

Barriers to Cancer Prevention and Oncologic Treatment for Homeless People

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Barreiras à Prevenção do Câncer e Tratamento Oncológico para a População em Situação de Rua Barreras para la Prevención y el Tratamiento del Cáncer para Personas sin Hogar

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Abstract

Introduction: Barriers to the universalization of the access to healthcare actions and services are intensified for historically neglected populational groups, such as homeless people. In oncology this scenario is not different, and studies are needed to help to reveal this reality. **Objective:** To understand the difficulty homeless people face to access cancer prevention actions and oncologic treatment. **Method:** Qualitative case report utilizing interviews with a team of street healthcare professionals in Rio de Janeiro. Data were analyzed following the hermeneutic dialectics framework. **Results:** The stigma historically attributed to homeless people makes difficult for them to access cancer prevention and treatment. Given the severe vulnerability condition of these people, cancer care has been presented as a secondary demand of their needs. **Conclusion:** It is essential to understand the health system as a building tool for citizenship and to add the theme of cancer to the daily practices of the healthcare street teams, considering the diversity of risk factors this group is exposed to and the necessity of overcoming the street life conditions.

Key words: Homeless Persons; Neoplasms/prevention & control; Neoplasms/drug therapy; Health Services; Public Policy.

Resumo

Introdução: As barreiras para a universalização do acesso às ações e serviços de saúde se intensificam para grupos populacionais historicamente negligenciados, como a população em situação de rua. Na oncologia, esse cenário não é diferente, sendo necessários estudos que ajudem a revelar essa realidade. **Objetivo:** Compreender as barreiras de acesso, das pessoas em situação de rua às ações de prevenção do câncer e tratamento oncológico. **Método:** Estudo de caso de abordagem qualitativa utilizando-se entrevistas com seis profissionais de uma equipe de Consultório de Rua do Rio de Janeiro. Os dados foram analisados seguindo o referencial da hermenêutica dialética. **Resultados:** O estigma historicamente designado à população em situação de rua dificulta o acesso aos serviços de prevenção e tratamento do câncer. Diante do grave estado de vulneração dessas pessoas, o cuidado oncológico tem se apresentado como uma demanda secundária às suas necessidades. **Conclusão:** É primordial compreender o sistema de saúde como instrumento de construção da cidadania e agregar a temática do câncer ao escopo de práticas cotidianas das equipes, haja vista a diversidade de fatores de risco a que esse grupo está exposto e a necessidade de superação das condições de vida na rua.

Palavras-chave: Pessoas em Situação de Rua; Neoplasias/prevenção & controle; Neoplasias/tratamento farmacológico; Serviços de Saúde; Política Pública.

Resumen

Introducción: Las barreras a la universalización del acceso a las acciones y servicios de salud se intensifican para los grupos de población históricamente descuidados, como la población sin hogar. En oncología, este escenario no es diferente, y se necesitan estudios para ayudar a revelar esta realidad. **Objetivo:** Comprender las barreras de acceso de las personas sin hogar a las acciones de prevención y tratamiento del cáncer. **Método:** Estudio de caso de enfoque cualitativo utilizando entrevistas con seis profesionales de un equipo de práctica callejera de Río de Janeiro. Los datos fueron analizados siguiendo el marco dialéctico hermenéutico. **Resultados:** El estigma históricamente asignado a las personas sin hogar todavía dificulta el acceso a los servicios de prevención y control del cáncer. Dado el grave estado de vulnerabilidad de estas personas, la atención del cáncer se ha presentado como una demanda secundaria a sus necesidades. **Conclusión:** Es esencial entender el sistema de salud como una herramienta para construir ciudadanía y agregar el tema del cáncer al alcance de las prácticas diarias de los equipos, dada la diversidad de factores de riesgo a los que está expuesto este grupo y la necesidad de superar las condiciones de la vida en la calle.

Palabras clave: Personas sin Hogar; Neoplasias/prevenición & control; Neoplasias/tratamiento farmacológico; Servicios de Salud; Política Pública.

