

## Homeless population and access to the health services: perspectives and determinants


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**Objective:** to understand the homeless population's perception about access to the health services. **Method:** the study has a qualitative approach of a descriptive nature. It counted on the participation of nine homeless individuals, selected through simple random sampling, with data collection from a semi-structured interview and content analysis. **Results:** the findings showed that the homeless population has precarious access to the health services, since barriers such as lack of knowledge and documentation and little or no access to preventive methods have been reported. The most frequently used devices were urgency and emergency services. **Conclusion:** from the perception of this population, the breaking of physical and bureaucratic barriers that restrict this access becomes emergent, in order to improve quality of care.

**Descriptors:** Homeless Persons; Health Services Accessibility; Public Policy; Integrity in Health.

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## **População em situação de rua e o acesso aos serviços de saúde: concepções e determinantes**

**Objetivo:** compreender a percepção da população em situação de rua acerca do acesso aos serviços de saúde. **Método:** o estudo possui abordagem qualitativa de cunho descritivo. Contou com a participação de nove pessoas em situação de rua, selecionadas através da amostragem aleatória simples, com coleta de dados a partir de uma entrevista semiestruturada e análise de conteúdo. **Resultados:** os achados evidenciaram que a população em situação de rua tem um acesso precário aos serviços de saúde, uma vez que foram relatadas barreiras como a falta de conhecimento, de documentação e pouco ou nenhum acesso a métodos preventivos. Os serviços mais utilizados foram os de urgência e emergência. **Conclusão:** a partir da percepção dessa população, torna-se emergente o rompimento das barreiras físicas e burocráticas que tanto restringem esse acesso, afim de que haja uma melhoria na qualidade da assistência.

**Descritores:** Pessoas em Situação de Rua; Acesso aos Serviços de Saúde; Política Pública; Integralidade em Saúde.

## **Personas en situación de calle y acceso a servicios de salud: perspectivas y reflexiones**

**Objetivo:** comprender la percepción de las personas en situación de calle sobre el acceso a los servicios de salud. **Método:** enfoque cualitativo de carácter descriptivo. Se contó con la participación de nueve personas en situación de calle, seleccionadas mediante muestreo aleatorio simple, con recolección de datos de entrevistas semiestructuradas y análisis de contenido. **Resultados:** los hallazgos mostraron que las personas en situación de calle tienen acceso deficiente a los servicios de salud, ya que se han reportado barreras como la falta de conocimiento, documentación y poco o ningún acceso a los métodos preventivos. Los servicios más utilizados fueron los de urgencias y emergencias. **Conclusión:** desde la perspectiva de esta población, emerge la necesidad de romper las barreras físicas y burocráticas que tanto restringen este acceso, para que haya una mejora en la calidad de la asistencia.

**Descriptors:** Homeless Persons; Health Services Accessibility; Public Policy; Integrity in Health.

## Introduction

Historically, urbanization and economic development highlighted social exclusion from the division of classes, producing people who are subjugated, unemployed and with few expectations for change<sup>(1)</sup>. These individuals are classified as "remnants", people disabled by the economic and social situation, whose survival depends on the labor market, thus characterizing a state of absolute poverty, linked to lack of belonging to formal society<sup>(2)</sup>.

It is in this context of social exclusion and inequality that the homeless population (HP) emerges, predominantly characterized as heterogeneous, surviving through productive activities carried out on the streets, without any housing as a point of reference and which, in general, had their family and social bonds broken<sup>(3)</sup>. They are also known as wanderers, mendicants and beggars who occupy places considered as of "passage" in order to establish ties that guarantee their survival<sup>(4)</sup>.

The most recent data about the HP were made available by 1,924 municipalities via the Unified Social Assistance System Census (*Censo do Sistema Único de Assistência Social, Censo SUAS*), estimating that, in 2015, there were nearly 101,854 homeless people in Brazil<sup>(5)</sup>. It is noteworthy that the absence of official data contributes to increased invisibility in the context of social policies and hinders the implementation of public policies aimed at this population.

