


Access to health services from the perspective of homeless people


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Objective: to identify the perception of homeless people about the barriers to guarantee access to health services. Method: qualitative, descriptive research carried out in a Specialized Reference Center for Social Care (CREAS) and a halfway house of a municipality in the northern region of the state of Mato Grosso do Sul. The participants were 11 homeless individuals. Data were collected through semi-structured interviews and analyzed through thematic analysis. Results: two moments were described: "living on the street" and "access to health". In the process of living on the street, many people reported having become accustomed to the homeless situation. Access to health care occurred in emergency services due to situations of emergency. Positive and negative experiences were reported. Conclusion: it is believed that, by understanding the peculiarities of this population and its demands, better quality care can be offered.

Descriptors: Homeless Persons; Health Services; Public Policy; Health Services Accessibility.

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O acesso aos serviços de saúde na perspectiva de pessoas em situação de rua

Objetivo: identificar a percepção das pessoas em situação de rua sobre as barreiras encontradas para garantia do acesso aos serviços de saúde. Método: pesquisa de natureza qualitativa, descritiva, realizada em um Centro de Referência Especializado de Assistência Social (CREAS) e em uma casa de passagem do município da região norte do estado de Mato Grosso do Sul. Os participantes foram 11 indivíduos em situação de rua. A coleta foi feita por meio de entrevistas utilizando o instrumento semiestruturado, analisadas por meio da análise temática. Resultados: pode-se descrever dois momentos: "o viver na rua" e "o acesso à saúde". No processo de viver na rua, muitos relataram ter se acostumado com a situação de rua. O acesso aos serviços de saúde se deu em pronto-atendimentos devido a situações emergenciais. Experiências positivas e negativas foram relatadas. Conclusão: acredita-se que, ao se compreender as peculiaridades dessa população e suas demandas, uma assistência de melhor qualidade pode ser oferecida.

Descritores: Pessoas em situação de Rua; Serviços de Saúde; Políticas Públicas; Acesso aos Serviços de Saúde.

Acceso a servicios de salud en la perspectiva de la gente de la calle

Objetivo: identificar la percepción de las personas que viven en la calle sobre las adversidades encontradas para garantizar un acceso a los servicios de salud. Método: investigación de naturaleza cualitativa, descriptiva, realizada en el Centro de Referencia Especializado en Asistencia Social (CREAS) y una estancia de un municipio en la región norte del Estado de Mato Grosso del Sur. Los participantes fueron 11 personas que vivían en la calle. La colecta de datos fue hecha por medio de entrevistas utilizando un instrumento semiestructurado, y por medio de un análisis temático. Resultados: se puede describir dos situaciones: "el vivir en la calle" y "el acceso a la salud". En la situación de vivir en la calle muchos testimoniaron que tuvieron que adaptarse a sus condiciones. El acceso a los servicios de salud fue se dio en atención inmediata a situaciones de emergencia. Las experiencias positivas y negativas fueron reportadas. Conclusión: se cree que, al comprenderse las peculiaridades de esa población y sus demandas, una asistencia de mejor calidad puede ser ofrecida.

Descriptorios: Personas sin Hogar; Servicios de Salud; Política Pública; Accesibilidad a los Servicios de Salud.

Introduction

In Brazil, there are approximately 31,922 people living on the streets according to a national survey carried out by the Ministry of Social Development and Fight Against Hunger/MSD⁽¹⁾, distributed in 71 different municipalities according to the last national population count of the street population in the years 2007 and 2008.

The street population can be defined as a heterogeneous group of people who have in common the condition of absolute poverty and lack of belonging to formal society⁽²⁾. Usually these people use public spaces like streets, viaducts, squares and hostels to spend the night. We can highlight some of the main reasons for the abandonment of home, namely, the use of alcohol and drugs, unemployment, and family conflicts⁽³⁾.

The determination of the exact size of this population constitutes a challenge due to the peculiar characteristics of defining what is exactly to be in a homeless situation. The survey revealed that about 18.4% of the interviewees reported having already had difficulty in receiving care in the health network⁽¹⁾. Our economic system, along with social inequality, the loss of social values, and the lack of respect for the different can have a great influence on this condition⁽⁴⁾.

