

## SURVIVING ON THE STREETS: PATHS OF RESISTANCE TO THE DENIAL OF HEALTH RIGHTS<sup>1</sup>

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**ABSTRACT.** Exclusion contexts constitute cycles of marginalization of population groups, such as the homeless people (HP). In this context, human rights violations are recurrent, especially related to the difficulty of access to health services. The effectiveness of the policies for HP in Brazilian cities is still scarce, due to its restriction to medium and large cities and the limited public investment. Thus, the study sought to investigate HP health care paths in a small city. Field observations and semi-structured interviews were carried out to identify and understand the resources used in health care trajectories, which were analyzed based on thematic content analysis. Several strategies developed by the public in the face of the denial to the health rights and self-care are highlighted. Among the results, the precariousness of offers to women's health care, the restriction of health care to the use of psychoactive substances, of medicalizing nature and centered on the abstinence paradigm were stood out. It was observed the importance of housing for comprehensive care, and social and community networks as a way of restoring health on the streets.

**Keywords:** Health rights; homeless people; social exclusion.

## SOBREVIVER NAS RUAS: PERCURSOS DE RESISTÊNCIA À NEGAÇÃO DO DIREITO À SAÚDE

**RESUMO.** Contextos de exclusão conformam ciclos de marginalização de grupos populacionais, como a população em situação de rua (PSR). Nesse contexto violações de direitos humanos são recorrentes, em especial a dificuldade de acesso à saúde. A efetivação das políticas para a PSR nas cidades brasileiras ainda é escassa, por sua restrição a cidades de médio e grande porte e ao parco investimento público. Dessa forma, o estudo tem por objetivo investigar os percursos de cuidado à saúde da PSR em um município de pequeno porte. Foram realizadas observações de campo e entrevistas semiestruturadas para identificação e compreensão dos recursos acionados nas trajetórias de cuidado à saúde, que foram analisadas a partir da análise de conteúdo temática. Ressaltaram-se as diversas estratégias desenvolvidas pelo público diante da negação do direito à saúde e ao autocuidado. Destacam-se entre os resultados a precariedade de ofertas ao cuidado da saúde da mulher, a restrição do cuidado em saúde ao uso de substâncias psicoativas, de cunho medicalizante e

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centrado no paradigma da abstinência. Observou-se a importância da moradia para o cuidado integral, e das redes sociais e comunitárias como forma de restabelecimento da saúde nas ruas.

**Palavras-chave:** Direito à saúde; população em situação de rua; exclusão social.

## **SOBREVIVIR EN LAS CALLES: RESISTENCIAS A LA NEGACIÓN DEL DERECHO A LA SALUD**

**RESUMEN.** Los contextos de exclusión conforman ciclos de marginación de grupos poblacionales, como la población en situación de calle (PSC). En este contexto, violaciones de derechos humanos son recurrentes, en especial la dificultad de acceso a la salud. La efectividad de las políticas para la PSC en las ciudades brasileñas sigue siendo escasa, por su restricción a ciudades de mediano y gran porte y a la poca inversión pública. Así, el estudio buscó investigar los recorridos de cuidado a la salud de la PSC en una ciudad de pequeño porte. Se realizaron observaciones de campo y entrevistas semiestructuradas para identificación y comprensión de los recursos accionados en las trayectorias de cuidado de la salud, que fueron analizadas a partir del análisis de contenido temático. Se resaltan las diversas estrategias desarrolladas por este público como forma de resistencia a la negación del derecho a la salud y autocuidado. Se destacan la precariedad de ofertas al cuidado de la salud de la mujer, la restricción del cuidado en salud al uso de sustancias psicoactivas, de cuño de medicalización y centrado en el paradigma de la abstinencia. Se observaron la importancia de la vivienda para el cuidado integral, y de las redes sociales y comunitarias como forma de restablecimiento de la salud en las calles.

**Palabras clave:** Derecho a la salud; personas que viven en las calles; exclusión social.

### **Introduction**

The existence of homeless people (HP) is emblematic concerning the contradictions of the current political-economic model, for which the policies of valorization of the city's central areas cities aggravate conditions of vulnerability since they push the poor to the peripheries (Dimenstein, Dalla Vecchia, Macedo, & Bastos, 2018). At the same time, the precariousness of urban infrastructure in the peripheries brings HP closer to city centers. This relationship explains its increase in large centers, as well as the presence of migrants in search of job opportunities (Burstyn, 2003).