Most of the actions that aim at improving the quality of life of the HP are developed under a curative perspective, equating in most cases to charitable gestures that, despite helping, do not contribute resoluteness. In order to change this reality, the Ministry of Health instituted in 2009, through Decree No. 7,053, the National Policy for the Homeless Population (*Política Nacional para a População em Situação de Rua*, PNPR) and the creation of the Intersectoral Monitoring Committee of this policy, in order to guarantee universal and humanized care<sup>(6)</sup>.

Linked to this, there are the Street Clinics (SCs) that integrate the Primary Care component of the Psychosocial Care Network, following the guidelines and foundations of the National Policy on Primary Care (*Política Nacional de Atenção Básica*, PNAB). They are composed of a multidisciplinary team, working together with the Psychosocial Care Centers (*Centros de Atenção Psicossocial*, CAPS) and other health services according to the needs of each individual<sup>(7)</sup>.

Given the implementation of public policies aimed at the HP, it is understood that they should be well assisted. However, the fact that the services exist does not guarantee that users have access to them; despite being a right that cannot be distinguished by class, there are sociocultural, organizational and economic barriers that prevent efficient access and greatly influence use of these services<sup>(8-9)</sup>.

The research is justified by the need to understand the physical, bureaucratic and institutional barriers that make access to health services increasingly unfeasible for the homeless population, characterizing a deficiency in the Unified Health System (*Sistema Único de Saúde*, SUS) in providing equal and equitable assistance.

Its relevance is academic, governmental and social as it intends to be a subsidy for future scientific research studies, improvement of health practices and promotion of quality of life for the homeless population in Iguatu-CE and improvement and implementation of targeted public policies for that population.

Thus, the research aims at understanding the homeless population's perception that about their health condition and access to the health services.

## Method

This is a descriptive and qualitative study carried out in the municipality of Iguatu located in the inland of Ceará, 364.6 km away from the state capital, Fortaleza, with an estimated population of 101,386 inhabitants<sup>(10)</sup>.

The data were collected in the city's streets, more precisely in the city center and its surroundings, characterizing the place where the homeless population lives. It is important to emphasize that the city does not have any shelter or other such device for this population.

Selection of the participants was carried out through simple random sampling in line with the following inclusion criteria: a) Being homeless; b) Being over 18 years old; and c) Being able to understand and answer the research content. As an exclusion criterion: a) Presenting cognitive limitations that prevent understanding the meaning of the questions and answering the interview.

The sample was delimited by the principle of saturation, which aims at preventing unnecessary information from being repeated throughout the research. There are also external validity criteria where the number of interviewed participants in other qualitative studies covering the same theme was analyzed, in which a sample of at least 5 and at most 29 interviewees was found<sup>(11-12)</sup>.

Data collection was carried out from a semi-structured interview, following a previous script prepared by the researcher and consisting of questions that allow the interviewee to talk freely about the subject matter and answer the researcher's hypotheses during the conversation<sup>(13)</sup>.

Questions were raised regarding the homeless population's perception about their health condition, as well as preventive measures and attitudes taken to face the health-disease process. The search for health services was also investigated, as well as which devices were the most used, the reasons that led them to seek these services, how care was provided and, on the other

hand, whether there is an active search for this population by the health teams.

For data collection, the technique of recording interviews was used, as this allows storage of the material provided by the informant in its entirety. The field diary tool was also used, in which notes were made about the researcher's perception of the field. At the end, all interviews were transcribed for further analysis.

Before data collection, a pilot test was carried out, which verified the interview's operability and effectiveness, allowing the researcher to make the necessary adjustments. Participation of all the interviewees was voluntary, upon clarification of the study objectives and signing of the Free and Informed Consent Form (FICF). The data were analyzed using the content analysis technique proposed by Minayo, which aims at validating the information obtained in a given context using technical and scientific procedures. This type of analysis aims at interpreting and understanding the explicit or concealed contents and their organization through the use of categories<sup>(13)</sup>.

Data collection took place from May to September 2017, after approval by the Research Ethics Committee (REC). The study had the participation of 09 interviewees who were identified by the letter "E" ("*Entrevistados*" in Portuguese) followed by a cardinal number according to the order of the interviews.

Regarding the ethical aspects, the research met all the requirements set forth in the Guidelines and Norms for Research in Human Beings - presented in Resolution 466/2012 of the National Health Council (*Conselho Nacional de Saúde, CNS*), obtaining favorable opinion from the REC of the Regional University of Cariri (*Universidade Regional do Cariri, URCA*), under number: 2,038,191.

