The vision of the population in street situation about the access to health care

Visão da população em situação de rua acerca do acesso à assistência em saúde

La visión de la población en situación callejera sobre el acceso a la atención médica

RESUMO

Objetivo: Analisar a visão dos usuários em situação de rua acerca do acesso à assistência em saúde. Métodos: Estudo descritivo, exploratório de natureza quantitativa. Para as análises descritivas, a frequência e a porcentagem foram utilizadas para as variáveis categóricas. O teste Shapiro-Wilk foi o escolhido para avaliar a normalidade da distribuição de dados, enquanto o teste de Fischer foi usado para realizar a análise comparativa das variáveis categóricas. Resultados: Foram entrevistados 30 pessoas. Por meio de Teste de Shapiro Wilk obteve-se um p valor = 0,504, com uma média de idade de 41,23 anos, variando de 19 a 62 anos de idade. Conclusão: A maioria da população em situação de rua na região Centro Sul em Belo Horizonte, possui cadastro no sistema único de saúde e não apresenta dificuldades em acessar o serviço. Presta-se uma assistência de qualidade, verificando a vinculação desse público à atenção primária do município.

DESCRITORES: Pessoas em Situação de Rua; Populações Vulneráveis; Acesso aos Serviços de Saúde; Sistema Único de Saúde

ABSTRACT

Objective: To analyze the view of homeless users about access to health care. Methods: Descriptive, exploratory study of a quantitative nature. For descriptive analyses, frequency and percentage were used for categorical variables. The Shapiro-Wilk test was chosen to assess the normality of data distribution, while the Fischer test was used to perform the comparative analysis of categorical variables. Results: 30 people were interviewed. Through the Shapiro Wilk Test, a p value = 0.504 was obtained, with a mean age of 41.23 years, ranging from 19 to 62 years of age. Conclusion: The majority of the homeless population in the Center-South region of Belo Horizonte, is registered in the unified health system and has no difficulties in accessing the service. Quality care is provided, verifying the link between this public and the municipality's primary care.

DESCRIPTORS: Homeless People; Vulnerable Populations; Access to Health Services; Health Unic System

RESUMEN

Objetivo: Analizar la visión de los usuarios de la calle sobre el acceso a los servicios de salud. Métodos: Estudio descriptivo, exploratorio, de carácter cuantitativo. Para los análisis descriptivos, se utilizaron la frecuencia y el porcentaje para las variables categóricas. Se eligió la prueba de Shapiro-Wilk para evaluar la normalidad de la distribución de datos, mientras que la prueba de Fischer se utilizó para realizar el análisis comparativo de variables categóricas. Resultados: 30 personas fueron entrevistadas. Mediante el Test de Shapiro Wilk se obtuvo un valor de p = 0,504, con una edad media de 41,23 años, con un rango de 19 a 62 años. Conclusión: La mayoría de la población sin hogar de la región Centro-Sur de Belo Horizonte, está registrada en el sistema único de salud y no tiene dificultades para acceder al servicio. Se brinda atención de calidad, verificando el vínculo entre este público y la atención primaria del municipio.

DESCRIPTORES: Personas en situación de calle; Poblaciones vulnerables; Acceso a los Servicios de Salud; sistema único de Salud

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INTRODUCTION

The Homeless Population (HP) is a group of people with different ways of life and relationships, who, for different reasons, broke their family ties, resulting in precarious living conditions and lack of regular conventional housing. [1] Several factors aggravate this context, such as social inequality and prejudice suffered by these people, which demands discussions about health care for this population with unique needs. [2]

In 2009, the National Policy for the Homeless Population (PNPSR - Política Nacional para a População em Situação de Rua) was created through decree n°7.053, which has as its premise the respect for the dignity of the human person, right to family and community life, appreciation and respect for life and citizenship, humanized care and respect for social conditions and sexual, religious and racial differences of these individuals. [3]

There are decentralized and articulated actions between the Union and other federative entities, with the realization of rights and the reintegration of HP into family and community networks. However, there is disarticulation between the health sectors, promoting discontinuity of programs aimed at HP, with palliative, isolation and medicalizing practices. [4]

For this to occur, a multi-professional look that guarantees the equity of the service provided according to the principles of the SUS is essential. [5]