This process constitutes a singular reality in which exclusion and inclusion social are two sides of the same coin: the exclusion/inclusion dialectic (Sawaia, 2014). Thus, exclusion and inclusion make up lifestyles resulting from the processes of social inequality in which inclusion is a perverse way of keeping a large portion of the population integrated through the very exclusion of basic social rights (Sawaia, 1999). The dialectical movement between exclusion and inclusion, thus, leads to ethical-political suffering, resulting from the relationship between the experience of social injustice and affective responses in the face of both economic and social as well as subjective processes (Sawaia, 2014). In this sense, before an experience, the subject is affected by emotions and feelings that modify him: what moves the human action is the desire of developing his action power for the physical surviving and the emancipation of himself (Sawaia, 2014)

The social exclusion process is reflected in access to public policies. However, although the legal achievements are relevant, the rights provided in the Política Nacional para a População em Situação de Rua – PNPSR (National Policy for the Homeless Population) are not guaranteed in all states and municipalities. The National Survey on HP revealed low access to health services, in general, focusing on acute and emerging situations (Brasil, 2009b). In this context, the psychologist's performance has the potential to promote the protagonism and autonomy of the subjects in the face of the subjective experience of excluding processes, contributing to the deconstruction of care practices and that seeks to protect the subjects (Sawaia, 2014).

To deal with the low access to health by the HP, countries such as the United States, Brazil and Portugal sought to adapt the offerings of health services because of the singularities of this public, thus avoiding unnecessary referrals and favoring comprehensive care: active search in the space of the streets, readjusting the flow of access and assistance in primary health care services, et so on (Borysow, Conill, & Furtado, 2017). For an effective integrality of the care to the HP, intra and intersectoral actions are necessary for the light of phenomenon complexity. Even so, despite the recent conquests of rights, there is a concentration of care actions by social assistance. In Minas Gerais, for example, the actions developed focus on the care of HP users of alcohol and other drugs (Conselho Regional de Psicologia 4ª Região [CRP-04], 2015). However, orthopedic diseases, cardiac and psychiatric disorders represent 56.1% of the cases (CRP-04, 2015). Access barriers are aggravated in small cities, where social policies are implemented more slowly and gradually in relation to medium and large cities, especially due to the low commitment on the political agenda with the implementation of public policies, the poor social control of these policies and the consequent misuse of public resources (Luzio & L'Abbate, 2009).

Thus, there is an important gap between the legal frameworks on HP and their effectiveness in municipalities, especially in small towns, suggesting the relevance of identifying the health care paths of this population. This article presents an excerpt from the master's thesis of the first author, developed under the guidance of the second author, which allowed unveiling the care networks triggered for self-care and the guarantee of the health rights. On that occasion, we sought to highlight HP's actions that make explicit the search for survival on the streets through resistance strategies facing the denial of the health rights in a small municipality.

## **Methodological approach**

Illness and healing are experienced in unique ways, according to rules, traditions and collective experiences, usually distinct from those formally codified by biomedicine (Minayo, 2010). The illness process and the search for care start from a field of different senses and meanings, with no univocal correspondence between the prescribed and adopted health care paths. This search for health care is based on the combination of multiple factors such as individual issues (values and ideologies), type vicissitudes and illness processes, access to goods and services and economic situation (Alves, 2016).

The research was carried out in a city in Minas Gerais that stands out for its historical and tourist characteristics, with trade and agricultural production as its main economic activities. The network of social assistance services to assist the HP is constituted by a Centro de Referência Especializado em Assistência Social - CREAS (Specialized Reference Center in Social Assistance) that offers the Serviço Especializado de Abordagem Social – SEAS (Specialized Service for Social Approach) for this public. To facilitate entry

into the field, the first author monitored SEAS actions by using participant observations, enabling immersion in the field, showing the understanding of the observed reality and sharing daily experiences (Fernandes & Moreira, 2013). Participating observations were carried out two days a week between September 2016 and April 2017 and were recorded in field diaries. There was a gap between December 2016 and February 2017 due to the change in municipal management and, consequently, the adjustments that were necessary to be made up.

In all, fourteen field observations were carried out in order to identify aspects of interpersonal relationships, ways of organizing people living on the streets, in addition to possible referrals and access to health services. In this process, interlocutors with a life trajectory on the streets were identified for conducting semi-structured interviews, which favored the encounter with experiences that enabled to broaden the understanding of the study object and its variability.

