
ATTENTION AND HEALTH CARE OF THE PEOPLE LIVING ON THE STREETS (UBERABA/BRAZIL)

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ABSTRACT. This study aimed at understanding the main difficulties and strategies reported by people living on the streets regarding their own practices to keep their health, as well as public health policies towards them, in order to discover whether those practices and policies meet their real necessities. This is a qualitative, exploratory and cross-sectional study. The participants (two women and four men), aging, in average, 38 years, have been living on streets for almost 16 years. All of them took part of the study willingly. The data were collected by means of individualized interviews and analyzed by using thematic content analysis. The main results showed that the participants have several health care needs, because of the precarious environment that they live in; moreover, they demand a space for being attentively listened to, so that they can express their social, material and subjective needs. Therefore, it could be noticed that there is a huge demand for the establishment and/or improvement of spaces that allow more satisfactory health care and more studies on this subject in the city of Uberaba (Brazil), taking into account the particularities of this population.

Keywords: People living on streets; public policies; health promotion.

CUIDADOS E ATENÇÃO EM SAÚDE DA POPULAÇÃO EM SITUAÇÃO DE RUA (UBERABA/MG)

RESUMO. Este estudo objetivou compreender quais são as principais dificuldades e estratégias apontadas por pessoas em situação de rua relacionadas às suas práticas e às políticas públicas de cuidados em saúde, averiguando se atendem de forma efetiva às suas demandas. Trata-se de estudo qualitativo, exploratório e transversal. Os participantes (duas mulheres e quatro homens) têm idade média de 38 anos, estão na rua em média há 16 anos e participaram voluntariamente da pesquisa. Os dados foram coletados por meio de entrevistas individuais e analisados por meio da análise de conteúdo temática. Os principais resultados apontam que os entrevistados apresentam várias necessidades não contempladas de cuidado em saúde tendo em vista a precariedade do ambiente que estão inseridos; além disso, eles demandam um espaço de escuta atenta e qualificada para suas necessidades e desamparos sociais, materiais e subjetivos. Portanto, nota-se a importância de estabelecer e/ou aprimorar espaços e serviços de saúde como o Consultório na Rua que viabilizem de forma mais satisfatória o cuidado em saúde na cidade de Uberaba-MG levando em consideração as particularidades dessa população.

Palavras-chave: Sem-teto; políticas públicas; promoção da saúde.

CUIDADO Y ATENCIÓN DE LA SALUD DE LAS PERSONAS SIN HOGAR

RESUMEN. Este estudio tuvo como objetivo comprender las principales dificultades y obstáculos mencionados por la gente en las calles (personas sin vivienda) relacionados con la oferta políticas públicas de salud. Es un estudio cualitativo, exploratorio y transversal. Los participantes (dos mujeres y cuatro hombres) con edad media de 38 años

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están en la calle por un promedio de casi 16 años y voluntariamente participaron en el estudio. Se recolectó los datos por intermedio de entrevistas individuales y analizados mediante análisis de contenido temático. Los principales resultados enseñan que los sujetos tienen varias necesidades de atención en vista del medio ambiente precario que viven; además, exigen un espacio de escucha atenta de sus necesidades sociales, materiales y subjetivas. Por lo tanto, es importante establecer espacios que permiten una atención más satisfactoria y más estudios sobre el tema en la ciudad de Uberaba (Brasil) teniendo en cuenta las particularidades de esta población.

Palabras-clave: Sin vivienda; políticas públicas; promoción de la salud.

The concepts related to health may acquire different meanings, depending on the population dealt with, the historical period and on the values and customs that each society has. In fact, the understanding that a certain group has in relation to health represents aspects of their way of living (Bacellar, Rocha, & Flôr, 2012).

Historically, the concept of health has had changes: from conceptions that prioritized pharmacological, healing actions and the absence of illnesses through conceptions that emphasize the physical, mental and social welfare as a whole (Pereira, Augusto, & Barros, 2011). Therefore, health, seen from the biopsychosocial paradigm point of view, requires the inclusion of subjective and collective dimensions, considering other aspects rather than only the biological ones within the process health-illness. It allows the understanding that health is a result of a social process which represents the existence conditions of the individuals (Pereira et al., 2011).

