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Homeless people's right to health: reflections on the problems and components

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Abstract *In the present context of neoliberalism, it can be seen that employment and family links are becoming more fragile, contributing to the phenomenon of social exclusion, and making people who are homeless – the Homeless – more visible. This population, situated on the margin of the healthcare network, challenges the universality, equity and integrated quality of Brazil's Unified Health System – the SUS, and has been the subject of focalizing policies. The debate on this theme is the subject of this study, which is an integrative review of Brazilian publications in the literature databases of Lilacs (Latin America and the Caribbean Health Sciences Database) and the BDENF (Base de Dados de Enfermagem – Nursing Database), to provide a survey of the literature on characterization of the Homeless as a group, their needs and the policies that have been developed to serve them. The study reveals that discussion on the homeless has been timid in production of knowledge, principally in relation to comprehension of the social determinants of the health-disease process of this group. The social policies addressing this population are, mostly, compensatory and existentialist, so that they do not allow for materialization of the right to health as a possible outcome. In this context, it becomes necessary to build social policies that are coherent with the social needs of the homeless.*

Key words *Health, Public policies, Homeless, Homeless population*

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Introduction

The development of capitalism, the internationalization of the economy, accelerated urbanization, the liberal hegemony, and other concepts that represent the new world order have, among other effects, resulted in a considerable increase in social exclusion – a state of affairs that leads to the possibility of social breakdowns capable of compromising the dream of a democratic and fair society[1].

As a result, there is an increasingly large number of people excluded from the basic social rights such as education, health, work, housing, leisure, safety and other aspects, and indeed human rights – with some groups being relegated to invisibility. This is the category of population in which we find the homeless population.

In spite of the visible growth in the number of homeless people in recent decades, this is in fact an old phenomenon. Its history goes back to the emergence of the pre-industrial societies of Europe in the process of creation of the conditions necessary for capitalist production. Peasants were expropriated and expelled from their lands, and not all of them were absorbed by the nascent industrial sector. This led to many of these people experiencing the bitter life of walking the streets[2].

The practice that leads to the phenomenon of homelessness has been treated historically as begging, laziness or indigence. In today's world, from time to time, violent actions against the homeless break out in a type of 'cleansing' of cities – in which the people in this population are expelled, to invisible spaces. In this context the State has used oppressive force to punish the people who do not fit into the logic of capital, market and consumption: in these inspection and enforcement actions in public places, they remove the few belongings of this public, their children, their documents; they demolish their precarious tents, making their very existence difficult and making their situation more intensively vulnerable. This represents a transition from the 'Social State' to the 'Penal State'[2-5].

The change in the political regime that took place in Brazil in the 1980s, followed by economic recessions, increase of unemployment and intensification of the process of globalization, helped the phenomenon of miserable levels of poverty to rupture spatial limits, expanding beyond the favelas and slums to the streets and squares of the cities[4].

Today the existence of people living in the streets is a social problem, calling for interventions by the State that take into account how it happened and the forms of survival that have been developed in this situation.

The *sine qua non* for construction of a universal, balanced and integrated care model is to get to know the people who live in the streets, identify their social needs and the complexity of their health-disease process, and also the reasons that led them to live in the streets[6].

The existence of people living in the streets is one of the howling contradictions of a society which has social security as a constitutional right and guarantees health as a right of all and a duty of the State.

Among several recent actions to offer possibilities for transformation of the reality that homeless people currently face, we highlight the following: The First and Second National Meetings of the Homeless [*I e II Encontros Nacionais da População em Situação de Rua*], which were spaces for vocalization by this group; the National Social Assistance Policy [*Política Nacional de Assistência Social* – PNAS], of 2005, which includes the homeless within the scope of special social protection; the National Policy for the Homeless (*Política Nacional para a População em Situação de Rua* – PNPSR), of 2009, which was the first Brazil-wide initiative for recognition of the rights of this group, which has historically been excluded, and the prospects announced by the 'Doctor's office in the Streets' [*Consultório na Rua*][2,3,7].