The interview, as a research technique, favors an intersubjective relationship and allows closer contact between researchers and social actors, making it possible to apprehend senses and meanings attributed to a given experience from the verbal and non-verbal exchanges established at the meeting (Minayo, 2010). The semi-directed modality allows the participant to freely talk about a theme, but with the beacon of topics understood as essential. We sought to contemplate aspects of health care paths based on the different resources used in the face of illness or as a strategy to promote self-care on the streets.

The interviews took place in the space of the streets. Eight people (seven men and one woman) were interviewed, with the audio recording after informed consent. People over 18 years old, who presented health demands during field observations and who were willing to share their experiences in seeking health care were included. For the analysis of the information, thematic content analysis was used, which allows a deeper interpretation of the statements based on inferences about the factors that determine their production (Braun & Clarke, 2006). The interviews were recorded with the consent of the interlocutors and transcribed by the researcher. The pre-analysis of the material occurred with the fluctuating reading of the information produced from the participant observations and the semi-structured interviews, being selected the reports about the forms of HP health care, which constituted the *corpus* of analysis. The exploration of this material generated an initial classification, revealing aspects of health care in the care paths. At that moment, recurrent themes and contextual aspects were delimited, which supported the understanding of senses and meanings (Braun & Clarke, 2006).

The research project was submitted to and approved by the Research Ethics Committee of São João Del Rei Federal University, having received CAAE under no.65848717.9.0000.5545. To ensure the anonymity of the informants, fictitious names are used throughout the text to designate the interviewees.

## Results and discussion

The themes identified from the semi-structured interviews were grouped into categories based on the similarities, differences and contradictions in the participants' reports about health care paths: (1) emphasis on problems arising from the use of alcohol and other drugs; (2) housing as a way of accessing health and the subversion of therapeutic communities' role; (3) the 'street family' as a source of care and (4) insufficient health care provided to homeless women.

## Emphasis on problems arising from the use of alcohol and other drugs

During the research, it was noticed a certain relevance given to the treatment for problems resulting from the use of alcohol and other drugs. SEAS' performance, in these cases, is centered on offering and referrals to hospitalizations in entities similar to Therapeutic Communities (TCs), often requesting resources from the Brazilian 'Programa Aliança pela Vida' (Life Alliance Program), even if the municipality is not included as a beneficiary.

The Programa Aliança pela Vida was implemented in the State of Minas Gerais in 2011 to grant benefits to TCs for the treatment of users of alcohol and other drugs. In the municipality in question, cases were identified in which homeless individuals are hospitalized in other municipalities, justifying the absence of a fixed address so that the program can bear the costs of hospitalization. By prioritizing abstinence and segregation, separating the subject from their life context, this contradicts the principles of harm reduction in health policies as a priority strategy, especially due to its openness to the uniqueness of the context and the subjects, who demand forms of differentiated care (Brasil, 2016).

Most of the municipalities in Minas Gerais have 20 thousand inhabitants or less; with this, the regionalization of assistance becomes essential to enable access to users of mental health services, facing logistical barriers. In general, municipalities in Minas Gerais justify joining the Program due to municipal public divestment in the area of alcohol and other drugs and the lack of their own services (Lopes & Vecchia, 2015).

However, there are socio-cultural aspects that act on adherence to therapeutic proposals, which may or may not coincide with the offers made (Leite & Vasconcelos, 2006). Given this, even though the asylum model of the TCs is the only offer of SEAS, the Psychosocial Care Center - Alcohol and Drugs (CAPSad) is, basically, activated when there is a demand for psychiatric evaluation, but not always addressed - the past experiences of each subject act in the decision to adhere or not to this treatment model. When reducing CAPSad to service for medical evaluation, the offer of comprehensive and intersectoral care through multi-professional teams that must prioritize the reception of subjects with their singularities and, above all, the different meanings and functions of using alcohol and other drugs is left aside (Brasil, 2016).

The interlocutors constituted health care paths that demonstrate resistance to the denial of comprehensive care rights. Maurício, for example, has been on the street for two years and has already 'admitted' five times to TCs. At all times, the period prescribed for 'treatment' has not been completed:

That's what I tell you [...]. It's not enough just for the person to arrive and go to the hospital, and then the person leaves there, after completing the treatment. The person leaves there and goes back to the street; it is not worth. It won't be long before he goes back to alcohol and drugs.