The SUS's principle is to change the scenario of inequality in health care, making it mandatory to provide care to every Brazilian or foreign citizen, making health service available at all levels of care with integrity, equity and universality. [6]

The inclusion of the homeless population in health care at the various levels of care is nothing more than a right guaranteed in our constitution. [7]

In Brazil, there is a significant number of people living on the streets, and the North Region has 4,399 individuals, the Midwest has 8,777 individuals, the South Region has 16,021 individuals, the Northeast Region has 22,864 people and the Southeast Region has 49,792. With a total of 101,854 homeless people, the Southeast Region stands out with the highest percentage of HP, in the order of 48.89% and the North region with the lowest percentage of 4.39%. [8]

In 2018, the Municipality of Belo Horizonte published that there were 5,607 people registered as people living on the streets. When analyzed by region, the Center-South has 3,292 people (58.71%), Barreiro has 212 (3.78%), East has 376 people (6.71%), Northeast 64 (1.14%), Northwest 580 (10.34%), North with 699 (12.47%), West with 50 (0.89%), Pampulha with 63 (1.12%), Venda Nova with 180 people (3.21%) and on unmanaged addresses with 91 (1.62%). [4]

Health institutions and their professionals have little experience in welcoming homeless people, as well as being unaware of their needs, which may occur due to the stigma of this group, as well as poor conditions of personal hygiene and use of drugs and alcohol. As a result, these homeless people experience access difficulties to schedule appointments and flexible schedules, mishaps in the Support Network for hospitalization, which further increases their social invisibility. [9]

Given the above, the objective of this study was to analyze the view of homeless users about their access to health care in the city of Belo Horizonte, Minas Gerais.

METHODS

This is a descriptive, exploratory study of a quantitative nature. For descriptive analyses, frequency and percentage were used for categorical variables, in addition to the mean or median, as appropriate, for continuous variables. The Shapiro-Wilk test was chosen to assess the normality of data distribution, while the Fischer test was used to perform the comparative analysis of categorical variables. Values of $p \leq 0.05$ were considered statistically significant. Data were analyzed using the SPSS statistical program version 22.0 for Windows. The research was carried out in the central-south

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region, as it holds more than half of this public, and the research sample is composed of individuals who meet the following inclusion criteria: individuals aged 18 years or over, female or male and who were in the central--south region. The exclusion criteria was not signing the free and informed consent form.

The interviews were carried out from Mondays to Wednesdays from June to July 2020.

The work began after data collection was authorized by the Ethics and Research Committee of Faculdade Ciências Médicas and the study site, with opinion number: 15740719.9.0000.5134. Participants were asked to sign an informed consent form, where they were informed about the research objectives, risks, benefits and confidentiality of this study.

RESULTS

Thirty homeless people were interviewed, 25 men and 5 women, the male sex predominates (83.33%) of the interviewees. Through the Shapiro Wilk Test, a p value = 0.504 was obtained, with a mean age of 41.23 years, ranging from 19 to 62 years of age. When establishing the age confidence intervals, it was demonstrated that there were no significant differences between the average ages of men and women.

Participants declared themselves brown with a percentage of 66.7% (n=20), black 20% (n=6) and white with 13.3% (n=4).

The variables sex/gender and level of education were crossed, and the results are presented in the following table:

Regarding the place of birth of the interviewees, a percentage of 40% (n=12) are from Belo Horizonte, 23.3% (n=7) are from cities in the interior of Minas Gerais, 30% (n=9) are from other states and 6.7% (n=2) are from other South American countries.

Regarding the level of education, 43.3% (n=13) have completed elementary school, 36.7% (n=11) have completed high school, 13.3% (n=4) have incomplete elementary school, 3.3% (n=1) have higher education and only 1 interviewee (3.3%) cannot read and write.

There was no significant difference between the sex/gender of the interviewees and schooling by the Fischer test p=0.145.

A possible relationship between sex/gender and consumption of illicit drugs, alcohol and tobacco was sought. By Fischer's Exact Test, there were differences, demonstrating that there is greater consumption by men in the three variables analyzed.

Table 1 - Association between sex/gender and consumption of alcohol, drugs and tobacco by respondents, 2020.

