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Unhoused people: stigma, prejudice, and health care strategies

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Abstract *Historical, social representations about stigma and prejudice related to unhoused people cause psychological distress, feeling of shame, and withdrawal from family and social relationships. This paper aimed to understand how unhoused people and health professionals perceive, reproduce, elaborate, and address the representations produced by their social conditions. This qualitative research employed participant observation, interviews with 24 unhoused people, and a focus group with professionals from the services providing care to the unhoused people. The study was conducted in Rio de Janeiro, Brazil, where crack use is very prevalent. An analysis was performed using the phenomenological narrative method. Stereotyping conjures the self-image of an unworthy, unwanted person, which justifies daily discrimination and, above all, the loss of the most critical condition of all beings, namely, their human condition, besides legitimizing the lack of care and violence against them. Deepening the relationship between prejudice and discrimination in the context of vulnerable populations and health services can assist therapeutic projects that promote the reduction of psychological distress, better care, and social recognition of citizenship of the unhoused people.*

Key words *Homeless people, Prejudice, Social discrimination, Health care, Health services*

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Introduction

The life story of unhoused people is marked by loss of bonds, ruptures, unemployment, social exclusion, and involvement – as a producer or target – with violent and criminal acts[1]. Society routinely typifies housed people as sluts, dirty, crazy, dangerous, and "poor thing", which legitimizes violence against them and serves as a reference for their identities[2] as people with poor living conditions and visible carelessness and unpleasant odor[3]. These meanings feed barriers and distance between unhoused people and the general population, increasing ignorance and attitudes of prejudice, contempt, hostility, and perversity against them, as reported repeatedly by the media. Despite living in highly violent situations, extreme poverty, and abusive use of alcohol and other drugs[1], most are not covered by social inclusion programs[4], and public policies geared to vulnerable populations are implemented in a one-off and fragmented fashion, with severe limitations in their practice[3].

From the health viewpoint, the prevalence of diseases such as tuberculosis, HIV/Aids, dermatitis, psychiatric comorbidities[5], and drug abuse is high[1]. Alcohol abuse and other drugs are often related to keeping people on the street and their exposure to violence. The characterization of unhoused people in scientific literature, medical records, media representations, and common sense encompasses highly stigmatizing social symbolisms – extreme poverty, unemployment, TB, AIDS, psychiatric diseases, drug use, "crackhead", violent person – implying difficulties in family and social reintegration. Besides these derogatory representations, unhoused people suffer the same prejudice and stigma of mental health users, which restrict their reintegration into family, social, and cultural life[6], with loss of the right to the city and citizenship[7].

In urban spaces, unhoused people are often prevented from entering public transport, health services, and other public agencies[4]. There is also a recurrent tendency to make them responsible for their problems without considering the contexts that produced them. Another negative consequence is the internalization and reproduction of this prejudice by unhoused people themselves, reflecting the identification of social representations directed against them[3] by the family, society, and the media, resulting from historical, social construction.

The effect of neoliberalism on the discontinuity of social policies has harmed living and working conditions, with unequivocal evidence of social indicators' deterioration. In four years, the number of Brazilians living in poverty grew by 13.5 million, added to the already existing 52.5 million poor[8]. The growing number of unhoused people is noticeable, and, in metropolitan regions, this population gains new visibility due to the strong association with crack use and its relationship with increased crime and urban violence. This process broadens the vision of unhoused people unable to live together, continuously placing them as a risk to society and reinforcing arguments in favor of adopting repressive and arbitrary public policies.

Established in 2009, the National Policy for the Social Inclusion of unhoused people[9] was a significant advance in adopting intersectoral actions to reintegrate family and community networks and expand access to constitutional citizenship rights, respect relationships, and living in the public space on the street. However, in Rio de Janeiro, the public authorities have addressed this issue under the logic of "urban cleansing" and "revitalization" of public spaces. Grounded on the discourse of "defending society", they promote the removal, exclusion, criminalization, and compulsory hospitalization of drug users and violation of rights[10]. A growing radicalization of the debate on drugs marked by recent neoconservatism is also observed, which escalates the actions such as compulsory collection[11].