However, these are recent initiatives, which still call for more investigations, and many of them have also not yet been put into effect in certain local situations. In practical terms, the homeless still live in innumerable situations of privation, violence, abject poverty, and social inutility, and thus constitute a challenge for public social policies, in particular health policies.

From a glance at the material in the literature databases one sees that there is a scarcity of surveys and studies in this area – making it clear that there is a need to identify the number of articles published and whether the studies that have been made have dealt with the situation of the homeless, and/or discuss public policies and the health-disease process of this population.

Reflecting on these questions, this study aims to be an integrative review of the BDENF and Lilacs databases, to report what exists in the literature in relation to characterization of the homeless population, their needs, and the policies developed to serve those needs.

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Methodology

Integrative review is the widest approach of methodology in revisions: it allows inclusion of experimental and non-experimental studies, for a complete comprehension of the phenomenon analyzed; favors the inclusion of both theoretical and empirical literature; and also studies with different methodological approaches (qualitative and quantitative)[8].

This study comprises an integrative review which brings the subject of public policy and the homeless into the discussion. It took place in these stages: (1) establishment of the subject area and the objectives of the review; (2) selection of the articles; (3) decision on the criteria for inclusion or exclusion; (4) decision on the information that will be extracted from the articles chosen; (5) interpretation of the articles chosen; and finally (6) presentation of the review[8].

The search for articles in the literature was made in the following databases: LILACS (the *Latin America and the Caribbean Health Sciences Database);* and BDENF (*Base de Dados de Enfermagem* – Nursing Databases). The search words combinations – 'Health' with 'Homeless'; and 'Public policies' with 'Homeless' – were used. 'Health' and 'Public policies' are descriptors established by consulting the Health Sciences Descriptors Database DeCS (*Descritores em Ciências da Saúde*).

The following criteria for inclusion were applied in selection of the articles: Articles published in Portuguese; in periodicals indexed in the Lilacs and/or BDENF databases; and complete articles dealing with the subject matter relevant to the review. Criteria for exclusion were: Articles repeated in the databases; those without complete text available; those that expressed only a biological approach to the problem of the Homeless; and theses, dissertations, monographs and manuals.

This bibliographical selection, using the keywords mentioned, identified 79 articles. After application of the exclusion criteria – including removal of repeated articles – 15 remained for analysis and detailed summary, to provide a presentation of the results and discussions.

Note that although year of publication was not a criterion for selection of the sample, due to the small number of publications chosen we decided to present them, in Chart 1, by decreasing date of publication, i.e. from 2014 to 1998. This table shows the number of publications increasing in the years 2000 – in itself an important result in the history of preparation of policies for this group which has historically been silenced. We did not go into this aspect in more detail, mainly because this is not the objective of this study.

The detailed analysis of data was based on an instrument constructed and validated by Ursi and Galvão[9], adapted for the peculiarities of this subject area. It presents a range of information, but does not use all the resources.

Initially we identified articles by: title, author/s, year of publication, database or periodical, population studied/scope of the study, results, and comments. We present these in a summary Chart 1. In our report on analysis of the articles, we chose three headings: *Living in the street* (– "I have no name, no identity, I'm not even certain I'm really a person")[10]; *The street and social needs* (– "We don't want only food, we want food, entertainment and art")[11]; and *The policy of inclusion, or lack of inclusion, in policies* (– "I'm ugly, I'm dirty, I'm antisocial, I can't appear in the picture postcards")[10].

All the phrases in double quotation marks are of course lines from Brazilian popular music; and we chose these theme headings because – like Escorel[12] – we consider Brazilian popular music to be a sensitive companion as we travel through the problems of this society.

Results

Living in the street: – "I have no name, no identity, I'm not even certain I'm really a person"

Homeless people do not participate in the surveys of the Brazilian Geography and Statistics Institute (*Instituto Brasileiro de Geografia e Estatística* – IBGE), since the collection of data for censuses is fundamentally based on households, and most of this population does not have a household[13,14]. Even so, these are thousands of people and families who live in the street, and live from the street. When organized, they prefer the description 'people in a street situation', aiming to characterize a principle this this process of total social exclusion is transitory, even though deep down many of them know that escaping from their homeless situation is not a simple matter[13,15,16].

