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Accessibility and quality of life for homeless people to primary care

Acessibilidade e qualidade de vida de pessoas em situação de rua à atenção primária

Accesibilidad y calidad de vida de personas en situación de calle a la atención primaria

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This is an exploratory and descriptive cross-sectional study, with a quali-quantitative approach, carried out in 2018, in the city of Ribeirão Preto, SP, in the state of São Paulo, Brazil. It aimed to learn about health conditions and access to primary health care for homeless people. The data collection techniques were: document analysis, application of a sociodemographic and quality of life questionnaire (WHOQOL-Bref) and audio-recorded semi-structured interviews. Quantitative data were treated by descriptive statistics and qualitative data were interpreted according to thematic content analysis. 60 people participated in the quantitative phase and 15 people participated in the qualitative phase. The results regarding sociodemographic data had the following profile: male (85%); 50% brown, 28.3% white and 20% black; single (48.3%), with incomplete elementary education (58.3%) and 10% are illiterate; regarding income, 36.6% had a family income of up to R$100.00 per month and 60.0% had a family income of up to 1 minimum wage. However, it is observed that 53.3% perform informal work and 30% are unemployed. Means were average or poor in all quality of life domains. In the "*Physical*" domain, mean was 62.6%, in the "*Psychological*" domain, it was 64%, in "*Social Relations*", it was 35.6%, and in the "*Environmental*" domain, it was 41.6%. In the self-assessment of quality of life, the average found was 51.5%. Four categories emerged: "*Public health policy in Ribeirão Preto*"; "*Self-assessment of health-disease conditions*"; "*Assessment of access and health care*"; and "*Barriers to access to Primary Health Care*". Access is restricted to health services and in general does not occur in primary care but in urgent and emergency services. The obstacles are: absence of specific public policies, requirement of proof residence and documentation, dehumanization, and prejudiced attitudes on the part of some health professionals.
Descriptors: Homeless persons; Health vulnerability; Social vulnerability; Health status disparities; Social determinants of health.

Trata-se de um estudo transversal do tipo exploratório e descritivo, de abordagem quali-quantitativa, realizado em 2018, na cidade de Ribeirão Preto, São Paulo, com objetivo de conhecer condições de saúde e o acesso à atenção primária à saúde das pessoas em situação de rua. As técnicas de coleta de dados foram: análise documental, aplicação de questionário sociodemográfico, de qualidade de vida (WHOQOL-Bref) e entrevistas semiestruturadas audiogravadas. Os dados quantitativos receberam tratamento por estatística descritiva e os dados qualitativos foram interpretados seguindo a análise de conteúdo temática. Participaram 60 pessoas na fase quantitativa e 15 pessoas na fase qualitativa. Os resultados referentes aos dados sociodemográficos obtiveram o seguinte perfil: gênero masculino (85%); 50% pardos, 28,3% brancos e 20% negros; solteiros (48,3%), com primeiro grau incompleto (58,3%) e 10% analfabetos; na renda, 36,6% recebem até R$ 100,00 por mês e 60,0% até 1 salário mínimo. Entretanto, observa-se que 53,3% realizam trabalho informal e 30% se encontram desempregados. As médias foram regulares ou ruins em todos os domínios de qualidade de vida. No domínio "*físico*" a média foi 62,6%, no "*psicológico*" 64%, em "*relações sociais*" 35,6%, e no "*ambiental*", 41,6%. Na autoavaliação sobre qualidade de vida, a média encontrada foi de 51,5%. Emergiram quatro categorias: "*Política pública de saúde em Ribeirão Preto*"; "*Autoavaliação das condições de saúde-doença*"; "*Avaliação do acesso e assistência à saúde*"; e "*Barreiras ao acesso à Atenção Primária à Saúde.* O acesso é restrito aos serviços de saúde e em geral não ocorre na atenção primária e sim nos serviços de urgência e emergência, tem como dificultadores: ausência de políticas públicas específicas, exigência de comprovante de residência e documentação, desumanização, e atitudes preconceituosas por parte de alguns profissionais de saúde.
Descritores: Pessoas em situação de rua; Vulnerabilidade em saúde; Vulnerabilidade social; Disparidades nos níveis de saúde; Determinantes sociais da saúde.

