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# Trapped in the Street: Defining the Health Care Use of the Homeless Adult in Salvador, Bahia

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*SIT Study Abroad*

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*Trapped in the Street: Defining the Health Care Use of the  
Homeless Adult in Salvador, Bahia*

*Nicole Lunardi, Spring 2010*

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**Abstract:**

**Objective:** This study analyzes the relationship between the homeless adult population and their use of medical care in Salvador, Brazil.

**Methods:** Formal interviews were conducted with five different advocates of the homeless population's well being from four different institutions. Informal interviews and participant observation with one of these institutions guided the analyses between theory and practice.

**Results:** There is a general consensus of the dependency on emergency care and lack of personal importance of well being among the adult homeless population. This consensus, however, is not unanimous.

**Conclusions:** The tendency of homeless people to utilize this type of emergency medicine is a direct result of the complex matrix of the horrors faced on the streets. This dehumanization affects the individual's sense of experience, self advocacy, and self efficacy which correlates to the perception of health and well being.

**Keyterms:** homeless, struggling along, experience, self efficacy, self agency

**Introduction:*****Problem Statement***

Homelessness is a universal problem. This population represents some of society's most marginalized members who, paradoxically, need society's help the most. In this study, data was collected in order to discern in which circumstances and how homeless people utilize medical care in order to better understand the concepts of self efficacy and self agency among this population.

***Question and Hypothesis***

In what circumstances and by what means does the adult homeless population seek medical attention?

Since the homeless population is marginalized by society, I believe that this population lacks the self efficacy and agency that is required to advocate for their own well being. Simultaneously, they also tend to lead very risky lives. Their realities include a daily struggle for survival so much so that health and the health consequences of their

behaviors may be easy to overlook. Due to this reasoning, I expected to find that most homeless people only seek medical care when their health can no longer lie in the periphery and becomes too urgent to ignore.

### ***Thesis***

The hardship of street life, including but not limited to drug addiction, fear and paranoia of violence, and inconsistency of food, water and shelter, changes the individual's perception of the concept of time with respect to the future. As a direct result, their self agency and self advocacy in relation to their health is compromised to the point that the individual is reliant on emergency medicine and specific methods that life has taught them have quick and easy outcomes.

### **Personal and Professional Motivation**

We all pass them everyday. Homeless people have become an integral part of most large cities around the world. Each individual has different reactions to them. Some fear that they will be aggressive, some laugh at their seemingly crazy antics, some are disgusted by their hygiene, others do not even notice them. I am usually overwhelmed by sadness.

During my lifetime I have witnessed a family member fall into a life on the streets and die there. His life spiraled into one of depression and alcoholism. He was in and out of shelters and prisons for the last years of his life. After his mother died of breast cancer, he seemed to have a new motivation to do better for himself. He vowed to get off the streets and finally got approved for an apartment. On his way to pick up the keys from his new land lord, he got hit by a car and died. Some say it was an accident. My mother and others close to him think he stepped into oncoming traffic as a suicide mission. This

research and my interest in this population are in dedication to him. It is in dedication to those who are lost in society and in themselves. This is dedicated to their struggle, one that I know I will never fully understand.

This particular project is the product of a lot of long conversations that I had with my host mother. She, like me, feels deeply for the well being of these people. Countless times, we have stayed up late sharing the problems homeless people face from our perspectives. It was through this that I started thinking about the universal nature of being marginalized by society; it transcends cultural differences. The problem of homelessness is distressing in this sense. It renders a feeling of helplessness.

That being said, I firmly believe that it is society's obligation to take care of its most marginalized members. A community is like a team, it is only as strong as its weakest players. Solidarity is essential to care of society's neediest and most desperate. As a public health student who hopes to enter the medical field, I stand by this reasoning. Someone needs to advocate for those who cannot advocate for themselves, if in no other realm at least in terms of health and well being. This is such an interesting time to study public health and solidarity as an American. As we fight for health as a universal right, it is an amazing opportunity to study the homeless in the context of SUS.

### **Location of Research**

This research was done in Salvador, Bahia. As the capital of the state, Salvador faces a lot of issues that tend to be associated with large cities. Since the 1940's, the city has experienced rapid population growth along with economic change. It was in this period that the city began transitioning from agro-export to petrochemical economic means. In 1950 the population was 420.000 and now in 2010 it is estimated to be

3.180.000 (Zibechi). The economic disparity, however, among the citizens is large and continues to grow. Most of the labor is informal in nature, causing income to be precarious and unstable for most residents. This is in a large part due to the intense bureaucratic procedures to open a business or even receive a paycheck by an employer (Rosa Lecture, 11 March 2010).

With the economic development, many people have moved from the interior to the city in search for work. It is in this process of migrating to the city and not being able to find work that some people fall into the situation of homelessness, especially since these people tend to lack a social network (friends/family) to protect them (Silva Santos 2010).

As another feature of the city, there has been a drastic rise in drug use, particularly crack. It is being considered one of the biggest social and public health problems of the city. The officials are even calling it an epidemic. Smoking and selling crack is becoming so common it is even done in day light. This epidemic has also been a fundamental problem in becoming and staying homeless (Consumo de crack se espalha por Salvador). Many use it as a means of survival. In 2008 alone the use of the drug increased by 140% in Salvador (Tavora).

Currently there are proposed to be 2.743 street people (Nascimento Santana 2010). The difficulty in counting this population in the city lays in differentiating the true homeless and those who have drug addiction problem but do not live in the street.

Another important feature of the city that is pertinent to this study is the Sistema Unico de Saude (SUS) of Brazil. The system dates back to the new constitution that declared health a human right in 1988. SUS is founded on four basic principles. It is a



*decentralized* system that utilizes all three levels of government. It uses an *integrated* approach to medicine and health, meaning it is prepared to both treat and prevent disease. This concept of prevention looks at not only biological determinants of health, but also social and political. SUS is *universal*. Anyone in the country of Brazil has equal right to health attention. This attention must be formed to address the patient's specific needs and in this way the system values *equity*. By this logic, the theory of the system favors the nation's neediest and poorest citizens with positive discrimination (Molesini Lecture, 29 March, 2010).