From this presupposition, the Brazilian Unified Health System, known as “Sistema Único de Saúde - SUS”, intends to offer health care in a broad way, including the basic care up to the most complex one, by means of comprehensiveness, universality and equality principles (Ministério da Saúde, 1990), enabling all the citizens to have their necessities supplied. However, it is known that the reality is different: Rosa, Secco and Brêtas (2006) point out that the impoverishment of Brazilian population influences on their life quality and on their health conditions.

More specifically, the population living on the streets is disfavored within the health care system. This population can be defined as:

... a heterogeneous population who has in common the poverty, broken or interrupted family ties, living in a process of social disconnection for the lack of salaried work and the protection provided or dependent on this kind of work; those people also do not have conventional regular place to live, having the streets as their space for living and for obtaining sustenance (Ministério do Desenvolvimento Social e Combate à Fome [MDS], 2008, p. 9 – free translation).

The first (and the only one up to the present moment) national research on the population living on the streets (MDS, 2008; Ministério da Saúde, 2012), carried out in 71 towns, revealed important data regarding this population: they are approximately 50 thousand people (considering only the ones who are 18 or older); they are aged between 25 and 44 years; they are men at most (82%) and black at most (67%); they have low educational instruction (48% of them are basic school dropouts and 15% have never been to school); they are on the streets for varied reasons (29.1% because of family estrangement, 29.8% because of the unemployment and 35.5% because of the abuse of alcohol or other drugs); 70% effectively live on the streets (public gardens, squares, public restrooms, empty lots, marquees, etc.), 20% live in refuges for the homeless and 10% live on the streets and in refuges; 71% of them have remunerated informal jobs (collecting recyclable materials, taking care of parked cars, working as porters, etc.), and a bit more than half of them (52.6%) get between R\$80,00 and R\$240,00 per month. This fact reveals the precariousness of their situation. Regarding health, 62% reported not having health problems and, among the 30% who reported having health problems, the majority (70%) go to hospitals or to health centers – few spontaneously go to or have as a reference the primary health care centers, such as “Consultório na Rua –CR” (Portuguese expression that can be translated as “Doctor’s Office on the Street”).

The CR is composed by a multidisciplinary health team. It consists of an interactive modality of basic health care, which provides psychosocial assistance of community-clinical character. It intends to offer health care to people in their own living contexts, especially on the streets, and not in institutionalized health spaces (hospitals, health centers, etc.) (Ministério da Saúde, 2012).

On one hand, CR carries the strategy of reducing damages as a way of approaching homeless people and providing care, incentivizing, by means of an informative attitude, the autonomy (in relation to the rights such as health, social assistance, protection, dignity, etc.) of the ones who are living on the streets (Ministério da Saúde, 2012).

On the other hand, though, it must be considered that CR has undergone many difficulties (logistic, operational, financial ones, as well as difficulties related to human resources), which make it hard to achieve its goals (Hallais & Barros, 2015). As a consequence, people living on the streets do not receive adequate health attention and care, for the CR health professionals cannot work satisfactorily (Londero, Ceccim, & Bilibio, 2014).

Because of this, the health care offered to the population living on the streets must consider the particularities of street conditions; there must be more attention to the reality of this population so that their peculiar living strategies and health care practices can be better understood (Pereira et al., 2011).

Therefore, the aim of this study was to investigate the main difficulties and strategies indicated by people living on the streets in relation to their practices towards health care, as well as public health care policies in a medium-sized Brazilian town (Uberaba/MG).

Research characterization and methodological procedures

This research can be characterized as exploratory, cross-sectional, based upon the qualitative approach. The research included semi-structured interviews, participative observation, note taking and field diary.

Participants

Six people living on the streets participated of this study. The choice for the expression “people living on the streets” can be justified by the necessity of highlighting the transience of this situation (Rosa, Cavicchioli, & Brêtas, 2005; Ministério da Saúde, 2012) and its stigmatization (Magni 2006; Schuch, 2007).

For the semi-structured interviews, we selected people aging above 18 years, of both genders, living on the streets and who agreed to take part of the interview. In total, six interviews were carried out, considering the data saturation criterion (Fontanella et al., 2011).

Procedures for data collection

The field work occurred from June to September of 2014, in two different places of Uberaba (MG, Brazil) where CR carries out its activities. These places, according to Secretaria Municipal do Desenvolvimento Social de Uberaba – SEDS (the city office for social development of Uberaba), were consolidated by mere chance and by the participation of the ones who usually go to the CR. In September of 2014, SEDS estimated that there were 105 individuals living on the streets; among those, 30 were assisted by CR. However, there are many other places in the town where people living on the streets stay.

