank after I just received some rent money, I got the wrong information from one place, and then it was a comedy of errors afterwards. I’ve had a similar runaround experience trying to get transportation vouchers too. It’s like we’re not having enough of a hard time already. It would have been easier if everything was all in one place. It was unbelievable sometimes.

3.1.2. Impacts of Hostile Structural Forces on Internal Perceptions

Most of our participants had been experiencing housing insecurity for many years with a few continuing to experience homelessness for several years at a time. As they described their experiences with navigating multiple steps to secure the support they needed, a few participants recounted the day they first lost their home and expressed how this memory still triggers not only strong feelings of helplessness but also a recognition of the impacts of hostile structural forces on their internal perceptions of self and life itself.

One participant, Kris (45 years old, White, 23 years HIV-positive), vividly recalled:
When I got evicted, it was the constables coming in. They were beating on the door and I frantically ran into the shower where I thought I’d be safe. They came right into the bathroom. I was naked and they didn’t care. It was so humiliating and I felt so helpless. I had fifteen minutes to get myself in and out. This experience haunts me to this very day. I try to stay hopeful and think that I’ll one day have my own home again. But oftentimes, it seems like it will never get any better.

Jay (41 years old, Black, 12 years HIV-positive) sounded equally crestfallen when he shared his own feelings of gloom during his interview, “Just being homeless. There’s no worse feeling. I just want to see a change in a positive direction and something to make my life stable. I wonder if I’ll ever become independent instead of always relying on other people.”

Much of the despair the participants were feeling was rooted in not only being housing insecure, but also not being able to secure their HIV care as they were constantly worrying about finding a place to stay. Kris (45 years old, White, 23 years HIV-positive) recalled:

Last night, I slept in an empty apartment. Uh, it’s like a showcase apartment. But not in the apartment. I slept in the patio storage area, which was very tight for me and my boyfriend. We’ve also slept in a steel container at the park. It’s hard to make those [doctor] appointments when you don’t have a car and you don’t know where you’re gonna sleep every night. It’s hard just to keep your chin up and care about your health.

3.2. Informal Support from Friends

Our participants’ experiences with trying to secure housing assistance and related supports were not all negative. One finding that stood out from the interviews was the fact that many of our participants received informal support from their friends during their time of need, even before they could gain any help from formal housing assistance and related services from the community. Whether soon after they were diagnosed with HIV, or much later after living with the virus for a while, when the time came that our participants consequently found themselves experiencing housing insecurity, many of them were able to turn to friends for help, especially when their families wanted nothing to do with them or refused to help them out. When their circumstances became worse, many of our participants were able to lean on their most reliable friends.

When they began experiencing housing insecurity, some of our participants were able to rely on their friends for help right away and never had to experience homelessness. Although he experienced difficulties making monthly rent on a few occasions, Gar (61 years old, White, 34 years HIV-positive) pointed out that he never really at any time experienced homelessness:

So far, I’ve never needed to use the homeless shelters. I’ve always been lucky that way. When the time came that I didn’t have enough money for rent, I was able to live with a friend for a while until I was able to afford my own apartment again. I know transitional housing and homeless shelters are out there, but I’ve never had to look into it. Hopefully, with the help of friends, that will never happen.

Although his shift in his housing security status was much more abrupt compared to Gar’s, Joseph (61 years old, White, 38 years HIV-positive) similarly received informal support from a friend soon after he learned of his HIV diagnosis:

I was in bad shape and my health deteriorated rapidly. After I had my first hospitalization, I wasn’t able to work anymore. I eventually realized I couldn’t afford to keep my house. Although I was in denial about it for some time. You know, bill due dates were coming fast and furious. I’m gonna say I came within two to three weeks of not having any place to live and move. I didn’t even have a car anymore. All I had was my best friend. She took me in for a while, and later, helped me find an apartment that I was able to afford after saving up. Uh, I was
just at a place where, without someone holding my hand and pushing me to keep going, I could have landed on the streets.

Some participants experienced extreme hardship and experienced homelessness not long after their HIV diagnosis. For instance, Jack (46 years old, Asian, 23 years HIV-positive) was only able to avoid living on the street with the help of some friends for a short time before he urgently needed to seek formal support from community-based services and programs. According to Jack:

I didn’t mind being on the street with my dog for a little bit. At first, I always had friends I could go to. I just couldn’t stay at their place overnight. I could go hang out with them during the day, or you know, go over for a couple hours, get something to eat or whatever. I just couldn’t live there on a permanent basis. It was good while it lasted. After a while, I knew I had to get help from housing assistance, food banks, and other homeless services.