Within this reality, public policies began to be created in the attempt to provide better living conditions for this population. In 2009, the National Policy for the Homeless Population was established, guaranteeing these people access to various public services. However, many of these policies are only compensatory and welfarist, giving no opportunities for reintegration into the social environment⁽⁵⁾.

With regard to health, in 2012, the Ministry of Health developed the first handbook on health care for the homeless population, expanding the access to health services through street clinics, which are a way of actively seeking this population and an important means of strengthening their link with the primary care network. The National Primary Care Policy (PNAB) considers every subject worthy of receiving care in accordance with the principles of SUS of comprehensiveness, universality and equity. For this reason, street clinics work in conjunction with Psychosocial Care Centers (CAPS), urgency and emergency services, among other services, to expand and guarantee the access to health care⁽¹⁾.

However, not all the municipalities have street clinic teams and it is still rare to see people who live in the streets seeking the health network. They do it only in cases of extreme need, such as in emergencies. As an attempt to improve this reality, the Family Health Strategy (FHS) came as a public policy of the Unified Health System (SUS) with the goal of meeting the

demands of this population investing in health promotion and prevention⁽⁶⁾.

As it is well known, homeless people have a way of life different from the majority of the population, which often leads to unpreparedness on the part of professionals. Furthermore, at the same time that the Unified Health System values equity and universality in care provision, it requires proof of housing to define a territorial base. Failure to access basic necessities, such as bathing and feeding, on a daily basis causes this population to suffer from poor cleanliness, as well as prejudice and discrimination⁽²⁾, which may become barriers for them to access to the health system.

There is a lack of studies about the access of this population to health services in the national literature, thus making the present research essential for the knowledge of the difficulties and facilitators and for the best adaptation of professionals in the area, identifying factors that would help to include them in the health network. In view of this, this study aimed to identify the barriers faced by homeless people to access health services.

Method

Qualitative, descriptive research. Qualitative research has as its data source the natural environment, and it was therefore carried out in the habitat of the study participants. The researcher's concern was specifically centered in the research process and not only in the results that were obtained⁽⁷⁾.

This study was carried out in conjunction with a Specialized Reference Center for Social Care (CREAS) and a halfway house of a municipality in the northern region of the state of Mato Grosso do Sul.

The participants of the survey were homeless individuals who were in the halfway house at the time of the interview and those who received support from CREAS. The inclusion criteria were: being over 18 years old; presenting the characteristics mentioned above; staying in the place until the end of the interview; being in condition to answer the questions; and having used the health service at least once. The exclusion criteria were: being under the influence of alcohol and other psychoactive substances or lacking cognitive conditions to answer the questionnaire, which was evaluated using an instrument prepared by the authors to measure the main mental functions such as consciousness, orientation, memory, thought, suicidal ideation, language and psychomotricity. Individuals who presented changes in mental functions were not included in the study.

Data collection was done through interviews using the semi-structured instrument, the guiding question being: "How do you get access to the health system of the municipality?" and a sociodemographic

questionnaire, with questions about the use of health services by this population during the period from May to August 2017. Visits to the halfway house were scheduled at times when the users were present for lunch and dinner/rest, and the street population was also actively searched in partnership with the CREAS team. Only one interview was made with each participant. The interviews were recorded, with permission of the interviewees, with aid of an audio recorder specifically used to the research.

The data were analyzed through thematic analysis in order to identify the experiences of the homeless individuals and their access to health services. First, all the interviews were transcribed to obtain the data. After that, they were coded and then categorized based on themes that were capable of responding to the objectives of the study⁽⁸⁾. To ensure anonymity, the participants were identified with the letter I (interviewee) followed by Arabic numerals indicating the order that the interviews were conducted (I1 to I11).

The research project was approved by the Research Ethics Committee of the Federal University of Mato Grosso do Sul under Opinion number 1936243, in the year 2017. All the participants were clarified about the objectives of the study and their rights, and signed the Informed Consent Form.

Results

Of the 11 interviewees, 10 were male and 01 was female; they were aged between 28 and 60 years. The majority of the participants was Catholic (6) and considered themselves white skinned (6). As for individual income, eight individuals reported receiving the "Bolsa Familia" grant, one had no income and received no financial aid, and two did not answer this question.