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INTRODUCTION

Cancer is a public health problem, more than 600 thousand new cases are anticipated in Brazil in 2020¹. The National Cancer Prevention and Control Policy (PNPCC) was launched in 2013² to reduce the incidence, mortality and impairment resulting from the disease.

The neglected populational groups as homeless people (HP) face several and particularly tough barriers to the universal access to health actions and services. This population is defined as a:

(...) heterogeneous populational group having in common extreme poverty, disrupted or fragilized family bonds and inexistence of regular conventional home, using public places and degraded areas as living and source of income, temporarily or permanently and overnight temporary facilities or provisory household³.

The National Policy of Homeless Population (PNPR)⁴, of 2009 aims to widen the access of this population to public services. This policy means a significant progress to conquer citizenship because introduces the respect to the human dignity, valorization and respect to life and citizenship as basic principles, individualized and universalized care and respect of social conditions. It endeavors to promote civil, economic, social, cultural and environmental rights⁴. But even with the current public policies, studies have highlighted the difficulties homeless people face to access health services^{5,6}.

Within the National Health System (SUS), the coordination of the care provided to this population is performed by basic attention. Defined as a specific population, care is provided mainly by the Street Office (eCR). The National Policy of Basic Attention (PNAB)⁷ disposed about these teams that are responsible for articulating and providing full healthcare for homeless persons. Based in the user's needs, the eCR activities are developed integrated to the units of the health attention network, oncologic attention centers and facilities⁷.

The discussion about HP and cancer prevention and treatment is incipient in the country. Internationally, studies evaluating the incidence, mortality and risk factors/behaviors of this population emphasize the great exposure of this group to risk factors of sickening^{5,6}. However, it is important to point out that precaution is advised while reviewing international studies, since, in addition to addressing different health system, the context of life of a US homeless can be quite different from ours.

Therefore, because it is advisable to widen the discussion about the theme in the Brazilian context, the current study has the objective of understanding

the barriers homeless face in accessing actions of cancer prevention and oncologic treatment.

METHOD

Qualitative approach case study attempting to conduct a deep investigation of actual life events, preserving its full characteristics⁸. As a case, the work process of an eCR responsible for caring for nearly 1,284 registered users of the municipality of Rio de Janeiro was chosen.

Six individual semistructured interviews between May and July 2019 were conducted with six staff members of the eCR, one physician, one nurse, one social worker, one licensed practitioner nurse and two social agents. A script with guiding questions was utilized, but based in the responses of the interviewees, new questions were presented to deepen the theme. The interviews occurred in a secluded room in the health facility of reference of the eCR, recorded and later transcribed for analysis. A field diary with notes the team took during their daily activities was used during one week of follow up.

The dialect-hermeneutic in three stages was used in the analysis: ordering of the data; classification of the data and final analysis^{9,10}. The field diary, with the records of the reflections the experience has given cause to, served as a complement for the analysis of the interviews that were categorized from the analytical reference selected. The work of Cabral Junior and Costa¹¹ was the option as analytical reference, where eight barriers to citizenship in social policies for HP are listed. For each barrier, it was attempted to specify the questions related to the actions of cancer treatment and prevention found in the interviews and in follow up of the staff. Four of these barriers were considered as contextual influence and the other were classified as direct interference in the actions (Table 1). Despite the effort in using this division, it is important to emphasize that the barriers are inter-related and must be considered in whole for decision taking.

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RESULTS AND DISCUSSION

BARRIERS OF THE CONTEXTUAL SCOPE

The barriers of contextual scope are those that, even if not directly related to health or oncology create an environment that contributes for the vulnerability status and to the condition of be harmed. There are differences

Table 1. Barriers HP face for citizenship in social policies

Scope	Barriers
Contextual	Concept that the street is a permanent living place
	Patronizing character of public actions
	Lack of representativeness and manifestation in public spaces
	Intimacy of the Brazilian political scenario with neoliberalism
Direct	Difficulty of conducting researches that aim to know the profile and necessities of HP because of its migratory characteristic
	Homogenization of actions targeted to HP
	Difficulty to instruct the HP about their rights systematically
	Only minimum efforts and resources must be dedicated to subsistence

Source: Cabral Junior e Costa¹¹, adapted by the authors.

between vulnerability and be harmed. The first is a potential condition for causing harm to the individual (from the Latin term *vulnus*) and the second addresses a concrete condition of the individual harmed, that is, has concrete and provable damages and necessities as is the case of the HP^{12,13}.