SUS and the ministry of health guarantee the following specific rights to all Brazilians:

1. Access to SUS
2. Adequate treatment for their medical issue
3. Treatment free from discrimination
4. Treatment that respects each patient and their rights
5. Shared responsibility in making sure their treatment is adequate
6. Commitment of the directors of health to guarantee that their rights are fulfilled

It is within context of this health system that the access of the homeless population is particularly interesting especially when the population's health is precarious in nature, biologically, socially, and politically (Direitos Dos Usuarios Do SUS).

## **Significance of Research**

This research is important on a local, national and international level. Here in Salvador, the number of homeless people is growing. In fact, the safety net of institutions set in place to protect their health and well being is breaking at its seams as the population continues to outgrow the resources with no end in sight. Since homelessness is a societal problem that is not going away, it is important to understand how to work with this population effectively. In this research I attempt to look at when and how homeless people access health care through the eyes of their advocates. Through this and participant observations I draw conclusions on their overall sense of self efficacy and self advocacy as a marginalized population. It is through this understanding that those who do attempt to help this population, whether it is through food, shelter, drug rehabilitation, etc, can improve their methods. I hope that the conclusions drawn from this work can illustrate how the limited resources can be used to their utmost capacity. This study can be extrapolated and repeated in the international arena since this population and their advocates seem to face similar challenges regardless of location.

I also think this is a particularly interesting population to look at within the national health system. Since SUS allegedly takes the most care of those who need the help the most, it is important to be critical of theory and practice. It is vital to look at these needy people and analyze how SUS is reaching out to them. For similar reasons, I think that it is even more important that this study took place in Brazil. Many countries all over the world are fighting for universal health care. As they make the transition they

can learn from the shortcomings and advancements of systems all ready in place, like SUS.

## **Background**

### ***The State of Health of the Homeless***

I pass this homeless woman every time I go through Pelourinho. There is so much to be said about her face alone. Her cheeks sink in. She looks emaciated. Without any noise you can see the growling of her stomach in her eyes. When her eyes meet mine, she hopes to find good will. I always bring a couple of bananas for her. Her lips crack with dryness and her rotting teeth make for a crooked smile. She keeps her hair shaved and dresses as a man to protect herself, she claims. The whole right side of her body from the neck down is tattooed with scars. Barefoot, she walks away peeling the banana for breakfast.

This woman, in so many ways, represents most homeless people and the health problems they face. Life on the streets is hard on the human body. To summarize, some of the typical behaviors that are detrimental to health include smoking, illicit drug use, heavy drinking, personal isolation, lack of hygiene, and promiscuity. The homeless also suffer from exposure to the elements, physical strain from being in constant motion, and violence from other homeless, the general population and the police (Gelberg, 1990; 2328-2329).

These risk factors manifest themselves in various health problems, both acute and chronic. Many, in Salvador, lose their lives to crack. It could be a direct result from smoking the drug or a secondary result such as violence. The latter is more common. In a

report about the increase of crack in Salvador, a homeless man Capenga, who had lived on the streets of Salvador for fourteen years at the time, described:

"Desde que saí de casa uso a pedra, mas sou moderado. Sei que ela mata rápido, se vacilar", ressalta. Como outros usuários, Capenga diz não ter colegas que não façam uso de crack e que já viu muitos morrerem, principalmente por causa de dívidas com traficantes.

*"From the time I left the house I have used rocks, but I am moderate. I know that it (crack) kills quickly," he emphasizes. Like other users, Capenga says that he does not have colleagues that do not use crack and that he saw many die, principally because of debts with drug trafficker (Tavora).*

Capenga continued to describe what it is like to sleep on the street as "[Eu] sempre [durmo] com um olho aberto e outro fechado; é muito perigoso, como não me envolvo em coisa errada, sempre tem os invejosos" *"[I] always sleep with one eye open and the other closed, it's very dangerous, since I am not involved in bad things, there are always envious people"*(Tavora). These 'envious' people that inflict harm on this population are not exclusively other homeless or drug lords. The general public and police have also been known to be violent, verbally and physically.

In August of 2004 the world's attention focused in on the brutality against homeless people in Brazil after seven were killed and nine left seriously injured in Sao Paolo. During the night the attacker(s) went around the city hitting homeless people with a blunt object on the head while they were sleeping. The crime was never solved but there are various pieces of evidence that point to the police. As a result of the increased rates of violence from all sectors of society, there is a higher incidence of trauma among the homeless (Matheiu).

As a result of the lifestyle of the typical homeless person, trauma is not the only adverse health effect of living on the street. There also tends to be an increase in

cardiopulmonary, musculoskeletal, and nutritional problems. Specific ailments include HIV/AIDs, chronic bronchitis, tuberculosis, diarrhea, weight loss, dermatological issues, tooth decay, muscle pain, and infection (fungal and bacterial). The whole other side to this issue that cannot be ignored is the very high rate of mental illness among this population. There is usually a range of addiction, depression to schizophrenia (Gelberg 1990; 2328-2330).

It is undeniable that homeless people suffer from various health issues. What is important to take away from this data, however, is not the specific ailments that have higher incidences. It is that these illnesses, chronic or acute, are not the sole result of biological influences. There are environmental, political, and social factors that are deeply inherent in each individual case.

