



Access to health care for people experiencing homelessness on Avenida Paulista: barriers and perceptions

O acesso à saúde pela população em situação de rua da Avenida Paulista: barreiras e percepções
Acceso a la atención médica para las personas sin hogar en la Avenida Paulista: barreras y percepciones

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ABSTRACT

Objective: To describe the perceptions of homeless people on Avenida Paulista in the city of São Paulo regarding access to health devices in the region. **Method:** This is a qualitative research conducted with 10 people who were homeless on Avenida Paulista in January 2019. Data were collected through semi-structured interviews, and analysis of the findings was made using hermeneutics-dialectics. Two categories of results were created: *Health services accessed in the region by homeless people*; *Barriers to health access faced by homeless people on Avenida Paulista, São Paulo*. This study obtained ethical approval. **Results:** Seeking emergency services occurs as the main gateway for homeless people in the region, and among the barriers faced, prejudice is placed as the main phenomenon. **Conclusion:** It is necessary to consider the specificities of this population, understand their conceptions of health-disease and their trajectories so that services can be improved and access to health for this vulnerable and growing group can be guaranteed.

DESCRIPTORS

Homeless Persons; Health Services Accessibility; Barriers to Access of Health Services; Social Vulnerability.

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INTRODUCTION

Taking street space as home is not a recent case; since pre-industrial cities, it is noticed people experiencing homelessness. "After the Industrial Revolution, however, this phenomenon has been increasing, related to the process of social disruption resulting from changes in the world of economic production since the growth of capitalism, especially the change in financial capitalism and neoliberalism, and the acute social inequalities produced in this process"⁽¹⁾.

"The social downgrade imposed by new forms of economic production has changed the profile of street populations. To the groups of homeless people of decades ago, composed of beggars, hippies and former patients of psychiatric hospitals, are added today new members: unemployed and underemployed, unemployed adults"⁽¹⁾, consequences of mass unemployment that started to increase the number of "invisible" people in the big cities.

In 2008, the Ministry of Social Development and Fight against Hunger published the National Survey on homeless people, which identified 31,922 homeless adults in the 71 cities where it was carried out⁽²⁾. Adding this value to the numbers found in municipal surveys carried out in São Paulo, Recife, Porto Alegre and Belo Horizonte, one reached approximately 50 thousand people who are in this condition especially in the metropolises⁽³⁾.

Specifically regarding São Paulo, recent publications and newspapers of great circulation warn about this growing fact being observed in the city. According to municipal data, of the 15,905 people living on the streets in the city, 3,864 are in the *Sé* district's subprefecture, a region that covers *Avenida Paulista*, which has approximately 206 people in this condition⁽³⁾, considered one of the most important avenues in the city, a notable financial and cultural center and also one of the most visited tourist spots, highlighting poverty, social exclusion and other problems inherent in large metropolises⁽⁴⁾.

The Brazilian National Policy for homeless people instituted in Brazil through Decree No. 7,053 of 2009 defines this segment as the group of individuals who share the experience of extreme poverty, interrupted or weakened family relationships and the lack of habitual housing; due to this condition, they use public places as a form of housing and subsistence, either provisionally or permanently, as well as social assistance services that offer overnight stays or as temporary housing⁽⁵⁾.

With regard to health, one of the concerns is the low rate of demand and access to public services, especially by people who use alcohol and other drugs in situations of extreme vulnerability and risks⁽⁶⁾. To address this issue, the Street Outreach (*Consultório na Rua – CnaR*), implemented in the Brazilian National Primary Care Policy (*Política Nacional de Atenção Básica – PNAB*), bridges the street and health services seeking to act against homeless people's different health problems and needs, including in the search active and care for alcohol, crack and other drugs users. CnaR are composed of multidisciplinary teams and develop shared and integrated actions also with the teams of Psychosocial Care

Centers (*Centros de Atenção Psicossocial – CAPS*), Urgency and Emergency services and other points of care, according to subjects' needs⁽⁷⁾.