3.3. Formal Support from Community-Based Sources Employing Diverse Support Strategies

Like Jack, almost all of our participants have accessed some kind of formal support from different community-based sources in Southern Nevada. In addition to accessing housing assistance for emergency housing, transitional housing, the use of homeless shelters, help with their rent, and/or other housing-related programs, many of our participants also availed of support from food banks and pantries, employment assistance and workforce services, transportation assistance, and disability support offered by the different not-for-profit agencies, governmental institutions, and non-governmental organizations of Southern Nevada. Although there were various types of agencies and networks with community-based services and programs in Southern Nevada that our participants could have turned to over the years in order to meet their needs, three specific sources stood out as the most vital to our participants as housing insecure, gay men living with HIV at midlife: (1) AIDS service organizations, (2) religious or faith-based charitable organizations, and individually, (3) competent and caring healthcare and service providers. In the following subsections below, our participants describe how the different community-based sources in Southern Nevada employed diverse strategies to support them. These diverse strategies include helping them sustain housing and prevent homelessness recidivism, addressing important SDoH-related issues, and even providing emergency responses to homelessness.

3.3.1. AIDS Service Organizations

As gay men living with HIV at midlife, most of whom have been long-term HIV survivors for over a decade, our participants have become seasoned and long-time service users of the different AIDS service organizations based in Southern Nevada. Many of our participants revealed that they have developed significant relationships with the existing AIDS service organizations in our region and have come to rely on the various services, programs, and referrals these organizations have offered over the years.

During their interviews, our participants repeatedly mentioned and lauded the housing assistance and support they received from specific Southern Nevada AIDS service organizations. Charles (52 years old, Black, 32 years HIV-positive) readily shared with us the kind of help he had been receiving over the years:

I get housing through [AIDS service organization 1]. So, part of my rent is only a third of what my income is and I can afford to pay for other basic needs. That’s really helpful because prices are going up here in the Valley with housing and I don’t believe I could afford to stay where I live otherwise without their help.

Charles recognized that not everyone in his situation is as fortunate as he is in terms of receiving this critical support. He explained:

So many of us are still homeless. In a way, you would have to be at the right place and at the right time kind of thing for that. You really have to do a lot of work and have a lot of patience to get that kind of service. But once you’re in,
just make sure you stay current, pay your rent, and communicate effectively with people. So, it’s a little bit not as good as it should be with the housing support. However, I have a good lease understanding with the people I rent from right now. As soon as I have my rent, I would pay it. You know, pay your rent first regardless of what things needed to be done in the house. The property owners, they have to pay bills, they have to pay insurance. You know, as long as I have a roof over my head, I’m gonna take care of my share of the rent.

Peter (50 years old, Middle Eastern, 29 years HIV-positive) also shared how much he really appreciated the support he received from another AIDS service organization:

Oh, yeah. the [AIDS service organization 2] helps me with my rent. They’ve helped me a lot through the years. Like, especially now, since I can’t work because of my legs. Um, you know, I have to get all this paperwork together. I have to scan it and I have to send it to my case worker. Then, she sends it to the [AIDS service organization 2], and they always pay [my rent]. You know, as long as I get all that paperwork done, I have a place to call my home! And then, there’s the food bank in Henderson. I get a lot of help from them too.

3.3.2. Religious or Faith-Based Charitable Organizations

Aside from receiving support from the different AIDS service organizations based in Southern Nevada, our participants also reported how grateful they were to receive services and avail of programs run by religious or faith-based charitable organizations from the region that helped them not only with their housing-related needs, but also their other fundamental and day-to-day needs (i.e., employment, financial assistance, food, health information, healthcare, transportation). In fact, a few of the participants mentioned that it was sometimes easier to gain wraparound services in one go from these religious or faith-based charitable organizations compared to other places since they would have housing services, a food pantry, clothing, and transportation vouchers all available in one visit.