### ***Previous Studies***

There have been similar studies done in the United States that have tried to identify the relationship between homeless people and health care. One study “Emergency Department Use Among the Homeless and Marginally Housed: Results From a Community Based Study” identified that the “violence, problems in managing chronic medical conditions, and difficulty in planning for health care” were some of the principle reasons why homeless people depend on emergency medicine as their primary, and in many cases, only source of health care (Kushel 2002; 778). In fact, based on this study, homeless people are three times more likely to use the emergency room than the general population. The emergency room itself is appealing since it is available at all hours and health

care for both chronic and acute problems can be treated without appointment (Kushel 2002; 782-783).

“Factors Associated With the Health Care Utilization of Homeless Persons” proposes that health in this population “competes with more immediate needs, such as obtaining adequate food and shelter” (Kushel 2001; 200). For this reason, hospitalization tends to be for longer amounts of time since the health problem is in a more advanced state. That is to say, most homeless people tend to seek care when the problem is too urgent to ignore.

Both of these studies are relevant in the sense that they also attempted to make the connection between homelessness and medical care. It is vital, however, to recognize the vast difference in the United States and Brazil. The health problems and risks they face as a result of being on the street are very similar, but the context in which they seek and receive care is very different. The privatization of health care in the United States as compared to the availability of free public care in Brazil makes the results impossible to extrapolate without doubt.

### ***Struggling Along***

After having discussed the state of health of the homeless and previous studies, it is important to refocus on the individual homeless person and how they negotiate their daily life. I will take a closer look at what considerations might be involved in people’s daily decisions and how this may relate to the prospect of seeking medical attention. I will explore the concepts of experience and “struggling along” in order to understand what forces push a person in one direction or another. In *Shelter Blues*, Desjarlais

explains that 'experience' and 'struggling along' have different temporalities. Experiences are story-like. They have a beginning, middle and end which are interdependent in nature. In this sense, they have some implication of general importance relating to one's past, present, and future. Although it is difficult to understand, some people "live in terms different from experience," (Dejarlais, 1994: 886). 'Struggling along' is defined by a series of events of no real importance in the big picture. It is merely a means of finding a 'stasis' in life. It consists of trying to block out a life filled with "noise, voices, bodies, pains, distractions, poverty, displacements, and bureaucratic powers", but at the same time "keep busy without getting bored" (Dejarlais, 1997: 19). A 'good day' for someone struggling along would be one that went smoothly, with little or no interruptions or surprises.

A homeless life, for the most part, is one characterized by struggling along. Experiences are rare in the sense that the 'future' is hardly considered, and most people just focus on making it through a day full of paradoxical phenomena like endless idle hours and the threat of violence at any moment. Thus, the decision seek medical care is largely based on where the individual (a homeless person) sees the least chance of obtrusive events; it is a way of getting along in avoidance of pain- of maintaining oneself in the face of this threat.

In the context of health there are many potential ramifications due to the perspective of struggling along. Since the concept of a future is almost lost, any behaviors which cause long term health problems lose their detrimental nature. For example explaining that smoking cigarettes causes lung cancer to someone who has difficulty conceptualizing one hour from now, never mind twenty years from now, is virtually

impossible. In the situation in which a homeless person is in physical pain, it is interesting to think about whether dealing with the pain or going to the doctor is seen as more obtrusive. This, I would argue, would depend on the individual themselves, the intensity/urgency of the pain, and their access to care.

### ***The Dynamic Relationship Between Self Efficacy and Self Care Agency***

In considering any person seeking medical attention, the concepts of self efficacy and self agency cannot be ignored. Various studies seeking to identify the relationship between the two theories have identified them as interdependent. Within the context of this study this relationship is believed to be dynamic.

Self efficacy has two basic elements. The first is the individual's perception of their capacity to do something. Whether or not a person believes in themselves in a certain task will affect their decision to do it, the amount of effort that is put into it, and their persistence. If a person is set on performing this behavior, it is with the intention that it will produce a specific outcome. That is the second part of self efficacy (Callaghan 2003: 248).

Self care is a set of behaviors that are undertaken with the intent of sustaining life, health and well being (Dormady, 1986: 127). Since they are learned, they are a function of age, health status, sociocultural factors, financial means, and other resources. The individual's ability to meet the requirements for self care is referred to as their self agency.

The concepts of self efficacy and self agency overlap since the individual's ability to perform a certain self-care behavior is based on whether or not one believes the action will result certain outcome. For example, an individual will seek medical attention when



ill, if they find themselves capable of doing so, with the intention of getting treatment and therefore regaining a state of well being. In theory, on the other hand, if the individual does not believe they are capable of doing this behavior, they will lack the efficacy and therefore the agency to take any action. The ability and the desire to act on behalf of maintaining well being is interesting to consider in the context of a homeless person struggling along. This study looks at when and how the homeless population accesses medical attention to better understand these concepts.

### **Definitions**

The following terms are used frequently throughout this research:

*Homeless* – any person who lives on the street; in this research there is no distinction between those who sleep on the street and those who use homeless shelters

*Medical Attention* – any type of consult from a medical professional, not necessarily a doctor

*Struggling Along* – the concept of viewing life not as a set of experiences, rather a series of unimportant and unrelated events

*Self Care* – a set of behaviors that intend to maintain life, health, and well being

*Self Agency* – the ability to meet the requirements of self care

*Self Efficacy* – the belief one's own ability to perform a certain task in order to maintain a specific outcome

### **Methodology**

To maintain data on in which circumstances and how the adult homeless population (over 18 years of age) of Salvador accessed medical assistance, I did both formal and informal interviews along with participant observation.

The information I collected was primarily from the ‘professional’ perspective. I was interested in finding out about the objectives of their work, their experiences as advocates, along with the health and perception of health of the homeless. I completed five different formal interviews with four different institutions. Two of the professionals were social workers in public medical facilities, one of which was a health post in Pelourinho and the other was the hospital Irma Dolce. I interviewed two members, one social worker and one psychologist, of the Abordagem da Rua program, which works to facilitate moving the homeless into more stable living environments. The fifth formal interview was done with a nurse who is the current director and founder of the Instituição Beneficente Conceição Macedo (IBCM) which, among many other things, works directly to protect the health of the homeless population.