Faced with this perverse symbolic universe to which the unhoused people are submitted, this paper aimed to understand how the unhoused people and health professionals perceive, reproduce, elaborate, and deal with the representations produced by their social conditions. Deepening understanding of identity construction in the context of a vulnerable population can help unique therapeutic projects that reduce psychological distress and increase self-esteem and social recognition of unhoused people citizenship.

Methods

The research that gives rise to this paper had a qualitative approach, with a comprehensive and phenomenological perspective and a reflective stance on the way of life and health care for unhoused people. The study was developed within the Health Care Network (RAS), primarily with the Street Clinic (CnaR), in a program area in Rio de Janeiro, Brazil, with a high prevalence of trap houses, from March 2017 to July 2019. The

CnaR consists of a multidisciplinary team and represents the modality of Primary Health Care (PHC) that provides health care to the unhoused people from outside itinerant to expand the offer of comprehensive care adequate to their demands and needs[12].

The operationalization of the research was built by combining three investigation techniques: (1) participant observation of the provision of health care; (2) interviews with CnaR patients over 18 years of age and (3) focus group with RAS health professionals who attend the unhoused people.

Participant observation occurred in the unhoused people reception and waiting spaces (for appointments and procedures, food, bath, and donation of clothes or hygiene items); of various services (appointment, procedure, dressing, test results); territorial scenes (shacks, drug use scenes, streets, Emergency Care Units, Hospitals, social equipment, and others), and CnaR team meetings.

The observations were carried out exclusively in the first 18 months of the research, in a few shifts per week, following more flexibly, for another six months, during interviews. The respondents were approached in the waiting space mentioned above, and the interview was held in a private room. There were no selection criteria for participation, aiming to meet the plurality of people. Those excluded were exclusively due to clinical contraindication (TB or urgent care). The interview questions were based on a previous roadmap, but they were conducted openly, with a possible free flow of the report, allowing the phenomenon to emerge in the language itself. Twenty-four unhoused people were interviewed, and three focus group meetings were held with health professionals from various RAS devices who provide unhoused people health care in the studied territory.

For analysis, we used audio transcriptions from interviews and focus groups and notes from the field diary. The transcribed material was handled with the assumption that the narrative is everything that has been seen, that there is no access to the "facts", and, therefore, no judgments were made about the veracity or not of the reports. In this regard, we adopted the ethnographic[13] approach of "taking the respondents seriously", establishing the categories that make sense to them. Following the phenomenological narrative method, the material was grouped into units of meaning, and, subsequently, a dialogic description was made between the subjects, making it historical, singular, and collective.

Conducting the interviews fluidly, meeting the research objectives through life stories enabled the emergence of empirical categories about an image of oneself, prejudice, fears, and sufferings perceived by the unhoused people. These categories could be revealed even without a direct question, enhancing a more unconscious and less tidy narrative. Likewise, perceptions of health professionals about prejudice and stigma experienced by the unhoused people and care strategies to mitigate these harmful effects also surfaced from the analyzed material. Fragments of the *ipsis litteris* narratives are marked with quotation marks to aid in the description of the analyses.

This research was approved by the Research Ethics Committees of the Sergio Arouca National School of Public Health and the Municipal Health and Civil Defense of Rio de Janeiro.

Results

Characterization of respondents and impressions of researchers

In the general sociodemographic panorama, the people interviewed were primarily male (N=14); in the 30-60 age group; blacks, with one-third whites; half had completed high school or higher education and one-third was illiterate or had studied until the first segment of elementary school; all were from the Southeast Region. Half of the respondents had been on the street for more than five years, and all had used or were using drugs, and a half mentioned using crack. While most were from the lower class, a third of the respondents were from the middle and upper-middle classes, which surprised us somehow and made us reflect on the preconceived idea that most unhoused people were lower social class natives.

Since the onset of the interviews, we were also surprised by the revelation of a large part of the respondents with a self-prejudiced view, mainly linked to drugs or crack, and psychiatric diseases, and the "recycling" work. The prejudice that unhoused people suffer and feel "through the eyes" of ordinary citizens or public service professionals was also observed, as were reactions and strategies that both (unhoused people and health professionals) use to mitigate it, given the long way to its overcoming.