Se trata de un estudio transversal de tipo exploratorio y descriptivo, de enfoque cualitativo y cuantitativo, realizado en 2018 en la ciudad de Ribeirão Preto, São Paulo, Brasil, con el objetivo de conocer las condiciones de salud y el acceso a la atención primaria a la salud de personas en situación de calle. Las técnicas de recogida de datos fueron: análisis documental, aplicación de cuestionario sociodemográfico, de calidad de vida (WHOQOL-Bref) y entrevistas semiestructuradas grabadas en audio. Los datos cuantitativos se trataron mediante estadísticas descriptivas y los datos cualitativos se interpretaron siguiendo el análisis de contenido temático. Sesenta personas participaron en la fase cuantitativa y 15 en la cualitativa. Los resultados relativos a los datos sociodemográficos obtuvieron el siguiente perfil: género masculino (85%); 50% pardos, 28,3% blancos y 20% negros; solteros (48,3%), con primer grado incompleto (58,3%) y 10% analfabetos; en ingresos, 36,6% reciben hasta R$ 100,00 por mes y 60% hasta 1 salario mínimo. Sin embargo, se observa que el 53,3% realiza trabajos informales y el 30% está desempleado. Las medias fueron regulares o malas en todos los dominios de la calidad de vida. En el ámbito "*físico*" la media fue del 62,6%, en el *"psicológico"* del 64%, en el de *"relaciones sociales"* del 35,6%, y en el *"ambiental"*, del 41,6%. En la autoevaluación sobre la calidad de vida, la media encontrada fue del 51,5%. Surgieron cuatro categorías: "*Política pública de salud en Ribeirão Preto*"; *"Autoevaluación de las condiciones de salud-enfermedad"*; *"Evaluación del acceso y la atención a la salud"*; y "*Barreras de acceso a la Atención Primaria de Salud*". El acceso es restringido a los servicios de salud y generalmente no se da en la atención primaria sino en los servicios de urgencia y emergencia, con los siguientes obstaculizadores: ausencia de políticas públicas específicas, exigencia de prueba de residencia y documentación, deshumanización y actitudes prejuiciosas de algunos profesionales de la salud.
Descriptores: Personas sin hogar; Vulnerabilidad en salud; Vulnerabilidad social; Disparidades en el estado de salud; Determinantes sociales de la salud.

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INTRODUCTION

The increase in the homeless population (HP) has affected several countries and tends to increase in large and medium-sized cities, mainly as a result of the consolidation of globalized capitalism. It is the result of economic crises, the precariousness of relations and working conditions and the structure of inequalities and social inequities[1].

This population suffers from social exclusion when they are treated as socially “useless” and do not have their human dignity recognized, have their rights violated, and are deprived of even basic human rights and universal guarantees, such as access to health[2].

The HP lives under conditions of social inequities; the main one being health inequalities, that is, unequal conditions of access to good health conditions resulting from social factors that are avoidable, unnecessary and unfair[3].

Studies[4-6] show that people living on the streets are at greater risk of becoming ill compared to the rest of the population, and may present a 3.5 times greater risk of death by age; high rate of alcohol consumption (between 44.2% and 81.5%); dependence on other drugs (31.3%); high rates of schizophrenia (between 9.6% and 10.7%); as well as six times higher prevalence of pregnancies and 57 times higher prevalence of tuberculosis; high rates of infectious and contagious diseases, such as syphilis (7%), with 60.4% of the population having some other sexually transmitted infection[7].

Associated with high rates of social vulnerability, increased risk of death, high prevalence of mental disorders, and other diseases, HP is faced with public health and social assistance policies that are ineffective or even non-existent[8]. The attention to homeless people, in most cases, is reduced to the problematic use of drugs, neglecting other health problems; and even actions aimed at drug consumption issues are often criminalizing and individualizing, covering up social determinations, political and economic conditions that underlie the social and health vulnerability of this population[9].