The first place where the study was carried out is located on the edge of the federal road that crosses the town. The individuals assisted are usually involved with criminality and with drug trafficking. The abuse of drugs and the prostitution made our access to those people more difficult. Because of this, it was possible to collect only one interview in that place. The other place is a square located in one of the central neighborhoods, where people usually abuse alcohol. The access to people living on the streets in that place is easier (we could make five interviews there), for their involvement with crime is uncommon.

The data collection was carried out together with the CR team, because the participants already had contact with them; it made the access to the participants easier. In this initial contact, the researchers observed people living on the streets and, after that, they invited the participants for the interview. The participative observation intended to understand how people living on the streets viewed their own situation and how they dealt with issues related to health (Queiroz, Vall, Souza, & Vieira, 2007), considering the actions from the CR (i.e., the public policies) and the ones carried out by themselves.

The semi-structured question guide included questions concerning life history (what took people to live on the streets), the understanding about health care (definitions, responsibilities, personal practices, CR team practices etc.) and their expectations aiming at the realization of this care/right.

Organization strategies and data analysis

The interviews were recorded in audio and completely transcribed. After that, they were analyzed vertically (one by one) and horizontally (as a group). It allowed us to define thematic categories from the participants' answers.

The data were organized according to the analysis of thematic content (Bardin, 2010) and understood by means of Moscovici's social representation theory (2012), which defines the social representations as forms of group knowledge socially elaborated, which guide the practices/actions. The social representations must be understood from its specific production contexts, i.e., from the particularities of each group.

Ethical arrangements

This study was approved by the Comitê de Ética da Universidade Federal do Triângulo Mineiro (UFTM) (Ethics Committee of Triângulo Mineiro Federal University) (document nº 667.568 dating from May 29, 2014). The anonymity and the secrecy of the participants' identity are assured (the names used are fictional).

Results and Discussion

The interviewees are four men and two women, with age average of 38 years. This was due to the availability of access to the interlocutors assisted by CR – it means that it is a convenience sample. Many other people living on the streets refused to answer the interview because they did not want to expose themselves due to the street dynamics, which, during the period of the data collection, was very turbulent, because of the death of a participant of the CR program involved with drug traffic.

In general, the time that the interviewees have been living on the streets is, in average, almost 16 years, with a variation from four months to 40 years. During this period, the participants have been exposed to many kinds of risks and social vulnerability. All the participants use psychoactive substances (legal or illegal). It is one of the main reasons for them to be on the streets. Regarding this fact, in accordance to the national harm reduction policy, what must be questioned is the style and the functionality of the use of those substances, instead of the mere proposal of abstinence (Ministério da Saúde, 2012).

Four thematic categories, assessed by referees, were organized after the data collection: Characterization and Background (characteristics of the participants and some of their experiences in the street environment); Health Care (meanings and practices about this care); Responsibilities for Health (perceptions in relation to the responsibility for the health practices); Expectations Regarding Health (self and other healthcare actions and expectations for the future).

Table 1 presents the main pieces of information collected from the participants:

Table 1. Identification of the participants interviewed (name; age; period living on the streets; psychoactive substances used; admissions to rehabilitation centers)

| Name | Age (years) | Time living on streets of Uberaba | Psychoactive substances used | Admissions (because of drug abuse) and general impressions |
|---------|-------------|-----------------------------------|---------------------------------------|--|
| Adriano | 23 | 14 years | Marijuana, crack and cigarettes | Admitted six times by force, some times not to hurt people who like him. |
| Eduardo | 49 | 16 years | Alcohol, cocaine and crack | Admitted by force twice. He did not recover. |
| Laura | 27 | 4 months | Crack and other drugs (not specified) | Has never been admitted, but intends to do it when she goes back home. |
| Marcelo | 34 | 10 years | Alcohol | Admitted twice. The last time, he had an argue with the coordinator of the institute and left. Does not want to be admitted again. |
| Orlando | 45 | 15 years | Marijuana, alcohol and crack | Admitted twice; stayed without using drugs for a long time. |
| Vanda | 51 | 40 years | Alcohol and cigarettes | Did not mention if she was already admitted. Does not consider herself an alcoholic. |

Category 1 – Characterization and Background

Each participant reveals a background that took him/her to the life on the streets. However, three reasons were noticed as being the main ones. For five interviewees (Orlando, Eduardo, Adriano, Vanda and Marcelo) family problems (estrangements with spouse, parents, step-parents) were the main reasons for abandoning their home. One of the interviewees reports:

I used to live with my wife's mother and my wife and mother of my son. After she left me, after we split up, she left and I sold my car, my house, started drinking again and went to live on the streets (Orlando – free translation).

