Health social inequality of the homeless in the city of São Paulo[1]

Desigualdade social em saúde na população em situação de rua na cidade de São Paulo

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Projeto de Vulnerabilidade Social no Centro de São Paulo[2]

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Abstract

To describe the sociodemographic characteristics, health status and access to services of the population living on the streets in a sample obtained from three homeless shelters in the downtown area of Sao Paulo. The sample included 251 subjects: 171 males, 78 females and 2 people who reported themselves as transgender. A structured questionnaire was applied about: sociodemographic characteristics, time on the street, physical activity, discrimination, social network and support, health status, alcohol or drug use, violence and access to health services. The subjects were adults, non-white, low education level, and with a monthly income lower than half the minimum wage. A third of the respondents had already been in this situation for more than 5 years. The health status for 45% of the respondents was considered good or very good health. The majority preferred to use primary care centers when needed and the precarious financial conditions and lack of family added to physical violence situations. Discrimination, poor hygiene and physical or mental disabilities are common in their lives. The challenge of formulating health policy is to incorporate the representations and care practices of these individuals, but also the services, as a starting point for organizing care.

Keywords: Homeless, Living Conditions, Health Conditions, Access to Health Services.

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Resumo

Descrever as características sociodemográficas, o estado de saúde e o acesso a serviços na população em situação de rua em uma amostra em três albergues do centro da cidade de São Paulo. Amostra de 251 indivíduos: 171 do sexo masculino, 78 do sexo feminino e duas pessoas que se autodenominaram transexuais. Foi aplicado um questionário estruturado contendo dados sociodemográficos, trajetória e tempo de vida na rua, atividade física, discriminação, rede e suporte social, estado de saúde, consumo de álcool ou drogas, violência e acesso a serviços de saúde. Verificou-se o predomínio de adultos do sexo masculino, não brancos, com baixo nível de escolaridade, e com renda mensal menor que ½ (meio) salário mínimo. Um terço dos entrevistados já se encontrava nessa situação há mais de cinco anos. 45% dos entrevistados consideraram sua saúde boa ou muito boa. A maioria prefere utilizar as unidades básicas de saúde quando tem necessidade. As precárias condições financeiras e ausência de família somam-se às situações de violência física sofrida. Discriminação, péssimas condições de higiene e incapacidade física ou mental são comuns em suas vidas. O desafio que se coloca para a formulação da política de saúde é incorporar as representações e as práticas de cuidados desses sujeitos, como também dos serviços, como ponto de partida para a organização da assistência.

Palavras-chave: População em Situação de Rua; Condições de Vida; Condições de Saúde; Acesso a Serviços de Saúde.

Introduction

The existence of people on the streets is a social phenomenon that takes on new expressions in contemporary society, particularly in large urban centers (Hwang et al., 2009). This social group which inhabits public parks or public/philanthropic shelters, experiences precarious work situations, living conditions and poor social integration (Vannucchi, Barros, 2009; Vieira, Bezerra, Rose, 1992).

Living on the streets is a problem that goes beyond homelessness. Having a home means having roots, identity, security, a sense of belonging and a place of emotional well-being (Editorial, 2008).

The transformations experienced by Western societies, through the processes of social exclusion and inclusion have produced different groups, more or less marginalizing the population on the streets (Castel, 1997; Nascimento, 1994).

The heterogeneity of social groups within the composition of the downtown area of São Paulo is too big. In this area of the city people co-exist on the streets, women and transvestites in prostitution, and lower middle classes occupying houses and apartments, are often interspersed with slums and Bolivian migrant worker workshops, among others. Depending on the location, the neighborhood can also be made up of housing units built by the government, with poor structural conditions, rapidly deteriorating and with a history of violence, delinquency and organized crime. There are also small slums and upper-class neighborhoods (Silveira, Amaral, Marsiglia, 2009; Frúgoli Junior, 1995).

People on the streets are among the most marginalized groups in society. Even among them there are differences across their individual trajectories, such as length of stay on the streets and their particular life strategies (Martins, 1997; Carneiro Junior et al., 1998; Hwang et al., 2010).