What was once seen as invisibility due to the lack of public policies that guarantee access to fundamental rights by people experiencing homelessness becomes a matter of requirement to comply with the current legislation through the implementation of services and actions and the guarantee of access of users to health services⁽⁸⁾.

Access is a complex concept, varying between authors and changing over time and according to the context, used imprecisely and very unclear when it comes to access to the use of health devices. The terminology adopted also varies. Some authors use the noun accessibility, a condition of what is accessible, while others elect the word access, as made of entrance and entry, both expressions suggest the level of ease with which people receive health care⁽⁹⁻¹¹⁾.

Access to health and use of health devices depend on a number of aspects that can be divided into determinants of supply and determinants of demand⁽¹⁰⁾. Meanwhile, on the supply side, the most important thing is the existence of services, and on the demand side, the main factor in the use of health devices is the state or the need for health. In other words, access is determined by the interaction between the domains: availability defined by provision of services at the right place and time to meet the population's prevailing needs; accessibility being rates, transportation costs and lost productivity; acceptability presented as a link between professionals' and users' attitudes and expectations of each other⁽¹⁰⁻¹¹⁾.

Due to this problem, this study is an important way to understand the dynamics of homeless people and their characteristics in relation to their experiences with health, in a region as populous and relevant as *Avenida Paulista*, in order to offer apparatus to improve both existing public policies and scientific production that is still scarce in this context.

Therefore, this article aims to describe the perceptions of people experiencing homelessness on *Avenida Paulista* in the city of São Paulo regarding access to health devices.

METHOD

TYPE OF STUDY

This is a qualitative research, with analysis by the hermeneutics-dialectics theoretical framework. The qualitative configuration in this research is justified by the need for a methodology that incorporates the historical, cultural and ideological aspects brought by the theme in question, which according to Minayo⁽¹²⁾, cannot be contained only in a numerical formula or in a statistical data. The qualitative method is the one that applies to the study of history, relationships, representations, beliefs, perceptions and opinions, products of interpretations that humans make about how they live, build their artifacts and themselves, feel and think⁽¹²⁾.

The hermeneutic approach is developed in the search for differences and similarities between the authors' and the

investigated people's context. It explores the definitions of an actor's situation, assumes sharing between the observed world and subjects, with the researcher's life world, supports reflection on the historical context and produces an account of the facts in which the different actors feel contemplated. Dialectics, on the other hand, searches in facts, in language, in symbols and in culture, for obscure and contradictory nuclei in order to criticize them. Dialectical thinking creates instruments and understands that analysis of meanings must be placed on the ground of social practices and emphasize the historical conditioning of speeches, relationships, and actions⁽¹²⁾.

The articulation of hermeneutics with dialectics is, therefore, an important way to support qualitative research, since both bring the idea of historical conditioning of language, relationships and practices, based on the assumption that there is no impartial observer and reuniting the power to "approach to the truth" investigated. However, while hermeneutics emphasizes consensus, mediation and agreement, dialectics is oriented towards difference, contrast, dissent, and criticism⁽¹²⁾.

SCENARIO

The study was conducted on *Avenida Paulista*, São Paulo, SP, Brazil, and surroundings, with homeless people in this region. Inaugurated in 1981, *Avenida Paulista* has been following the process of change and industrial, commercial and cultural development for more than a century and has great visibility at the international level⁽⁴⁾.

POPULATION

The population was 10 people experiencing homelessness on *Avenida Paulista*, over 18 years old, who were identified as such and approached at the time of data collection and who agreed to participate in the research by signing an Informed Consent Form (ICF). Those who did not have conditions to understand the questions and did not complete the answers were excluded.

Linear snowball sampling was used, where the first interviewee indicated another participant with the same profile to compose the sample and so on. Of the total of 11 people interviewed, one was excluded due to inability to complete the answers and understand the questionnaire, thus totaling 10 participants.