In 2009, the Brazilian Ministry of Health instituted the National Policy for the Homeless Population, reinforcing the importance of street clinics and re-establishing the principles for the expansion and construction of new ways of acting in face of the health problems of this population[10].

The access of homeless people to health services takes place through Primary Health Care (PHC), which organizes the path to be followed in the health care network with a view to comprehensive care. However, as a study[11] points out, this access has been hampered due to the lack of understanding of the constitutionality of health care, the requirement of documentation for care in the services, the prejudiced and stigmatizing attitudes of professionals and the logic of focused and guided care in the paradigm of care in family visits, in addition to territorialized work based on addresses and residences.

The street clinic (SC) was created to reduce these obstacles and act as a bridge for people living on the streets to access health services, especially PHC, to later establish the path of integrality[12,13].

New care strategies and new proactive work processes in health care are needed, as well as flexible forms of care and diagnosis that even consider extramural care or in an open environment, such as street offices, extending the health service to the homeless population[14]. However, even though it is considered a good practice in public health, the street clinic policy is rarely implemented in the Brazilian states, with only five states that adhered to it: Distrito Federal, Santa Catarina, Rio de Janeiro, São Paulo and Pernambuco[15]. Thus, this research aims to know health conditions and access to primary health care for homeless people.

METHODS

This is an exploratory and descriptive cross-sectional study, with a quali-quantitative approach[16,17], carried out in the city of Ribeirão Preto, located in the Northeast region of the state of São Paulo, 313 km from the state capital, with a population of 674,405 inhabitants, composed mostly of women (52%) of working age (46%)[18].

It is noteworthy that this city has a PHC Network composed of 23 Basic Health Units (BHU), 18 Family Health Units (FHU) and 1 Community Social Medical Center (CSMC). It has 7 secondary level health care units (District Basic Health Units - DBHU and School Health Centers - SHC) and 1 Emergency Care Unit (ECU)[19] and no street clinic team.

The research sites were constituted from places commonly frequented by homeless people in this city, such as: squares, public places, viaducts, among others, located in the central region, demarcated by the Municipal Health Department.

The constitution of the sample of research participants was for convenience and not probabilistic[16]. The inclusion criteria were people living on the streets in the city of Ribeirão Preto, regardless of gender, race or any other individual characteristic, and who signed the Free and Informed Consent Form (FICF) to participate in the research.

During the period of data collection, from April to August 2018, a search and document analysis was initially carried out in the databases of the Municipality of Ribeirão Preto. The documents sought consisted of policies, programs or strategies aimed at the homeless population at the Municipal Health Department of Ribeirão Preto. Subsequently, we proceeded to the quantitative stage with the application of two questionnaires: sociodemographic (built by the research researchers) and the WHOQOL-Bref[20], a quality of life questionnaire established by the World Health Organization (WHO), which has 26 questions. The answers in this instrument follow a Likert scale (1 to 5). The higher the score, the better the quality of life, except for questions where the score is advised to be inverted. In addition to its two questions (1 and 2), the instrument has 24 facets, which comprise four domains: Physical, Psychological, Social Relationships and Environment (Chart 1).

Chart 1. Domains and their respective Facets of WHOQOL-Bref[20].

DOMAINS	FACETS
Domain 1 – Physical Domain	1. Pain and discomfort
	2. Energy and fatigue
	3. Sleep and rest
	4. Mobility
	5. Daily life activities
	6. Dependence on medication or treatments
	7. Work capacity
Domain 2 – Psychological Domain	8. Positive feelings
	9. Thinking, learning, memory and concentration
	10. Self-esteem
	11. Body image and appearance
	12. Negative feelings
	13. Spirituality/religion/personal beliefs
Domain 3 – Social Relationships Domain	14. Personal relationships
	15. Social support
	16. Sexual activity
Domain 4 – Environment Domain	17. Physical secutiry and protection
	18. Home environment
	19. Financial resources
	20. Health and social care: availability and quality
	21. Opportunities to acquire new information and skills
	22. Participation in, and opportunity for, recreation/leisure
	23. Physical environment (pollution/noise/traffic/climate)
	24. Transportation

At this stage, the research team was immersed directly in public places frequented by homeless people, to invite them to participate in the research. There was a refusal to

participate; as main reasons: indisposition and/or insecurity about which institution was behind the research, drunkenness and apparent mental disorder. The data obtained in the quantitative stage were analyzed using the statistical program Epi Info, version 7.2, to calculate scores and descriptive statistics of the questionnaires used.