The last census, in 2011, listed 14,478 people on the streets in the city of São Paulo, of which 47% stayed overnight in public places and 53% in municipal or philanthropic shelter. There has been an increase of 65% in the past 10 years of the number of people in this population in São Paulo. Administrative districts with the highest number of people living on the street are those who are in the

"central area" of the city, with St. Cecilia, Cathedral and the surrounding neighborhoods having a higher concentration of this population, amounting to 16% (Prefeitura do Município de São Paulo e Fundação Escola de Sociologia e Política de São Paulo, 2012).

Taking the people on the streets as a social issue for health care is relevant because their living conditions that determine health-illness care is a very different process, requiring new technical health care arrangements and public policy (Carneiro Junior, Jesus, Crevelim, 2010).

In order to develop public policies aimed at this population, the Brazilian government issued the Decree 7,053/2009 establishing a national policy for the people on the streets, aimed at building institutional and social mechanisms to promote intersectoral programs and actions ensuring access to public goods and effective citizenship (Brazil, 2009).

The purpose of this article is to describe the sociodemographic characteristics, health status and access to services of a homeless sample living in downtown São Paulo, and compare these features to those observed among the most socially vulnerable residents, living in the same area.

Methodology

This article used results from "Social Inequalities in health and access to services for groups with varying degrees of vulnerability and social exclusion living in downtown São Paulo," a household survey carried out in 2008 that included four groups: residents living with social vulnerability; residents living without social vulnerability; Bolivian immigrants; and people living on the streets.

For the group of people living on the streets, we selected for convenience, three city shelters situated in downtown São Paulo, with 642 places for adults, 532 (83%) occupied by men and 110 (17%) women. A sample of 251 individuals was included. All women (78) present in the three shelters were included. For men, a systematic sample of 173 individuals was obtained. Data was collected in a single day by a team of 30 interviewers.

The sample of residents living in a socially vulnerable area was obtained in three stages. All census tracts in the central area were classified according to the São Paulo Social Vulnerability Index, developed by the SEADE Foundation, based on socioeconomic data and types of households. 25 census sectors were randomly selected among those classified as medium, high or very high social vulnerability. Households that occupied these 25 sectors were listed, 40 addresses (20 + 20 reserves) were drawn in each of the sectors through a systematic procedure. Only one of the residents aged 18 or over in each household was randomly selected. It included 487 residents with social vulnerability. The collection was done in a month by a team of trained interviewers.

A structured questionnaire containing demographic data, history, lifetime on the street, discrimination, social support, health status, alcohol consumption, tobacco or drugs use, violence and access to health services was applied. The data was submitted to double typing and processed with SPSS 17 software.[3]

The research project was approved by the Research Ethics Committee of, the *Irmandade da Santa Casa de Misericórdia de São Paulo* with 061/07 protocol. All participants signed the informed consent form (ICF).

Results

Table 1 shows the sociodemographic characteristics of the sample population consisting mainly of adult males, non-white (non-white category includes: black, brown and native yellow, whitch are and the color classes used by IBGE), those with low educational level, living without a partner, with a monthly income lower than ½ (half) the minimum wage (R$207.00 at the time of the survey) and those working outside of the labor market.

Table 2 shows the amount of time on the street and the reasons that led to this situation. One-third of respondents were in this situation for over five years while another third has been on the street for less than a year. For most, the reasons for

3 SPSS v17 is a paid software developed and marketed by IBM that allows processing and statistical analysis of research data. A database can be created and entered in the software itself or imported from other software. The processing and analysis are performed through commands.

Table 1: Sociodemographic data of individuals on street condition, residents in census tracts with social vulnerability, central area of São Paulo, 2008

Variables	Population in street condition		Homeless in social vulnerability	
	Quantity	%	Quantity	%
Age*				
20-39	69	27,7	262	53,8
40-59	147	59	160	32,9
60 or more	33	13,3	65	13,3
Gender*				
Male	171	68,1	209	42,9
Female	78	31,1	278	57,1
Color**				
White	90	36,3	220	45,2
Non-white	158	63,7	259	53,2
Education*				
Functional Illiterate	69	27,5	128	26,3
Elementary School	75	29,9	191	39,2
High School	29	11,6	142	29,2
Higher Education	8	3,2	26	5,3