If prejudice is manifested by verbal and non-verbal actions, these can also produce the

power of personal care through the welcoming touch, the interested look, attentive listening, continuous activity in the territory, and acceptance and bonding. We could observe signs of self-prejudice in the surprise and "happiness" that these people showed when receiving a hug from the researchers, and in statements like: "you can hug me [again], because I don't have lice".

Prejudice expressions in unhoused people narratives

From the narratives about the unhoused people way of living and history, we could perceive the prejudice experienced and (re)produced by them, the most expressive being those related to livelihood means (recycling and prostitution), disease (psychic, TB, and HIV), crack abuse, and self-image. A man, 56 years, proud worker, talks about his dead brother:

[...] I had a brother who was problematic and didn't work. He was also a drug user, and... he caught a... bad spirit, from walking around all dirty in the street, picking up these things: bottles, cans, and all that stuff. That's a bad spirit that gets into someone. Because it's not normal for someone to go out there picking things up and walk around all dirty in the middle of the street. Then they go out there in full swing of drug use, picking up everything, reaching into everything. In the trash, everything. [...] He just lives like that, rooting around like a dog in the garbage. That's a bad spirit that got into my brother, and there are a lot of them on the street out there, you see.

Later, the respondent talks about bribery in the place where he usually works as a street vendor:

Friday, all police stations have money on the side, [...] The misdemeanor exists because there is a bribe. Otherwise, it wouldn't exist. If there's a car thief, it's because there's a junkyard. But it's not a game to end up with a junkyard. If everyone walks right, no one wants to be a cop because they don't have a bribe. Are you going to want to earn minimum wage to get shot in the street suddenly? You won't, would you? [...] The MP salary doesn't reach four, five thousand. You arrive at the MP parking lot and see an imported car worth one hundred and fifty thousand. Tell me, how is he going to buy it? If the guy must pay the private school for his son and daughter, rent. He won't live in a favela. [...] He's a policeman. If he lives there, a crazy nigger's going to kill him. And how does he still manage to own a car worth a hundred, a hundred and fifty thousand? It's the bribe. If everyone were walking straight, my son, damn it, the guy wouldn't even want to be President of the Republic because he wouldn't go looking after anything.

The respondent, who was proud of not looking like a "homeless person" and the Styrofoam box for the sale of snacks that he carried, reveals his values about the world of work as a symbol of social recognition and human dignity. On the other hand, he disapproves of the unhoused people daily sustenance and survival activities (collecting, digging out, recycling things), making an analogy to animalistic behavior. The "collection", related by the brother's probable psychiatric illness, is called "bad spirit", a recurrent term in the discourses of neo-Pentecostal churches, showing that unhoused people with mental illnesses are targets of exacerbated prejudice.

On the other hand, the narrative also reveals the cynical face of the corporate world and institutions. The respondent's high power of observation and lucidity lacks self-criticism and serves as justification, reinforcing capitalist values that determine that "you can do anything", and there is an excuse for everything. Thus, institutions do not have a "bad spirit", even if they display reprehensible behavior. The report also illustrates ambiguity, in which "collection" has a pejorative, derogatory, and prejudiced tone while attenuating and normalizing the receipt of bribes by police officers. Of course, this prejudice is sometimes contradictory, showing that the weight of unhoused people judgment is crueler to it than to the general population, reproducing society's *status quo*. A 54-year-old man went to the streets for fear of murdering his son as a result of psychotic episodes and talks about the difficulty with a psychiatric diagnosis:

The medicine bothers me. It bothers me. Because it gives me this crazy feeling, you know? [...] These voices, ... for me it would be easier, I wanted to hear it so badly that this [schizophrenia] was spiritual, you know? I wanted so much for someone, in this hospitalization, saying, he's religious, he's Catholic, right. I really wanted them to tell me it was spiritual. I wanted to hear it so bad, but they said this is mental. That's my mind. They confirmed what I already knew, got it? [...] that my mind creates all this stuff.

After losing hope that his diagnosis was not spiritual, he looks for a new cause for his illness, even if he no longer uses crack:

Crack left me with some sequels; hearing voices...