DATA COLLECTION

Data were collected, in January 2019, through semi-structured interviews, which according to Minayo⁽¹²⁾ facilitates the approach and ensures that the research assumptions will be covered in the conversation.

The research instrument was developed by the researcher and composed of 10 open-ended questions that answered the research objectives: when you feel bad, what do you try to do? When do you seek a health device? Do you know any health services nearby? Which health device(s) do you usually access? Does(do) this(these) device(s) usually meet your needs? What makes you look

for this device? Do you have any difficulty accessing a health device? If so, what are the difficulties? Have you ever been approached by a technician from any CnaR team being here? How do you think having a home would influence your access to health?

Together, a sociodemographic questionnaire was applied, following the three complementary dimensions of vulnerability (individual vulnerability, social vulnerability and programmatic vulnerability), determinants for the health/disease process production collectively⁽¹⁰⁾.

The interviews were recorded and later transcribed by the researcher.

DATA ANALYSIS AND TREATMENT

Data analysis took place through dialectical hermeneutics following the phases proposed by Minayo⁽¹²⁾. By ordering and classifying the data, it was possible to group everything into a smaller number of units of meaning and seek to understand and interpret what was exposed as most relevant and representative by the group studied.

Two main result categories were created: *Health services accessed in the region by homeless people*; *Barriers to health access faced by homeless people on Avenida Paulista, São Paulo*. The interviewees' statements are presented in the results by letter I, followed by the number of their respective interviews (I001, I002), in order to maintain their anonymity. For treatment and discussion of the findings, one relied on national policies for homeless people as well as scientific literature.

ETHICAL ASPECTS

This study was conducted based on Resolution No. 466/12, approved by the Research Ethics Committee of *Universidade de São Paulo* School of Nursing (EEUSP), under Opinion 2.969.796/2019.

RESULTS

PARTICIPANTS

Of the 10 individuals interviewed, nine were male and only one female, five of whom were between 20 and 40 years old and the other five, between 40 and 60 years old; of these, four declared themselves white and six as black. Regarding place of birth, three were born in São Paulo capital, three were born in the countryside of São Paulo, three were born in northeastern Brazil and one person was born in northern Brazil region. Regarding education, one person reported having completed higher education, three people reported having completed high school, two reported having incomplete high school and four reporting incomplete elementary school. Regarding marital status, seven of them reported being single, two reported being separated and only one reported being married. With regard to the use of psychoactive substances, three of the interviewees refer to the use of alcohol only, six refer to the use of multiple substances such as marijuana, cocaine, crack and solvents, and only one reports being abstain.

HEALTH SERVICES ACCESSED IN THE REGION BY HOMELESS PEOPLE

When asked what they do when they feel physically ill while on the street, respondents present a variety of responses, ranging from seeking a health service, intensifying substance use, looking for a hostel and even doing nothing. The most frequent answer is the search for an emergency service. There is also a lack of knowledge about existing services in the region and a demand for services in the central region of the city, in which some say they were better assisted.

I only know "Redenção", even I go there next week to be hospitalized. I know that I stay a month and leaving there I get a fixed place in a hostel (I001).

I got sick, but I waited (I001).

It is that, on the street, you have other concerns besides health, you are hungry and there is a time for you to stay at the restaurant door for you to eat, you have to ask. Then sometimes you don't have time either. Then you get tired, you want to lie down (I002).

If I see that I am in a very bad state, I'm going to call SAMU [mobile emergency service], right? (I002).

I usually go there at AMA [Ambulatory Medical Assistance] near Cracolândia [Cracolândia is a popular denomination for a region of São Paulo, which is notorious for high incidence of drug trafficking and drug use in public. It is located within the central region of São Paulo] there is the best place for you to go when you're bad, for homeless people like that. Several doctors see you quickly (I004).