Variables	Population in street condition		Homeless in social vulnerability	
	Quantity	%	Quantity	%
Marital status*				
Single	132	52,6	162	33,3
Married	25	10	192	39,4
Divorced/ Widower	94	37,4	133	27,3
Monthly income*				
< ½ minimum wage	122	64,9	10	2,1
½ to 1 minimum wage	49	26,1	47	9,7
> 1 minimum wage	17	9	402	82,5
Working status*				
Working[a]	29	11,9	346	71
Eventual[b]	75	30,6	0	0
Unemployed[c]	53	21,3	64	13,1
Outsite of the labor market[d]	71	29	29	6
Retired[e]	17	6,9	46	9,4

a) Formal and Informal Workforce; b) Eventual workforce; c) Looking for a job; d) Unemployed and not looking for a job; e) Retired on disability, age or lengh of service

*p<0,001, **p<0,05

homelessness are precarious financial conditions and the absence of family. Those with families are separated from them by personal choice or for other unspecified reasons. Almost all respondents stated the intention to get out of this situation.

Table 3 deals with the perception of discrimination and the social support network of the respondents. The vast majority of respondents feel discriminated against, particularly, with the homeless situation. The reason is that the lack of hygiene, physical appearance and physical or mental disability. About two-thirds feel unsafe walking in downtown at night. The majority does not have friends or relatives living nearby and do not identify institutions to whom they can turn to if they have a problem. In the shelter, 40% identify social workers as people who support them, while 22% say they cannot count on anyone; however, 60% say they feel good in the shelter.

The situation of health and exposure to violence are presented in Table 4. Most respondents considered themselves as having fair or poor health, but 45% report having good or very good health. Only 30% think that their health conditions interfere with everyday activities. The experience of attacks in the last month was reported by 46% of respondents, of which 16% reported physical or sexual assaults, in the shelter or on the street itself. The assaults were committed by homeless or other people living on the streets. About 10% reported having suffered abuse by the police.

Table 2: The moving to the street path and time experience on the street, sheltered individuals living the center of São Paulo, 2008

Variable	Quantity	%
Reasons that led them to street/shelter		
Financial conditions	158	62,9
Absence of relatives	81	32,3
Expelled by family	37	14,7
Health treatment São Paulo	25	10
Temporary job in São Paulo	14	5,6
Passing through the city	12	4,8
Workplace distant from home	8	3,2
Withdrawal from family		
Yes	183	73,8
No	65	26,2
Reasons for family withdrawal		
Personal choice	53	30,1
Marital disagreements	30	17
Job loss	17	9,7
Alcohol or illicit drugs abuse	15	8,5
Others	61	34,7
Plans to leave the street/shelter		
Yes	222	89,2
No	27	10,8
Time of homelessness		
< 1 year	76	31,1
1 a 2 years	34	13,9
3 a 5 years	53	21,7
> 5 years	81	33,2

As for risk of exposures: 57% are smokers; 34% consume alcohol, of which 18% reported consuming more than six drinks at a time and 19% answered yes to three or four questions from the CAGE[4] questionnaire (hazardous drinking). About one-third reported ever having used marijuana; 10% to 14% reported the use of inhaled cocaine, crack, or amphetamine; 8% reported sniffing perfume, glue, *loló* (solvents) and other inhaled drugs; 5% reported the use of injectable drugs, LSD or ecstasy.

Table 5 shows the access to health services. Most respondents are always looking for the same service and two-thirds seek primary care centers. Only 20% reported seeking emergency room when they have health problems. About 42% reported health problems in the week preceding the interview. Of these, 62% sought care at a health facility and 95% had their needs met. The most popular services were the primary care centers. Only 19% had sought the emergency room. Most evaluated the care they received as good or very good (84%).

Among those who had health problems, but did not seek treatment, 43% considered it unnecessary and 22% resorted to self-medication. Only 5% said it was due to lack of money and 8% claimed that the service would be time consuming.

Hospital admissions were reported by 21% of respondents and 7% had never been to a dental appointment. Of the rest, 49% had not had a dental appointment for three years or more and 26% less than a year. About two-thirds of women reported a Pap smear in the past three years and 42% reported mammogram in the past two years.