Dependency	Men (n)		Women (n)		p value*
	Yes	No	Yes	No	
Alcohol	22	2	2	0	0,018
Drugs	15	9	1	1	0,011
Tobacco	14	10	1	1	0,13

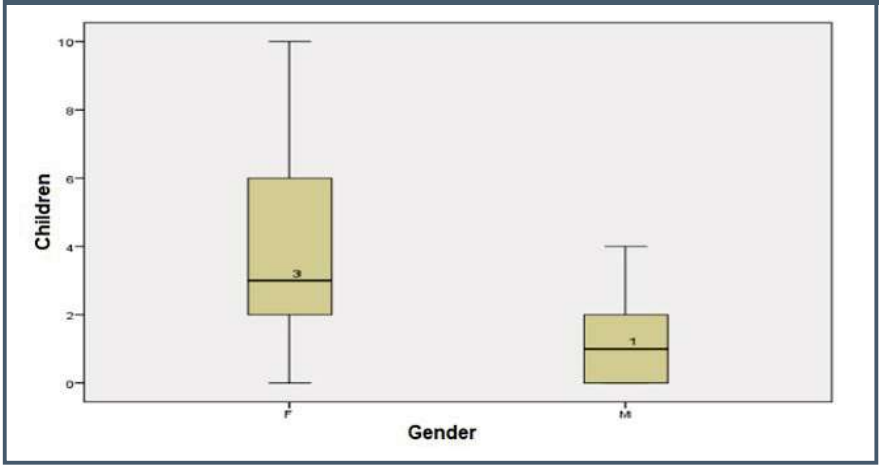
Source: Survey data, 2020.

Table 2 - Association between education and consumption of alcohol, drugs and tobacco by respondents, 2020.

Dependency	Incomplete Elementary School (n)	Complete Elementary School (n)	Complete High School (n)	Complete Higher education (n)	p value* complete(n)
Alcohol	3	10	10	1	0,328
Drugs	3	8	4	1	0,385
Tobacco	3	6	5	1	0,656

Source: Survey data, 2020.

Figure 2. Median number of children by sex/gender, 2020.



Source: Survey data, 2020.

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The analysis of the consumption of alcohol, illicit drugs and tobacco in relation to the level of education of the participants did not show significant differences using the Fischer Test:

As for marital status, 90% (n=27) are single, 6.7% (n=2) are married and 3.3% (n=1) are divorced.

Regarding children, 60% (n=18) have children and 40% (n=12) say they do not. It was observed that the median for women corresponds to 3 children and for men, the median is equivalent to 1 child.

In relation to possible deficiencies, 90% (n=27) declare not having any, while only 10% (n=3) have deficiencies. Among those interviewed with disabilities, 1 woman mentioned great difficulty in locomotion due to obesity and 2 other male residents mentioned atrophy and paresis of the upper limb.

As for the evidenced comorbidities, 73.3% (n= 22) reported not having them, 6.7% (n= 2) reported having diabetes, 6.7% (n= 2) hypertension, 6.7% (n= 2) respiratory diseases, 1 interviewee reported anemia and another interviewee reported having hernia, each corresponding to a percentage of 3.3%.

Among the reasons that led the interviewees to live on the streets, a percentage of 50% (n=15) with family ties breaking, 16.7% (n=5) reported the use of alcohol and illicit drugs, 13.3% (n=4) did not want to report the reason, 10% (n=3) for unemployment and another 10% (n=3) mentioned their own choice.

A percentage of 83.3% is registered in the Unified Health System. It was evidenced that 73.4% have access to benefits granted by the government, 46.7% (n=14) have a family allowance and 26.7% (n=8) have emergency aid.

Regarding the place of birth of the interviewee and the way in which he was received at the health services, there were no significant differences (Fisher's exact test p =0.151). It is mentioned as an observation that the 2 interviewees from other countries never accessed the health service in BH.

There were no significant differences between the level of education of the interviewees and the reception of the professionals by the Fisher's exact test (p=0.327).

There was no difference between the reason that led the interviewee to live on the streets and the treatment given by the health professional in his approach using Fisher's exact test (p=0.953).