Escorel (2006) claims that when family problems are mentioned as a reason for people to live on the streets, other factors may be involved (alcohol addiction, domestic violence, mental diseases, conflict of values etc.). Among these factors, alcohol and drugs significantly affect the family dynamics, causing conflicts because of the increase of expanses for acquiring those substances, which affects the domestic budget and the family dynamics – causing estrangements.

The second reason most mentioned for going to the streets is the abuse of psychoactive substances, like Orlando and Marcelo point out. Marcelo highlights (free translation): *“The situation I live at home... my step father is too stupid, doesn't accept I [sic.] there taking drugs, so he keeps telling me to go away so I prefer to stay on the street”*. Lovisi (2000) claims that sometimes the break of family ties or its weakening may precipitate the action of going to streets due to violence, alcohol addiction or unemployment, but, in general, the use of psychoactive substances happens before the action of going to the streets.

The third reason most mentioned by the interviewees are financial difficulties, such as reported by Laura (free translation):

I went to Alagoas, where my kids live, then I came back. I would go back to São Paulo, but I took a clandestine bus and it left me here [Uberaba], then I stayed here. I first lived in a boarding house, but after some time I didn't have money to pay for it and I ended up living on the street.

It is possible to notice then that family ties break on the same proportion as the permanence on the streets increase. It makes it difficult for the homeless to return to their homes and their original families. In relation to that, only Laura mentioned that her family offers her support to be able to leave the streets, having demonstrated the will to return to her mother's house. Orlando, in his turn, reported not having contact with his relatives; Eduardo, Adriano, Vanda and Marcelo reported that this tie is weakened and that they hardly ever meet someone of their family. Marcelo says:

Some days ago I stayed at my mother's, but before that he [step father] came and told me to wake up early, six in the morning and leave. One day I slept in the garage with the dog.

As a whole, the main reasons mentioned by the participants to go to the streets are the same reasons mentioned in the national research on the population living on the streets (Ministério da Saúde, 2012). The following interviews excerpts also reveal representations related to their lives on the streets – space (street) that was noticed from the reasons previously cited.

For Varanda and Adorno (2004), people living on the streets are vulnerable because of the fragility/lack of family ties. This way, the streets become the place left for them to try to exist and establish processes that compensate the losses and create new survival and subsistence sources, such as the use of drugs. Because of that, for Varanda and Adorno (2004), differently from Lovisi (2000), drugs are not always the main reasons for people going to the streets, but are one of the consequences and a strategy to withstand in that context. Because of that, the harm reduction policy is extremely important as a guide for public policies.

The street, therefore, for both Orlando and Eduardo, is understood as a precarious environment, without rules; at the same time, it is a place where the homeless meet people who have the same experience as theirs. Besides that, for Adriano, that environment allowed him to find love and affection, which he had never received from his family. For Vanda, the street is her house, where she was born, starved and learned many things; for her, living there requires a lot of strength, implying that even though this experience is difficult and sad, it is also full of lessons to be learned. Laura reports being fearful of the street, because it is a dangerous environment, where there is too much exposition. Marcelo presents the street as a place where he can stay without any rules or restrictions regarding the abuse of alcohol.

Besides Marcelo, Eduardo and Orlando reported difficulties to live in institutionalized environments, where it is necessary to follow rules (such as rehabilitation centers, boarding houses, their home and refuges for homeless people). The street is seen, therefore, as an expression of liberty and identification with other people with similar experiences, who understand their weaknesses and addictions. It corresponds to what is mentioned by Souza, Fortini and Domingues (2010), when they claim that the street becomes a synonym of freedom and lack of responsibility, where it is possible to make friends based upon the use of drugs and/or alcohol and to escape from the struggle against life difficulties that cause frustration.