Most of the participants were married (4) or single (4), and among the participants, two were husband and wife and were together in the street at the time of data collection. Regarding schooling, the majority had incomplete elementary education (6), and as profession, they informed to be machine operators (4). Eight participants responded that used alcohol and tobacco, three reported not to smoke or drink alcohol, and only one reported that used drugs.

When asked about mental illness in the family, three reported having family members with mental disorders, six reported no having such cases in the family, and two said there had already been suicide attempts among relatives. Regarding their mental health, five said they had tried or thought about committing suicide, five said they had never tried or thought about it, and one did not answer the question. Most of the interviewees (6) reported considering their health very good or reasonable.

Regarding the time they last used a health service, the longest time was four years ago, reported by only one participant, and the shortest was one month also mentioned by only one participant. The time living on the street varied from three months to 20 years.

Based on the analysis of the interviews, two categories emerged: "Living on the street" and "Access to health". These categories are described below.

Living on the street

According to the reports of the participants of this study, there were descriptions of situations of staying on the streets, and being homeless. The first situation, staying on the street, was related to reports where the participants still have/maintain contact with the family and stay on the street for short periods, mainly in hostels and in the halfway house, and when there are no institutions of this type in the municipalities, they stay on the street. The second, being homeless, referred to the participants who described the street as their place of reference. In this sense, in both situations, the participants reported being accustomed to these situations and they said that, sometimes, do not bother anymore with their situation.

I've already got used to it, it's normal, I travel all over Brazil, I'm already accustomed to this life (I:8); Ah, whatever, I've got kind of used to it too. (I:3)

However, other participants described this experience as bad and painful. They reported frequently going through various difficulties like cold weather, sleepless nights, lack of food, and situations of risk.

(...) at three o'clock p.m. there is lunch, you eat, this is lunch and dinner, and that's it. You have to sleep but alert, because sometimes there is trouble in the street, others want to kill, they go arrested as a thief, as a good-for-nothing, a wanderer, you have to live on the street to understand, you have to feel it on the skin (I: 9); (...) suffered, it is a good deal of suffering (the life). Sometimes there aren't any (hostels) in the city so you have to go to the network, sometimes the money ends too. (I: 10)

They also mentioned situations of discrimination, lack of respect and prejudice, especially when they ask for food in family homes.

It's like this, you stay in the cold, you spend the night without sleeping, without bathing, mosquitoes, lack of food, it's all part of this. If you are living like this, you cannot disturb people. If knock in a house: "Madam, for God's sake, give me a glass of water", nobody gives. Sometimes there are good-hearted people who gives us, but there are people who say, "Hey, vagrant get out of here right away". This is the situation of being homeless. (I: 5); This homeless experience is a very bad life, a lot of discrimination, a lot of it. (I: 11)

In this context, some participants reported the desire to change their routine linked to lack of hope in believing that they would achieve this change.

I wanted, of course (to change the life). This life is not good for anyone, to wander without destiny. (I: 4); I like (live out of the street), who doesn't want to? I would like it (to change of life). But the only thing is that today, today I am not for that. I'm already 43 years old, I'm already a veteran. (I: 7)

Difficulties in the family bond, mainly due to some type of demand, are described as one of the factors that took them and kept them in the homeless situation. However, being on the street was also mentioned as a factor that favors the loss of family bond.

I have my family there (in another city), but I stay here more than there. It's that, every once in a while you have to keep in touch. Ah, but keep calling all the time, it's annoying. (I: 3); (...) four years that I do not look for them (family), I've been here for five years, and there's four years that I don't care. (I: 1); My sister and brother-in-law do not get along with me, that's why I do not look for them. (E: 9)

In this context of difficulty in living on the street, it is also noticeable in the reports the frequent consumption of alcohol, cigarettes and other drugs. Some argued that consumption in this environment was easier because no one bothered them about the fact that they used them.

Do you know why I was going to the street? Because nobody bothered me there, I drank, I ate, whenever I wanted. (I: 9); Oh, I take a drink every now and then, a shot of brandy, a beer (I: 3); (...) drinking cachaça (brandy), going to bars. Not bars, a boteco (little bar), a neighborhood bar, drinking cachaça (brandy), sleeping on the street. (I: 7)

Access to health

The reports made it possible to perceive that health care for this population is not denied. They said that having personal identification documents and/or the SUS card is an important factor for accessing these services, since they all had this documentation.