## Results

To characterize the interviewees, sociodemographic and economic characteristics were listed, chosen according to the preponderance of the research content, namely: age group, ethnicity (self-reported), gender, schooling, profession and monthly income.

The sample was mostly characterized by male individuals, self-declared as black-skinned, aged between 27 and 48 years old, single, with incomplete elementary education, without a fixed income and with different professions such as gardener, car and motorcycle guard and artisan.

Regarding the age group, the interviewees were aged between 27 and 72 years old, with an equal percentage prevalence of the age groups from 27 to 37 and from 38 to 48 years old (33.3%), thus characterizing a predominantly adult profile. As for ethnicity, there was predominance of black-skinned people (55.5%) followed

by brown-skinned (33.3%) and, to a lesser extent, white-skinned (11.1%). The interviewees' profile was predominantly male (88.8%). With regard to schooling, the prevalence was of individuals who declared to be illiterate (44.4%), followed by those who had Elementary School, up to 4<sup>th</sup> grade (22.2%) and with equal results for Elementary School, up to 8<sup>th</sup> grade, and incomplete High School (11.1%). No participant completed High School and Higher Education.

The low schooling level reported by them may reflect the fact that most of the interviewees have no income and survive on begging. Lack of formal schooling is an impediment to finding jobs that guarantee certain stability and provide a change of scenery for this population, both economically and socially.

The largest number of interviewees did not have any profession (22.2%), followed by an equal percentage of 11.1% for the professions of gardener/bricklayer, car guard, general service assistant, motorcycle guard, artisan, laundry washer and retired. Of the total number of interviewees, 44.4% reported not having any type of income, surviving only on begging. There was a percentage of 22.2% for those who did not report their income.

According to the study objective, and with the data found, the results were divided into two categories: "Concepts of the homeless population about their health condition" and "Determinants of access to the health services by the HP".

### Category 1: Concepts of the homeless population about their health condition

This category encompasses the HP's perception of their health condition, as well as preventive measures and attitudes taken to face the health-disease process.

As for their health condition, most of the interviewees (55.5%) consider themselves healthy people, as they were able to carry out their activities "independently" and rarely sought health services. This shows that, for them, the concept of health is directly related to the absence of disease, as shown in the following statements:

*Thank God I consider myself healthy, you know? Thank God within 5 years nothing has happened to me, but when it happens, it's to die. Right? Thank God (E01); Ahh, I consider myself, because I can still walk 30, 50 km. When I need to, I walk (E03); Boy, look, thank God I behave and I'm healthy because thank God I, no, I'm not sick. Because I cough, but that's not important, coughing (E06).*

Regarding the questions about being healthy or not, there were also disagreements, as reported in the speeches.

*Not a, not a little bit, not at all. Because I have diabetes, I have high blood pressure, diabetes, high blood pressure, I also cough like no other (E07); I don't consider myself, no. Because*

*the person who has an asthma problem, he ain't healthy, he always has the problem, then after a while the problem comes back again (...). There are times when the ear hurts too, it almost bursts in pain. Now I have a problem that I'm getting deaf, half deaf, if the person speaks from a distance, I don't listen (E08).*

A large part of the interviewees stated that they did not resort to any prevention means, either due to lack of knowledge or for feeling unable because of their precarious way of life on the streets. However, some claimed to do whatever possible to avoid getting sick.

*How do you mean? No, if I'm here I don't control anything. I'm soon without eating. Soon without eating as we spend all day without eating today. He earned a little money there, he bought cachaça to drink (E07); I don't do anything because I can't, I don't know anything, I don't know anything, then it's difficult (E08); So, I take my personal care, right, bro? I don't drink Coke, I don't drink cachaça, I don't use hard drugs, I smoke a cigarette, I smoke marijuana from time to time, which is good (E03).*

When asked about the attitudes adopted towards the disease process, a large portion of the interviewees reported seeking the health service, while a minority stated that they self-medicate or do not take any action.