It was with this IBCM that I completed the participant observation. I assisted in the work of feeding the homeless population, meanwhile checking in on their health status. It was during this time that I did informal interviews with the other members of this team and some homeless people themselves. From this work I was able to not only witness homeless people in a safe environment, but also one in which they were frequently discussing their health. This data was helpful to give a more complete answer to the proposed question. Another informal interview was with some of the Dra. Patricia Moura of the Hospital General do Estado (HGE).

It was through these formal and informal interviews along with the participant observation that I collected data used in this study.

## **Limitations**

The access to the homeless population is very limited. Due to safety issues in working with the homeless, it is essential to be in the company of someone that is trusted and known by the population. I was very restricted to Dona Conceicao's work as my exposure. This sample is not representative of the entire adult homeless population of Salvador. This is especially true since she has been working in these specific areas for twenty years. This may have greatly affected the participant observation part of the methodology. Furthermore there is limited information available about this population in Salvador. This made the some of the secondary research more difficult.

The other major limitation of the study was time. This project would have benefited greatly with more than one month's time to do more in depth research.

## **Delimitations**

In working with this population, even the professionals of the city agree that it is extremely difficult to differentiate between people who are in fact homeless and those who go to the street everyday but do in fact have a home. The latter tend to be addicted to drugs. For this reason, this research may include people who are not 'homeless' by definition but physically appear as such. It was not possible or appropriate to ask every individual what their housing situation was during this process.

## **Results**

### *Objectives*

The four different organizations that I did interviews reported the following objectives with in their work with the homeless population.

Amelia Araujo at the health center in Pelourinho reported that her biggest task when she finally gets to sit down and speak to a homeless person is to give them information on the prevention of STDs , HIV, and their rights. She is also sure to make sure to give them condoms (Araujo 2010).

Dona Conceicao of IBCM focuses on going to the street and working primarily with the health of the homeless. This comes not only in the form of going to the get medical care and buying medication but also in terms of hygiene and nutrition (Macedo 2010).

Lucia Chaves, the social worker at Irma Dulce, works with the homeless patients that have no where to go after they are discharged. She works to send them to a shelter, a rehabilitation program, or to reconnect them with their family. The family is her priority. The social workers go as far to make house visits in order to rebuild the broken relationships. She explained that the point of her work is to break the cycle of using medical care solely in cases of emergency. It has been her experience that when they return to the street, she is sure to see them again with the same health problems (Cheves 2010).

Vera Lucia Silva Santos, the psychologist, and Simone Nascimento Silva, a social worker, work together for Abordagem da Rua. Their goal is also to help move the homeless people into more stable living situations, whether it is shelters or families. Vera Lucia pointed out that these shelters also provide a place for immigrant homeless to wait until they can be transported back to their home cities (Silva Santos 2010). Simone spoke a lot about how they attempt to do this work. She said they first have to make the individual conscious that the street is no place to live (Nascimento Santana 2010).

### ***Risk Behavior and Health Problems Reported***

The following is a compiled list of all of the behavior and health conditions all five interviews reported. The stars represent the number times the each of the given items was repeated.

#### Health Problems:

HIV\*\*\*, meningitis, tooth decay, wounds\*\*\*\*\* (burns, cuts, broken bones, etc), anemia, mental problems\*\*\* (emotional, addiction), diabetic, cataracts, infection, diarrhea, respiratory problems\*\*\* (tuberculosis, asthma, infection)

#### Risk Behaviors:

Drug use\*\*\*\*\*, alcoholism\*\*\*\*\*, poor hygiene\*\*\*\*\*, violence\*\*\*\*\*

(Macedo, Arauju, Chavez, Nascimento Santana, Silva Santos 2010)

### ***Accessing Health Care: Getting There***

Dona Conceicao reported that she takes homeless people to get medical attention on a weekly basis. In many cases she escorts them herself. In a more urgent situation, they call her to tell her they are already there. According to Dona Conceicao, she has known instances of police, ambulances, and a passerby accompanying homeless people in need. Not everyone is bad, she told me in the interview. Out of every ten people there is probably one that would care enough to help a homeless person in need (Macedo 2010).

Lucia Chavez spoke on her experience specific to Irma Dulce. Homeless people come escorted by the police, in ambulances from other hospitals and other institutions, and by themselves. Since Irma Dulce does not have an emergency room, they can only attend to cases that are not a matter of immediate life or death (Chavez 2010).

Simone, of the Abordagem da Rua program, spoke about how the team takes homeless people to the emergency room to do medical tests before bringing them to the shelters. According to her, it is very easy to spread disease within such a confined space. One of their principle concerns is tuberculosis, particularly drug resistant tuberculosis (Nascimento Santana).

### ***Accessing Health Care: Resistance and Acceptance***

In the informal interview with Dra Patricia Moura at Hospital General do Estado, she spoke briefly about her experience with homeless people in the emergency room setting. Most of the time, they are usually there for a wound or a drug complication. She told me that she treats them and passes them off to the social workers without much conversation. They tend to be very resistant. They do not want to stay in the hospital even if they have not fully recovered. These patients are not easy, she told me (Moura 2010).

Lucia Chavez reported a very similar tendency at Irma Dulce. Her work is to try to make sure they do not return to the street, but rather to a shelter, rehabilitation center, or to their family. She said that most of these patients, however, want to be discharged immediately upon feeling better. Even if the doctor recommends that they stay for more time, they get impatient and flee. This is especially true of the younger homeless people. The elderly are more likely to stay or accept recommendations to go to a shelter (Chavez 2010).