A nationwide study by the Ministry of Development and Combat of Hunger (MDS), in 2007-8, identified 31,922 adults aged 18 or over living in the streets, in the universe of 71 Brazilian municipalities with population of more than 300,000[14].

Though this number is impressively large, it is estimated that the total number of homeless

Chart 1. Distribution of the articles by title, author, year of publication, periodical or database, population studied or scope of the study, and results or comments.

Title / Author(s) / Year of publication	Periodical or database	Population studied / Study location	Results / Comments
Life in the street and cooperativism: transition through production of values. Ghirardi MIG, Samira RL, Barros DD, Galvani D[17]. 2014	*Revista Latino-Americana de Enfermagem* [Latin American Nursing Review] BDENF	Homeless men in shelters. Survey by the São Paulo Homeless People's Referral Center.	This is a strategy proposed for a specific group, with the intention of reinserting it into the labor market through the cooperativist sector.
Access to intersectoriality: Monitoring of homeless people with serious mental disorders Borysow IC, Furtado JP[18]. 2013	*Physis* Collective Health Review Lilacs	Homeless people with severe mental disorders. Survey in the SCIELO and CAPES databases.	Deals with the problems of mental health of the homeless population and of access to health services. Shows that intersectorial work needs to be better developed.
Meanings and practices of health and illness among the homeless population in Salvador, Bahia, Brazil. Aguiar MM, Iriart JAB[15]. 2012	*Caderno de Saúde Pública* Lilacs	13 homeless people. Study carried out in Salvador, Bahia.	Describes how homeless people perceive their health-illness process, in the point of view of supporting public policies that go beyond hygienism and existentialism.
Vulnerability and its causes: The homeless population, a question of ethics. Sotero M[5]. 2011	*Revista de Bioética* Lilacs	Residents of occupied public lands, in North Wing and central zone of Brasília, Federal District.	Describes factors of vulnerability related to the precariousness of homeless people`s existence, calling for protective measures from the public institutions.
Promotion of health and adolescents: An example of intervention with homeless adolescents. Morais NA, Morais CA, Reis S, Koller[19]. 2010	*Psicologia & Sociedade* Lilacs	Health professionals and educators of institutions for homeless children and adolescents, in Porto Alegre, in the Brazilian State of Rio Grande do Sul.	This reports an experience in promotion of health of adolescents in a situation of social vulnerability. Points to the need for changes in the assistential logic.
The family health strategy for equity of access directed to the homeless population in major urban centers. Carneiro Junior N, Jesus CH, Crevelim MA[20]. 2010	*Saúde Sociedade* Lilacs	Homeless population served by the Family Health Strategy (ESF). Study carried out in the city of São Paulo.	Discusses the experience in implementation of the ESF for healthcare of the homeless population, presenting a specific public policy with emphasis on equity.
The process of health and illness in the homeless population of the city of Londrina: Aspects of living and becoming ill. Aristides JL, Lima JVC[18]. 2009	*Revista Espaço para a Saúde* Lilacs	Individuals sheltered in institutions. Survey carried out in the city of Londrina, Paraná State	Deals with a specific municipal program – Sinal Verde ('Green Light'), which provides facilitated access to health for the homeless population. Indicates the need for services to flexibilize rules and practice equity.