Home is a basic right connected to the dignity of the individual and because of this, the street should not be considered a place for living¹¹. It is imperative to consider that people are homeless, and this is a process potentially revertible through public policies, respecting the wish and particularity of everyone. It is necessary to establish actions capable of overcoming the adverse circumstances this population is submitted to.

Living in the street interferes directly in the health conditions of these persons, consisting in complex demands that are beyond the reach of the health practice¹². It is essential the inter-sector articulation that understands the innumerable possibilities of being harmed this population is challenged with¹³. Although disposed in PNAB and having been strengthened with the creation of the eCR¹⁴, the inter-sector actions the eCR accompanied by the author performs are still far from being productive and effective. The difficulty of integration of eCR with other services, health or other, was also observed in a study conducted in São Paulo¹⁵. During the period of field work and with the interviews, joint actions with other sectors like education, culture, leisure, labor and income were not identified. The intersection with other public security services, even if actually happening, was not what the health staff would like to be.

Today, we were in a territory at Praça da Cruz Vermelha and there was an action conducted by the outreach team and some law enforcement agents were around; and a situation came up. We were extremely uncomfortable in caring, knowing there were three agents bullying the patient (Participant 1).

The narrative brings the ostensive action of public security law enforcement officers dealing with the HP, result of a violent government policy that reinforces the stigma this population is submitted to. In other occasions, it was reported that the presence of municipal law enforcement agents caused embarrassment and the users rejected what was being offered. Immediatism solutions reinforce the social exclusionary process. The proposal of compulsory hospitalization of the HP must be followed up closely because many of these measures are simply for social control.

On the other hand, actions merely patronizing are barriers for the construction of citizenship because they do not aim the overcoming of the condition of be harmed. The result is that the HP ends up exposed to high risk of sickening and more difficulty to access health services, including oncology. It was identified that the eCR accompanied by the author prioritizes individual patronizing actions over collective actions, limiting the results of the minimization of the condition of be harmed. Despite the effort of the professionals, the work environment of an eCR is permeated by tensions and difficulties that interfere directly in the possibilities of each service¹⁵. To reach the results that are meant to be achieved, it is necessary to invest in new forms of caring, surpassing the institutional barriers of the health system and lack of inter-sector articulation¹⁶. The everlasting *status quo* can contribute for the increase of cancer incidence and late diagnosis, which may lead to reduction of survival and more distress.

Another barrier of contextual scope is the non-representativeness and poor manifestation in public spaces. Despite the National Policy of Social Inclusion of Homeless Population goal of encouraging the political organization and participation in instances of social control¹⁴, data indicate that 95.5% of this population is not included in any social movement or associated to class organs. Likewise, it was identified that 61.6% don't even own the right of basic citizenship through vote because they don't have the voter registration¹⁷.

Even with the legitimately acknowledged spaces of participation and social control there are still difficulty for its actual activation because our participative culture moves forward at a very low pace¹⁸. Regardless of the difficulty of participation not being exclusive for this

population, its social invisibility and associated stigma exacerbate this situation.

It was identified that the HP in the territory did not participate of discussions about planning, execution and evaluation of health actions and services targeted to them. This situation is worrying since SUS itself appeared as a social conquest soon after the long process of burdening and fights involving several social movements¹⁹.

The last contextual barrier, the intimacy of the Brazilian political scenario with neoliberalism, made social politics far from redistributive and instead, as a compensatory charge in relation to the social and economic inequities derived from capitalism²⁰. In this scenario, SUS is undergoing a neoliberal dismantling, with underfunding impacting significantly the principles of universality and equality. The operationalization of a universal and equalitarian SUS is a challenge because it conflicts with the established economic order^{21,22}.