In the qualitative stage, semi-structured interviews were carried out, with an average duration of 20 minutes, in the same public places, in order to know the self-perception of homeless people about their health, their access to health services and the difficulties they encounter in the access to health services.

The interviews were audio-recorded with a mobile phone and fully transcribed and double-checked to ensure reliability of the transcription. When transcribing and reading the interviews, the data saturation criterion was applied[21].

Data were analyzed using the thematic content analysis method, following the pre-analysis phases; exploration of the material; treatment and interpretation of results[17]. In pre-analysis, a fluctuting reading of the material was carried out in order to identify the relevant and significant units to compose the units of analysis. In exploring the material, the units of analysis were examined in order to find certain thematic components. Finally, in a third stage, the thematic components were grouped according to their contents, from the units of meaning, to compose the categories.

The interpretation of the results was articulated according to the theoretical framework of the Social Determinants of Health Model of the Commission on Social Determinants of Health of the World Health Organization[3,22]. Which points out that health-disease processes are determined by social, political, economic, cultural, ethnic and geographic factors, that is, the health gradient of a population, as well as social groups and people, is determined by the way in which a society organizes itself, governs itself and structures itself (Structural Social Determinants of Health). Or even, the structural social determinants of health produce the intermediary social determinants, which are characterized by the material living conditions of the population[3,22].

As this is an investigation involving human beings, the research project was submitted to the Research Ethics Committee of the Faculdade de Medicina de Ribeirão Preto – USP, being approved under Opinion No. 2.324.368. The anonymity of participants was respected and the interviews were conducted after acceptance and signing of the consent form, and the term "I" (interviewee) was used, followed by Arabic numerals, in the description of speeches.

RESULTS

60 people participated in the quantitative phase and 15 people in the qualitative phase. The results regarding sociodemographic data had the following profile: male (85%); 50% brown, 28.3% white and 20% black; single (48.3%), with incomplete elementary education (58.3%) and 10% are illiterate; for income, 36.6% had a monthly income of up to R$100.00 and 60.0% had a monthly income of up to 1 minimum wage. However, it is observed that 53.3% perform informal work and 30% are unemployed (Table 1), and, as they do not receive any income, they can be classified as "*beggars*".

Participants had average or poor means in all domains. Note that in the "*Physical*" domain, the calculated average is 62.6%, and in the "*Psychological*" domain, 64%. As for the "*Social relationships*" domain, the average was 35.6%, and in the "*Environmental*" domain, 41.6%. In the self-assessment of quality of life, the average found is 51.5% (Table 2).

In the self-assessment of quality of life, in 45% the answer was "*poor*", followed by 35% "*neither poor nor good*"; and, only six subjects consider their life "*good*". In the health self-assessment, 50% are "*neither satisfied nor dissatisfied*", 15% are "*dissatisfied*" and 10% are "*very dissatisfied*" (Table 2).

Table 1. Sociodemographic profile, homeless people Ribeirão Preto, SP, Brasil, 2018.

VARIABLES	No. (n)	%
GENDER		
Female	09	15.0%
Male	51	85.0%
AGE		
18 to 30	40	66.6%
31 to 50	16	26.6%
51 to 70	04	6.6%
COLOR/RACE		
White	17	28.3%
Brown	30	50.0%
Black	13	21.6%
MARITAL STATUS		
Married	11	18.3%
Single	29	48.3%
Widowed	06	10.0%
Divorced	14	23.3%
CITY (ORIGEM)		
Ribeirão Preto	29	48.3%
São Paulo	03	5.0%
Franca	04	6.6%
Cravinhos	02	3.3%
Batatais	02	3.3%
Campinas	03	5.0%
Others	17	28.3%
EDUCATIONAL LEVEL		
No education	06	10.0%
Incomplete elementary education	35	58.3%
Incomplete high school education	18	30.0%
Technical course	01	1.6%
CURRENT WORK SITUATION		
Retired	03	4.2%
Unemployed	18	30.0%
Informal work	32	53.3%
Self-employed	07	11.6%
INDIVIDUAL YEARLY INCOME*		
Up to 100 reais	22	36.6%
Up to 1 minimum wage	36	60.0%
1/2 minimum wage	02	3.3%