Da Matta (2004), explaining the meanings of the street (public space) in our society, corroborates many representations that the study participants have of what it means to live on the streets. The participants recognize the streets as their home, but, concomitantly, they describe them as being a dirty, unknown violent and unsafe place. Therefore, they believe the society have a wrong image of them: they are not people living on the streets, but people from the streets (and thus they are dirty, violent and dangerous). According to Laura (free translation): *“But sometimes there are people who think that we are on the street because we are lazy, because we do not want to work, but sometimes things happened, and these things make the person weak to leave [the street]”*.

Therefore, Da Matta (2004) argues that the street is the place of the anonymity, where the mass, the population constantly moving meet, where there is competition, social disorder and exacerbated capitalism. It means that the street is understood as a public space where no-one is respected as a citizen with rights.

Considering what the participants said regarding the street, we could notice a representation shared by those individuals. This representation organizes their ways of living and thinking (Moscovici, 2012): an indefinite situation between public and private place, in which the street is a collective space (public)

and, at the same time, a personal habitat (private). For this, the ones who are living on the streets are stigmatized by the characteristics attributed to the street.

Category 2 – Health care

Thinking about health care and attention means looking at to the diversity of meanings that these terms carry. This way, it is important to show the meanings given by the participants regarding these subjects.

Orlando, Eduardo and Laura understand that healthcare is related to feeding and sleeping. *“Taking care of health? It starts with a good diet, a good sleep night, get it? It is something that I don't have on the street, get it? I'd say it is precarious”* (Eduardo – free translation).

Personal hygiene was mentioned by Adriano, Vanda and Laura as part of health care. For Laura, one must go to the doctor when necessary; however, Marcelo said that the health care will only be possible when he can be able to stop abusing alcohol. *“For me, I need to stop drinking so I can leave the street”* (free translation).

Besides some representations of the participants concerning health care, it was necessary to understand better if they perform health practices and how they do it (according to their possibilities) so that health care is carried out. Orlando, Laura and Marcelo said that they tried do eat better. Eduardo, Adriano and Vanda answered that they frequently take a shower. Marcelo mentioned drinking water often; Vanda reported trying to sleep well, but not being completely able to, for the street does not offer conditions for this to be accomplished; but she tries to brush her teeth every day (she carries with her a toothbrush, a towel, underwear, sponge and soap). Orlando makes an effort to stop drinking alcohol every time he does not feel well.

The attention to diet was described as being the easiest action to be accomplished, for all of them receive food donations from restaurants, charities or Spiritist Centers. Nevertheless, during the participative observations, we could notice that the storage of that food is precarious, and, in many moments, it was possible to see pigeons eating or walking on semi-open takeaways or unpacked bread.

Keeping personal hygiene (teeth brushing, shaving, shower and clothes changing) is also difficult, for some must pay to use restrooms/bathrooms in public squares, bus stations or boarding houses. According to Vanda (free translation): *“To have a shower, I have to beg for money in this square, just like all the others. To drink my alcohol, to buy my cigarette and to have a shower, because Dilma [president of Brazil then] doesn't know to give a public shower.”*

In short, the personal care is precarious in the street environment. Like Graeff (2012) showed in a research on people living on the streets in Paris, some of them have body marks that show the social abandonment, once they wear dirty clothes, without having a shower for days, with odor, and, sometimes, having air-exposed wounds (mainly in their feet, like our participative observation allowed us to notice). It is important to bring some reflections regarding those body marks, trying to know if it is possible to avoid them when so many difficulties regarding personal care are found on the streets – difficulties linked to lack of financial resources and lack of hope for changing the reality that those people face (this subject will be exposed in Category 4).

In relation to those body marks, it can be said that they are results of health conditions, being common to almost all of the interviewees. They can be seen in Eduardo's and Orlando's bare cracked feet; in Eduardo's long, badly trimmed bear; in the dirty torn clothes that all of them were wearing; in the air-exposed wounds that many other individuals seen in that environment had.

Because of their precarious life conditions, all the participants mentioned having had health problems, such as headaches (Laura, Vanda and Adriano), gastrointestinal problems (Orlando and Eduardo) or dermatological problems (Orlando) and HIV (Laura and Marcelo). Only four of the interviewees said that they only go to hospital or to emergency unities when they have a more serious problem – without knowing, though, the difference between what is more or less serious. On the other hand, they highlighted the fact that they resort to self-medication or try to ignore the pain and suffering by taking illegal drugs or alcohol. It makes it more difficult for this population to have a bound with preventive health services such as CR.