This tendency to flee causes an endless cycle, Chavez reported. They gain their health back, go back to the street, re-enter into the same lifestyle, and sooner or later return with, if not the same, a similar health issue. While they are in the hospital, she and her colleagues try to interrupt this cycle. At the beginning of each new case, the

individuals are very cold and closed to their questions. Day by day, they continue trying to break through to the patient and in some cases they gain their confidence. It is in this that they find out the “*verdadeira historia*”, *the real story*, of the patient. Depending on how things were left with the family, Chavez will contact the family and try to recreate this connection. Success is rare in the case of reintegrating the patient back into society or into the family. In most cases the homeless person will flee back to their life of, how Chavez described, ‘freedom’ and ‘adventure’ on the streets (Chavez 2010).

Araujo recognized this same difficulty in working with homeless people. She recalled a case of a woman named Elisabet. She is pregnant, addicted to drugs, and has various health problems. She comes into the clinic a lot to get medication and condoms. When she enters Amelia’s office to get condoms, there is “*muito pouco conversa*” or *very little conversation*. Elisabet comes in to get the condoms and leaves (Araujo 2010).

Araujo brought up a different side to this problem that is interesting juxtaposed to Lucia Chavez and Patricia Moura’s responses. She said that the medical professionals themselves are resistant to treating these patients. “*O servico publico deve ser aberto,*” she explained, “*pra esses moradores de rua.... Agora a gente ainda tem muito resistencia dos propios profissionais do saude*” “*The public service should be open to these homeless people. Now, we still have a lot of resistance from our own medical professionals*” (Araujo 2010). According to Araujo, this resistance is due to the violent and aggressive nature associated with homeless people.

She believes the post needs to find strategies to make these homeless people welcome in the clinic primarily due to their location. In Pelourinho, she explained, the amount of homeless people is overwhelming but within the clinic, however, it is very

low. She reminded me, “Altravez do SUS e justamente isso, e o atendimento universal pra qualquer pessoa que procura o sistema.” “*By the means of SUS, it is exactly this, it is the universal care for any person who seeks the system*” The resistance, according to her experiences, has been on both the side of the professional and the homeless person (Araujo 2010).

The Abordagem da Rua program reported very similar experiences to that of Lucia Chavez at Irma Dulce. They too try and gain the trust of the homeless individual in hopes to remove them from street life. They do so, not in a hospital setting, but on the street. Vera Lucia told me, “[Eles] nao querem falar com a gente. Eles negam, e isso e respeitado.” “*They do not want to talk to us. They deny [us] and this is respected*” (Silva Santos 2010). If they get rejected today, then they go back tomorrow until they break through to them. According to Simone, this rejection is not always peaceful. She cited cases in which the homeless person cursed and threw rocks. In these cases, the individual was convinced that the team was there either as police or there to take of their things. In this team’s work, success is also very rare. Sometimes they never even get to talk to the individual, while in other cases they bring them to the shelter (Nascimento Santana 2010).

Simone and I had a very interesting conversation why success is so hard with this population. She explained that it is hard to gain the trust of someone who is not ‘conscious’ of their rights. With their life style and their way of thinking, they tend to not only feel excluded as a citizen, but as a member of the human race. She explained this ‘way of thinking’ in a very simple way. When you live amongst the trash and the dogs, she said, you start to identify more with the dog than other humans. Life has taught them



to be defensive and live like an animal; their resistance is strong (Nascimento Santana 2010).

She also believes that programs that supply this population with water, food and even clothing, only promote life on the street. It gives them less reason to want to reintegrate back into society. A program like this “esta fortalecendo” or strengthens life on the street, not help the homeless individual’s improvement (Nascimento Santana 2010).

It was very interesting to interview Dona Conceicao after speaking with Nascimento Santana, especially because her work ‘reinforces’ street life. According to Dona Conceicao the homeless people she tends to show very little to no resistance to medical care. They want the care and the treatment. For this reason they take their medicine that they receive, even for chronic illnesses in her experience. She justified this by explaining that people of the street do not die of AIDs, they die of other causes. When I asked her if she faced any resistance by the medical community she said no. She is very well known among the hospitals and the clinics. She was a nurse for SUS for years and a member of the Ministry of Health. Every medical setting she is in, she explained, she knows someone. This facilitates the work she does in the sense that it is easier without any resistance (Macedo 2010).

Having discussed the content of the interview with Dona Conceicao, I would like to talk about Jose, an approximately sixty year old homeless man. He is abandoned by his family. When we first saw him on May 12 he had a soar on his leg that was nearly disabling him. Dona Conceicao said she would be back on Friday May 14. When I caught up with Dona Coneicao the following week, she reported that he refused to go to the doctor. He is afraid, she told me, of being discriminated against. By May 26, when we

saw him again his leg was doing much better. Dona Conceicao eventually escorted him to see a doctor with success despite his initial resistance to go.

### ***Accessing Health Care: Taking Advantage of the System***

In the interview with Lucia Chavez she told me a story about a homeless man with no legs. On three separate occasions, she gave him a new wheelchair. Each time he would come back to the hospital to get treated for wounds on the lower portion of his body, he would go to Chavez for a new wheel chair. She found out that he was selling the wheel chairs for drug money. He was using the system to support his habit. On his next visit she told him she would not fall into his trap again (Chavez 2010).

I would also like to make reference to Araujo's experience with Elisabet described in the above section. This patient is not receptive to conversing with Araujo, she goes to the clinic to get the condoms and leave. While this is not the same the situation at Irma Dulce, it is an interesting the way in which the system is used in instances where the patient is sure they can get what they want (Araujo 2010).

### ***Perception of Health***

According to Vera Lucia Silva Santos, Simone Nascimento Santana, and Amelia Araujo, the homeless have lost all perception of health. "Tem uma alta estema muito comprometida. Entao eles acham que nao tem direito nada," Araujo explained. "*They have a compromised self esteem. So they think they do not have any rights.*" She continued, "Eles acham que nao sao dignos. 'Ai, eu estou mau vestido. Eu nao tenho direito.' Nao tem consciencia de direito humano". "*They do not think they are dignified. 'Oh, I am badly dresseed. I do not have any rights.' They do not have consciousness of human right.*" (Araujo 2010).