The report shows the paradoxical consequences of mental illness: experiencing distress,

discrimination, stigma, and life medicalization and its side effects. For the respondent, even if the medication relieved the hallucinations, it was somehow indisputable proof of his psychiatric situation, which he wants to get rid of. Seeking an external culprit (medication, "spiritual possession", negative energy, and crack) for a chronic disease represents relief and a perspective of "cure" for a condition that is unacceptable for the patient, given that these conditions are liable to treatment. Madness for the respondent represents two reasons for distress: symptoms (hallucinations) and prejudice against it. Female, 38 years old, graduated in History, Psychology and Occupational Therapy, says:

The reason I came here is that I have the greatest prejudice with the treatment of TB [tuberculosis]... and then, I trust the [health professional]. I have TB. I start the treatment and stop. Start and stop.

The respondent shows self-prejudice for another socially stigmatized disease and, equally, the practice of interrupting treatment for conditions against which there is prejudice or non-acceptance. She also emphasizes that bonding and trusting relationships favor the treatment of stigmatizing diseases. Other respondents showed different expressions of stigma and prejudice because of crack use:

I use crack. I'm using the stone, but I don't stay in a trap house. I'm ashamed to stay in a trap house, understand? (Male, 45 years old, evangelical, and delivery boy).

The problem is not the drug. It's getting caught. Crack is a problem for the family, due to prejudice". (Man, 35 years old, suffers from loneliness).

People say I'm a fag just because I don't get naughty with a female crack user. I don't really have sex with a female crack addict. Me being dirty is enough. Ah! It's a woman. But she doesn't take a shower. What's this? [...] We all know that a clean woman is normal. (Male, 29 years old, crack user).

My brother, who has been a churchgoer for forty years, said that he desired to see me dead inside the coffin. [...] Because of crack. Because he's prejudiced, it's part of it. I use it all the time. I also depend on crack and marijuana, along with the medicines I mentioned earlier [...] to stabilize this thing that is my head more. You have no idea what it's like to live with all these [schizophrenic] thoughts. And when they come all at one? When I use crack, I get like this. The way I am, normal. There's no difference. It's complicated without crack because then I'll have to increase the number of legal medications a lot. Then I'll become a vegetable. (Male, 47 years old, addicted to reading).

Besides the highlighted reports, several respondents revealed a prejudice against drug users ("addicts", "I don't like addicts", "crackheads"), even if they made compulsive use of crack.

Besides the harmful physical and psychological consequences of its use and the difficulties of abstinence, crack is also a reason for suffering resulting from shame and family disruptions. Among drug addicts, crack is considered the worst of all worlds, extending this stereotype to its users. The condition of being a woman, homeless, and crack user embodies the combination of triple prejudice arising from conservative and sexist values still present in society in general, which are also reproduced in those who live on the streets.

One respondent shows suffering both for the lack of control of psychiatric symptoms and the alienating side effect of psychiatric medications. He argues that he does not see a distinction between the use of legal drugs (prescribed by Medicine) and illegal ones to control the hallucinogenic and paranoid thoughts he suffers. He dwells on a topic that is still taboo in society and with substantial barriers from conservative ideology to deepen this discussion.

Other narratives harbored prejudice of some unhoused people against unhoused people, perceived by the expressions: "gangs", "bumps", and "people who do not bathe". Some showed prejudice concerning diseases/conditions common in these groups (chemical addiction, Mental Disorder, HIV/Tuberculosis: "I don't accept it", "I don't deserve it") and against prostitution, perceived by the use of ambiguous terms, such as "exchange", "money falling from the sky". "Self-prejudice" is evident when the subject of a particular group or activity (crack use) morally judges his peer, which shows that such people somehow see themselves "inside" and "outside" these groups. Prejudice represents the effort the subject makes to differentiate himself and not belong to that group. The reproduction of prejudice and discrimination in society in general by the unhoused people is also notorious. Denial as a measure to move away from what is prejudiced shows the degree of psychological distress these people are exposed to and feel due to stigma and discrimination.

Expression of prejudice and discrimination in the context of health care

Several respondents report cases in which they perceive themselves to be the target of prejudice from others, especially in health services.