The interviewees claimed to seek the outpatient and emergency services, which can be justified by the agility of moving to rescue services and the curative model used in these care locations. Among other reports, faith was also mentioned as a way of coping with diseases, as shown in the statements below:

*Then I ask someone to call an ambulance (...) then they'll take me either to the regional clinic or to the emergency, right? Then, I don't want to come here anymore, I want to go to my sister's. Because I imagine that if I come here, I just die right away (E07); Go to the hospital, call the ambulance and the ambulance takes me, then drink cachaça, which gets better (E05); I ask God to cure me, bro, because I can't even take any more medicine (E03).*

## **Category 2: Determinants of access to the health services by the HP**

This category deals with the homeless population's access to the health services offered. For this, we investigated the search for health devices, the most frequently used services, the reasons that led them to seek them, how care was provided and, on the other hand, whether there is an active search for this population by the health teams.

A large part of the interviewees claimed to seek the health services whenever they needed, while a minority reported having difficulties in reaching the service, or even disinterest in seeking. Among the services attended, in order of use, are: hospital, CAPS, Basic Health Unit (BHU) and, finally, Emergency Care Unit (*Unidade de Pronto Atendimento*, UPA). The search for primary care, which is

considered a gateway and responsible for care continuity, ends up being neglected.

It is important to understand that Iguatu does not have a street clinic team, which means that the HP is not a direct target of health actions and services. Thus, the HP is at the mercy of limited care that only covers the needs demanded by this group.

*I went to the hospital here but... I didn't like it (E02); I've already spent some time in the CAPS AD, without smoking or drinking, then when I left the CAPS and I started to do that again, drinking and smoking (E06); It was the leg that was swollen today, then I went in the morning to the UPA, I went in pain, girl, the stomach was sick, cause I wasn't eating, (...) When I'm at home, I go to the care unit almost every day (E07).*

The same happens with the search for the Psychosocial Care Centers, especially the ADs, aimed at users of psychoactive substances. Even admitting dependence, most often on alcohol, a large percentage of the participants did not show interest in seeking help, or could not do so, as dependence becomes a palliative capable of reducing the suffering caused by the street environment.

*Grief comes first, you know? That grief cause I lost my mother and I'm like this in the middle of the world, then when I drink, then it starts to feel funny, I forget about life, then I keep talking, I talk to one and another, I forget about my poor life, then it seems that I have a good life, it seems that my life has changed, I'm happy. Then I sleep drunk, right? I go to sleep drunk. Then, when I wake up in the morning, the same unhappiness. I don't know, dear girl (E07).*

With regard to the reasons that led them to seek these services, most of the participants who sought the hospital or emergency unit did so due to cuts, pain in the lower limbs and accidents. The basic health unit was only attended in cases of tooth extraction and drug dispensing.

*I didn't go, but I was thinking that I had broken my nose, you know? Blood was coming out like that, a friend of mine told me, hey man, that's ugly, ok? And I: no, bro. Then I looked in the motorcycle's mirror and it was cut (E01); 'cause of a knock on the head they gave me, I didn't even remove the stitches, look here, look the stitches. Never removed. It was a rock that the guy threw, a rock to me (E04); In the UPA it was the swollen leg. At the unit the woman says, girl, you don't need to come every day, the pressure is good, [...] Then I prick my finger like this, to check diabetes. Then, when I'm using the medicine right, it's only one hundred and ten, [...] but when I'm not, it's about three hundred, 'cause of the cachaça, the drinking (E07); Just a car accident. It hurt the spine, leg, head. Then you go to the hospital, then you drink cachaça and get better. I went to the unit some time ago to pull a tooth, when I needed I went (E05).*

Within the questions, the way in which the research participants were received in these services was listed. All the interviewees unanimously stated that they were well cared for, as observed in the reports below:

*Boy, I was treated well, calm (E03); I liked it there because it's a delicious thing, everything, I was good there, I was well received, I wasn't badly received, I was well received, by everybody (E06).*

Unfortunately, most of the interviewees stated that they had not been contacted by any health service professional during the time they were on the street, as mentioned in the following statements:

*Not yet (E02); From the little center? No. I never saw, no, from nowhere (E07).*

Another important factor is the fear or difficulty that many individuals have in physically re-establishing themselves on the streets, as they do not have basic conditions, such as a place to rest, adequate food, help from a family member, among others, as reported below:

*No, I don't have a document, I don't have anything, then how do you arrive at the hospital without a document, with nothing? I'm glad I know some people, you know? The staff, the doctors, everyone likes me, you know? [...] Then the secretary there said no, you'll have to go, we'll take you. My luck was that she spoke to the boy there, then I went on a motorcycle with the boy there. Then it worked (E01); There's a hernia, (shows the hernia) it's been there for a while, I've already been operated on. Then it appeared again, the doctor said he was going to operate and everything, but I didn't let him, I didn't want to. Because I was afraid, and because I was going to have a surgery and stay on the street, right? (E02).*

## Discussion

The findings of this research are in line with the studies analyzed, where 53% of the interviewees were adults aged between 25 and 44 years old, the majority (63.7%) declared themselves as non-white, that is, black brown-skinned and indigenous, 80% were male and 30.6% performed occasional jobs, while 29% were out of the labor market<sup>(14-16)</sup>.

It is known that living on the streets is a constant challenge, especially when it comes to survival. Exposure to cold, hygiene difficulties, inconstancy related to food and, above all, violence, are factors that, when correlated, cause greater vulnerability of the individual to pathologies.

Thus, there are social and psychological components, considered important factors with regard to the health of the HP. Lack of social belonging, denial of basic rights, discrimination, prejudice, and absence of emotional bonds are some of the reasons that lead this population to develop pathological conditions that are often irreversible<sup>(17)</sup>.

The findings obtained in the National Survey, in line with this study, reveal that 27.9% of the interviewees claimed to have some health problem. On the other hand, a study carried out in Mato Grosso do Sul revealed that most of the research participants reported considering their health to be very good or average<sup>(4-17)</sup>.

It is understood that, even in situations of extreme vulnerability, the HP tends to make a positive assessment of their health status. This may be justified based on the assumption that, for them, health is linked to the ability to be alive and to resist the difficulties faced daily on the streets<sup>(18)</sup>.

In the reports found, it is noticed that diseases are portrayed as an impediment to work and to ensure survival and that non-disabling health problems become irrelevant, as they do not affect the search for daily supplies.

For the HP, the perception of the health-disease process arises from psychological, social and behavioral dimensions. It is known that health is not the opposite of disease; however, the disease process cannot be considered only from the physical and objective point of view that culminates in the production of a diagnosis. It is necessary to understand the social construction of the disease<sup>(19)</sup>.

Starting from the premise that the body is the only asset of individuals living on the streets and, therefore, an indispensable instrument to guarantee their survival, there was a need to know if the research participants used any method to prevent diseases, reaching the conclusion that, for them, prevention is not a priority. As much as some sporadic measures are taken, these individuals most often rely on luck. Even being patients with chronic diseases that need monitoring, many prefer, or feel obliged to neglect, seeking help only as a last resort<sup>(20)</sup>.

This dimension about the health-disease process was also seen in other studies where the HP showed certain neglect in self-care, precisely because they experience health as the opposite of diseases, not understanding that being healthy also includes facing illnesses, seeking help and understanding what is happening<sup>(16)</sup>.

Addressing preventive aspects with the HP is complex, precisely because there are no basic subsidies on the street for this to happen, such as accessible hygiene strategies. It is therefore necessary to guarantee a minimum of citizenship for this population, to later make them responsible for the basic issues of their own existence.

A study also asserts that surviving on the streets means accumulating a series of disadvantages that translate into greater exposure to risky health situations, unhealthy behaviors, greater possibility of mortality and low life expectancy<sup>(15)</sup>.

As for the search for health services, a study reveals that 83% of the population studied sought them while 17% did not resort to these services<sup>(21)</sup>. Likewise, a research study reports that other ways of dealing with health problems included waiting for the spontaneous remission of symptoms, drinking alcoholic beverages to ease discomfort, which most often reveals itself as abusive and dependent use, and search for comfort in religiosity<sup>(18)</sup>.

The manual on health care for the homeless population reveals that, when sick, 43.8% of the interviewees first sought the hospital/emergency unit, while 27.4% sought the health centers. On the other hand, another study carried out in São Paulo showed that two-thirds of those surveyed sought the basic units and only 20% sought the emergency services. Among those who did not seek care, 43% thought it was unnecessary and 22% resorted to self-medication<sup>(6,15)</sup>.