Silva Santos agreed that they are ‘conformados’ or *conformed* to their way of life and the resulting health status. Nascimento Santana spoke a lot about the same lack of consciousness that Araujo did. In a previous section, I already introduced her ideas of the homeless person relating more to a dog than another human being. Nascimento Santana explained that health is not a worry of the homeless. She justified this based on their behavior. They do not value hygiene. They have means to go to any beach and rinse off and clean themselves in the ocean water or the showers on some beaches, but they do not. They do not take their medicine for chronic illnesses, since they lack the notion of what is grave. This is also evident in their tendency to leave hospitals right when they feel better, even if it is against doctor’s orders (Nascimento Santana 2010).

Lucia Chaves went into further detail and explained that homeless adults only care about health in the case of an emergency. They go through day to day accustomed to pangs of hunger and pain. She agrees with Nascimento Santana that so much of their attitude is conveyed in their tendency to flee the hospital once they are feeling better. This reinstates the cycle of poor health on the street that inevitably leads them back into the hospital (Chaves 2010).

The only interview that was in opposition to this point of view was Dona Conceicao. In her experience the homeless do worry about their health. If this were not the case they would not call her on their way to the hospital without her having to directly escort them. Dona Conceicao, may have had many of these experiences, but other instances such as the one with Jose described above can not be overlooked.

It was Edmilson’s first time being fed and introduced to Dona Conceicao on May 26. He had no shirt on. He had a scar the stretched down his abdomen. It was not from

surgery. It was thick and not uniform, crooked. This was a problem of the past. His right arm was his current problem. He could not grasp anything with his hand. In fact as he approached us he held his whole right arm up with his left. He quietly got his plate of rice and beans, went to go put it down realizing that he could not carry both that and his cup of juice. He came back for his juice and scurried away to go eat. While he was waiting to get food, the social worker Maria Lourdes told him he should talk to Dona Conceicao about his health. He did not. He just wanted food.

### **Conclusions**

Based on the results of the interviews, the participant observation, and agreement with the secondary resources, it is clear that most homeless adults do not value health in the same way Brazilian society does in the context of SUS. The more difficult task it is to answer why this is the case. I do not agree with Lucia Chavez in her justification that the street represents freedom and adventure. In fact, it is the opposite. The street life, in its nature, is a prison without walls. It is a mental prison. It dehumanizes the individual from being able to identify with human kind and their human rights, into an individual that identifies more with a dog, as Simone Nascimento Santana put it.

The hardship of the street cannot be oversimplified. It is an ill that dominates the biological, social, and political entities of being an individual and their environment. Drug addiction, fear/paranoia of the constant threat of violence from all sectors of society, and the lack of consistency in the most basic of life's needs for survival – shelter, water, and food – just scratch the surface of the struggle that is the everyday of a homeless individual.

It is this means of existence that changes the mindset of a homeless person from one based on experiences to one that struggles along. There is no tomorrow, or next week, there is just here and now. There are no solutions to these daily 'struggles', there is just surviving each moment as it passes with the least disturbances possible. In this sense there is an innate loss in self agency and self efficacy.

Self care behaviors, normally defined by ones that maintain life, health, and well being, are reduced to ones that maintain life. This is why medical attention is usually only sought in the case of a traumatic emergency or the advanced stages of a diseases development. There is no primary care. There are no yearly check ups. There is just attention in the moments that are on the brink of life and death. By definition, the lack of the ability to meet the requirements of self care, self agency is therefore compromised. The ability of the homeless individual to care for one's self is impaired. For this very reason the population requires the advocates; they are dependent on the solidarity and care by their society. It is heartbreaking to think about how society treats those who desperately need their help.

In this sense I would also like to look at the self efficacy of the population. It is human nature to behave in a way that, life has taught, gets a certain result. Let's look at what life has taught the homeless adults I have discussed in the previous section in terms of self efficacy.

- If you call Dona Conceicao to be with you at the hospital, you will not get discriminated against since she is well known. The prescription will also be paid for. (Jose, Dona Conceicao)

- If you go to Irma Dulce to get a wheel chair, the social workers will get you one and then you can get drug money. (Lucia Chavez story)
- If you go to the posto to get condoms, you will get them and not have to talk to anyone while there if you are aggressive enough. (Elizbet, Amelia Araujo)
- If you stand in line for food, you will get some as long as you are quite and grateful. (Edmilson, Dona Conceicao)

Through these seemingly different results there is a common thread in when and how homeless adults seek medical attention. Due to their unique view of life as a marginalized member of society, they lack the proper behaviors required to be an agent of their own health. They have, unfortunately, lost the concept of well being. The few situations in which a homeless person does act reveals their sense of self efficacy. They tend to only seek care in an emergency situation (trauma or advanced stages of a disabling disease) or in specific ways that life has taught them has certain and easy outcomes. The tendency of homeless people to utilize emergency medicine is a direct result of the complex matrix of the horrors faced on the streets.

### **Ethical Considerations**

It was vital to protect the identities of the homeless people discussed in this study. All observations were done with minimal interaction.

### **Indications for Further Research**

The precarious nature health, in a biological, social and political sense, is not improving but only getting worse. Further research on the topic is essential. There is still much more to be developed in this question alone. It would be important to recreate this

research with a larger population sample as the basis of the sample population. It would be helpful to look at the work of these advocates in practice. The little access I had proved to be a vital source of analysis.

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Appendix A:

Agente Social

Com que frequência o/a senhor(a) vê moradores de rua aqui no hospital?

Se eles vierem aqui, seria obrigatório falar com o/a senhor(a) antes de receber alta?