Maurício questions the challenges for the continuity of treatment after discharge from treatment at the TCs. On the other hand, Gilberto, who has been for five years on the streets, reports that this situation constitutes a series of vulnerabilities where the use of alcohol and other drugs becomes functional: "[...] those who do not drink, smoke. It's difficult. From 100 homeless people, you take off two who don't drink or use anything. Nobody can live in that way. Almost nobody can stay like that, you know".

The Rede de Atenção Psicossocial – RAPS (Psychosocial Care Network) provides spaces for detoxification and physical recovery: beds 24h, in CAPSad or psychiatric wards in general hospitals (Portaria nº 3.088, 2011). In addition, social inclusion strategies are

central for maintaining treatment in order to change the pattern of use of psychoactive substances on the streets. In this regard, Maurício reports:

Ah, having a hospital stay, which I think the person needs, is to get the chemistry out of the body. However, after you leave, you have a group, an institution that [...] That can help and monitor you. Having a house for him to stay in, getting him a job. Then there is a great possibility that the person will get out of this addiction.

However, when asked about public facilities that offer this type of care, such as CAPS and CAPSad, they do not express adherence to these services: "I have heard that they [CAPS / CAPSad] are very fond of medication so they can control the person, and then the person ends up becoming addicted to the medication, he cannot be without it" (Murilo, six months on the street).

Gradually, Medicine, as an institution, assumed the hegemony of the discourse about adequate ways of life, previously exercised by religion and the law. It is noticed the transposition of single-causal to multi-causal etiological models that include aspects of daily life, framing the lifestyle of each one in symptoms related to certain diagnoses (Freitas & Amarante, 2015). It happens that the autonomy of the very body to circulate in search of sustenance is the basis for life on the streets and, consequently, its restriction is disregarded and devalued. If the space devoted to mental health care is not a support in this sense, it will not be part of the therapeutic itinerary of HP. Given the certainty of this subjection, and the fact that the interviewees used widely informal resources, they reject specialized mental health care spaces. Souza, Pereira and Gontijo (2014) claim that it is still possible to identify mental health services that require the subjects to be bathed, accompanied by a family member or carrying documents, contrary to the legal guidelines for the care of this public.

I asked if there is any partnership with CAPSad from the city, and he [SEAS technician] said yes and informed that the first CAPSad hospitalizations were for homeless people. In other words, CAPSad was a means for hospitalization and not a legitimate space for treatment. He also said that treatment for homeless people is not effective because relapse always happens at night (Field Diary).

It was observed that the public service network itself does not recognize health equipment for the treatment of problems arising from the use of alcohol and other drugs. The idea presented is that the subjects will 'relapse' at night, which would cancel the work done during the day at CAPSad. Such a posture refers to the abstinence paradigm, which is clearly a guideline for social assistance work in the municipality.

SEAS is responsible for intersectoral articulation, offering, among other actions, access to public policies. However, the centralized action in offering hospitalizations for the use of alcohol and other drugs goes beyond its attributions, exactly because it does not need to evaluate the clinical condition of the subjects. Such evaluation must be carried out by health equipment qualified for this in the municipality, as indicated by the Ministry of Social Development (Brazil, 2016).

Comprehensive care for users of alcohol and other drugs requires crosscutting measures, as it constitutes in assisting the needs related to fields such as justice, education, social assistance and the generation of work and income. Besides, the street situation is based on structural issues in contemporary society, namely, structural social inequality, which directly interferes in the processes of social exclusion/inclusion. Dealing with issues of such complexity, it is recommended to act in the promotion of individual and collective health protective factors, including psychosocial rehabilitation and social reintegration through the activation of social assistance and community networks (Sanches & Vecchia, 2018).

## Housing as a way of accessing health and subversion of therapeutic communities' role

Having a fixed residence, for the interviewed HP, is considered a means for maintaining health, since life on the streets is assessed as an obstacle to this: “[...] to be healthy? Just find a better place for me to stay, that's all, I can be. Just a better place for me to stay” (Sebastião, seven years on the street). Sebastião's speech underscores the inadequacy of the current hegemonic model of service to HP, in which the priority actions are (1) Temporary Institutional Reception, through shelters, (2) the offer of care for problems arising from the use of alcohol and other drugs, (3) reintegration into the formal labor market and, finally, (4) decent housing. Sebastião's account is emblematic of demonstrating the inversion operated at the same time. In this way, various obstacles present themselves for the overcoming from the street situation, and what is realized is the subjects' recurrence to the health services and social assistance.