Regarding the reason for seeking health services, the participants reported that one of the reasons was emergencies because of health problems, such as injuries resulting from physical aggression or melee weapons and firearms.

That's when I was stabbed (that had to look for the health service), in other city, not here, in other city. (I: 9); (...) (was) hospitalized, that I was stabbed here (points to the site where the injury was inflicted) (I: 5); He called me a jerk and punched me here (points to the site of the body where the injury was inflicted). But I did not fall, he just wanted to knock me down, but he did not get it. Then, everyone went to the hospital. (I:7)

Another reason also described by them was chronic health problems and/or problems related to physical limitations and pain.

I don't remember, but it was here (in the city where the research was conducted) if I'm not mistaken. There was a

problem in my spine that I got really bad. (I: 3); It's because of a problem in my leg. (I: 4); I have lung cancer, I take medication. For example, tomorrow I will make inhalation and take an injection for the bones. (I: 8)

The only woman of the study reported that her last access to the health service occurred in the birth of one of her children. However, because she receives the grant from the "Bolsa Família" program, she often goes to a health facility make preventive examinations and to vaccinate the children.

It was to have the baby. (I: 6); The health primary service, because I make preventive exams, and I vaccinate my children. (I: 6)

However, one of the health problems also reported was mental illness, including suicidal attempts and ideations, but most participants said they did not seek health services such as a CAPS, a service whose existence was unknown for some of them.

Who tried was me (suicide). They let me jump, but they did not let me die. I was rescued by firefighters. (I: 1); It was cutting the wrist, the throat. After that I started to see a psychiatrist and never have it again (suicidal ideation). It was because I was depressed. My mother had recently passed away. (I: 4); I've tried (suicide), I think it's normal. (I: 9); I already thought about that (suicide). (I: 11)

Regarding the access to these services, the participants described how they were received and assisted by the professionals. Some reports showed delay/waiting for service.

You wait hours and hours to receive care, a vaccine. The normal is you to go into a health post and go straight there, right there in the vaccine. It takes hours for you to be assisted (I: 2); It depends on the place. There are places that it delays. You get into a queue get a chip and wait. You come in, but it's always like this. Brazil Everything you take has queues, everything has queue. (E: 6); For me it was always good. When I had to wait I waited, I did not get disturbed, no. (I: 8)

Many reported positive experiences regarding care.

It was cool! I gave a gift once, a bear with a heart, for a doctor. (i: 1); He assisted me well! (I: 3); It was good, my goodness! (I: 10)

However, other participants described negative experiences regarding assistance and health care, permeated by indifference, prejudice, judgment and neglect. From the perspective of the participants, this was true especially with those who used alcohol and drugs.

(...) many treat with indifference or neglect, they do not look on their face. The vast majority are like this. There are very few places (health services) that treat people well. (I: 6); Yes, poorly assisted, poorly assisted. (I: 11); Many people judge you because of alcohol and drugs. When it's alcohol and drugs they do not even care. They take care of another person, but you stay there dying. (I: 9)

Discussion

Most of the participants in this study were men, a result also described in a study that aimed to map the existing public policies for this population and the urban landscapes in which they make social relations⁽⁹⁾. However, different from the findings of these researchers, the present study differs in relation to the skin color of the majority of participants, since most of them reported to be white.

As for profession, machine operator was the main occupation. This fact can be related to the fact that it is a work of easier access to this population, since it does not require specialized workers and it may also be justified by the region itself, where the research was carried out, because it is a strong region in terms of properties of agricultural production.

Although it is a right of any person to transit or remain on public streets, survival in this environment was described in this study as permeated by situations of violence, lack of basic living conditions and lack of food. The abandonment of a comfortable life, in general coupled with the process of disruption of all social and family ties, can lead the individual to become a "homeless" person⁽⁴⁾.

However, despite all the difficult situations reported by study participants, most of them considered their health to be good or fair. This differs from the data of another study in which the majority of respondents considered their health to be regular or poor⁽⁵⁾.

Despite all the difficulties of living on the street, whether by choice or lack of choice, many reported having become accustomed to that situation. The habit, here described through the fact of having become "used" to the life on the streets, was reported in another study that evaluated life strategies among the residents of the city of Santos, where it was noticeable in the narratives that the participants had "become used" to living on the streets and its consequences⁽¹⁰⁾. This familiarization with this type of life can lead them to difficulty of getting used to a house again, since the house was related to rules and feelings of "imprisonment" while the street now signifies a place of freedom, data that is in line with the present study.