Although some religious or faith-based charitable organizations elsewhere may have historically had negative reputations in terms of how they have treated LGBTQIA+ individuals and PLWH in the past, our participants claimed that their own experiences with the religious or faith-based charitable organizations from Southern Nevada have been mostly positive. Roy (41 years old, White, 7 years HIV-positive) described his experiences:

I know that nationally the [religious or faith-based charitable organization 1] has a bad name for dealing with the LGBTQIA+ population. But here in town, they’re more progressive. They have an LGBTQIA-focused shelter. So, they have actually, I think it’s 24 beds. I think it’s something like 17 to 24 beds, I forget the number. But they have those beds dedicated to people from the LGBTQIA+ population. So, accessing that has been so helpful for some of us who have experienced, you know, housing displacement for a period of time.

Likewise, Jay (41 years old, Black, 12 years HIV-positive) expressed his genuine appreciation for his own positive experiences, “I have used homeless shelters a few times. Mostly though, I have used the shelter of [religious or faith-based charitable organization 2], and I have used their mental health counselling in the past. They have been non-judgmental and really kind”.

3.3.3. Competent and Caring Healthcare and Service Providers

Apart from being quite vocal about their gratitude and apparent affinity to the community-based services and programs of the AIDS service organizations and religious or faith-based charitable organizations in Southern Nevada, our participants also sincerely expressed their profound appreciation for the most competent and caring healthcare and service providers they have had the opportunity to encounter. Jack (46 years old, Asian, 23 years HIV-positive) is all praises when it comes to talking about his family doctor. According to Jack:
Access to a community health clinic has been wonderful. I could see [name of Jack’s doctor], and I don’t have to worry about a bill. I would see her no matter what my health concern was and she would be wonderful. She would also hook me up with different providers if she saw something wrong that she could pinpoint with me. Once, she was able to hook me up with someone else in their building that could help me with my finances. She doesn’t just look after my HIV care but she does what she can to help me with all my other problems that affect my care.

Roy (41 years old, White, 7 years HIV-positive) shared with us in his interview how he eventually got to a better place in life thanks to the connections, care, and excellent one-on-one support he received from his case worker:

Um, I finally got myself in a more stable home. I got off the street. Actually, while I was homeless, I went to a pop-up event in the park, and was talking to one of the ladies there about my addiction and being in recovery. She and I got to talk in detail about all that. I actually asked her if there were any sober living homes that she was aware of, and she went out of her way to get me in communication with the director of a home she knew...and on the same day, I was able to get off the street.

David (61 years old, White, 28 years HIV-positive) had a similar story as Roy’s and was not shy about complimenting his peer navigator for the comprehensive support he has helped him access during his most challenging times:

My peer navigator is also living with HIV and is very open about his HIV status, recovery, and life experiences. He explained to me how his diagnosis actually helped save his life and it made sense. He has been in sustained recovery from substance use for seven years since he was diagnosed with HIV. He shares with others like me how his diagnosis is part of the stories that he uses to help other people who are newly diagnosed with HIV, fresh into recovery, or experiencing homelessness. His role is specifically peer support where he works one-on-one with people. Anybody recently diagnosed with HIV that comes through their doors, they have them talk to him. He works very closely with newly diagnosed people, those with substance use issues, and housing insecurity. He uses his own experiences with the system to help other people who may not understand that HIV isn’t a death sentence anymore and that they can get help with their addiction and homelessness through sober living programs just like he did. He’s inspired me to get better and do better. So, many of us think we’re very lucky to have him.

Our participants recognized that it has taken competent and experienced healthcare and service providers who go above and beyond the scope of their work to help them stay in the HIV care continuum and thrive despite their multiple challenges. They emphasized how critical it was to their survival and wellbeing to have providers who would go the extra mile to help them overcome the challenges they had while living with HIV, experiencing homelessness, and struggling with a range of other issues that deterred them from aging healthily. The competent and caring healthcare and service providers that our participants described represent or significantly promote specific SDoH, which are known protective factors against housing insecurity. These SDoH include the informal (i.e., social support) and formal (i.e., access to quality health services) care networks that are vital to the survival and wellbeing of gay men living with HIV at midlife who are experiencing housing insecurity and homelessness.