Discussion

The demographic profile of the surveyed individuals is similar to the last census of the population living on the streets in the city of São Paulo. This population group is predominantly male, with an average age of 40, "non-white", with schooling up to elementary school and coming from the Southeast zone, specific to the state of São Paulo (São Paulo, 2012). Similar profiles are reported in studies conducted in Canadian cities, in Glasgow, Scotland, and Los Angeles, and the United States (Hwang et al., 2009; Morrison, 2009; Teruya et al., 2010; Palepu et al., 2012).

Even when compared to other socially vulnerable populations residing in the center of a metropolis, the group of individuals on the streets showed conditions of extreme vulnerability and social exclusion.

4 The instrument CAGE (Cut down, Annoyed by criticism, Guilty and Eye-opener) is used as a screening for alcohol abuse or dependence (CASTELLS, FURLANETTO, 2005).

Table 3: Discrimination, neighborhood and social support, sheltered individuals living in the center of São Paulo, 2008

Variables	Quantity	%
Perception of prejudice or discrimination		
Yes	212	85,8
No	35	14,2
Reasons for prejudice or discrimination		
For living on the street	189	89,2
Physical appearance/hygiene	128	60,4
Physical/mental disability	108	50,9
Color or race	77	36,3
Age	77	36,3
Sexual orientation	61	29,3
Others	57	27
Place where the discrimination occurs		
Streets, squares and other public places	184	87,6
Restaurants	138	65,7
Stores and other commercial establishments	117	55,7
Banks and financial institutions	111	53,4
Working place	100	47,4
Shelter	99	47,4
Leisure spaces	88	42,5
Health services	72	34,3

Variables	Quantity	%
Safety on walking after dark		
Yes	82	34,7
No	154	65,3
Feels good in the shelter		
Yes	146	59,6
No	99	40,4
Relatives or friends living near by		
Yes	67	27,1
No	180	72,8
Who to count on when in need of help		
Government social protection services	95	38
Health services	68	27,1
Social institutions as churches, NGOs and others	57	22,7
Friends	55	21,9
Relatives	28	11,2
Who gives support in the shelter		
Social worker	99	41,6
Other employees	38	16
Colleagues	20	8,4
Directors	10	4,2
No one	52	21,8

They have uncertain role in the labor market, characterized by odd jobs and unemployment. Among those some enjoy a monthly income but a large part lived on less than half the minimum wage. This data is compatible with those observed in the census and in other studies in urban cities (Sao Paulo, 2012; Teruya et al., 2010; Palepu et al., 2012).

A small portion of respondents presented a circumstantial reason for being homeless, such as health treatment in the capital or temporary jobs. Most attributed their condition to economic problems, removal/lack of family relationships motivated by disagreements, unemployment or use of alcohol or drugs. Similar reasons appeared in studies of other cities (Editorial, 2008; Palepu et al., 2012; Hudson et al., 2010).

The perception of discrimination is extremely high among the group living on the streets, widely surpassing those residents reported living with social vulnerability (16%) in the downtown area of the city. Among the reasons indicated, the group identifies their condition of living on the street as the main reason for discrimination. There is also an overlap of other forms of racial, generational and sexual orientation. Milburn

Table 4: Health condition, violence, alcohol abuse, drugs and tobacco, sheltered individuals living in the center of São Paulo, 2008

Variable	Quantity	%
Health condition self-proclaimed		
Very good	25	10
Good	88	35
Regular	87	34,7
Bad	51	20,3
Health problems interfere with everyday activities		
Yes	73	29,3
No	176	70,7
Any aggression last month		
Verbal	76	30,3
Physical	38	15,1
Sexual	1	0,4
Place of aggression		
Street	42	45,7
Shelter	42	45,7
Bar	5	5,4
Others	20	21,7
Aggressor		
Another sheltered homeless	32	35,2
Another person in street condition outside the shelter	24	26,4
Police	9	9,9
Employees of commercial establishments	4	4,4
Others	32	35,2
Daily cigarette consumption		
None	106	42,6
1 a 10	86	34,3
> 10	57	22,7