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Chart 1. continuation

Title / Author(s) / Year of publication	Periodical or database	Population studied / Study location	Results / Comments
Children and adolescents living in the streets: contributions to understanding of the process of vulnerability and destruction of social attachments. Gontijo D, Medeiros M[22]. 2009	*Ciência & Saúde Coletiva* Lilacs	Review of the subject of homeless children and adolescents, based on the theoretical viewpoint of Castel. Study with nationwide scope.	This is an investigation of the specific group of homeless people, taking the concept of vulnerability as a starting point, based on the model of social cohesion and the determinant factors of the health-illness process.
Serving the homeless population in a Teaching Health Center in the city of São Paulo. Canônico RP, Tanaka ACDA, Mazza MMPR, Souza, MF, Bernat MC, Junqueira LX[23]. 2007	*Rev Esc Enferm* Lilacs and BDENF	Homeless population as a whole. Survey carried out in the Geraldo Honório de Paula Souza Health Center, of São Paulo University.	Presents an assistance program – 'A gente na rua' ['Us, in the street'], including discussion of aspects related to homeless people's health, and gives the orienting directives of that program.
The social network and promotion of the health of the 'urban disposables'. Souza ES, Silva SRV, Caricari AM[24]. 2007	*Ribeirão Preto Nursing School* Lilacs	Homeless people and workers of the social mechanisms serving the homeless in the municipality of São Paulo.	Analyzes homeless people's policies and experiences. Criticizes the isolated and assistential practices that sustain homelessness and make it a chronic situation.
Organization of fair and equal health practices in primary care in the metropolitan region in the context of the processes of social inclusion and exclusion. Carneiro Junior N, Andrade MC, Luppi CG, Silveira C[25]. 2006	*Saúde Sociedade* LILACS	Homeless population as a whole. Survey carried out at the Barra Funda Teaching Health Center, in the city of São Paulo.	Experiences of organization of primary healthcare services obeying the practice of the guiding principles of the SUS, especially social participation.
Healthcare for the homeless: Reviewing the meaning of the health-illness process. Rosa AS, Secco MG, Brêtas ACP[16]. 2006	*Revista Brasileira de Enfermagem* [Brazilian Nursing Review] BDENF	Homeless people and workers in a community center serving the homeless in São Paulo.	Discusses aspects related to health and healthcare of the homeless population, investigating experiences and concepts on the health/illness/care process.
The health/illness/care process and the homeless population. Rosa AS, Cavicchioli MGS, Brêtas ACP[13]. 2005	*Revista Latino-Americana de Enfermagem* [Latin American Nursing Review] BDENF	Homeless people in general of the São Paulo metropolis.	Discusses the aspects relating to the health of the homeless population, making technical, scientific and political points about nursing care for the homeless population.

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people in Brazil is over 50,000, since some major municipalities – including São Paulo, Recife and Belo Horizonte – did not take part in this study because they had themselves carried out recent

Chart 1. continuation

Title / Author(s) / Year of publication	Periodical or database	Population studied / Study location	Results / Comments
The Urban Disposables: Discussing the complexity of the homeless population and the challenge for policy. Varanda W, Adorno RCF[25]. 2004	*Saúde e Sociedade* [Health and Society] Lilacs	Population mainly of homeless adults. Geographical location not identified.	Evaluates the conditions of healthcare and social interventions with discussion of implementation of public health policies for the homeless population.
Health services and the homeless population: Contribution to a debate Carneiro Junior N, Nogueira EA, Lanferini GM, Ali DA, Martinelli M[26]. 1998	*Saúde e Sociedade* [Health and Society] Lilacs and BDENF	Representatives of the homeless population and of the principal health services located in the central region of the municipality of São Paulo.	Discussion of aspects related to the health of the homeless population and their living conditions. Shows relationships with the health programs and services from the point of view of the various social actors.

studies on their own homeless populations. According to the MDS, this population is predominantly masculine (82%), and more than half (53%) of the adult homeless people interviewed were aged between 25 and 44[14].

A large part of this homeless population are in work: 70.9% of them work at some remunerated activity. Highlights among these activities are: collection of recyclable material (27.5%), informal (unregistered) parking attendants (14.1%), building work (6.3%), cleaning (4.2%), and loading/storage (3.1%). Only 15.7% of this population begs for money as a principal means of survival[14]. These data are important for demystifying the conception that the homeless population at any time consists exclusively of 'beggars'.