At the international level, since the 1980s, the ‘Housing First’ model has been adopted in the United States and some European countries. For this model, the offer of housing must be a priority, contributing to the organization of life and access to other social rights (Tsemberis, 2016). The importance of the right to housing for access to health services is demonstrated in Luzia's care path. Her trajectory is marked by staying on the streets for a period, followed by the return to his sister's house, and subsequently returning to the streets. The most frequent access to formal services by Luzia, especially Unidade Básica de Saúde - UBS (Health Basic Unit) and Estratégia Saúde da Família- ESF (Family Health Strategy), stands out among the other interviewees: “[...] the doctor? Who do I look for? I have a record in all the health units, got it?”.

Likewise, Júnior, after suffering a foot burn, stayed for a few days at Gilberto's house, a friend of his, looking for UBS to make medical dressings:

Ah, now that I remember, I went [to the basic health unit]. It was on my feet, I went to change the dressing, and everything was fine [...]. I bandaged. Gilberto helped me, too, ok? I was there at Gilberto's; he helped me. He gave me medicine at the right time.

When asked how the treatment would have been had if he was not at his friend's house, his report demonstrates that there was no possibility of taking care of the injury while remaining homeless: “[...] then I was lost. I was supposed to lose even my foot. If Gilberto didn't help me and welcomed me, I'd lose my foot; it was really burned”.

In this sense, in the care paths reported, the temporary removal from the streets during health restoration is recurrent. Seeking shelter at friends and/or family home is repeated in the stories based on episodes of illness marked by gravity. Such reports refer us to the proposal of the ‘Housing First’ model, which provides HP access to permanent and dignified housing, financed by the government, through the rental of private properties. Each person or family remains in different areas, avoiding the stigmatization that could result from concentration in a specific urban space, and the rooms are individual or, at most, they are shared among family members, favoring privacy and the organization of a home (Tsemberis, 2016).

In the absence of housing policies, homeless people seek other solutions. Luzia and Lúcio are stood out due to their contact with their families, who live in the municipality. On the other hand, Júnior, Valdo and Sebastião have fragile and/or broken relationships with their families and seek shelter in the house of friends or entities similar to TCs. It is clear that the networks used to restore health alternate between formal and informal, with

emphasis on the complementarity between them. Because of the unavailability of own housing, as well as conflicting relationships with family members, the TCs take the place of spaces for the reestablishment of health:

The doctor set up a clinic there. The guy, the guy was a friend of some of my relatives. He wanted to send me there to my house, but my mother and father had died, so I said, 'no because I don't have anybody to change ideas, find a place for me to stay'. Then I stayed there for about six months. I healed there; they helped me with everything there at the clinic (Sebastião, seven years on the street, authors emphasis).

In this case, the supposed role of the TCs as a space for the treatment of problems related to the use of alcohol and other drugs is confused with that of a place for the recovery of health, without counting the technical apparatus and recommended material. Despite its contradictory character, this function is legitimized by the Ministry of Health, which institutes TCs as a residential care service.

PNPSR encourages the implementation of services that act as support houses for health after hospital discharge (Brasil, 2009a). In addition, the reception units established at RAPS provide for continued care for people with problems resulting from the use of alcohol and other drugs in situations of social and family vulnerability. However, such units can only be enabled in cities with at least 200 thousand inhabitants, and referral is made through CAPS (Portaria nº 3.088, 2011).

In this sense, the TCs act from the lack of RAPS devices, which is due both to the underfunding of public policies and to the care model that is not structured around the goal of social inclusion through access to decent housing. The reality of small municipalities, in this sense, highlights burning issues for the health care policies of the HP.

### **The 'street family' as a source of care**

Given the precariousness of offers in the face of comprehensive health care, it is observed that the social and community network is the main source of support for the restoration of the interviewees' health - in particular, friends, relatives and people who live close to the place that they frequent: "I have a great friend of mine over there who bought [medicine]. He always wanted to help me; then he buys it for me" (Maurício, two years on the street).

The family is a source of informal care that is present in different cultures (Helman, 2009). In the street situation, the restriction of family care is perceived, showing the role of social networks in the recovery of health. Social networks are constituted by the relationships built among individuals, interests and actions in a system of mutual and shared support and, because they demand the involvement and participation of their actors, it becomes a potent factor for the promotion of citizenship (Serapioni, 2005). This author adds that social networks play a significant role in supporting daily health problems among vulnerable groups due to the precariousness of formal care systems maintained by the social security system. Shy advancements of the social policies were observed in Brazil in the first decade of the century XXI related to the access and health care of HP in large-sized cities. However, in the small-sized cities, the informal social networks supply possible support:

Júnior's finger is still injured, and I asked him if he had gone to the health facility. He said yes and that it is getting better, but Gilberto said, 'He didn't go there, that was the girl who brought the ointment for you'. According to them, a college student bought an ointment for him to pass on the wound (Field Diary, authors emphasis).