We only go when impossible to bear, when we see that there is no way. We don't even remember going to the doctor (I005).

When I feel bad, I go to the reception center (I006).

When I want health care, do you know where I'm going? I go to AMA and Sé BHU [Basic Health Units], for me it is the best service here in this great center, when I want to be well assisted, I go there. Every time I went, I was well assisted (I007).

I know that there is a health service in Princesa Isabel Square, close by I don't know (I008).

BARRIERS TO HEALTH ACCESS FACED BY HOMELESS PEOPLE ON AVENIDA PAULISTA, SÃO PAULO

Regarding the barriers presented when accessing or trying to access a health device, prejudice is a word that marks the answers to this question. Referrals and bureaucratization appear as important data, as well as the delay in scheduling an exam or the arrival of an emergency mobile service. Regarding treatment due to problems arising from the use of alcohol and other drugs, two interviewees bring their experiences.

Like it or not, there is a prejudice. Like, this one we call him father, because he is the oldest here, he is our favorite; these days he was sick, he had a seizure at 10 am, we called the rescue service, ambulance, nobody came. What are we? Homeless people, ambulance did not come. We crossed to the other side because it

started raining, then he had another seizure, we called again, nobody came. The ambulance arrived almost 7 pm, he almost died (I003).

You call a public service, and they don't want to answer you because you're a homeless person. Because if you can't give basic support to homeless people, bums, as we call them, then you have to close everything, I think this way. Now if I said that I lived in a building at Paulista, I bet there would be 3, 4 or 5 for the rescue. Regardless if it's here in Paulista, if it's anywhere else, if you say you're a homeless person, they leave (I003).

I stayed one day and one night in a therapeutic community, I had a friend with me and I said, "Bro, I didn't like it. I saw some bugs coming down the wall, in the morning I went to have coffee and it wasn't coffee, it was tea". The bread was the day before yesterday, so I said, "I can't believe, I'm in jail". I asked my Bro if he liked it and he said no. The wall was the size of that building. I was never arrested, and was I going to stay now? I will never go back there (I005).

The person approaches me here, takes some information from me and then says that I have to go to a health center in Barra Funda or nearby, the person is on the street here on Avenida Paulista and has to walk there, then the person arrives and there is no record, the place has lost record, it has not arrived, I myself have been angry several times (I007).

Here in São Paulo, I went to Prates [health care place] once. I called that 156, then I slept in the hostel, my leg was leaking a lot because of osteomyelitis, and I waited until the morning to see the doctor but they didn't get an x-ray, they didn't do anything, nor a blood test. And I know more or less what has to be done, and nothing was done. So, I didn't go either (I008).

In evangelical recovery clinics, for God's sake, they make us a slave (...) they want us to work, they don't give an activity, a conversation. There is a swimming pool, court, field and they don't let us use them because they believe it is a sin (I009).

I am not undergoing treatment because where I do it is on the side of Cracolândia, and as it is in this region, I know that if I go, I will not return (...) these are places I prefer to avoid (I009).

For me, to do an image exam, it takes a year, for me, to do a head MRI, by then, it had already been blown (I10).

DISCUSSION

The results obtained based on the socio-demographic questionnaire are similar to data from the census of homeless people of São Paulo, which demonstrate that the majority of these individuals are male, migrants, with an average age of 40 years, living alone and that make use of psychoactive substances⁽³⁾.

Regarding the problem of the study, one will discuss the findings based on three complementary dimensions to be analyzed as determinants for access to health, namely: individual vulnerability, collective vulnerability, and programmatic vulnerability. The first concerns individuals' demographic and sociobiological characteristics; the second refers to the conditions of social insertion of individuals or groups

in the productive and reproductive process of society; the latter is due to the characteristics of public policies and social responses to health problems⁽¹⁰⁾.