According to Rosa et al.[13], it is hard to arrive at a population of the homeless, since the multiplicity of personal conditions, and the diversity of solutions adopted for subsistence and housing, are factors in which it is difficult to formulate unambiguous concepts.

It is possible to identify various different situations in relation to the condition of living in the streets: There is: being in the streets – circumstantially, at this moment; there is living in the streets since a recent date; and there is the situation of being permanently homeless. The time for which homeless people have lived in the street is an exacerbating element in this process: the longer they remain there, whether or not the initial conditions are circumstantial, or recent, the greater the probability of their becoming permanent members of the homeless population[13].

The homeless population has a strong presence in the central regions of major cities, since these areas appear to offer greater possibilities of making their 'means of running their lives' a possibility: a high concentration of services, low concentration of homes and high traffic of people – all these factors contribute to their choice of territory[20].

According to Escorel[12], although they are homogeneous in their common needs, and in the attitude of exclusion applied to them, and their lack of support, homeless people have all become part of this group for different reasons – factors may include how long they have been homeless, the strength or weakness of any family ties, and the survival strategies adopted.

Among the main reasons for which these people began to live in the street are problems related to alcoholism and/or drugs (35.5%), unemployment (29.8%), and disagreements with father/mother/siblings (29.1%). Of those interviewed in the census, the majority cited at least one of these three reasons, which may be inter-related, or one may be consequence of another[14]. The move to living in the street is connected to various different determinant factors; but in our opinion one must not lose sight of the social process that pushes thousands of people into this condition[7].

Ghirardi et al.[17] present the following as determinants in the process of living in the street: Tough competition in the labor market; weakening of employment links due to lack of professional qualification; production activities with high potential for substitution, and borderline

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revenues for subsistence; stigmas reflecting work roles; and unemployment.

Although various countries in Latin America, including Brazil, have experienced reduction in unemployment rates during the first decade of this century, it is important to note that one of the principal consequences of the changes in the world of work at the end of the 20th century and the start of the 21st has been the formation of a reserve industrial workforce – the population that is 'left over' awaiting the needs of capital[28].

The act of going to live in the streets causes a rupture with the generally accepted social means of survival according to the principal that legitimizes the market – in which work functions as provider of housing, food and other needs. Living in the street is a break with the market and its lifestyle. This does not mean total elimination of work or prevention of subsistence, but the development of new codes, specific new ways of guaranteeing survival[15].

In view of the complexity of the life and work of the homeless population, one cannot begin to characterize that population with a stereotype or pattern that would annul or massify its multiple identities. These are men, women, children, old people, and young people, who daily fight and struggle for survival. However, the context in which this population lives tends to maintain them in a position of individuality, deprived of the condition of citizen: "[...] *I have no name, no identity*"[10,15].

When they are not ignored, people living in the street are treated as the subjects of state protection, private philanthropy or charity of the churches. The latter, with the philosophy of 'doing good, no matter to whom', finish up even further reinforcing the invisibility of this population[12].

Possible ways forward for redeeming the citizenship of homeless people may be: to remove the mantle of invisibility of the homeless population; and to break with the classic image of the vagabond and beggar. One of the challenges is the need to get as close as possible to the daily life lived by these people – so as to understand the complexity of their health-illness process, and identify their real needs.

The street and social needs – "We don't want only food, we want food, entertainment and art"

As seen, the people who live in the street are heterogeneous, they have characteristics which are their own, such as values, meanings, attributes, personal structure, survival strategies and conditions of life. These various different characteristics give rise to a diversity of needs. Thus, to look at all the aspects of their individual and collective needs requires the adoption of a wider concept of health, able to go beyond the biological dimension and make it possible to construct health strategies that aim to intervene in the problems and determinant factors relating to the health-illness process.