4. Discussion

Our participants’ interviews keenly highlighted how experiences of housing insecurity and homelessness among gay men living with HIV at midlife are inherently and intricately tied to several SDoH issues, which could significantly impact this population’s chances of
survival and healthy aging. In the past two decades, research has shown that experiences of housing insecurity and homelessness among gay men and other PLWH are often compounded and complicated by SDoH issues specifically related to lower education levels and insecure employment (Henry et al. 2008; Melo et al. 2022); food insecurity (Graham and Plankey 2023; Munasighe et al. 2024); limited transportation and mobility (Archibald 2018; Graham and Plankey 2023; Martinez 2023); lack of social support from family and friends (Anderson et al. 2021; Cummings et al. 2022; Gonzalez Corro et al. 2024); and poor access to quality health services, particularly access to quality HIV care and support programs (Armstrong et al. 2023; International AIDS Society 2023; Martinez 2023; Melo et al. 2022; Milloy et al. 2012), and this phenomenon was underscored by the lifetime experiences that were shared with us by our participants in their interviews. It has become apparent that in order to effectively examine and address this phenomenon, challenges resulting from housing insecurity or homelessness then need to be assessed and tackled simultaneously with efforts to investigate and overcome concurrent challenges related to various SDoH issues relevant to those experiencing housing insecurity or homelessness.

Many participants reported that over the years they often sought support for their other SDoH-related needs such as food supplies, clothing, transportation vouchers, social support, and referrals to other basic services, around the same time they sought housing assistance. Participants were also quick to mention that they wished that they could avail of this wide range of support all from one place or a single resource. Their testimonies emphasized that it is all the more critical for us to not only examine our participants’ experiences from an SDoH perspective, but also generate appropriate recommendations for interventions that would take housing insecurity and homelessness, as well as all the other relevant SDoH issues they described, into deliberate and greater consideration.

Research has documented that supportive housing undoubtedly supports people from all walks of life experiencing housing insecurity and homelessness (Gambini 2017), and improves their health (Kidder et al. 2007). Supportive housing has positively impacted gay men living with HIV at midlife as it has historically helped bring them into HIV care as well as stay in the care continuum (Ontario HIV Treatment Network 2011). In fact, supportive housing has been found to be closely linked to successful HIV treatment outcomes as it has provided PLWH better access to HIV care and support services, improved their therapeutic relationships with their healthcare and service providers, increased their adherence to ART, and kept them in the HIV care continuum for their long-term recovery (HIV.gov 2023b; National Academies of Science, Engineering, and Medicine 2018; National Alliance to End Homelessness 2023; NYC.gov n.d.). Additionally, research has shown that prioritizing housing for PLWH and other comorbid conditions ultimately decreases public health burdens in the long run (Buhl 2020).

While ensuring that supportive housing that works for gay men and other PLWH remains a priority, attention still needs to be paid to exerting simultaneous efforts to address issues related to SDoH most relevant to the housing insecure or homeless among them. During their interviews, hardly any of our participants mentioned that they went directly to known resources in Southern Nevada to gain housing assistance and other concomitant SDoH-related community support. Instead, most reported that when they sought support for housing, food, transportation, and their other SDoH-related needs, they sought help primarily from the AIDS service organizations that they were already used to gaining support from even before they began experiencing housing insecurity or homelessness. This was because they had already established long-term and/or strong relationships with these AIDS service organizations, where they had been going to regularly for their HIV care and services. These AIDS service organizations were also the places where they had found the competent and caring healthcare and service providers they have come to rely on since their HIV diagnosis. Additionally, many of the participants acknowledged that when they did seek out more support from outside of the AIDS services organizations that they were already comfortable with, they chose to seek help from religious or faith-based charitable organizations in the region that have earned a local reputation for not turning anyone
away and for providing supplies and support to people with less steps, paper work, red tape, and fuss. The implications of these preferences for their AIDS service organizations, Southern Nevada religious or faith-based charitable organizations, and competent and caring healthcare and service providers are two-fold. First, it is important to remember that in order to successfully provide housing assistance and SDoH-related support to gay men living with HIV at midlife experiencing housing insecurity or homelessness, it would be ideal for all the support they need to be networked and made available in specific locations under one roof. Second, it would also be important for these locations to be places where they feel safe and comfortable, know they would not be judged or turned away, and will have knowledgeable, experienced, and caring providers to work with to address their housing insecurity, homelessness, and multiple SDoH-related needs (e.g., AIDS service organizations, religious or faith-based charitable organizations, not-for-profit LGBTQIA+ agencies).