According to Dantas (2007), people living on the streets are intensively vulnerable to health problems, presenting various pathologies inherent in their life conditions. According to the manual on health care for people living on the streets (Ministério da Saúde, 2012), the life on the streets may precipitate health problems, due to the increase of the exposure to illnesses, violence, ingestion of contaminated water and foods, extreme weather changes and many other factors. However, as most of the interviewees reported, people living on the streets rarely go to health care assistance centers, and, when they do, they go to institutionalized centers that offer treatments based on healing by means of drugs, which are not aware to apply preventive health practices (such as the ones offered by CR). This fact reveals structural difficulties of health public policies (Hallais & Barros, 2015).

Besides those facts, some participants reported their fear of sleeping on pavements and squares, for the street is seen as an environment where they are exposed to violence. This reality was equally reported by Aguiar and Iriart (2012), in a study carried out in Salvador (Bahia state, Brazil), with people living on the streets. According to the authors, the violence is described as a worrying factor, especially at night, once night assaults and aggressions (including murdering) are very frequent. Therefore, many of them prefer to sleep (in fact, only take a nap) during the day and do other activities at night.

In relation to the violence occurring in the street environment, Nascimento (2006) argues that people living on the streets should not be labeled as being dangerous beforehand. The danger is within the environment where they are, for they share this space with criminality, with institutional violence (lack of conditions that can avoid their moving to the streets), with drugs illicit commerce and with prostitution.

Specifically in this study, the participants reported having suffered violence on the streets. Adriano's case is emblematic, for it shows not only the fear of being assaulted, but also his involvement with criminality: he was hit many times after stealing and/or buying drugs "on the cuff" from a trafficker.

In this category, it was possible to understand some representations on the health care that people living on the streets have, modulated by their specific reality (Moscovici, 2012). However, the impressions reported by the interviewees do not match the concepts on health proposed by the World Health Organization (Sá Junior, 2004). For the interviewees, health is about the basic and immediate necessities; thus, it must be considered that the idea of perfect welfare is far from the reality of those who live on the streets, where the existence conditions are extremely precarious.

Category 3 – Responsibility for Health

When we consider the meanings that the interviewees express about health, we are led to another question: who is responsible for this care?

Adriano, Vanda and Marcelo believe that the responsibility for health care belongs to the individual him/herself: *"Ourselves. We have to look for it, because there are health professionals, we need to look for them, they will not deny assisting us, but we are responsible for ourselves"* (Marcelo – free translation).

Together with this representation, ideological principles (according to an ideology Marxian conception) are implied, aiming at legitimizing and naturalizing our society's relational (unequal) processes, which establish social control practices and keep the current social order (Chauí, 2012). The representation that the responsibility for this care is only individual takes out the State (collective) burden to assure, create and apply public policies that meet the necessities of each population.

Still regarding this aspect, the idea of meritocracy of the social relations (including health practices) hangs over the popular imagination, as if the population living on the streets were not allowed to make use of social benefits and rights, for not participating of the productive class (that pays taxes) and of the society consumer portion (Chauí, 2012).

On the other hand, Orlando and Laura understand that this care is responsibility of the individual and of the State:

I think that one part depends on us, and another part depends also on the government, then we are talking about politics, uh? Because maybe the person is sick, on the street, knowing that the

hospital is there and it does not work going there if you are going to stay half a day in the line there (Orlando – free translation).

Orlando describes the reality of health in Brazil in the same way that Fleury (2011) argues about the precarious working conditions of hospitals. It is against the citizens' rights, for quality health care is advocated being a universal right. In only one interview (Eduardo – free translation) this responsibility appears as belonging only to the public power: *"It's a State responsibility, which involves the city, the state, everything as a whole"*.

One can notice that many factors influence with the legitimation of health care as a responsibility of the State, of the individual, and/or of both. Nevertheless, in all cases, for those living on the streets, such responsibility is neglected, despite of the actions of the CR professionals, who cannot develop specific actions and interventions because they do not have support and material conditions (Londero et al., 2014), harming the effectuation of health public policies for that portion of population.

Lovisi (2000) points out many factors that may be associated to the health conditions of the ones who are living on the streets: the first one would be the structural or macrosocial variables (extreme poverty; lack of housing; migration; deinstitutionalization of psychiatric hospitals, among others). The second level reaches the family dynamics and the lack of social support. Finally, the third level includes individual or microsocial variables (personal and individual characteristics).