Existing social networks promote the supply of food, clothing and blankets, with little interference in health rights. Such actions sometimes contribute to a minimum of dignified life on the streets; however, they run the risk of having an end in themselves. The challenge is to collaborate with the strengthening of the subjects' power and political recognition, beyond the charitable way, avoiding the individualistic logic that blames the subject for the situation in which he finds himself and promoting access to public policies. Research participants perceive that they depend on social and informal networks to meet the type of care needs they have, noting significant obstacles in formal networks:

I never have to stay in bed to depend on others. Thank goodness, because I don't know what it would be. Because once I ... That was even a fear of mine, 'my God if I stay in bed, who will take care of me?' (Gilberto, five years on the street, authors emphasis).

The neoliberal and fiscal adjustment context, making the State insufficient in the provision of social policies that minimize situations of vulnerability, bequeathed to social networks the effectiveness of assistance and informal care through different actors such as family, friends, neighbors or even volunteers and mutual help groups. In this sense, not only the family assumes actions of state responsibility, but also especially the third sector becomes a relevant actor in this process (Serapioni, 2005). Such a relationship creates an ambiguity, and the responsibility to meet social needs is sometimes seen as the responsibility and guarantee of the State, sometimes of the third sector. In the face of such uncertainty, life on the streets establishes networks of solidarity, especially in the face of weakened and/or broken family ties (Cunha, Garcia, Silva, & Pinho, 2017).

Each of the social actors interviewed has singularities of the experience of life on the streets that acts on their therapeutic itineraries. There are cooperative relationships among some people in the group interviewed, such as Valdo's report (twenty-five years living on the street) about the symptoms before the diagnosis of tuberculosis, "[...] oh, those ones, Gilberto, Sebastião, they caught me and brought here, I couldn't walk. They used to bathe me". Sebastião, seven years on the street, describes, "I always count on the help of people. A guy I always count on is Valdo. As you can see [...] and Valdo, we take care of each other".

In this sense, informal networks such as those created on the streets show spaces for exchanges and solidarity that contradict univocal relations between material and moral misery. Merhy et al. (2014) suggest that these are holes in institutional networks, where networks and connections marked by plural and specific codes and conduct of street life are managed. Here, there is a crucial point in the health care of vulnerable groups: unveiling such holes in the networks, identifying the development of the social determinants of the health-disease process in unique situations, enable to unveil the life experiences of these subjects and their power to act.

However, cooperation among the groups is not common to all the contacted interlocutors. Other factors interfere with the meaning of relationships on the street. The reports of greater cooperation are among the informants who have more time on the streets, in this case, more than five years. In these cases, family ties are more deeply broken, constituting what is here called 'the street family'. Likewise, Cunha et al. (2017) identified different interpersonal relationships of life on the streets, for some, mere coexistence among colleagues, and, for others, the construction of new bonds. Gilberto highlights the nuances that shape the type of assistance provided and received:

Due to the street situation, there is a problem like this: some are united with each other. each other. Others are not. Because in the street situation there is everything: there is 'cachaça' [a traditional

Brazilian northeastern alcohol drink], there are drugs, and there are all these things. So, depending on one, on the other, some only think about that, what he wants. Therefore, he is not always available to help others.

Lúcio and Luzia have greater contact with their family members, who live in the city, unlike the other interviewees, who develop a network of cooperation and bonds with each other: “[...] is this my main thing? Yeah! This is everything in my life. First, it is God up there, and on earth, there is my family” (Lúcio, one year and six months on the streets). Luzia makes the following report: “[...] it was supposed to be here [refers to the antihypertensive drug]. My sister is afraid that I will take these medicines and mix them with ‘cachaça’. Then she doesn’t let me get it, because she can be anything, but she wants my welfare” (Luzia, five years on the street).

Contact with family members acts on the therapeutic itinerary of Luzia and Lúcio, and both are welcomed into the home of relatives when they are affected by health problems that require rest or continuous care. Family ties, in these cases, provide support and care, even after the family member leaves home. In this sense, HP are essentially constituted by heterogeneity without necessarily breaking with the family bond, which was also observed in other studies (Cunha et al., 2017; Kunz, 2012).