Existing literature on interventions and recommendations to address housing insecurity and homelessness among PLWH have predominantly focused on care, services, and programs specifically revolving around or rooted in clinical practice (e.g., HIV screening, risk determination, personalized post-test and risk mitigation counseling, diagnosis and evaluation, treatment planning and management, comprehensive HIV education, enhanced telehealth HIV case management, referrals to medical specialists) (Brody et al. 2021; Cironi et al. 2021; Health Care for the Homeless Clinicians’ Network 2013; Health Resources and Services Administration Ryan White Program (HRSA RWP) n.d.; Kherghelpoush and McKeirnan 2023) and on public policy (Hwang and Burns 2014; National AIDS Housing Coalition 2012; Song 1999). Drawing from an SDoH perspective, we offer some recommendations on what future interventions could look like based on our study’s findings. By adopting existing effective interventions that concentrate on clinical practice, and then incorporating essential aspects that take SDoH-related needs into greater consideration, these interventions could potentially harness both the informal and formal forms of support that our participants have appreciated and found helpful in the past.

Apart from needing to develop or promote interventions that simultaneously address HIV transmission, homelessness, and housing insecurity (Arum et al. 2021), we concur that relevant stakeholders of local and federal programs from the community should tailor existing interventions to meet the unique and distinct needs of the diverse subpopulations they serve (Cummings et al. 2022). For example, during the COVID-19 crisis, local and federal governments bought several empty hotels to house people experiencing housing insecurity and homelessness to immediately address the rapidly growing and compounding pandemic-related issues associated with the needs and plight of the housing insecure and unhoused population (Munasighe et al. 2024). Since researchers and advocates have agreed that supportive housing should be the priority when it comes to starting and building a network of SDoH-related supports for housing insecure and unhoused PLWH (Buhl 2020; Gambini 2017; HIV.gov 2023b; NYC.gov n.d.), this is one intervention that could potentially be adopted outside of a pandemic context in order to lay down the foundation on which subsequent interventions could build on to concurrently address multiple SDoH-related needs.

As housing needs are being addressed, both informal (i.e., reliable family and/or friends) and formal (i.e., AIDS service organizations, religious and faith-based charitable organizations) supports should be brought in to consolidate and bolster the network of supportive community-based sources that gay men and other PLWH could rely on to meet their needs (Ecker 2024). Also, research has underscored the critical importance of ensuring the involvement of knowledgeable, highly networked, and compassionate case managers and navigators in the care of vulnerable and/or underserved PLWH (Henry et al. 2008; Hickey et al. 2021), which our participants emphasized in their interviews. Although competent patient navigation has not always been proven to have direct or lasting positive effects on housing insecurity, research has documented that it has been able to directly and positively impact retention in HIV care among PLWH experiencing housing insecurity.
or homelessness (Rajabiun et al. 2018; Rajabiun et al. 2020). As a logical extension of the recommendation to involve competent and caring providers such as case managers and navigators to help address the SDoH-related needs of those experiencing housing insecurity and homelessness, ample opportunities should be provided to gay men at midlife and other PLWH who show promise, interest, and evident potential (based on their own lived experiences, capacity to learn, desire and willingness to give back to the community) to become excellent, competent, and caring case managers or peer navigators themselves. This recommendation staunchly supports the greater and meaningful involvement of PLWH (GIPA/MIPA) principles that have long been a part of the CBR work to serve and empower gay men and other PLWH (Travers et al. 2008).

Finally, in line with the International AIDS Society’s (IAS) recent thrust to enhance the access of PLWH experiencing housing insecurity or homelessness to quality HIV care and services by promoting initiatives such as person-centred care and street medicine programs (International AIDS Society 2023), we recommend a rational expansion of this work of directly providing clinical care (e.g., HIV testing, pre-exposure and post-exposure prophylaxis, ART) to those experiencing housing insecurity and homelessness. In addition to having healthcare providers bring HIV screening and testing kits, prescribe and provide HIV medications, and conduct HIV care follow-ups where they live, a network of service providers could also join this effort by mustering the direct provision of comprehensive services for housing insecure or homeless gay men at midlife and other PLWH to address their SDoH-related needs. Only by bringing the HIV care and wraparound services that will address their SDoH-related needs directly to the housing insecure will healthcare and service providers, as well as HIV activists and advocates, be able to help ensure that those experiencing housing insecurity and homelessness will receive the support that they require to overcome food insecurity, transportation issues, financial insecurity, lack of social support, and limited access to healthcare, while they strive to gain housing assistance, and eventually, housing security.

Limitations of the Study

As we acknowledge the contributions of our study to the existing literature, it is important for us to recognize the limitations of our study. One limitation of our study is related to its participant recruitment strategy. Since our interviewees were primarily recruited with the help of our Southern Nevada partner community-based organizations, community health centers, and clinics, it stands to reason that the majority of our participants would be ongoing, and possibly, even long-time service users of these organizations, health centers, and clinics, and would likely have a strong appreciation for the care and services they provide. It was not likely that we were able to access much of the lifetime experiences and perspectives of gay men living with HIV at midlife from Southern Nevada who did not avail of the services and programs of our community partners.