Variable	Quantity	%
Weekly consumption of alcohol		
Never	161	65,7
< Once	24	9,8
Once or Twice	23	9,4
3 times or more	37	15,1
Doses of alcohol consumed each time		
1	20	8
2 a 3	19	7,6
> 3	46	18,3
CAGE test		
1 ou 2 positive answers	25	10
3 ou 4 positive answers	48	19,2
Use of drug during lifetime		
Marijuana	68	27,5
Inhaled cocaine	34	13,7
Crack	32	12,9
Amphetamines	26	10,5
Huffing, Sniffin' Glue, etc...	20	8,1
Injectables	12	4,8
LSD	10	4
Ecstasy	10	4
Use of drug in the last 6 months		
Marijuana	16	6,4
Inhaled cocaine	7	2,8
Crack	8	3,2
Amphetamines	4	1,6
Huffing, Sniffin' Glue, etc...	1	0,4
Injectables	1	0,4
LSD	1	0,4
Ecstasy	1	0,4

et al. (2010) studied adolescents living on the streets in Los Angeles, finding racial discrimination values ranging from 12% in whites and 42% among Latino immigrants. In the group studied racial discrimination was reported by 36% of respondents.

About a third of respondents felt discriminated against them in health services. Although the proportion is high, it was the lowest among the areas surveyed. In Toronto, discrimination in the health services accounted for 40% of the homeless respondents (Khandor et al., 2011).

The feeling of insecurity on the streets is indeed high among this group living on the streets (65%), but much lower than those residents who reported social vulnerability (96%) or residents without social vulnerability (78%).

Table 5: Access and use of health services, sheltered individuals and homeless in social vulnerability on the census tracts, 2008

Variable	Population in street condition		Homeless in social vulnerability	
	Quantity	%	Quantity	%
Which Service demands when sick*				
Health center	141	59,2	143	29,4
ER	50	21	141	29
Clinic	29	12,2	63	12,9
Others	18	7,6	140	28,7
Demands always the same service				
Yes	192	80,7	390	80,1
No	46	19,3	77	15,8
Had any health problem during last week***				
Yes	106	42,4	243+	49,9
No	144	57,6	244+	50,1
Demanded for health service**				
Yes	66	62,3	182	74,9
No	40	37,7	61	25,1
Has been attended				
Yes	63	95,5		
No	3	4,5		
Service demanded*				
Health center	36	56,3	56	30,8
Clinic	13	20,3	42	23,1
ER	12	18,8	28	15,4
Others	3	4,7	55	30,2
Reasons not to demand for health services				
Felt it wasn't necessary	16	43,2	19	31,1
Took a medicine by its own	8	21,6	18	29,5

Variable	Population in street condition		Homeless in social vulnerability	
	Quantity	%	Quantity	%
Reasons not to demand for health services				
Thought it would have to wait long to be attended	3	8,1	4	6,6
Didn't have money	2	5,4	1	1,6
Others	8	21,6	19	31,1
Evaluation of the assistance				
Good or very good	53	84,1	134	73,6
Regular	7	11,1	32	17,6
Bad or very bad	3	4,8	14	7,7
Hospitalization in the last year*				
Yes	52	20,9	10	5,5
No	197	79,1	172	94,5
Last dental appointment*				
Less than 1 year ago	63	25,7	217	44,6
From 1 to 2 years	44	18	107	22
3 or more years	120	49	150	30,8
Never went to the dentist	18	7,3	10	2,1
Papanicolaous examination in the last 3 years*				
Yes	48	63,2	219	78,8
No	28	36,8	58	21,2
Mammography in the last 2 years				
Yes	32	42,1	113	40,6
No	44	57,9	162	58,3

+ in the last 30 days

* p<0,001; **p<0,050; *** p=0,053

Much of respondents live alone and when there is company, there is no relationship. Many of them report having children, with whom they have contact sporadically. There are few who participate in political and social activities promoted by targeted entities for this population.

Respondents highlight social workers, who work in the shelters, as people who they can tell if they have problems or difficulties in daily life. In a survey conducted in four Canadian cities, the authors identified conflicting perceptions between negative and positive aspects related to shelters among the participants. Among the negative aspects appeared the restrictions imposed by the regulations, conflicts with the teams, lack of privacy and interference with aspects of everyday life. The positives that were mentioned were having a roof over their head, or being housed (Palepu et al., 2012).