The neoliberal policies impose an agenda of social expenditures restriction, as for instance, the Constitutional Amendment number 95 of 2016²³. With scarce funding, the current constitutional principles can be fated to oblivion and the full right to health is replaced by low-cost services and actions. Neoliberal proposals defy four basic constitutional rights of SUS: against universality, focused policy; against integrality, basic staples; against equality, favor and back door of some hospitals; against public control, market laws¹⁹.

Within oncology, the initiatives of the federal government are not followed by concrete actions for its activation because PNPCC (National Policy for Cancer Prevention and Control) does not cover the proper funding for its achievement²⁴. For the HP historically excluded, the restriction of access is dramatic.

Still in relation to funding of actions, it is relevant to emphasize that the crisis announced as financial is political and social. The austerity practiced implies in lowering the performance of the health system and there was the option of stopping the centrality of the agenda of consolidation of primary attention with realignment of the focus in hospital attention²⁵.

It is observed that the four contextual barriers bring several challenges to the scope of PNPCC. There are issues that, much more than the pursue to overcome the homeless situation of these individuals, contribute for its maintenance. Little can be expected to improve the life and health conditions of the HP should this scenario continues.

BARRIERS OF DIRECT REACH

The HP is migratory. This characteristic hampers researches that aim to understand its profile and

necessities, blocking the more in-depth understanding about their way of being and living in the world¹¹. This barrier is not restricted to the health area, affecting the Census and National Household Sample Survey. The estimate of a national HP (around 100 thousand persons) was made only in 2015²⁶. Within oncology, this barrier impacts directly the planning of actions and the bond between the team and users.

The complexity in territorializing and define the profile of the population in the territory as disposed in PNAB (National Policy of Basic Attention), led to the difficulty the eCR faces in planning actions and may result in poor structured and less befitting practices with the necessities of this population.

The intricacy involving the HP demands an organized intervention. However, the current registry of the population in the territory utilizes the same base for users living within the scope of the strategy of family health²⁷. In practice, given the own characteristics of this population, the data that feed the registration files do not comprehend the specificities of the individuals in question:

Some aspects of bureaucracy make me nervous. This registry we do in file A has a lot of things not applicable to our population. This is very difficult (Participant 3).

Further to the difficulties for planning, the itinerant profile of the HP hampers the contact of the team and the users and the construction of bonds and trust networks. For the HP, who transits in urban spaces systematically, the form how they create bonds is unique. The particularities of this public challenges the professionals to redefine the standards of bonding usually understood:

We, as health system are not prepared to work with the itinerancy of the persons. And we think that because the individual roams all around, it doesn't create bonds with us, this isn't true. Sometimes, the individual disappears for six months and appears. He needed to stay six months making ends meet in another place and he appears because there is some issue in that moment, he knows he will be able to sort out in that place. Then I think that (the bond) is possible, really is, but we need to rethink how we as healthcare professionals, expect this bond to happen (Participant 2).

A new look about how the relation professional-user can define how to offer health care. Different services have different forms of establishing that bond. In a study about the therapeutic itinerary of the HP with TB it was addressed the fragility of the relations between users and emergency and urgent services. In contrast, it was observed

that when the entrance door was primary attention, the bond was established effectively²⁸. There are no studies addressing the bonds created by this population and professionals of tertiary attention in oncology.

The team has issues to provide care continuously, because the HR roams across urban spaces and has no fixed home, despite the possibility of construction of a new modality of bond:

We followed up a user who was investigating skin cancer, concluded it was actually cancer after the biopsy, but he disappeared in the territory and we thought he had gone back to his sister house. He was referred for surgery (...) but we were unable to continue for this reason, because he disappeared in the territory (Participant 2).

The lack of information about the continuation of the care in other points of the network, in oncology for instance, is determinant for the prognosis of the user, since the delay of the beginning of the treatment can be associated to reduction of the survival time for some types of cancer²⁹.