A 43 years old woman, crack user, HIV+, with a dream of being a mother, says:

Because I like coming here [CnaR] because I am treated well. In other facilities, they look at us with a disgusted face. Sometimes you're lucky to get... a nice doctor who treats you like a human being. But let me tell you something. I am terrified. Do you know why? I'm afraid to get there. Some people hate crackheads. [...] Here comes my fear. [...]: "Ah! that crackhead over there will take the spot of sick people. Give her an injection in the vein right away! Kill her already...Ah! She already has an HIV memo..." I am already dead before I do... the biopsy of I don't know what.

[When] I arrive at the hospital, I arrive like, "Hi, how are you? Nice to meet you, my name is [...], I'm a crack user, but I'm not...". I arrive already communicating, making friends, because I'm not dumb. I'm afraid they'll give me an injection... and I die.

Woman, 32 years, on the streets since she was 17:

Elsewhere, I got more or less assistance. Not even when I was hospitalized [...], there was also prejudice and disrespect by some nurses and doctors [...] for not having a fixed address and being a user. Because I don't hide it. I'm really a user. What am I going to hide for? Then, there was that discrimination, sometimes of... me asking for something, needing something. Nothing. No one cares.

The reports show the fears of unhoused people in the face of actions motivated by prejudice during health care in the RAS services. The representation of "undocumented, non-domiciled, drug user" builds a negative self-image in these people, who start to feel unworthy and unwanted. This ongoing process can lead to the loss of the essential attribute of all beings: their human condition. People who are constantly put in the place of the unwanted lose their right to citizenship and life.

Often, the strategy used by unhoused people to reverse discrimination and be taken care of by the health services is reacting within their possibilities: being communicative, making friends, and prioritizing trustworthy services, in short, showing that there is a human being capable of acting, interacting, and reacting.

Perceptions of health professionals about prejudice and discrimination against unhoused people

The health professionals participating in the research shared the same concern about prejudice and discrimination faced by unhoused people in health services, whether from professionals, other patients, or even in prioritizing more authoritarian or restrictive behaviors of autonomy, exclusively because they are unhoused people. It was unanimously recognized that drug addicts living on the streets have a double burden of prejudice and discrimination in their relationship with the health services.

According to these professionals, the discrimination in the daily services can vary:

a discriminatory look"; "*no service provided when called for due to the unhoused people condition*"; "*puts a 'living on the streets', or 'social' diagnosis and doesn't even listen to the patient*"; "*induces the Guardianship Council to remove the custody of the child who is born to a drugged street dweller*"; "*professionals who only think about protecting the child and despise the mother. It's a ham-fisted Social Worker's practice*"; "*sometimes, believing that the unhoused people will not address the consequences of the procedure, they choose less indicated procedures, such as using a plaster cast instead of surgery because they don't know how to do the postoperative period*"; "*when it is a [drug] user, there is always a lecture on drug treatment to the detriment of any other diagnosis.*

Besides the lack of assistance, the reports show the practice of negligent or inappropriate care, whether due to overcare or undercare, motivated by the simple fact that the health professionals are unaware of unhoused people conditions and support networks and do not even ask about their preferences. Homeless patients, treated as subjects devoid of desires and choices, are at the mercy of the professionals' values, beliefs, and priorities concerning health care, reiterating the relationship of exclusion of unhoused people with themselves and the world.

Furthermore, discriminatory behavior of other patients with unhoused people in health services was mentioned: "some patients do not accept to be seen after the homeless population, even if they arrived after them".

Prejudice in the health care of the unhoused people exposes the practice where someone's "life" does not depend on their health condition but the behavior of each professional, further aggravating the vulnerability of this population.

CnaR professionals shared their strategies to combat discrimination and provide care, whether through embarrassment, the vigilance of health services to avoid early discharge or lack of assistance, or patient care, regardless of how they act to obtain care to minimize the deleterious effects of the performance of health services.

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Sometimes we carry with us the Ordinance [establishing] the SUS card in the van, [...] it's not talking about the Individual Taxpayer Number (CPF) [in the Ordinance] on the SUS [Unified Health System] Card, [...] it asks the mother's name and the full name of the individual... Then we have the embarrassment [...] for that to be realized.

There needs to be a professional who is sensitive to the unhoused people *so that they are treated like any other.*

The team took over, right? The dentist didn't walk away anymore, the [health professional] didn't leave the UPA [Emergency care unit] either, if the [patient] didn't leave there, the case was resolved, and being in the emergency room. That's how the street clinic works.