O que são os objetivos das assistentes sociais quando trabalham com eles?

Como é que foi atender esses pacientes? Eles tiveram algum tipo de resistência?

Quais são os problemas médicos que fazem com que essas pessoas sejam trazidas para sala de emergência?

Quais são os problemas que eles têm, em sua opinião, quais são os mais graves?

O/A senhor(a) conseguiu obter algum tipo de informação sobre a maneira de vida dos pacientes que fosse relevante para saúde deles (tais como: uso de drogas, dieta)?

Quando o/a senhor(a) conversa com eles, a senhora percebe o que eles pensam sobre seu próprio bem-estar, especialmente em relação do saúde?

O/A senhor(a) acha que existe bastante ajuda para proteger a saúde dessa população?

Appendix B:  
Dona Concecao/Colleague

Por quanto tempo a senhora está trabalhando com os moradores de rua?

Como foi para a senhora ganhar a confiança deles como uma desconhecida?

Quais são as metas de trabalho que a senhora está fazendo com esta população?

Quais são os riscos de saúde que estas pessoas enfrentam como resultado de estarem na rua?

Quais são os problemas de saúde mais comuns que a senhora vê entre estas pessoas?

Em quais situações a senhora já testemunhou estas pessoas procurarem ajuda medica?

Elas alguma vez procurarem ajuda medica por si mesmas? Por quê, por que não?

A senhora, alguma vez, já levou alguma dessas pessoas ao medico? Com que frequencia a senhora faz isso?

Os moradores de rua algumas vezes fazem resistência em ir ao medico com a senhora? Quando isso acontecesse, quais são as razões?

Em quais situacoes é fácil levar estas pessoas ao medico?

Com a experiência que a senhora já tem, é fácil procurar assistência medica para as pessoas e representar-las? Ha dificuldades que a senhora confronta em nome delas com frequencia?

Normalmente, para onde a senhora leva os moradores de rua quando eles precisam de medico?

Como a senhora ver o pensamento dessas pessoas em relação as suas próprias saúde? Elas parecem preocupadas quando a senhora as consulta?

A senhora acha que existe bastante ajuda para proteger a saúde desta população? O que poderia ser feito para melhorar esta ajuda?

## Appendix C: Questions

Could you have done this project in the USA? What data or sources were unique to the culture in which you did the project?

I could have done this project in the USA. In fact, many studies have been published on the topic of the utilization of emergency services by the US homeless population. These studies focus on a wide array of topics, from cost burden to discrimination. What made this project unique to Brazil was the presence of SUS. It was interesting to look at the health of this population within a system which pledges to provide care to all, but particularly to those who need it most. The other very unique feature of this project was having the opportunity to work with Dona Conceicao. While it is not impossible to find another similar NGO in the US, it made the project really come to life.

Could you have done any part of it in the USA? Would the result have been different? How?

I could do this project anywhere in the US with a homeless population, this tends to be in urban areas. If I were to do the project in the US, I think I would find similar results. I think that within marginalized populations the problems with self efficacy and agency are universal. By sharing the sentiment of being rejected by society, I think both populations in the US and Brazil do not value self care outside the most basic means of survival. That being said, I think that this sentiment, with respect to health, would be heightened in the US where there is no public system to which the population has access.

Did the process of doing the ISP modify your learning style? How was this different from your previous style and approaches to learning?

The ISP made me value hands on learning. It is so much more interesting to go to the source itself than read it in a book. There is something to be said about being in the location and not only being able to list facts, but also be able to describe how it smells, what the walls look like, the attitude and body language of people, etc. There is so much that gets lost when you are trying to describe something on a piece of paper. In addition to this, the ISP also made me more analytical. Just because someone is an 'expert' in their field does not mean that everything they say should be written in stone. You, as a student, a colleague, or a researcher, should be analytical of what they say. It is important to ask if what they say is consistent with what you observe.

How much of the final monograph is primary data? How much is from secondary sources?

I would say most all of the data is primary. There were plenty of secondary sources used were to set the context of homelessness in Salvador, Brazil and the most basic of theory. I would argue that the bulk of the paper is based off of primary resources.

What criteria did you use to evaluate your data for inclusion in the final monograph? Or how did you decide to exclude certain data?

The data that I excluded was irrelevant to the question. I was exposed to a lot of primary data, in both the interviews and the participant observation that did not help in answering the question proposed. For example, in my work with Dona Conceicao I also witnessed a lot regarding children and prostitution.

How did the “drop-offs” or field exercises contribute to the process and completion of the ISP?

The drop off exercise helped in the sense that I was more accustomed to finding an unknown location on my own. If I had to go somewhere new for my ISP, I was comfortable with heading to the bus station by myself and just asking around how to get there.

What part of the PHMFSS most significantly influenced the ISP process?

To be honest, I did not think the PHMFSS was very helpful in the process of creating my ISP. In a lot of ways, the information regarding how to write the proposal and ISP itself were overwhelming at the time they were presented. I truly feel the time could have been better spent really developing the individual topics with the help of the Academic Director. I also think it would have been useful to talk about the actual month of the ISP and how to use the time wisely. It may have been nice to work through scenarios of having to change your original idea to better fit the data you are collecting, etc.

What were the principle problems you encountered while doing the ISP? Were you able to resolve these and how?

My principle problem is having access to this population. Even though there are homeless people everywhere in the city, they are not a population you can approach and ask questions. I was lucky enough to have access through someone they trust, Dona Conceicao. That being said, however, my access was not one in which I could sit and talk to these people, due to the fast pace of their work. I was truly observing their interactions and short conversations. The major issue I had was being able to get in touch with some of my contacts. We all lead busy lives, so it was difficult to find a time where our schedules could overlap. Fransisca helped me with this. She would call these people when I was off working during the day to set appointments up for me. Even still, there were some people that I did not get in touch with.