Still according to Lovisi (2000), some researches show that the microsocial level is the main reason for people to live on the streets. It puts the evident structural origin of that reality aside. In short, one more time the individual fault is seen as being responsible for the extreme poverty of existence and health (Chauí, 2012), and, as this idea is constantly highlighted, it is necessary to fight against it.

Category 4 – Expectations regarding Health

After designing the representations on the responsibility for health care, it is significant to understand the dynamics of this care, from the perspective of the expectations that the population living on the streets have. The actions that encourage this care should stem from public polices focused on those people, aiming at playing the State role to assure the accomplishment of social rights (MDS, 2008).

Considering that the person living on the streets must be assisted by a specialized attention and care network, this study does not aim at showing the existing services, but at exploring some of the representations of the interviewees on the performance of public services. Therefore, this category presents issues related to the expectations of health practices focused on the population living on the streets.

Three participants mentioned the services specifically performed by CR. Orlando reports that such assistance is important, and that it meets each person's demand in a general way. In his turn, Eduardo believes that the actions implemented by the CR are good, but more strategies could be realized if there were more investment/incentive from State.

Adriano recognizes the actions of CR, but he does not detach it from its charitable character: *"I think that... it's cool. Because [CR] worries every day about us and it is with us, it brings coffee, affection, giving us things that we didn't have in our childhood"*. It reveals the difficulty to understand health as a right, for it is seen as a favor or charity, obstacles for CR actions towards the ones who are far from the formal health attention and care (Ministério da Saúde, 2012). The CR must offer multiprofessional care to the assisted people in their own life contexts, adapting to their particularities. Its goal is to provide accessibility and integrity in health care for the assisted people in social exclusion situation, aiming at offering a concrete space for the exercise of citizenship and fulfillment of rights.

Unfortunately, in general, CRs have many problems and limitations (Hallais & Barros, 2015) that do not allow them to reach their aims. An example of that was the fact that, during the data collection for this study, the program CR of Uberaba had only one professional nurse and one social worker, for the psychologist quitted voluntarily, causing difficulties in the services. Therefore, even if the representations of the participants on the CR show that the team is a reference for health access, more

actions could be carried out (as Eduardo remarked). Therefore, it is necessary to strengthen CRs in their local activity contexts.

Orlando, Eduardo, Adriano and Marcelo reported having been admitted in rehabilitation private centers. Eduardo and Adriano said that they were taken by force – and Adriano reported not agreeing with compulsory admission. The predominant ideology argues that the drug abuse must be solved by means of strategies of mere prohibition and abstinence from use/consumption of these substances. Because of this, the compulsory admissions are considered important; they do not take into account, however, the fact that drug abuse is a matter of public health and not only a(n) (wrong) individual choice (Nascimento, 2006; Wurdig & Motta, 2014).

Eduardo, Adriano and Marcelo denounced neglect actions with health care in rehabilitation centers: *“Here in Uberaba there are few; some of them harm [the patients], they don’t offer an adequate diet. I even ate pure cooked papaya, and my father was paying R\$ 400 per month”* (Adriano – free translation). Eduardo also mentions the necessity of investing in centers that work more properly and that offer varied interventions in order to strengthen the patient during the process of detoxification:

A center where people stay for nine months is a storage of drugged people. Storage of alcohol-hooked people. Throw them there, they make you get up the time they want, pray the time they want, eat the time they want. Do what they want. But nobody sits down close to you, like you’re doing now and try to know why you drink, why the hook, why you are taking the drug again (Eduardo – free translation).

Nevertheless, the participants also raised alternatives for care: *“If there were a refuge where people could keep working – they would work during the day and go back to sleep, with a hot shower, their clothes there, with a locker and a key, a padlock and everything right there”*. (Adriano – free translation). *“In there [São Paulo] there are places where people arrive and can take a shower and wash their clothes, there are activities that they can do during the day, eat. Then one doesn’t need to stay all day long in the street. I have stayed in one place like this there and took a course on hospital scullery”* (Laura – free translation).

Orlando and Laura reported having been treated with prejudice when they needed help from hospitals, for being people living on the streets: *“I think that in the hospital they don’t pay much attention. I don’t know if it’s because they see us differently”* (Laura – free translation). This narrative is extremely significant, when we consider that, whenever necessary, most people living on the streets go to institutionalized spaces for receiving treatment; however, they are discriminated (Ministério da Saúde, 2012). This fact, together with the difficulties found in CRs (which should be the access to SUS), ends up putting those people away from SUS.