When he arrives [...] he goes into that terror impact or goes "I am a poor thing" [...]. With time, he starts to understand that we are there regardless of what story he has to tell and that we will attend him anyway.

Another way to reduce prejudice is by bringing reality closer. The resident shares his reflection on a trap house during the journey to the itinerant care.

When you really enter the scene, you see that there is none of that, there will be no one attacking you, no one being violent with you, robbing you with a gun. You see people suffering in inhuman conditions which are lacking in affection.

The reflection shows the contrast in the vision of those who see the scene from the highway, from inside a car, and those who enter the stage. Lack of knowledge of reality projects a situation far more dangerous than that felt in the experience. As a result, knowledge is one more possibility to alleviate prejudice, tear down barriers, and reduce indifference with unhoused people.

Discussion

This paper aimed to identify how prejudice and stigma affect the unhoused people and highlight ways to overcome the social barriers within health services. Pejorative social representations vis-à-vis unhoused people, which materialize in social relationships, are not new in academic literature[1-4,6,9]. However, few people address self-prejudice, or its effects produced in the context of health care.

A repulsive look at fellowmen represents the rules and values of the current society internalized by unhoused people, as seen in the depreciative activities such as recycling and prostitution, besides the opinion that women (and not men) must be clean. This process allows the unhoused people to use derogatory labels as a reference to configure their identities[2]. Therefore, incorporating a self-pejorative view leads to the gradual construction of an identity of "fallen, useless, and failures."[14] These social constructions imply more significant difficulties in family and social reintegration[2], including siblings preferring the respondent's death because of the shame of him being a crack user.

Regarding prejudice and tuberculosis, Snowden[15] points out that there are pathologies with greater prevalence in conditions of poverty, diseases with the historical power to mobilize public opinion against the poor, reinforcing stigmatization mechanisms that promote social exclusion[15]. Regarding this fact, unhoused people show prejudice precisely with diseases socially related to poverty. The research also showed that "non-acceptance" and prejudice with stigmatizing diagnoses interfere with the continuity of treatment for conditions with severe consequences for the health and life of the patient and their social group.

Unhoused people reproduction of society's prejudice shows the convergence of values and beliefs. It raises the question of whether unhoused people are really at the sidelines of society, or if they are marginal only in assuring the constitutional right, as expressed in the fifth article: "Everyone stands equal before the law". The lack of assistance and negligence by the health professionals and patients demanding to be serviced ahead of the unhoused people in health services just because of their social condition and not their health are blatant examples of violations of these rights.

The research shows the relationship between prejudice and taboo themes, such as the use of illicit drugs, prostitution. It warns that the lack of knowledge and dialogue about these banned contents feeds psychological distress, limiting possibilities in health care, such as "drug treatment to the detriment of any other diagnosis" and "ham-fisted Social Worker's practice". Furthermore, the religious dimension in the reproduction of prejudice and "jargons" by the unhoused people, especially from neo-Pentecostal religions, exposes the competitive relationship between health and spiritual practice, harming users' therapy[6].

Even as a field under construction, the Brazilian Psychiatric Reform brought invaluable ad-

vances in the discourse and practice to address madness and mental distress, contrary to the institutionalization of madness[7]. However, despite the intertwined unhoused people – Mental Health relationship, homeless people did not benefit from their achievements as they could. Moreover, the Policy for the inclusion of unhoused people[9] is recent and has not reached the revolutionary movement and the advances of the Psychiatric Reform. Asylums, hospitals, and shelters seem to produce the institutionalization and disfiguration of subjectivity, just like the street – an institutionalization without an institution.

Based on reflections on concentration camps, Arendt[16] details the process of transforming citizens of law into "living dead" – unwanted, worthless subjects, without belonging, and superfluous. She argues[16] that "living dead" is the one treated as if he did not exist, as if the events of his life did not interest anyone: as if he were dead[16]. The methods of preparation for this condition are historically and politically explainable, distinguished by systematically eliminating people's rights, morals, and uniqueness[16]. Self-abandonment and loss of spontaneity are consequences of this practice and were observed in this research[16].