* Minimum wage, Brazil, year 2018 - R$ 937.00.

Table 2. Quality of life domains of homeless participants, based on the WHOQOL-Bref questionnaire, Ribeirão Preto, SP, Brazil, 2018.

DOMAIN	Mean %	Median %	Minimum %	Maximum %
Physical (0-100)	62.6	61.00	38.0	86.0
Psychological (0-100)	64.0	62.00	24.0	78.0
Social Relationships (0-100)	35.6	38.00	15.0	62.0
Environment (0-100)	41.6	44.00	30.0	58.0
Self Evaluation	51.5	60.00	20.0	76.0

From the interviews, four categories emerged: "*Public health policy in Ribeirão Preto*"; "*Self-assessment of health-disease conditions*"; "*Assessment of access and health care*"; and "*Barriers to access to Primary Health Care*".

Public health policy in Ribeirão Preto

Most interviewees consider that there is no specific health program aimed at homeless people and report the absence of public social protection policies:

We are by ourselves; here there is no help; there is no one from the health center or city hall who helps us, who thinks about us. Not even the mayor is helping. (I1)

I don't know anything not for our health; we're not very careful [...] *There's just that project that's coming, Anjos da Noite, that brings us food during the week. From the government, I don't know anything from the government.* (I2)

The only policies mentioned that they know and/or use in the municipality of Ribeirão Preto are represented by actions of 3rd sector agents, especially actions of Non-Governmental Organizations (NGOs) and churches, but isolated and punctual ones, as seen in the speech:

We have some examples of assistance here in the square. There are some points where they [church volunteers] *come to donate food and clothes, serve us breakfast* [...]. *They ask if we need any medicine and sometimes they give it to us too.* (I3)

Self-assessment of health-disease conditions

In this category, it is observed that the majority initially had difficulty talking about their health conditions, 40% recognized themselves as having poor health conditions, 20% rated their health condition as "good" or "great", as seen in speech:

My health? [...] *My health, I don't know, ok?* [...] *My health is great, 8/12 blood pressure. A few days ago I measured my blood pressure, and it came 8/12. It's great, right?* (I4)

Respondents recognize as health only the biological aspect of "*absence of disease*". Only 13% of respondents cited health in addition to non-disease, recognizing their housing, food and leisure conditions as poor health conditions:

The big health problem here is the police. They come and tell us to get out of here, send us to the other side and don't let us sleep. Sometimes, they even attack us, they come at night to attack us [...] *Then, there is no health that can be maintained.* (I5)

I live in fear, because you are here on the street and there are still many people who come when we are sleeping, I am very afraid, especially of abuse. I'm very afraid of sexual abuse. (I9)

Assessment of access and health care

In 66% of respondents, the predominant gateway is the urgency and emergency units and do not consider PHC as a possibility of help and care:

When I get sick, I go to the ECU and they give me some medicine. (I4)

[...] *when I feel very bad, for example, when I'm in severe pain, a severe malaise* [...] *I look for emergency care.* (I8)

Only 7% of respondents cited the Screening and Counseling Center - IST/AIDS Program as a gateway to access to health and about 15% reported access to health through the "*street clinic*", which is a team of the Center of Screening and Counseling that performs health prevention with the HP, but this team is not institutionalized as a street clinic, does not have the real resources of this program and works in a precarious way.