Formal networks need to support informal networks in health promotion, especially among the HP and seek the coordination of both in a systemic process. Serapioni (2005) points out that there is a constant attempt to bureaucratize the informal networks, with little appreciation of the knowledge produced by the HP, and to overcome the delegation of the State's primary function of managing public policies to the social and community network.

### **Insufficient health care provided for homeless women**

The PNPSR identified the predominance of 82% of men among the HP, the main reason for women to go to the streets is the housing loss, that is, when there are no more options and intrafamily violence can no longer be supported. One of the factors that explain the lower number of women on the streets may be that they did not find a way forward to break with the extreme situations of violence experienced within homes (Brasil, 2009b).

Historically, public and private spaces have been fragmented into roles understood as typically from men or women, and the private sphere of home and family care were attributed to women. Contemporary feminism criticizes these binary and polarized positions, constituting more contextualized ways of analyzing the relationships between men and women, giving visibility to female participation in public spaces constituted by multiple relationships, such as the neighborhood, work and the streets (Brito, 2001).

Given the greater number of homeless men and the predominantly macho socio-cultural background, homeless women are constantly exposed to situations of submission and physical, sexual and psychological violence (Rosa & Brêtas, 2015). In the municipality in question, several networks are activated to promote women getting off from the streets, primarily to enable hospitalizations in TCs.

Although the street, and the public space as a whole, are not places for housing and survival, it is observed that there is still greater rigor in the face of the female gender and, given that, institutional arrangements are made to 'protect' them by taking them off the streets. It is not possible to affirm peremptorily whether this withdrawal occurs for the purpose of assistance, protection and guarantee of rights, or fundamentally the government of their lives. During the observations, three homeless women and one woman who had lived on the streets and had her own housing obtained through inclusion in the Programa

Minha Casa Minha Vida (a Brazilian social program aimed to help low-income people to get their housing) were identified. During the interviews, two of these women were contacted in the city, and only one expressed an interest in participating.

Luzia has been on the street for five years with her partner and her son. She reports restrictions on the relationship with other homeless people. In this case, the fact of being a woman, and being alone, daily, among them, delimits her own ways of acting:

I was dizzy, do you understand? [...] Alexandre [Luzia's partnership] came to hug me and threw me there [in an area with grass that grows on the edge of a stream that cuts through the city] after I got up, they came here to ask me how I was doing. If I were not a woman to go there [UPA – emergency health facility], I would have broken the spine.

Street life for women is permeated with violations that feed back into a stigmatizing cycle. Street companions, conflicts over space and sexual practices (Rosa & Brêtas, 2015) link such stigmas to gender oppression. In the streets, the degree of exposure of women increases and, consequently, the feeling of threat to the integrity of their own bodies:

However, I will talk to you, tell you the truth: I may be stinking and all, but I never got gonorrhoea or anything. I don't go to bed with any man; that's their anger, you know? You can lie by my side me and everything, but don't touch my body like Alexandre.

It is also noteworthy that prostitution becomes, in many cases, a way for women to survive on the streets guaranteeing financial resources. However, it contributes to increasing vulnerabilities concerning health and various forms of violence (Biscotto, Jesus, Silva, Oliveira, & Merighi 2016). Varanda and Adorno (2004) point out that the problematic use of alcohol and other drugs in pursuit of assuming aggressive behavior to keep men away is a resistance strategy adopted by homeless women. Luzia was quite aggressive in the weeks before the interview and with a noticeable increase in alcohol use. The change was noticeable during the group's follow-up, and in the absence of her partner, Luzia avoided the risk of sexual violence by men on the street through aggressiveness: "Hey, the paunchy is here, my son. I'll go by. Ohhh [...] take it easy! I'm talking to the girl here, take it easy. I'm not afraid of anyone, no. My husband is also arrested".

It is worth mentioning that, for Luzia, her relationship is not restricted to protection from the various forms of violence that women suffer on the streets but mainly desire, affinity and the construction of a shared life. A study carried out in São Paulo identified the subversion of the stereotype of fragility and dependence associated with the life of women on the streets, with the reports collected describing less tolerance to the aggression practiced by the companions and the search for relationships that are not restricted to the protection and are based on affection (Rosa & Brêtas, 2015).