The obstacle for bonding, together with the prejudice the HP faces when seeks for healthcare result in difficulty of early diagnosis of neoplasms. Detection and diagnosis of cancer for this population have been associated to more advanced stages where curative treatment becomes unfeasible and rapid evolution to death:

I followed up a case. He complained about abdominal pain and the staff provided an MRI and identified there was a mass, something odd, complained all the time, difficulty to eat. Regrettably the user was too ill, debilitated. One week, 15 days later, he passed away (Participant 4).

Cancer screening and monitoring are critical for the HP⁶. The lack of a physical address and contact to follow up were the causes the team detected. Therefore, because of the limited practicality of secondary prevention, the emphasis in education and primary prevention seems to be unavoidable and the most effective form, considering the wide exposure of this population to risk factors⁵.

The unfamiliarity of the actual necessities of this population and the difficulties of creating a bond and continuous follow up of this population are connected also to another barrier, the homogenization of the actions towards the HP as if this population had the same necessities¹¹. The HP is heterogeneous and must be understood in its specificities, both in the elaboration of broad public policies or individualized attention.

Homogenizing actions and policies do not ensure the integrality of the care, being necessary a model that

manages to address its peculiarities. The inexistence of information in SUS systems, even a specific registration file contributes for the continuation of this problem. It remains clear the unfeasibility of accepting demands of the HP and meet their specificities that differ from the usual population living in their households and it is also clear the incapacity of the government in pursuing equity.

Another issue related to the access to cancer treatment is the regulation of this user by SUS associated units. In Rio de Janeiro, there are two current systems for oncology, one of municipal management (SISREG), that organizes the access to diagnosis and the other, under the State management (SER), that regulates the flow for treatment. The access to oncologic treatment is restricted to the population in general and gets worse when it is for the HP because of the barriers herein discussed:

(...) he complained of abdominal pain and the team arranged to submit him to MRI and identified there was some mass, but the practitioner at the time had just started and made a request through SISREG and an appointment at an outpatient consultation in INCA was done. The INCA practitioner received and explained "look, the diagnosis is cancer, but I can't receive him like this, you have to go back to the unit, request the biopsy and with the result, schedule the appointment here". The persons were unaware of the flow, I understand it was an error of the team having done this without knowing how the flow worked. At the time, the director of the unit explained that the biopsy would come first and with the result, an appointment for outpatient consultation would be scheduled at INCA (Participant 2).

We need, as health policy, to rethink how these referrals are being done, how the appointment is being done. When I was a resident, I lived the experience of following the manager and saw how the appointments at SISREG were done and there was something that quite bothered me. Because, in fact, I still think that as much as we fight to do otherwise, a universal policy, it is still done, sort of 'oh, it is for this people, for these persons that have no cash to pay for a health insurance, then, anything goes, at the time we want, where we want' and I think this is a huge barrier to the access (Participant 2).

The narratives demonstrate that, even with the informatization of the regulation system, there is still a human component that must be reported about the processes and it may act with prejudice and misleading in face of the stigma imposed to the HP. Another issue is that, as much as the regulation system facilitates some processes

when well used, the lack of beds for treatment increases the waiting line continuously. There are not studies so far that evaluate whether informatization of access in these two systems in Rio de Janeiro have helped to reduce the waiting time and contribute for the democratization of the access or resulted in more bureaucracy and difficulty of access, mainly for this public.

The eCR, based in the understanding that the users demand differentiated actions, have attempted to construct its own attention network. In order to ensure the access of the HP, the team has been developing the professional regulation³⁰, in addition to the formal regulation, with informal partnerships and concurrence with other services and professionals:

When we need a referral, we have someone we know, we call and say “look, we are going there. Has room?”. We have contacts (...) Then, the woman there answers ‘can send over this week, there is room’ or ‘make the referral, when they arrive, we do it here. Is faster. If we have to wait for SISREG and it doesn’t give this, takes more time (Participant 6).