Considering what is exposed by the author mentioned above and the data obtained through the present investigation, it is perceived that homeless people are in a condition that subjects them to have a disadvantage in these three dimensions: from the street situation, the place where they remain or circulate and the ailments that affect them by that individual condition; unemployment as a mark of a collective dimension; even a public policy that, despite the existence of specific services to the homeless people, is unable to reach everyone.

A study points out that especially the lower socio-economic groups often have problems with quality of care received in health services⁽¹³⁾. In this regard, one can relate these issues to the significant increase of these people and the unpreparedness of professionals in meeting the demands and specificities of these individuals, in addition to the discrimination to which they are exposed, which covers the dimension of programmatic vulnerability⁽¹⁴⁾.

In search of staying away from the big scenes of use and the truculent actions carried out by agents of the state, homeless people on *Avenida Paulista* and surroundings are in a territory where the existence of tertiary and quaternary health services prevails; which marks the boundary between the regional health coordinators and the areas covered by primary care services such as BHU that have CnaR teams on the street as well as specialized care services such as CAPS.

From an analysis of the category of perception regarding access to health, each person on the street establishes their own therapeutic itinerary. Therapeutic itinerary is the search for therapeutic care and individual and socio-cultural health practices in relation to the paths taken by these individuals in an attempt to solve their health problems⁽¹⁵⁾.

Through the interviewees' narrative, the demand for urgent and emergency services arises, a report that appears in seven of the 10 interviews, demonstrating that the search for a health service is made as the last resource. The demand for services in the central region of São Paulo is also reported, where some say they are better assisted. Looking for a reception center and intensifying substance use also appears as a way of dealing with a health issue, as well as doing nothing and admitting to a functioning of not seeking help in any situation.

Five of the 10 interviewees said they were unaware of the existence of health services nearby or mentioned services that are in the center of São Paulo. When they report knowing a service in the region, they mention the *Nossa Senhora do Brasil* BHU, being the one that appears most in the interviewees' statements. *Professor Luís da Rocha Pereira* CAPS Adult II, a service close to *Avenida Paulista*, is mentioned by only one of the interviewees.

Through the statements, the prejudice that they experience daily is clear. This fact is reported by authors, who say that the homeless population indicates their own condition as the main reason for discrimination. Characteristics "such as dirt, bad smell and the effect of legal and illegal drugs are often determinants for the precariousness in welcoming homeless

people in health services"⁽¹⁵⁾. This reason is superimposed by racial, generational and sexual orientation discrimination. Prejudice followed by discrimination is felt within the health services, as mentioned and felt by the interviewees, and which is confirmed by scientific literature⁽¹⁶⁻¹⁸⁾.

Respondents point to bureaucracy in care as a factor that makes access difficult, referrals, the delay in being able to perform tests, distance from certain devices and ignoring the report of individuals regarding their health status. This means that many do not return to seek a health service, resorting only when necessary to an urgent and emergency service.

A study carried out in Canada points out loss and/or lack of confidence of this population towards health professionals, inappropriate professional conduct, low professional listening, difficulties in transportation and accessibility, lack of understanding and empathy, and inappropriate judgments as barriers to access health services faced by homeless people⁽¹⁹⁾.

Individuals were excluded due to the lack of flexibility in the opening hours, difficulty in scheduling exams and consultations, as well as the requirement for proof of address, identity documents and the SUS (Brazilian Unified Health System – *Sistema Único de Saúde* – SUS) Card⁽¹⁵⁾.

Some of the interviewees bring difficulty of access to treatment related to problems arising from the use of alcohol and other drugs, from the conditions that a service offers permanence, such as food, infrastructure, religious bias, labor therapy and requirement of abstinence. This demonstrates that these services do not work under the Brazilian National Policy on Alcohol and Other Drugs guidelines such as harm reduction and low demand.