However, what has been seen in the reality of the health services is that the multi-causal model has inspired the planning of actions to promote health at the various levels of care; and there is also a reinforcement of society's biomedical, medicalizing model. This way of thinking and producing health services has not succeeded in solving the problems related to the health-illness process of the majority of the Brazilian population, and the homeless in particular. It is noted that few studies approach the question of the health of homeless people, especially from the point of view of understanding how the individuals themselves see the process of health and illness and face their health problems. An approach that looks at the meanings in health of homeless people also makes it possible to give these people a space to vocalize on these issues, since in the context in which they live these people so often remain in a position of invisibility, deprived of the condition of citizenship[15].

A large part of the scientific output associates the health-illness process of homeless people with dermatitis, hematoses and various forms of physic suffering, that is to say, it limits understanding of the health process to biological/pathological issues and, in some cases, associates it with a social factor usually related to lifestyle, the consequence of which is to put the blame on the people for the condition in which they find themselves or for the pathology that they acquire. Thus, it forgets, masks, or leaves out of account the relationship of determination established between the health-illness process and this population's way of working and living.

Health and illness have a diversified range of meanings for people in a homeless situation: there are no larger or smaller concepts, but rather concepts that have meaning for the individuals who are living the situation. Some associate health with absence of illness. Others relate health to wellbeing, happiness, prevention of chemical dependence, and a place for shelter[21].

The conceptions of health for the homeless population are associated with the capacity to remain alive, and to resist the day-to-day difficulties in the streets – illness is reported as associated

with a state of not being able to work, impossibility of battling to earn money, prevention of carrying out simple tasks, or in the extreme case, the organism not bearing the suffering, weakening and succumbing[15,26].

For this population, the body is the only asset and instrument that is indispensable for ensuring survival. The attention that individuals give to their own bodies grows as they rise in the social hierarchy. In the contrary direction, the further one falls in the social hierarchy, the greater is the use of the body as an instrument of subsistence through its capacity for strength and work. Health problems that do not affect the capacity to work or to move to seek food are seen in second place in relation to the need to ensure survival[15].

Attention to the health-illness process is an indispensable tool for deciding the action of the health sector for the homeless population. However, this attention has been given only in emergency situations, often by professionals without the due technical training and information for understanding their health needs[16,21].

Labelled as 'leftover', unnecessary individuals without identification and social utility, dangerous, drugged, dirty, lacking rights, lacking ties of affection, or education, they finish up being reduced merely to ... their illnesses[13,29].

Homeless people need privacy, dignity and recognition as citizens. The healthcare of this population necessarily requires comprehension of the street culture, in which it is necessary to consider certain factors. For example: Who are these people? How do they succeed in surviving? What is the meaning that they attribute to their existence?[13,29].

As discussed in the previous analytical category, most are men, young adults, who survive through productive activities carried out in the street, among other strategies. The meaning that they attribute to their existence appears to go beyond the immediate necessities manifested by their needs. The National Survey on the Homeless[14] clarified this issue when it asked this public what was their greatest desire. Among the responses, we highlight: a place to live (30.6%), work (24.1%), reconstruction of family links (14.9%), leaving the street (10.0%) and others (20.4%).

Here is a demonstration that the population of the homeless "*don't want only food*": it shows that policies focusing on social protection will not completely satisfy their needs; more frequently such policies help exacerbate the situation of the homeless, further de-personalizing the people who are living in these circumstances, in such a way that, to get access to what is their right, they need to prove a situation of indigence or a religious vocation. By this we do not mean to say that providing food or hygiene, for example, are not important needs, but that they alone are not sufficient to recover a condition of citizenship for the homeless population[23]; and they also run the risk of restricting attention to immediate solutions for this population's circumstances, negating their essence – which is covered up by the expressions of the inequalities existing in the capitalist society[7].

The policy of inclusion, or lack of inclusion, in policies – "I'm ugly, I'm dirty, I'm antisocial, I can't appear in the picture postcard"

The Homeless Population, this anonymous personage that is growing in the streets of the cities, excluded from the conventional structures of present-day society, such as employment, housing and privacy, constitutes a challenge for health policies, and other public policies[16].