Another topic of the regulation identified was the availability of eCR in following up the user referred by a high complexity or distant service:

(...) there are many patients who know how to act, gets its pension, are coherent, are focused. But some don’t. Sees the doctor, come here and knows nothing (...) can’t articulate to be understood, then we have to go with him and in these days, there is a car (Participant 3).

Despite the availability be positive, it is the result of negative situations as eCR concern with how HP will be treated and difficulty of the user in expressing its needs. Had the services been prepared to care for these persons with dignity, this process could be unnecessary.

The team did not describe difficulties of access because identification documents did not exist, a common situation of the HP. Seemingly, this particularity was well worked out. As the team reported, even if the documental issues do not hinder the regulation, it can create problems when this patient is referred and will be received by another unit.

Another important barrier is the difficulty of informing the rights the HP are entitled to¹¹. The National Survey of Homeless Population showed that 88.5% do not receive any type of financial support from governmental social programs and, most of the times, are unaware of them¹⁷. This unawareness is beyond the dimension of the right to social policies and it is an issue within the scope of health education actions. Few collective actions are developed,

either by the resistance of the health unit of reference in offering the space for such or the difficulty the team has in using the street and place to interact and exchange:

During the months I’m here, we still were unable to organize to hands-on for many reasons, including the own resistance in developing group activities, individual consultations within the unit, this is a difficult barrier for our work (Participant 1).

Even if during the individual consulting the issue of promotion of health is a working tool, the focus is almost exclusively in reducing the damages of alcohol use and other drugs, an intrinsic characteristic of the old model of street office that failed to meet the assumption of full care:

I believe it was not a specific action for cancer prevention. I don’t think it was. It was more to respond to the issue of damage control, alcohol and other drugs (Participant 1).

The main risk factors for the development of cancer this population is exposed to are smoking and alcoholism. But this population is exposed to other conditions as exposure to the sun, obesity and more sexual partners⁵. Under this perspective, efforts must be made to reach an understanding about the forms to protect the user. In the situation they live, more than a simple personal choice, these individuals end up conditioned to present risky behaviors of sickening. For this reason, there must be serious efforts to introduce emancipatory measures to leave patronizing behind.

Staff members know HP is unaware of the risk factors they are exposed to:

They don’t care much. They fail to see the importance of some factors that interfere in their health (Participant 5).

Many don’t understand the risk factor because it was not brought to their attention, it was not discussed and then is the time for actions, mainly in the territory, in group, I think is something that needs to be implemented (Participant 1).

On the other hand, in other moments, the interviewees noticed that it does not seem information is missing, but difficulty of the HP to assume behaviors that reduce the risk, by the life conditions they face or non-priority of health because of the adverse situations imposed by living in the street:

We talk, but I think they don’t care as they should, because they think: “They are homeless, it is the end of the line”, you see? A patient told me when I asked

why he didn't use condoms, he said "I'm out there in the street, standing up, have to think in putting condom?" (Participant 6).

Studies indicate that the HP has concerns about cancer, they believe the risk among them is higher than the general population and think screening is a necessity³¹. But in their daily fight for life, a possible risk of future development of cancer may not be a priority. Therefore, among the required measures to qualify the access of this population to the promotion of health, is the awareness of the professionals to deal with the priorities of this group.

It would be quite inappropriate that the actions of promotion of health were restricted to the transmission of information about a possible healthy practice disconnected from the reality. It is necessary that this population has actual conditions of using the information both in what concerns their self-accountability of their practices and the role of the health system in ensuring their health. It is essential that the actions of health aimed to instrumentalize the individual about the allegedly health behavior are based in the principle of autonomy of the individual in adopting or not such attitudes³². While fighting for emancipation, the actions of health are not meant to be restricted to the transmission of information about what is healthy, exerting prescriptive power about what the individuals must or must not do. Education must respect the operationalization of the construction of the users knowledge ensuring the individual autonomy.