A second limitation of our study is the limited diversity of our interviewees. At the start of our study, it was our full intention to include participants with a wide range of experiences living with HIV in terms of the number of years since they had been diagnosed with HIV. In the end, it turned out that over 80% of the interviewees who joined our study were long-term survivors who had been living with HIV for more than two decades. We then realized that we were not able to fully explore the lived experiences of gay men living with HIV at midlife who had been recently diagnosed and living with HIV for less than five years. We speculate that this result may have been due to the possibility that most gay men living with HIV at midlife from our community who were both qualified and willing to participate in our study were also those who have had more confidence and experiences with joining research studies over the last 20 years. Nonetheless, this meant that our study was unable to gather the range of participant experiences we hoped we would include. If we had been able to interview participants who have been recently diagnosed or who have been HIV-positive for less than five years, we may have been able to gather data from participants who have considerably less experience navigating the HIV care and support
services that have been available in Southern Nevada for decades or from participants who have experiences of accessing housing and other SDoH-related services that have been available only in recent years. Such participants who had been recently diagnosed or living with HIV for less than five years could potentially have different insights and perspectives that have not been influenced by critical changes in SDoH that occurred over long periods of time. It is also important to acknowledge the impact of factors such as recency bias and recall issues in reflecting on historical moments in the not-so-recent past. These factors could have very well influenced the data that we were able to gather from the participants who joined our study. Additionally, although we received considerable support from our community partners to recruit a diverse range of participants from Southern Nevada in terms of how they identified in terms of their sexual identity (e.g., gay, bisexual, queer) and their ethno-racial background, all our participants identified as gay and only 50% identified as ethno-racial minorities. We recognize the significant importance of other critical factors to the impediment or promotion of housing security among gay men living with HIV at midlife, which we were unable to discuss in this article as they were factors cognate to but outside of the WHO SDoH perspective, and not within the scope of our study. Despite this, we acknowledge that crucial factors such as ethnicity, race, intersectional stigma, and other sociodemographic factors are critical influences to attaining the housing security of gay men living with HIV at midlife based on the findings of prior related research (Liboro et al. 2021a, 2021b).

A third limitation of our study is related to the set of questions that we were able to include in our interview guide. Due to the inductive nature of our research questions for the study, we recognize that our interview guide could prospectively have included more specific and probing questions on housing insecurity. In spite of this concern, we believe that we were able to sufficiently derive important findings for the focus of the study based on the richness of the data we gathered from our participants.

Lastly, it is important to stress that the findings of our study are limited to the context of the Southern Nevada region, and are potentially applicable only to other relatively younger, fast growing, and sprawling urban regions of North America that continue to have a growing number of HIV services and housing assistance programs. Despite the limitations we have described, our study was able to address several research gaps in literature not only by meaningfully engaging the rich lifetime experiences and perspectives of housing insecure, gay men living with HIV at midlife in Southern Nevada from a distinct SDoH perspective, but also by generating recommendations for interventions that could potentially combine housing assistance prioritization with the development and establishment of collaborative networks that would concomitantly address the multiple SDoH-related needs of our participants and the vulnerable and underserved population they represent.

5. Conclusions

The findings of our study corroborated the results of prior related research as well as presented new edifying insights based on the lifetime experiences of housing insecurity among gay men living with HIV at midlife in Southern Nevada. Our study identified and described our participants’ challenges to obtaining housing and other SDoH-related support, and the informal and formal supports they found particularly useful over the years as they struggled to achieve housing security and meet their basic needs for survival. To date, as far as we can determine, only a few empirical studies have utilized the SDoH perspective in the conduct of their research to examine the healthy aging and housing security of gay men living with HIV at midlife, and none have used it as a framework to generate recommendations for interventions that could be used to address HIV, housing insecurity, homelessness, and other concomitant SDoH-related issues, as we have. The insights and recommendations we presented in this article are significant contributions not only to the existing academic literature focused on addressing the housing insecurity of gay men living with HIV in the 21st century, but also to the armamentarium of strategies,
programs, and services that HIV providers, advocates, and other relevant stakeholders could use to help gay men living with HIV at midlife overcome housing insecurity.


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