The Brazilian National Drug Policy has brought advances in care for people with mental health problems, resulting from the use of alcohol and other drugs, with new devices and practices, guided by the harm reduction that is the case of CAPS alcohol and other drugs. However, the current guidelines imposed are increasing in the implementation of exclusionary institutions⁽¹⁹⁾. It is noteworthy that the asylum culture today is present with other facets and among them stands out an emptying of the subjective and existential dimension of mental suffering, in favor of a physicalist, eliminative and reductionist version⁽²⁰⁾.

Often, referrals made by a team to another service come up against institutional bureaucracies, as occurs in the attempted hospitalization, in which the hospital team bars their admission for considering the discharge process complicated, as this population does not have a fixed address and a support network for full recovery⁽¹⁵⁾.

Literature reveals flaws in meeting the mental health needs of these people, with a gap in which the subjects may prefer non-pharmacological treatment, but health professionals do not present accessible options for this⁽¹⁸⁾. Another factor is that people experiencing homelessness understands health care anchored in the biomedical and curative model of the disease and considers it inaccessible due to the specificities of the context of the street they live on, leading to avoidance of demand⁽²¹⁾. In short, there is an immediate need to invest resources that can help facilitate access to health services for this population⁽¹⁸⁾.

The health device that forms the bridge between the street and health services is CnaR, as it promotes accessibility to the equipment of the institutionalized network, comprehensive care and the promotion of social bonds for people in situations of exclusion and social vulnerability, building a powerful space for the exercise of rights and citizenship^(6,15). The proposal is to provide street outreach, offer care where there is not yet an explicit demand for help⁽⁶⁾, build care in subjects' daily lives based on basic human needs⁽²¹⁾.

It is necessary to consider subjects' specificities, understand their health-disease process conceptions, their trajectories so that, in this way, services for them can be improved. It is understood that these devices do not aim to remove these people from this situation, nor at least clean the city, but rather to provide health care and promote subjects' autonomy before an exclusionary and unequal society. Much more than implementing new services, it is necessary to promote network actions that articulate sectors other than health, such as social assistance, housing and work, that constitute bond and trust and that have an active participation of this population in the formulation of public policies and assessment of this access.

CONCLUSION

It was possible to conclude with this study that despite the existence of specific health services for people

experiencing homelessness that remain or circulate on Avenida Paulista and surroundings, its access is not guaranteed. Seeking emergency services occurs as the main gateway for respondents and among the barriers faced, prejudice and bureaucratization are the main phenomena pointed out.

It is clear that there was an advance in relation to public policies aimed at this population in the municipality as well as in the constitution; however, there are still setbacks and, therefore, it is necessary to claim the principles advocated by the Unified Health System in its definition as universality, equity, and integrality.

New approaches are possible. Harm reduction actions linked to low-demand housing projects can be effective and have positive results in this complex problem that is care for homeless people. Research on this theme is far from resolving the social inequality phenomenon, but it is present as a driver for reflection among academics, workers and the population in general to reflect new thinking and doing.

Further studies are suggested in different regions with large urban centers, to identify the existing services and access barriers found by homeless people. It is understood that in this way, it is possible to add different care strategies and approaches to improve access to health for this population.

RESUMO

Objetivo: Descrever a percepção de pessoas em situação de rua que permanecem na Avenida Paulista da cidade de São Paulo em relação ao acesso aos dispositivos de saúde da região. **Método:** Pesquisa de abordagem qualitativa, realizada com 10 pessoas que se encontravam em situação de rua na Avenida Paulista em janeiro de 2019. Os dados foram coletados por meio de entrevista semiestruturada, e a análise dos achados se deu pela hermenêutica-dialética. Criaram-se duas categorias de resultados: *Serviços de saúde acessados na região pela população em situação de rua*; *Barreiras de acesso à saúde pela PSR da Avenida Paulista de São Paulo*. Este estudo obteve aprovação ética. **Resultados:** A procura por serviços de emergência se dá como a principal porta de entrada para as pessoas em situação de rua da região, e entre as barreiras enfrentadas, o preconceito é colocado como o principal fenômeno. **Conclusão:** É preciso considerar as especificidades dessa população, compreender suas concepções do processo de saúde-doença e suas trajetórias, para que, dessa forma, possa-se aprimorar os serviços e garantir o acesso à saúde deste grupo vulnerável e em crescimento.