The absence or weakness of social ties have deleterious effects on the physical and mental health of the person and increases the probability of suffering new attacks (Hwang et al., 2009). Living on the street means an accumulation of disadvantages that translate into: greater social discrimination, lack or limitation of ties, sense of insecurity, lack of trust in people and institutions, exposure to numerous health risks, unhealthy behaviors, increase in mortality and a lower life expectancy (Morrison, 2009; Dibben et al., 2011).

A significant portion of the group on the street (55%) considered their health fair, poor or very poor, reflecting the precarious living conditions. Compared to downtown residents, both in areas with and without social vulnerability, this group reported a higher proportion of subjects with fair health, poor or very poor (18% and 39%, respectively). In a sample of homeless in the city of Ghent, Belgium, 40% reported a fair, poor or very poor health status, compared to 34% of the general population (Verlinde et al., 2010).

Physical violence adds to the prejudiced actions of violence and discrimination suffered in the daily lives of people living on the streets. Physical violence suffered in public parks often repeats itself in institutionalized spaces such as shelters, not leaving these people safe spaces to ensure their physical and mental integrity.

The proportion of smokers observed is high surpassing residents with social vulnerability (50%). The proportion of those who refer alcohol consumption is lower for the group on the street (34% versus 52%); however, the risk consumption is almost three times more common in this group. Consumption in life of illicit drugs is more frequent among the group on the street, for all considered drugs.

In a sample of people living on the streets in Toronto, they recorded 36% of alcohol use, similar to the rate observed in São Paulo; and 46% of drug use, a higher rate than that reported in this study (Hwang et al., 2009). In four studies in Detroit, alcohol abuse was reported in 11% of adolescents, reaching 57% among the elderly. Drug use ranged from 19% among adolescents, and 56% in the elderly (Tompsett, Fowler, Toro, 2009). The differences can be attributed to various factors such as the possibility of information omission in São Paulo, the fact that consumption is considered a crime in Brazil, there is less access, given the cost of acquisition, or even that the sample bias for the exclusive inclusion of homeless located in shelter in the present study.

Gelberg, Andersen and Leak (2000) proposed a behavioral model for vulnerable populations that may be useful in the analysis of access to health services. In this model access is seen as the result of predisposing factors that determine the propensity to seek services, facilitate or inhibit access and use of services sought, and the health needs that determine the search for care. The concept of access to health services is complex, highlighting three dimensions: availability – offering, accessibility - the service organization, and acceptability - user satisfaction (Aday, Andersen, 1992; Frenk, 1992; Bronfman et al., 1997; Hortale, Pedroza, Rose, 2000; Mendoza-Sassi, Bérua, 2001; Travassos, Martins, 2004; Marsiglia, Carneiro Junior, 2009).

The propensity to seek services usually increases with age, is lower in men and higher among individuals with less education and lower income for curative services, but for this same group, the search for preventive practices is low. The perception of discrimination, little or no trust in institutions and the instability of social ties in this group can function as factors that hinder the effective pursuit of health services. On the other hand, the existence of a public health system with

universal access and a greater emphasis on primary care could facilitate the access and use of services, even for marginalized groups. Finally, the health needs expressed by the self-health assessment above, shows that exposure to situations of aggression, the use of drugs, alcohol and tobacco, presuppose this population to a greater need to search for care.

The type of service that was most sought by the homeless was provided by primary care centers and emergency units, and the primary care centers were reported twice as much by the group living on the streets compared to residents with social vulnerability. About 80% reported always seeking the same services when they have a health problem, this aspect did not differ in the residents with social vulnerability. This data did differ from those previously published which pointed to low utilization of primary care in the group living on the streets and almost exclusive use of emergency services. Even in the UK, which has a national health system, barriers were identified in this population group such as access to GPs (General Practitioners). However, the homeless in the city of Ghent in Belgium, consulted a GP more often than emergency services, which is in line with this study (Verlinde et al., 2010).

When looking at the prevalence of health problems in the week preceding the interview, the rate for the homeless in São Paulo were extremely high, reaching about 42% of respondents (three times higher than that observed in residents with social vulnerability). This high prevalence is expected to the unpredictable living conditions and numerous harmful exposures of this group.