The participants reported the lack of health resources to be cared for in a better way on the streets. Orlando and Marcelo believe that to change the condition in health care it is necessary to move away from the streets, for while they are living there, their condition will not change. For Eduardo, Adriano, Vanda and Laura, the lack of solutions is the result of low investments from State to the reality of streets; Eduardo and Adriano also mention lack of qualified professionals to assist their population.

Many services are offered to that population in Uberaba. The participants themselves raised the necessary changes for those services. From the interviewees’ narratives, it can be noticed that there are difficulties in the services provided to that population, for models of health attention and care actions tend to focus on healing and on the prescription of medications. Those activities do not try to understand the individual in his/her singularity. Therefore, it is urgent that professionals are qualified and committed not only technically, but also and mainly ethically with that population, aiming to improve the quality of the care offered (Rosa et al., 2006).

Marcelo, Eduardo and Orlando reported that the life that they have currently is full of disillusion. All of them, in different conditions, miss their lives before going to the streets, as well as their original families, but only Orlando and Laura present real perspectives to change, being equally distressed by the conditions they have been into.

During the interviews, their need to report their stories and background was evident. It reveals that this kind of affective care and this attention to subjectivity (mental health) almost never happen

effectively on the streets, either because it is suppressed by the drug abuse or for the lack of space for taking care of this necessity/demand.

Ayres (2004) emphasizes that the important interaction between people living on the streets and the health care services is based upon acceptance (capacity of attentive and respectful listening to the individual), being extremely necessary for the health professionals to offer qualified listening. In case of the population living on the streets, affective aspects are related to the conditions for taking care of oneself and to the reasons why they went to live on the streets. Because of this, it is very important that this kind of space/listening is provided, such as Eduardo (free translation) reports: *“Sometimes, it seems not, but talking to you [interviewer] here makes some things happen, you know? You already made me think differently”*.

Finally, the intention must be offering services that embrace the various health demands presented by that population. The offer of assistance must be carried out from a humanized perspective, which brings life quality improvement for these people, without moralism or discrimination (Londero et al., 2014). This way, it is important to reconsider the current practices (of these SUS users and of the health care professionals) in order to enlarge the possibilities of health access for this population.

Final considerations

Taking into account the main results of this study, it can be noticed that the participants have many necessities of health care, considering the precarious environment of the street and its limitations for this care, mainly caused by the lack of financial resources. Those limitations block their expectations to change or to improve their condition, considering their stories, permeated by pain, distress, frustration, abandonment and suffering.

This way, it is necessary to reconsider the health care services offered, namely the composition and the actions of CR (which should be enlarged), in a way that allows to evaluate whether that population is being well assisted in their necessities and demands. Moreover, it is highlighted the necessity to qualify better the professionals who receive, advise and make the interventions in this population, in order to exercise their health rights and alter their current ways of living. Therefore, we believe that the best way to improve the service is not by changing radically the public health policies, but fulfilling integrally the existing guidelines established for the CR.

When we research on population living on the streets, we can notice their involvement with the abusive use of or dependence on legal or illegal psychoactive substances – frequently as a strategy to bear their own situation on the streets and the social exclusion. This way, it is important to reconsider and to question the arguments (which stem from the political classes as well as from health professionals) that deal with the subject from only one point of view: the one that advocates the prohibition of and the abstinence from the use of those substances. What must be carried out is the understanding of the logics, the meanings and the functions involved in those drug-taking habits, in order to insert them as ways to access health programs and to provide health care, in spite of simply banning them.

In order to carry out our study, general national data on population living on the streets were used. It made us notice the necessity to carry out studies that evidence multiple local realities of Uberaba, considering the diversity of this population and the importance of this town in regional context.

When investigating health attention and care practices with some people living on the streets in a medium-sized Brazilian town (practices performed by those people themselves or practices towards them), it was possible to understand the organization and working logics of those actions as being correlated to the immediate existence conditions of that population. Therefore, in order to change this reality, it is extremely necessary to alter the living conditions of that population, in this case, the obstacles to access SUS – to which CR could contribute a lot, as long as it is treated with dignity by the creators of local, state and national public policies.

We understand then that the aim of this study was reached. It is hoped that it can contribute with the intensification of the discussion on this issue, and that, consequently, with the alteration of public actions and policies towards the health care of people living on the streets.

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