It is a group that suffers a superimposition of situations of exclusions and of cutting of ties in various dimensions: social/family; work-related; in terms of cultural reputation; in terms of citizenship; and in terms of human life. This group suffers from accumulated stereotypes that have been socially constructed. Its members are individuals considered to be: superfluous and unnecessary to social life; people who live beside human garbage, and are discarded in a manner similar to solid waste (to use expressions stated by Varanda and Adorno in *Descartáveis Urbanos* ["Urban Disposables"])[25].

It is what Escorel[12] characterized as "[...] a dynamic process in which individuals transit from integration to vulnerability, or slide from vulnerability into social non-existence".

Although Brazil's federal Constitution guarantees health as a right of all, and a duty of the State, to be achieved through economic and social policies, in practical terms one does not see the extension of these rights to the Homeless: they live on the margin of, or outside, the processes of inclusion, and suffer accentuated degrees of vulnerability and marginality in terms of access to goods and services[21,30].

Although access is often enough difficult for any citizen, in the case of the homeless, there are aggravating factors. To achieve healthcare service, the individual needs to arrive very early at the health posts, and wait several hours, and often needs to go out, to earn money or for example fetch lunch. And, when he doesn't know what he will eat or where he will sleep, other needs may

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take second place, but "[...] *we don't want only food*" is still true[11]. It is also common for the homeless person to have dirty clothes and/or not to have recently washed or showered, another factor that causes him not to be well received in the health service waiting room[21].

Aspects related to these individuals' conceptions of becoming ill, and the process of care, also contribute to their not using the services. Other aspects relate to the organization of the service itself, which plays a fundamental role in the access. Examples are: requirement for documentation; restriction on response to spontaneous demand; limits on inter-sectorial activity; prejudices; and other factors that cause the link with the health service to be precarious[20].

All these aspects discourage homeless people from seeking the help of, and becoming involved with, the health services in the future – tending to cause them, like the population in general, preferentially to seek emergency care only when they are no longer able to resist the symptoms, that is to say, when the body is actually prevented from taking part in the struggle for survival "[...] *and thus the conception of health as absence of illness is reinforced.*" (Our emphasis)[13,18].

Homeless people do not need a new health system, since the equity, integral character and universality of service are guaranteed by the 1988 Brazilian Constitution, with the creation of the SUS[6]. However, reconstruction of the health system is necessary – it is hegemonically centered on the biomedical model, and thus distant from the real social needs of the homeless population.

This point of view leads us to consider the organization of the work processes, and conception of new approaches to the homeless population, that would be able to introduce equity in access to the health services[21], give visibility to this social group, incorporate their demands into health practices, and articulate them into the group of other social practices[25].

An innovative experience, from the point of view of equity, was described by Carneiro Júnior et al.[20], through the *Family Health Strategy for Homeless People*, in which: 'home visit' becomes 'street visit'; 'household' becomes 'usual street location'; and 'family', whatever is 'constituted by declared individuals at the moment of registration'. (The registration files include particularities such as the existence of a pet animal, locations for meals and hygiene, and other aspects.) These adaptations were necessary due to the singularities of the 'lifestyle' of homeless individuals.

According to Reis[7], supporting Escorel, designing health policies that aim to ensure the right to health of the various subgroups that live in the streets is not an easy matter.

Brazilian and international experience seems to indicate that, in this case, the services should go to where the users are, instead of waiting for the users to come to them and demand action and healthcare. This, however, is not enough; policies that articulate health and social protection, employment, housing, education, etc., also become necessary.

It is certainly true that healthcare for homeless people has undergone a positive process of allocation of new meanings. The last several years of debate have resulted in construction of a proposal for care of this public, associated with production of knowledge, characterization of this population, successful experiments on work with this group, and religious initiatives (such as the 'Mission to the Homeless', in the 1970s and 1980s) – mainly due to the valuable role played by the organized homeless people's movements, whose permanent struggles and demands have resulted in achievements including publication of the PNPSR[31].

There was a surge of increase in mobilization of homeless people in 2005, when the first *National Homeless People's Meeting* was organized – this aimed to understand the challenges, and establish strategies, for construction of public policies. It resulted in the approval of Law 11258, governing creation of specific social assistance programs for homeless people[29].