Luzia continuously accesses formal health care services. Her care pathway involves treatments for hypertension, kidney problems and various accidents. In all cases, the search for care occurs when the health problem becomes more acute; however, more continuous care is not carried out. The last preventive exams were said to have taken place four years ago, even though her care reference was a gynecologist at the UBS in the neighborhood where her sister lives: "[...] with the [doctor] from [the neighborhood], he attends there. Ah, it must be about four years ago that I did some exams. I have to do them again".

Luzia had begun to notice changes in her menstrual cycle: "[...] this is awesome. I know where I take care, I only stay there for two days. I am about to enter into the menopause period". Even though the changes are attributed to the physiological process of menopause, it is worth mentioning that Luzia is 36 years old, making it impossible to affirm any

relationship between the situation on the street and the decrease in menstrual flow, since possible comorbidities in her health condition were not also explained.

The discontinuity of care for her health problems seems to be related to a different factor from those presented by the other research participants: Luzia constituted care relationships along with other people, and with each social approach performed, she sought help for some members of the group. Either she, sometimes, requested for hospitalization for third parties, or sometimes for the technicians to accompany some of them in the health service, or for them to mediate the return to the city of origin of a migrant.

Luzia's actions demarcate the social role of women involved in the care and care of others, but not really about themselves. In informal conversations in the course of field observations, when the theme approached self-care, Luzia changed the subject or moved away:

Luzia has a deep cut on her hand and showed it to me. I told her she needed a stitch, and she said she didn't look for care. I asked her why she didn't seek care, and she evaded it. Shortly afterward, she approached and said that she is not taking her medicine for high blood pressure, reporting that the intake is not doing her any good and, once again, when I try to explore her speech, she does not talk about it, evaded (Field Diary).

Gutierrez and Minayo (2009) describe the representation of the women's role as the main provider of family care, especially concerning health. It is also noteworthy that sometimes women's self-care is confused with the care of other family members through intergenerational practices. Given the cultural elements that involve the social role played by women, Luzia's posture highlights in relation to the informal care provided and the activation of formal networks to assist street colleagues, without the same investment in self-care.

## **Final considerations**

Institutional omissions involving the health and social assistance sectors, both in isolation and with one another, lead the HP to negotiate different strategies for self-care, integrating formal and informal networks. How the TCs are included in the itineraries has evidenced its place in suppressing the absence of reception units, as recommended in the RAPS, as a temporary housing solution for the recovery of the health of the HP. A transitional reception unit, with shared regional management, for example, would be strategic to contribute to the effectiveness of the health rights in this municipality.

The reports highlight the role of the right to housing in promoting health and preventing the risk of becoming ill. Creative strategies have been identified to deal with the denial of health rights. It is necessary to move forward in the debate about housing as a right and not only in the Manichaean right to private property that, despite social injustice, suffers from real estate speculation that increases social segregation. The promotion of social housing experiences is the basis for overcoming this situation.

The interlocutors' reports and field observations make it possible to infer the lack of intersectoral work along with the HP. The precariousness of the current notion of rights subjects acts as preventing the collective organization of the HP in the face of an assistentialist and non-emancipatory culture. If, on the one hand, the achievements in the scope of public policies for HP arise from the grassroots work consolidated by collective organizations such as the National Movement of the Street Population, on the other hand,

investments in social policies are needed to induce the strengthening of HP policy mobilization in small and medium-sized cities.

The awareness of ethical-political suffering can generate collective actions when they mobilize hope and the action power in each subject. That is why it is essential to act in order to mobilize singular desires and affections in their mediation with the collective, transforming needs into social demands articulated by the subjects (Sawaia, 2014). The public authorities daily harass HP, mainly due to the stigmas associated with the use of alcohol and other drugs. Even if the psychologist performance, in this sense, does not directly intervene in economic and power relations, it is necessary to consider, in exclusionary contexts, both the sharpening of the constitutive contradictions of the capitalist production mode and the unavoidable character of the power of acting of the subject facing the experience of social injustices (Sawaia, 2014).

The care paths enabled to observe actions motivated for survival, fruits of resignation, limited due to the structural social inequality that coopts the subjects' potency of action, as well as actions that, in addition to building a therapeutic itinerary, demonstrate forms of resistance of the HP to ethical-political suffering and, more specifically, to the denial of health rights. Above all, it is highlighted that such actions stem from the welfare regime of public policies, where the subject is not considered as the protagonist in the construction of the actions, but as his mere dependent.

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