One of the main reasons for going to the streets is the loss of family bond and the consumption of psychoactive substances such as alcohol and drugs⁽¹¹⁾, which could also be observed in the reports of this study. For both, after some time in the street, there is a gradual decrease of bond with family and increase of consumption of alcohol and drugs. They are, therefore, factors that make it difficult to return home and to build/resume new family ties.

In the intention of knowing why the family bond is lost, other authors have identified that the motive can happen since adolescence, when there is a distancing of the parents and the identification of other social groups and involvement with drugs⁽⁴⁾. Another reasons are marital separation, or separation between parents and children where one of the parents has to leave home and, depending on the previous family conditions, they may end up experiencing the condition of homelessness, where most of the times, men are the ones ending in this condition.

In relation to access to health services, the access of this population often occurred due to the consequences of living on the street such as situations of violence, use of alcohol and other drugs, and non-follow-up/treatment of chronic health conditions. In the view of a researcher, the main health problems presented by this population are also related to excessive use of alcohol, such as individuals who are run over, or who get involved in fights⁽¹²⁾.

The most frequently sought services are also emergency units⁽⁵⁾, as found in the present study. In fact, homeless people do not routinely attend health services, they rather make such contact only in moments of emergency. The main public service sought by this population is social services⁽¹³⁾.

Although there are barriers to care, all the interviewees reported having received attention when they sought health services, and reported having had both negative and positive experiences. It was presented in a research that, although the majority of its participants were individuals with low socioeconomic conditions, they had access to health care and described it as a positive experience, which can be simply attributed to the fact that they were attended⁽⁵⁾.

Regarding prejudice, the participants reported experiencing both social prejudice and prejudice in health services on the part of the professionals.

Health services are not prepared to receive and attend the peculiarities of this population⁽²⁾. Even when demand is spontaneous, it clear that prejudice and discrimination are still present. However, prejudice occurs not only during health care, but also socially, evidenced by the difficulty in obtaining formal jobs, which makes them often to depend on informal and/or occasional jobs, generating an income below one minimum wage. Moreover, when they ask people on the streets or in family homes, especially for food, they also live the prejudice⁽⁵⁾.

In this context, access to mental health services is even more difficult because mental disorders are one of the main problems affecting this population, mainly due to the consumption of alcohol and other

drugs. In this aspect, it is possible to identify a flaw in the network of psychosocial care because none of the participants mentioned having received any type of treatment in the CAPS. Working with "homeless crazy people" is even more complicated because not even the institutions specialized for this kind of health problems, like CAPS, have good results due mainly to the fact that the whole policy of care of these services is based and linked to the family and social context, and often focused on the approach to biologic care, which excludes people living on the street who present psychic disorders⁽¹³⁾.

In order to provide good health care and, especially, nursing care for homeless people, we must know the "culture of the street" through questions such as, who they are, how they live, how they survive and what meaning they attribute to their lives. Care is effective when there is the concept of humanity attributed to it and when one believes that it is possible to transform the reality of this population. Several instruments can be used, because for them, to be in the situation of homelessness is the lowest status of society that anyone can reach, and this raises questions about the meaning of their existence, which is a worrying factor for health⁽¹²⁾.

Conclusion

This study aimed to describe the barriers identified by people in homeless condition to access health services. The results showed that access to health services by the street population happens basically in moments of emergency, as they are often alcohol or drug users, and for this reason, they suffer prejudice there. Despite these situations many have had both positive and negative experiences. In no report the denial of care due to lack of documentation, fixed address, or companion was mentioned.

Health care teams face several challenges to provide care in the various health services and for the diverse user profiles, but it can be said that there is a greater precariousness in the care offered to the homeless population because in many of the times they report lack of preparation and adequate knowledge to deal with the homeless population. It is believed that by understanding the peculiarities of this population and its demands, better quality care can be offered.

This study has limitations because it was carried out in a small city and with a small group of participants. In addition, the participants experienced access to health services in several cities where they lived, which makes it difficult to understand this process.

Further studies on this population must be carried out to understand how the experience of living on the street is and, in this way, allow the implementation of public policies of better quality to this population, aiming at the reduction of health problems.

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