Regarding the evaluation of health care, the participants evaluated the health care services in an uncritical way, or, in doing so, they presented justifications for this, naturalizing the injustices they suffer, as shown in the following statement:

When I really need it, I go there to the emergency room next to the bus station. Oh, they even care for you very well, but it's a lot of people, right? They don't do it politely, but there's no way, right? It's a lot of people for them to care for. (I6)

20% of respondents described health care as "poor" or "very poor", especially due to negligence in care, delay in care, low resolution and poor treatment by the health team. One respondent mentioned that the service is largely unstable and dependent on the team on duty for the day:

The service depends a lot on who is there; it depends on the doctor who is treating you there, there are days when I was well serviced and others, I wasn't even looked at. (I7)

Another respondent, in turn, reported poor service:

I will tell the truth. A little bit of mistreatment, a little prejudice. When we, homeless people, go there, they treat us like that, with no care [...] *That's it, they see us, give us a medicine, ok, but the care* [...] *It's not the best, not at all!* (I8)

Barriers to access to Primary Health Care

The main difficulties and barriers encountered in health care reported were: delay in care; absence of specific health services and policies; requirement of proof of address and documentation; dehumanization of access to care; and prejudice. Another participant reports numerous deficiencies in access to health:

[...] *I go to the emergency room when I need to, go to the clinic and everything else* [...] *But it's difficult, ok? Because they ask for a home address, they ask for proof of it and we don't have it. It's very neglectful, I'll be honest. Wherever*

you go, people scold you. The same, today I have no prescription, I take topiramate, and I even had a prescription, but then I lost it and went there, but they didn't see me, they didn't give me another prescription, I didn't have proof of a home address, but I don't even have a home. (I9)

DISCUSSION

The study showed a homeless population in the city of Ribeirão Preto with a sociodemographic profile similar to those found in other studies[23,24], being 85% male, mostly young adults, brown (50%) or black. (20%), aged between 18 and 30 years, and 26.6% are from 31 to 50 years.

Regarding city of origin, 48.3% report being from the municipality itself and about 40% come from smaller municipalities in the metropolitan region of Ribeirão Preto, referring to the urbanization process, in line with the Brazilian National Survey on homeless people held in 71 Brazilian cities[25].

When compared to the most socially vulnerable groups, the homeless population showed conditions of extreme vulnerability and social exclusion. They have a low level of education (58.3% have incomplete elementary education and 10% of respondents report being illiterate)[26].

In the current individual income, 60% lived on up to 1 minimum wage, with 3.3% living on up to half the minimum wage and 36.6% living on up to 100 reais a month in the municipality of Ribeirão Preto, whose GDP per capita is 41,736.07 reais. These data are compatible with those observed in the census of the homeless population in the municipality of São Paulo and in other urban centers[23].

These data can be explained by the various factors that can lead people to live on the streets and have a low level of education or have unfavorable individual income. Among them: unemployment, weakened or severed family ties, difficulties in accessing education, professional training, dependence on legal and illegal drugs[27], and others.

Life on the street, in most cases, is caused by a general lack of opportunities and access to resources and basic policies aimed at human dignity, a situation aggravated by a neoliberal orientation of economic policies as factors that generate structural and mass unemployment, and which are at the basis of the exclusion of these layers of the population worldwide[9,27]. Social vulnerability and exclusion are part of the family history of these people, who are usually inserted in families and communities marked by illiteracy, low-income work activities and low social capital, in addition to social bonds of violence[9].

Low averages and medians in the quality of life of people living on the streets were evidenced, especially in the global quality of life domain, in which 55% reported "*poor*" or "*very poor*" quality of life. Similarly, 35% reported being "*dissatisfied*" or "*very dissatisfied*" with their own health and 50% reported being "*neither satisfied nor dissatisfied*" with their health. There was a low quality of life, mainly in "*Personal relationships*" and "*Environment*". This low quality of life may come from the fact that the homeless live in a situation of poverty, social exclusion and violence, which ends up making their health condition more vulnerable. Living in this situation for long periods can lead them to develop mental illnesses and have their quality of life drastically affected[27].

Living on the street represents an accumulation of disadvantages that translates into greater social discrimination, absence or precariousness of bonds, feeling of insecurity, lack of trust in people and institutions, exposure to numerous risk situations, unhealthy behavior, and greater possibility of mortality and shorter life expectancy[28].