Similarly, Gofman[17] describes the process of "self-mortification" as the production of acute psychological tension, with degradations and humiliations, on the individual disillusioned with the world or a feeling of guilt so that that mortification can cause psychological relief. A practice that deprives someone of their citizenship[16] affects different aspects of an individual's life, producing feelings of shame and humiliation, causing family distancing, isolation, or establishment of groups that provide them with a stable identity[2].

Prejudice, discrimination, and lack of assistance play a direct role in this process. These combined experiences – in the family, services, and society – transform the citizen into the "living dead" or a "self-mortification", affecting unhoused people self-image and self-esteem, causing neglect in the care of people with precisely the most significant social needs. Escorel[18] speaks of people who "live stubbornly", since even with reduced fields of possibilities, they break with these restrictions, creating new opportunities to establish themselves as active players of the same society that denies them opportunities.

Unintentionally, the research could reflect on stigmas, prejudice, shame, fears, and unconscious ways of overcoming them as possibilities for transforming realities devoid of hope. The prioritization of studying unhoused people from their life story aimed at its valorization as active subjects and players of stories, trajectories, and values, in contrast to the invisibility, ignorance, and prejudice often characterized.

As for the paper's limitations, we highlight that the study population has a high prevalence of drug use, especially crack, which may have stressed this issue, and that the original research did not intend to directly study prejudice and discrimination, which may have limited this topic. However, the fact that prejudice was so evident through the unhoused people and health professionals in a survey without this purpose shows the latency of these issues and the suffering that this brings for those cared for and those who provide care. In this sense, it reinforces the importance of new investigative studies on prejudice and female homeless women, prejudice, and interrupted health treatment and strategies to face it.

Conclusion

The findings show that, in a contradictory way, the main prejudice events (re)produced by unhoused people against themselves are also those that represent their identity in the society's imagination, related to their careless and smelly appearance, their livelihood activities, more prevalent diseases (Mental Disorder, TB, HIV), and drug use, especially crack.

Like the *status quo*, being a homeless woman and a drug user was a critical discriminatory combination, besides sexist and socially biased. Likewise, suffering from a mental disorder and being on the streets increased stigma and, thus, the individuals' psychological distress. Unhoused people highlight the social taboo and resistance to the debate on Medicine-prescribed and illicit drugs, implying consequences of health and violence.

This entire discriminatory process showed that it is not innocuous but produces many harmful effects, such as distress, low self-esteem, family breakdown and social exclusion, deprivation of rights and citizenship, abandonment of treatment, and lack of assistance.

On the other hand, strategies to deal with the suffering in the face of the prejudice suffered are not to look like a 'homeless person', stay away from trap houses, self-denial, and abandonment of treatment for stigmatizing diseases. Discrimination against unhoused people is evident in

health services, whether due to appearance, lack of documents and residence, or drug use. This stereotype justifies the lack of assistance and curtailment of rights, citizenship, and life.

Aware of their condition as a dispensable and unwanted being, unhoused people attempt to circumvent their disadvantage and stay alive by being communicative, making friends, and prioritizing trustworthy services, showing that the Policy for the inclusion of unhoused people[9] and the establishment of the CnaR[12] were significant advances in their life, the respect for diversity, and human rights. The CnaR team and other professionals, sensitive to the non-verbal abuse suffered by unhoused people, join forces and adopt strategies to combat discrimination in favor of life, sometimes through embarrassment, the vigilance of health services to avoid lack of assistance, sometimes through the sensitive attitudes of professionals, an interested look, attentive listening, or the subject's incessant search for the territory. The bond and trust relationship with health services favors the persistence of treatment for diseases, which produces significant effects when discontinued. Caring for life starts with empathic care. Solidarity actions can alleviate suffering and inequalities and produce subjectivities, desires, and autonomy projects[19].

Reflecting on actions reproduced in a mechanized way and the disastrous effects of prejudice, besides knowing the reality under judgment, helps break down barriers, bring dialogues closer, and contribute to a more balanced and equitable life. Studies in this area can improve public policies and reduce the gaps in urban spaces with such significant social disparity.

Collaborations

BC and SLN participated in the design, analysis, writing, and critical review of the manuscript.

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