Did you experience any time constraints? How could these have been resolved?

One month is such a short amount of time for field work. The general outline that I saw my month go by was as follows: week one was setting up the contacts and meetings, week two was getting to know the contacts and their work, week three I was really into the work and making great strides, and week four was analyzing the data and writing the ISP. I could have used a couple more ‘week three’ to have a more in depth study. I think the only way this could have been resolved was to get to know all my contacts before the village study. Even that would have been difficult.

Did your original topic change and evolved as you discovered or did not discover new and different resources? Did the resources available modify or determine the topic?

My topic changed the first week of the ISP. I decided to change my population from children to adults. I realized that I had more access to information about homeless adults. There were more ethical problems in working with children. Furthermore, since it proved difficult to get into an emergency room I changed my plan from doing most of my interviews with medical professionals to working with mostly social workers. I was not disappointed with the changes made, I still loved my topic.

How did you go about finding resources: institutions, interviewees, publications, etc?

I found my primary resources mostly through networking and word of mouth. I started with Dona Conceicao and found out about the Casa de Triagem in Pelourinho. When I went to HGE I found out about Irma Dulce and the Abordagem de Rua program. From the Abordagem program I found out about the Triagem in Baixa do Zapateiro. I let the city's experts guide me on my field work. It proved to work out great. In terms of publications I did basic research in online libraries. I also used some work I did last semester with homeless people as a guide.

What method(s) did you use? How did you decide to use such method(s)?

I used formal and informal interviews along with participant observation. I knew that interviewing the population themselves would be very difficult. I compensated for this by doing formal interviews with the people that advocate for their health and well being. Participant observation was essential for my study since it was the only contact I had with the homeless people themselves. This was, in my opinion, the most important part of my methods. It helped me be more analytical about the information I got from the 'experts'.

Comment on the relations with your advisor: indispensable? Occasionally helpful? Not very helpful? At what point was he/she most helpful? Were there cultural differences, which influenced your relationship? A different understanding of educational processes and goals? Was working with your advisor instructional?

Dona Conceicao is an absolutely amazing person. Her work is inspiring and she made it very easy for me to do my participant observation. That being said, however, she is a very busy woman. It was difficult to just find a time to sit down and do our formal interview, never mind talk more frequently about my work. I found that I was mostly on my own with my research and troubles that were outside of the work that I did with her. To be honest, I loved her as a contact but I wish that I had a different advisor. It would have been nice to have an advisor with a little more time to bounce my ideas off of. I don't think there were cultural differences, I think she gave me all the time she could but it was not enough. She was most helpful with the participant observation.

Did you reach any dead ends? Hypotheses which turned out not to be useful? Interviews or visits that had no application?

All of my interviews and visits were useful. I do not think that I reached any dead ends once I changed my focus from children to adults. That being said, I was more in the situation where I wish I had a little more time. I never got the chance to return to HGE and have my formal interview with Patricia. I also never got to go back to the Triagem in Baixa do Sapateiro. These contacts would have been useful, but it was difficult to get a hold of Patricia and the Triagem came in too late. I think the way in which I made my connections by networking helped prevent dead ends.

What insights did you gain into the culture as a result of doing the ISP, which you might not otherwise have gained?

Through my ISP, I got to see the under-belly of this city. I got to see, in depth, the side of the city no one wants to talk about or acknowledge. I saw the city's most marginalized populations: street children, homeless adults, and prostitutes. I would have never gotten to really spend time with these populations otherwise. My work was incredible and life changing in a lot of ways, but at the same time heart breaking. I am very grateful for the insight my ISP gave me.

Did the ISP process assist your adjustment to the culture? Integration?

By the time the ISP started, I already felt adjusted to the culture. This period did help me feel integrated into the professional realm of the city. Up until this point, I felt very much that many people did not take me seriously. I took on the role of the 'silly gringa' on an intercambio program just here to learn Portuguese. For the first time with my new contacts I felt like a colleague. It was a great relief.

What were the principle lessons you learned from the ISP process?

I learned a lot about field work. This is my first experience in the field attempting to answer a specific question based on my own interest. I learned that it is very rewarding to pick a question and population that you are sincerely interested in. I really did love my ISP month. I also learned how important flexibility is in this type of research. You literally need to be able to roll with the punches and always be ready with a 'plan b'. There were many times that people cancelled appointments and that I could not get in touch with someone. There was no point in being upset, but a plan b always helped make sure that I was not wasting precious time.

If you met a future student who wanted to do this same project, what would be your recommendations to him/her?

I would first and foremost warn the student about the difficulty in working with this population. Not only in the sense that they are hard to have access to, but in an emotional sense. There were many times this month that I found myself very sad and upset about the things I had witnessed. If the student is sincerely interested, this was an amazing experience, life changing in fact. I would recommend keeping the focus since your access to this population is very limited. If you were looking into the use of emergency health by this population, it would be worth getting in touch with medical professionals early in the ISP period. They tend to be very busy. That is one sector I really wish I got to work with, especially with Patricia at HGE. The earlier you start, the better. If you are committed to this idea start going with Dona

Conceicao as soon as possible, even if that means before the ISP period begins. The social workers and the contacts I made were very friendly and helpful, they would be worth getting in touch with. To further the research I would see if it could be possible to work with the Abordagem de Rua group and do participant observation with them. This would be interesting to compare to Dona Conceicao's work. The very different opinions and results from their individual interviews could be further explored by doing this work. A research question might include the following: what is the difference in advocating for the health and well being of the homeless population as a trusted and known resource as compared to an unknown resource?

Given what you know now, would you undertake this, or a similar project again?

I would absolutely do this project again. I am excited to continue my work in this area back at home. This work was indefinitely rewarding. I think it is very important to work and focus on otherwise marginalized populations. There are too few people willing to analyze and understand their being. I am dedicated to this cause and this ISP just reconfirmed that.