DESCRITORES

Pessoas em Situação de Rua; Acesso aos Serviços de Saúde; Barreiras ao Acesso aos Cuidados de Saúde; Vulnerabilidade Social.

RESUMEN

Objetivo: Describir la percepción de las personas sin hogar que permanecen en la Avenida Paulista de la ciudad de São Paulo con relación al acceso a dispositivos de salud en la región. **Método:** Investigación cualitativa, realizada con 10 personas sin hogar en la Avenida Paulista en enero de 2019. Los datos se recolectaron a través de entrevistas semiestructuradas, y el análisis de los hallazgos se realizó mediante hermenéutica-dialéctica. Se crearon dos categorías de resultados: *Servicios de salud a los que accede en la región la población sin hogar*; *Barreras al acceso a la salud*. Este estudio obtuvo la aprobación ética. **Resultados:** La búsqueda de servicios de emergencia se presenta como la principal puerta de entrada para las personas sin hogar en la región, y entre las barreras enfrentadas, el prejuicio se ubica como el fenómeno principal. **Conclusión:** Es necesario considerar las especificidades de esta población, comprender sus concepciones del proceso salud-enfermedad y sus trayectorias, para que, de esta manera, se pueda mejorar los servicios y garantizar el acceso a la salud de este grupo vulnerable y en crecimiento.

DESCRIPTORES

Personas sin Hogar; Accesibilidad a los Servicios de Salud; Barreras de Acceso a los Servicios de Salud; Vulnerabilidad Social.

REFERENCES

1. Bursztyn M. Da pobreza à miséria, da miséria à exclusão: o caso das populações de rua. In: Bursztyn M, organizador. No meio da rua: nômades, excluídos e viradores. Rio de Janeiro: Garamond; 2000. p. 27-52.
2. Brasil. Ministério do Desenvolvimento Social e Combate à Fome. Secretaria de Avaliação e Gestão da Informação, Secretaria Nacional de Assistência Social. Rua: aprendendo a contar: pesquisa nacional sobre a população em situação de rua. Brasília, DF: Ministério do Desenvolvimento Social e Combate à Fome; 2009 [cited 2019 Feb 12]. Available from: https://www.mds.gov.br/webarquivos/publicacao/assistencia_social/Livros/Rua_aprendendo_a_contar.pdf