The existence of a universal health system with a strong emphasis on primary care facilitates use and access to the health services. On the other hand, proportionally lower schooling and income levels are justifications for the scarce search for preventive practices, since the aspects of the disease process are differentiated<sup>(15)</sup>.

According to a national research study, the most common problems reported by the HP included hypertension, psychiatric/mental problems, HIV/AIDS and sight problems, thus diverging from the findings of this survey<sup>(4)</sup>. Reports on cases of being run over by a car, beatings and bruises are common, among other reasons that lead to the search for immediate assistance. In these cases, the relation with the health unit ends at discharge, without care longitudinality<sup>(20)</sup>.

As for the care modality in the health services, there was discrepancy between the research findings and the arguments provided in a study, in which episodes of deficient care, denial of access and refusal by the professionals are described, including episodes of prejudice, discrimination and negligence with the HP that is increasingly at the mercy of the inability and inefficiency of the public services<sup>(7,20)</sup>.

It is important to understand that the opinion attributed to care in the health devices by the HP is part of one of the most subjective pillars of access, which is acceptability, a dimension which includes social, economic and cultural factors that define the degree of satisfaction with the service used<sup>(9)</sup>.

The provision of services by the health teams characterizes access with regard to prevention and health promotion in primary care, being of paramount importance for ensuring comprehensive care. Generally, the active search for HP is made by the Community Health Agent, who, in addition to carrying out the individual and household registration, must guide and inform about the routine and services offered by the Basic Health Unit<sup>(21)</sup>.

As a care model, the Family Health Strategy must remain resolute and equitable, since it has the ability to create bonds, solve problems and reorganize the use of other care levels<sup>(22)</sup>.

A number of studies claim that, many times, the requirement of proof of residence to define a territorial base ends up being an inconvenience, both for the professionals and for the HP. However, it is important to

know that, in the e-SUS electronic information system, the registration forms contain a specific field for the HP, thus reiterating the professionals' responsibility in this effective search<sup>(23)</sup>.

It is noticed that the fact that a significant percentage of the population interviewed does not have documents such as general registration, CPF and birth certificate, further restricts access to the services. Some for lack of knowledge, and others for fear of being denied this right, end up not looking for health devices, even in strictly necessary cases.

A number of studies claim that the bureaucracy listed in the routine of the health services, such as scheduling appointments and requiring documentation, hinders access by the HP, since the particularities of these users are not taken into account<sup>(12)</sup>, who end up discrediting the effectiveness of the service, also considering the fear of not being able to recover or "treat" themselves in the street environment<sup>(18)</sup>.

It can therefore be seen that this is an old problem and that, even with the emergence and implementation of new policies aimed at this population segment, it still represents an impediment to reaching the services. In addition, the study addresses the concept of health in a dynamic way, based on the relationship established between the determinants and conditions related to the context in which the HP is inserted.

## Conclusion

Through the analysis performed, it was revealed that the HP perceives health care in a very subjective way, not resorting to prevention strategies, making inadequate use of the health services and relying, in most cases, on strategies that ensure their survival and alleviate the problems caused by the challenges inherent to living on the street.

A deficiency on the part of Primary Care was also revealed, as it is responsible for the active search and insertion of the HP in the health unit. The professionals responsible for the BHU must keep a critical eye on this population, free from labels and judgments. They must recognize them as subjects of rights, belonging to the same territorial space and, therefore, worthy of quality and of resolute and equitable care, since access to health is constitutionally guaranteed as a right for all and a State duty.

This premise is not limited only to the BHUs, but extends to all services considered a gateway for the HP. It is necessary that the welfare and charitable view, which has been widespread for so long, gives way to the perspective that places the individual on the streets as a protagonist and not as someone invisible to society.

It is also necessary to break the physical and bureaucratic barriers that so restrict this population's

access to the health services. Carrying out active search and registration, passing on guidelines and information about the operation hours of these services, and carrying out education in health actions are some of the measures that may be taken to minimize this problem.

It was noticed that, in addition to macro-structural difficulties such as scrapping of services and lack of investment, what would be within the reach of professionals is the use of light technologies, especially dialog. As long as intersectorality and comprehensiveness of services are not priorities, access will remain lacking and the HP will remain at the mercy of a universal health system that does not put its principles into practice.

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