DISCUSSION

Historically, the attention given by the government to the HP was based on hygienist and repressive practices, in which the individual was stigmatized by his condition, forced to live on the margins, so that his presence did not cause discomfort to the society that repressed him. The National Policy for Attention to the Homeless Population highlights the importance of intersectoral actions, considering housing, education, work, in addition to the health care itself aimed at this public. Thinking about the health of this population means tracing a profile to identify this public and its demands so that, through these data, intersectoral health actions can be traced that cover the needs of this public.

Studies show that homeless people

Table 3 - Association between how it was received and the place of birth of the respondents, 2020.

			How it was received				
			Great	Good	Regular	Never accessed the health service	Total
Participants' birthplace	Belo Horizonte	Score	3	8	0	1	12
		%	25%	66,7%	0%	8,3%	100%
	MG countryside city	Score	1	5	1	0	7
		%	14,3%	71,4%	14,3%	0%	100%
	Other states	Score	1	6	0	2	9
		%	11,1%	66,7%	0%	22,2%	100%
	Other countries	Score	0	0	0	2	2
		%	0%	0%	0%	100%	100%
Total		Score	5	19	1	5	30
		%	16,7%	63,3%	3,3%	16,7%	100%
		P value	0,151				

Source: Survey data, 2020.

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Table 4 - Association between how it was received and the participants' level of education, 2020.

			Participants' level of education					
			Illiterate	Incomplete Elementary School	Complete Elementary School	Complete High School	Complete Higher Education	Total
How it was received	Great	n	0	0	1	4	0	5
		%	0%	0%	20%	80%	0%	100%
	Good	n	1	3	10	5	0	19
		%	5,3%	15,8%	52,6%	26,3%	0%	100%
	regular	n	0	0	0	1	0	1
		%	0%	0%	0%	100%	0%	100%
	Never accessed the health service	n	0	1	2	1	1	5
			0%	20%	40%	20%	20%	100%
Total		n	1	4	13	11	1	30
		%	3,3%	13,3%	43,3%	36,7%	3,3%	100%

Source: Survey data, 2020.

experience exclusion and marginalization from society and that they seek the central regions of cities to live; because these locations contain large shopping centers that contribute to access to basic services and help from third parties. [10,11]

There are numerous factors that lead people to live on the streets, with the loss of family ties being cited by more than half of the interviewees in the present study. In a survey carried out in the city of BH, 35.7% indicated that the main motivating factor for living on the streets was family problems. [4] Similar results were found by Balieiro, who highlighted conflicts and lack of support in family life as a motivating factor for abandoning their homes and families. [12] In addition, there was an increase in the proportion of individuals who started to live with friends and people with no kinship relationship to the detriment of living with family. [13]

In addition, there was an increase in the proportion of individuals who started to live with friends and people with no kinship relationship to the detriment of living with family. [7] Drug consumption has been highlighted. A study carried out in the central region of Belo Horizonte showed that the most ingested licit drugs were cigarettes and alcoholic beverages, such data being similar to those of the present study. [14]

A study showed the greater consumption of drugs by men to the detriment of consumption by women. Men are predisposed to use illicit drugs early, for an indefinite period in large quantities. [15] In the present study, the consumption of alcohol, drugs and tobacco was higher in the male population.

Comparing the total population of respondents living on the streets, in the central south region, in Belo Horizonte, it was possible to observe that more than 83.3% were male. Similar data were found in a survey carried out by the Ministry of Citizenship in which 82% of homeless people were male. [16]

The male population living on the streets has always been higher than the female population. The fact that the number of women is lower can be explained by cultural differences in relation to the environment in which they live, or even the family environment. Man seeks survival by becoming the environment of the social street. [17] Due to gender, women become more vulnerable to aspects such as sexual abuse, physical violence, sexually transmitted infections and unplanned pregnancies. [1] In this way, they seek to maintain them in a domestic environment, even if it does not offer the desired security.

In the reality studied, the dominant color declared by the interviewees was brown with 66.7%, black with 20% and white with 13.3%. The data are in line with the sense made by the Municipality of Belo Horizonte, in which 61% of the individuals declared themselves to be brown, 23% black and 16% white. [4]

In contrast, a study carried out in the city of Itajaí in Santa Catarina, the dominant color was white with 70.2%, brown 22.4% and black 7.1%. The justification in the numbers compared is given by the migratory profile presented in the South Region, in which the predominance of the brown and black population is lower compared to the rest of the country. [18] In general, the studies did not point to any interviewee who declared himself to be

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yellow or indigenous.