Qualitative analysis showed that most homeless people in Ribeirão Preto do not resort to PHC for assistance and care, opting for urgent and emergency services in order to meet their needs. It is observed that these services are more accessible than PHC, which has historically been the main gateway to health services in the Unified Health System, which points to the weakness of this level of health care in identifying this population and recognize it as a user of

all services that make up the health care network. This situation can also be identified in studies carried out in the city of São Paulo[26] and Belgium[29].

There is a need for the PHC services to overcome the tight and stigmatizing logic of the requirement for addresses, baths and documentation to care for the HP. It is also essential to invest in the implementation of street clinics, to make up for deficiencies among this population and thus revert theHP's priority search for urgent and emergency services[30].

It was difficult to recognize and carry out a critical analysis of health itself and not recognize health as a universal right. It is necessary that the multidisciplinary team that serves these people develop actions that can make them aware of their health rights, in order to ensure comprehensive care for this population[30].

It was observed, in the speeches of the interviewees barriers regarding the access of these people to health services, such as: lack of specific care for their health needs and problems; requirement of proof of residence and personal documents for registration and service; delays in care, overcrowding, mistreatment and prejudice.

Although Brazil has advanced in access to health services through the expansion of coverage by the Family Health Teams, in Ribeirão Preto and in several municipalities in the country, there are still groups, such as homeless people, who find it difficult to access services due to their organization and their own ways of life and singularities[6]. Such barriers and access difficulties are similar to those described in other investigations: requirement of proof of home address, health treatments applied to rules that do not take into account the living conditions of these individuals, and professional unprepared for reception[4,30].

The municipality of Ribeirão Preto does not have an institutionalized Street Clinic team, and a team that works to prevent sexually transmitted and infectious infections has developed work similar to that of a street clinic, but it is not accredited as such, and does not have all material and human resources required by this approach and provided for in Ordinance No. 122 that regulates the SC[12].

In this research, it was found that social, economic, political and cultural factors are definitive social determinants for the health condition, producing health inequalities in the homeless population that are unfair and avoidable because they are produced by the social structure. By relying on an unfair social stratification, this structure excludes layers of the population from the opportunities for a dignified life, generating social inequalities, among them, the lack of access to health services and treatments in a context of equity[9]. In addition, some participants considered the violence of the state, the police and the health services themselves as a factor of poor conditions, verifying a structural social determinant of health.

Structural and intermediary social determinants of health (SDH) are the main factors that produce health inequities in the HP[22]. It was observed that structural SDH includes social, economic and political mechanisms and cultural and societal values of exclusion by generating and maintaining important social inequalities, which are at the base of the exclusion of this population from the labor market, education, and all services necessary for a dignified life[3].

Furthermore, it is observed that these structural determinants influence the intermediary determinants of health by producing terrible material circumstances of life, such as homelessness, violent neighborhood relations, consumption of expired food and a poor quality environment. Under these conditions, psychosocial stressors are immense, generated by social relationships of violence and low social support. In addition, risk behaviors in the studied population: high consumption of tobacco, alcohol and other drugs[3].

CONCLUSION

Participants who are homeless in the city of Ribeirão Preto had a low quality of life, which may result from the condition of poverty, violence and social exclusion, and because they suffer varying degrees of vulnerability and marginality in accessing goods and services such as work, education, housing and health.

These people had difficulties in accessing Primary Care services due to the requirement for documentation, lack of permanent housing, delays in care, overcrowding, prejudiced attitudes by some health professionals, and others. Thus, they end up choosing to seek urgent and emergency services in an attempt to solve their needs.

The limitation of this study concerns the fact that it was carried out in only one city in the state of São Paulo and the small number of participants, resulting from the refusal of homeless people to participate in the research, which makes it impossible to generalize the data. Thus, it is necessary that studies be carried out in other cities in Brazil to confirm the findings.

However, the findings provided important information for understanding the health conditions of this population and their access to health services, as well as enabling the awareness of health managers for the construction of intersectoral policies.

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