In December 2009, in a major achievement of the Second National Meeting of Homeless People, the text of the PNPSR was published, based on the point of view of guaranteeing that public policies were of an integrated nature, and ensuring access for homeless people to their rights of citizenship[32]. However, we note that in most of the Brazilian states, this policy has not yet been implemented[29].

Among other achievements, Ministerial Order 122/123 of January 2012 laid down guidelines for teams of 'Street Consulting Rooms' (eCRs). These 'consultation rooms' are part of the Basic Psychosocial Healthcare Network, and seek to act in relation to the various health problems and needs of the homeless population, including active search for and care of users of alcohol, crack and other drugs[32].

However, these are recent initiatives that call for more investigation. The traditional design of social protection policies is still marked by discontinuity of projects and programs, one-off actions of distribution of food, clothes, baths and showers, and the predominant culture of taking people into shelters, 'previously into prisons' (our emphasis), with a narrow entry door into institu-

tions, but without the utopian exit door be able to ensure reinsertion into society[3,25].

In the field of health policies, the problems persist: problems of access, stigma, prejudice, lack of professional training, lack of articulation between the sectors, and single-professional care – in other words a healthcare still centered on assistentialist and medicalizing actions[24,25].

It is thought that the challenge is in the (re) definition of public policies, of the State, so as to be coherent with the real needs of the homeless population. In relation to health policy, the subject of this debate, it means: (re)defining health policy, to recognize the existence of the homeless population, whose demands are specific because they are differentiated, and their 'lifestyles' are diversified. And this in turn means: a policy built on the basis of inter-sectoriality, respect for the principles and guidelines of the SUS, conceived first by the Health Reform Movement, in the permanent quest for (re)construction of citizenship.

Final considerations

This study has made it possible to see that the debate involving the homeless and social policy, especially health policy, is still timid in the production of information, and especially in terms of any approach that goes beyond the factual and takes into account the social determinants of the health-disease process of this population.

The studies presented described one-off successful experiences of actions directed towards the homeless population, but restricted to epidemiological staff of some health units, to an alcohol and drugs referral center, and to specific groups who live in the streets. Some of these experiences, however, were the bases for the construction of public health policies directed toward this population.

It is indeed true that a major step has been taken in terms of incentives to public policies for the homeless population, especially in the constitutional field, but it is necessary to bring public policies more closely in line with the needs of the homeless population, and also to consider the principles of universality, integration and equity, which are specified in the definition of the SUS.

In the sphere of social assistance policies, the study revealed the lack of articulation between sectors, discontinuity of the programs implemented to help the homeless population, and the predominance of focalizing policies, with a tendency for use of punitive and isolation practices to persist.

In relation to the health services, as has been seen, the public social equipment usually does not promote a care policy that answers to the needs and demands of the homeless population. Some authors state that the professionals who operate in the public health services frequently do not have the training, knowledge and experience to serve this population, since they are not aware of its particularities, and homogenize it under stigmas and labels. Also, problems of access, actions of a palliative and hygienist nature, medicalizing actions based on a unicausal model, at most a multicausal model of illness, also persist.

Understanding the homeless population, their peculiarities, their life, and their health problems does not resolve the problems of inequality and social exclusion. However, we do believe that this survey helps open the way forward in providing a mechanism for knowledge, and denunciation of problems – thus giving visibility to the situation, so that actions to establish more universal and fair public policies may be promoted.

Collaborations

IKS Paiva constructed the paper based on extraction of part of the review of literature in her master's degree dissertation. She was responsible for drafting of the paper, collection and analysis of data, interpretation of the results, critical review, and the final version of the manuscript. CDG Lira and JMR Justino worked on drafting of the paper, collection and analysis of data, interpretation of the results, critical review, and final version of the manuscript. MGO Miranda and AKM Saraiva participated as supervisors, contributing to the conception and execution of the project, its intellectual content, the critical review and the final version of the manuscript.

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