3. Fundação Instituto de Pesquisas Econômicas. Pesquisa censitária da população em situação de rua, caracterização socioeconômica da população adulta em situação de rua e relatório temático de identificação das necessidades desta população na cidade de São Paulo: sumário executivo. São Paulo: Secretaria Municipal de Assistência Social e Desenvolvimento; 2015 [cited 2019 Feb 12]. Available from: https://www.prefeitura.sp.gov.br/cidade/secretarias/upload/00-publicacao_de_editais/0003.pdf
4. Cordeiro AT, Mello SCB, Bastos AFS. [This is our beach! Appropriation and use of paulista avenue in the context of urban development policies]. *urbe. Rev Bras Gest. Urbana*. 2019;11:e20180104. Portuguese. <https://doi.org/10.1590/2175-3369.011.e20180104>
5. Brasil. Decreto nº 7.053, de 23 de dezembro de 2009. Institui a Política Nacional para a População em Situação de Rua e seu Comitê Intersetorial de Acompanhamento e Monitoramento, e dá outras providências. *Diário Oficial União, Brasília, DF*, 2009 Dec 24.
6. Brasil. Ministério da Saúde. Coordenação Nacional de Saúde Mental,. Consultórios de Rua do SUS: material de trabalho para a II Oficina Nacional de Consultórios de Rua do SUS. Brasília, DF: Ministério da Saúde; 2010 [cited 2019 Feb 12]. Available from: http://prattein.com.br/home/images/stories/PDFs/consultorio_ rua.pdf
7. Brasil. Ministério da Saúde. Manual sobre o cuidado à saúde junto à população em situação de rua. Brasília, DF: Ministério da Saúde; 2012 [cited 2019 Feb 12]. Available from: http://189.28.128.100/dab/docs/publicacoes/geral/manual_cuidado_populacao_ rua.pdf
8. Hino P, Santos JO, Rosa AS. People living on the street from the health point of view. *Rev Bras Enferm*. 2018;71(suppl 1):684-92. <https://doi.org/10.1590/0034-7167-2017-0547>
9. Donabedian A. An introduction to quality assurance in health care. New York: Oxford University Press; 2003.
10. Barata RB. Acesso e uso de serviços de saúde. *Sao Paulo Perspec*. [Internet]. 2008 [cited 2019 Feb 12];22(2):19-29. Available from: http://produtos.seade.gov.br/produtos/spp/v22n02/v22n02_02.pdf
11. McIntyre D, Thiede M, Birch S. Access as a policy-relevant concept in low- and middle-income countries. *Health Econ Policy Law*. 2009;4(Pt 2):179-93. <https://doi.org/10.1017/S1744133109004836>
12. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 12th ed. São Paulo: Hucitec; 2010.
13. Monteiro CN, Beenackers M, Goldbaum M, Oldbaum M, Barros MBA, Gianini RJ, Cesar CLG, Mackenbach JP. Use, access, and equity in health care services in São Paulo, Brazil. *Cad Saúde Pública*. 2017;33(4):e00078015. <https://doi.org/10.1590/0102-311x00078015>
14. Neves-Silva P, Martins GI, Heller L. "We only have access as a favor, don't we?" The perception of homeless population on the human rights to water and sanitation. *Cad Saúde Pública*. 2018;34(3):e00024017. <https://doi.org/10.1590/0102-311x00024017>
15. Hallais JADS, Barros NFD. [Street Outreach Offices: visibility, invisibility, and enhanced visibility]. *Cad Saúde Pública*. 2015;31(7):1497-504. Portuguese. <https://doi.org/10.1590/0102-311X00143114>
16. Varanda W, Adorno RDCF. Urbans discarded: discussing the homeless population complexity and the challenge for public health policies. *Saúde Soc*. 2004;13(1):56-69. Portuguese. <https://doi.org/10.1590/S0104-12902004000100007>
17. Barata RB, Carneiro Junior N, Ribeiro, MCSDA, Silveira C. Health social inequality of the homeless in the city of São Paulo. *Saúde Soc*. 2015;24(suppl 1):215-17. <https://doi.org/10.1590/s0104-12902015s01019>
18. Ramsay N, Hossain R, Moore M, Milo M, Brown A. Health care while homeless: barriers, facilitators, and the lived experiences of homeless individuals accessing health care in a Canadian regional municipality. *Qual Health Res*. 2019;29(13):1839-49. <https://doi.org/10.1177/1049732319829434>
19. Souza SEFD, Mesquita CFB, Sousa FSPD. Street approach to people who use psychoactive substances: an experience report. *Saúde Debate*. 2017;41(112):331-9. <https://doi.org/10.1590/0103-1104201711226>
20. Barros S, Oliveira MAF, Silva ALA. [Innovative practices for health care]. *Rev Esc Enferm USP*. 2007;41(spe):815-9. Portuguese. <https://doi.org/10.1590/S0080-62342007000500013>
21. Silva ICN, Santos MVS, Campos LCM, Silva DO, Porcino CA, Oliveira JF. Social representations of health care by homeless people. *Rev Esc Enferm USP*. 2018;52:e03314. <https://doi.org/10.1590/s1980-220x2017023703314>



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