Regarding the level of education, a study showed a percentage of 47% of individuals with incomplete elementary school and 20.4% with complete elementary school. [18] In a sense carried out in the city of São Paulo, only 15% completed elementary school. [13] In the present research, 43.3% had completed elementary school and 36.8% had completed high school, demonstrating a level of education that differs from previous research.

Regarding the search for care, research shows urgent and emergency services as the most sought after by this population. The insertion of the homeless person in the health center occurs by spontaneous demand, when he goes to the unit with complaints and other comorbidities. [19]

The search for emergency care units occurs due to the difficulty of accessing primary care. [20] On the other hand, in our research, the level of care most sought after by HP is primary care, represented by the Carlos Chagas Health Center. There is a bond between health professionals and interviewees who maintain a relationship of mutual respect.

The PHC (primary health care), with its qualified professionals, are able to insert the HP in a new context, the professional who performs the reception inserts people into services that the UBS offers the population. Health care for this population does not have an exact time to occur. The service demands time, collaboration, recognition of difficulties, so that the professional can provide effective care, and it is in this line of organization that the bond between professional and client is created through the understanding of the peculiarities of this population. [2]

The affections created are essential in linking with the other. The population living on the streets is often treated without empathy, without the opportunity to create bonds. [1] In contrast to the results of the previous research, in the present study the link with primary care was demonstrated, with a percentage of 53.5% (n= 23) who allege that they frequently seek to resolve their demands.

HP's lack of access to private and public services has always been present in research. Access refers to the availability and ability to use health services, considered the first phase to be faced by users in the search for care to solve their needs. [19]

The health team needs a unique look towards this public, in the search for strategies that aim at quality care and guarantee this access. [20]

Studies portray difficulties in accessing health services related to prejudice from the community and health professionals associated with poor hygiene, lack of documentation and registration in health units. [21,22]

The absence of registration and documentation are factors that can prevent your connection to health units. [19] This fact was demonstrated in a national survey that showed a percentage of 18% of the HP who did not have access to health care because they did not have documents and a general record to access SUS services. [23] On the contrary, in the present study, a high percentage of people registered with the SUS was identified, which favors access to health services by this public.

However, the prevention of comorbidities is not something present in the routine of this group. It is perceived the difficulty of identifying that health care is necessary due to the lifestyle. Health prevention is best seen in groups with greater stability, favoring the individual's search for employment, housing and family. [24,25]

Regarding the comorbidities that most affect HP are tuberculosis, infestations, sexually transmitted infections (STIs), high-risk pregnancy, compromised oral health, chronic diseases (hypertension and diabetes mellitus), hepatitis, exaggerated use of licit and illicit drugs. [26] Comparatively, our study identified that 73.3% of the HP declared that they did not have comorbidities and the diseases presented with the highest rate were diabetes mellitus and hypertension. No infectious comorbidities were found in our sample.

CONCLUSION

We believe in the relevance of the present study, as it allowed us to see that the majority of the homeless population in the Center South region of Belo Horizonte, has a registration in the Unified Health System and does not have difficulties in accessing the service. Quality care is provided according to the interviewees' reports, through knowledge of the conditions of these users, linking them to primary care.

It is important to highlight that the causes that led this public to live on the streets, such as family conflicts, alcohol and drug use, homelessness, unemployment did not interfere in the behavior of professionals who maintained care in a humanized way.

There are numerous challenges imposed on managers and technicians to manage actions collectively, to unite efforts and strategies, emphasizing the differences and potential of these subjects, in order to give them social visibility. The positive results of access to health seen in the present research should be emphasized as guiding a promising path for the inclusion of this public in society.

However, as limitations of the study, the size of the sample stands out and the fact that it contained only individuals treated at the Centro De Saúde Carlos Chagas. This unit is a national reference in serving the homeless population, being, therefore, a place with professionals who deal daily with people in situations of social vulnerability.

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