Sickening by cancer is quite affected by this barrier. Prevention, diagnosis and treatment are long time processes demanding full participation of the user in its own care. If this population is not well informed about its condition and rights and is not instrumentalized by the State to overcome this situation, little will serve the offer of individual caring practices within the scope of health attention because they have barely any effect in the change of the social status of these persons.

The last barrier analyzed consists in the understanding that homeless should receive only the minimum effort and resources to ensure their subsistence¹¹. Therefore, the subsistence would be a subclass, deserving only the minimum for their survival.

The constitution ensures the access to actions and services of health, affirming the obligation of the integrality of the attention. Among the barriers homeless face to ensure their basic social rights, the denial of health as a right is one of the forms of exclusion³³. In despite of the law, HP has been finding innumerable difficulties to access different health municipal services, many of them related to the stigma this population endures:

(...) (the facility staff) complains to the manager, to the director, that there is homeless walking around the premises. But there is no homeless walking around, they are persons, human beings, walking in the premises. And this is good, must walk around because the health facility should be a space for everyone (Participant 1).

(...) the own direction of the facility will say 'I don't want these persons in here' (Participant 2).

It is as if in the imaginary of the unit's healthcare professionals, the HP, through eCR has already access to health services it is entitled to and must be limited to it and avoid disturbing the routine of the services aimed to the civil population. This prejudicial and exclusionary conception is the result of the historical stigma this population was assigned to. The stigmatization and failing to understand the accountability of these professionals towards HP can be seen as a cause for the health unit to see this population as something different, disconnected of their reality:

Had to change the perspective of the treatment about this type of population. Patients and staff show prejudice. At least in this unit. Staff hamper the access or provide poor care, you understand? I don't know if they do this to make them give up because every time the poor population fails to be cared or comes from other places, it is not the same thing, it is not the same care, not the same attention. It is something type "let's do it quickly to make them go away" or "let's say there is no consultation to make them come back another day", that the consultation is not here, is in the fourth floor (Participant 6).

The social stigma and prejudice involving HP are significant factors that influence the action of the professionals of the services this population seeks for care, including health services³⁴. Despite the guidelines established in PNPR, the practice of the professionals who do not belong to eCR continues to be exclusionary.

CONCLUSION

Direct or contextual barriers to cancer prevention and oncologic treatment imposed upon HP were exposed. Despite eCR efforts, the main barriers are the continuous patronizing character of the actions, budget reduction for social policies and the difficulty of involving other services to ensure the full rights of this population. It must be understood that the necessity to overcome these barriers brings up the constitutional guarantee of universality,

integrality and equity. Therefore, it is advocated that health is a basic and inalienable right of everyone and it is the State duty to ensure this right.

Oncological care is seen as a secondary demand within the necessities of this population fighting daily for their life. Regardless of this, it is advisable to reflect about the emergent feature of the care that must be provided during the disease because a death sentence may have been established. Consequently, the health teams should pursue new formats of more appropriate care adjusted to the particularities of these users, integrating the individual caring practice to inter-sectorial actions of promotion of health that try to overcome their current homeless conditions.

The main limitation of this study is the analysis of the work process limited to one eCR and its reality, a fact inherent to every case study. For that reason, the results should be reviewed critically and reconsidered to other scenarios.

At last, it is understood that, despite the advances in previous years, the repeated dismantling of social policies institutionalized by the State makes essential to retrieve the values of the Brazilian sanitary reform and reaffirm the necessity of understanding the health system as an instrument to build up citizenship and not merely a market asset. Within this concept, ensure the HP the access to health actions and services, oncology included in them becomes even more an ethical-political duty healthcare professionals should assume to help these individual to surpass their current vulnerability where they live.

CONTRIBUTIONS

Mayara Castro Lustosa Moura Granja participated of the conception and planning of the study, gathering, analysis and interpretation of data and wording and final approval of the published version. Fernando Lopes Tavares de Lima participated of the conception and planning of the study, analysis and interpretation of the data, critical review and final approval of the published version.

DECLARATION OF CONFLICT OF INTERESTS

There is no conflict of interests to declare.

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