Among those living in the streets, approximately 40% of the individuals who reported having had a health problem did not seek care. The reasons given were self-medication and that they did not deem it necessary to search for service. For the group of residents with social vulnerability the proportion of non-demand was lower (25%) but the allegations were similar. The lower rate of demand for the group living on the street, probably, reveals: a lower valuation of health problems, fatalistic attitude toward health problems, lack of knowledge of their rights regarding the use of services, avoidance attitude towards previous discrimination and prejudice experiences, less pressure for attendance resulting from lack of inclusion in the labor market, and predominance of men in this patient subset. Similar data were observed among the homeless in Toronto (Khandor et al., 2011).

When exploring the dimension "of health services" in the population census of the homeless, the majority of respondents disclose not have health problems, although they state separately injuries related to falls, fights with pedestrians as well as respiratory problems; often mentioning the use of the emergency room for these situations (São Paulo, 2012). This data does not coincide with those found in the literature, probably due to the methodological differences in the questions or the existence of differences between the people on the streets, homeless or not.

Among those who sought health services, 95% of their needs were met, thereby demonstrating that despite the barrier factors, individuals had access. This high rate of attendance may reflect greater access for sheltered individuals, assuming the intermediation of the staff and professionals at the shelter assist in obtaining care. For those who had their needs met, the care received was considered good or very good in 84% of the cases. This high degree of satisfaction may result from the simple fact of having achieved compliance or, also, means a lower level of expectation on the part of these individuals, suggesting lower standards.

The hospitalization rates over the past year were also high for this population, mainly composed of adults 40-59 years, reflecting once again, that health needs are closely related to poor living conditions of this population group. Several authors mention the increased risk of hospitalization for most people on the streets, even among the young (Hudson et al., 2010; Baggett et al., 2010). The existence of a public health system with universal coverage and service delivery at all levels of complexity can ensure access even to groups with higher levels of social exclusion.

With regards to access to dental care, what draws attention is the proportion of people who have never received this type of care, almost 4 times higher among the homeless in comparison to residents in areas with social vulnerability. However, this ratio is lower than that what was observed for the Brazilian population in the same year, probably due to the wide range of services in the city of São Paulo and the existence of dental care in primary care centers

(Peres et al., 2012). As for the time from the last query, the situation of the population is very similar to that observed among residents of areas with social vulnerability in São Paulo. The group on the streets presents a worse situation in this respect; since almost 50% said that their last visit was three or more years ago. A national survey with elderly people on the streets, in the United States, found that 41% of their dental care needs were unmet (Baggett et al., 2010).

Access to preventive screenings for breast cancer was similar in the group of women living on the street to the residents living in areas with social vulnerability, in downtown São Paulo. For cervical cancer screening, it was lower among the women on the streets. For the same year, the population of Brazilian women ages 25 years or more, the examination rates for Pap smear and mammography were 70% and 55% respectively. Among women living on the streets in the downtown region of São Paulo, the proportions were lower than the national average.

The focus on the specifics of this group and their internal differences seems to be the best way to understand their needs. The consideration of the specifics would include this group's complex needs and create projects that would completely address those needs, as a guideline of actions in health and social services aimed at greater social inclusion.

Social and health care policies require the government's: flexibility in ways to observe and understand this group's diversity, consider the various interested social groups in its design, and implementation of actions and services that will incorporate the diverse health needs, such as violence in public places or in private life, sexually transmitted diseases, chronic respiratory diseases, mental diseases, among others (Nakamura, 1996; Carneiro Junior, Silveira, 2003; Silveira et al., 2009).

Decree No. 7,053/2009, which established the National Policy for the Homeless Population, meets this specific incorporation, with a benchmark of equity when it says that one of its principles is to "respect the social conditions and differences of origin, race, age, nationality, gender, sexual orientation and religion, with special attention to people with disabilities "(Brazil, 2009).

Implementing this policy will require state and civil society efforts to overcome this social reality, facing obstacles of various dimensions, such as the dynamic life of these individuals including: poor social background, fragmented social relationships without solidarity, fragile intersectoral joints, the capacity of the public administration, among others, limit, therefore, the possibility an effective policy.

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Authors' Contribuition

Barradas Barata was responsible for preparing the text and final review. Carneiro Junior and Silveira participated in the drafting of the text. Ribeiro participated in drafting of the text and analysis of statistical data. The authors listed in the "group authorship" participated in stages of research and discussions of the results.

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Social Vulnerability Project in Downtown São Paulo

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