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ARTICLE (Continuous Flow)

TUBERCULOSIS IN HOMELESS BRAZILIAN WOMEN: GENDER ANALYSIS IN HEALTH

TUBERCULOSE EM MULHERES BRASILEIRAS EM SITUAÇÃO DE RUA: ANÁLISE DE GÊNERO NA SAÚDE

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Abstract
Objective: This study describes the profile of notified tuberculosis cases in homeless women and its relations with gender determination in the showed context. **Methods:** It was conducted through a descriptive quantitative research based on resources of a brazilian public database (SINAN) in the gap of 2014 to 2019. **Results**: It shows high percentage of retreatment (36, 5%) and treatment failure (43, 5%). In comparison with men in the same conditions, these women presents lower cure percentage (29, 7%), higher illicit drugs use (68, 7%), HIV/AIDS coinfection (35, 9%) and mental illness (8,4%). **Conclusion:** In this way, we identify that homeless women manifests singular characteristics in relation to the tuberculosis illness, making urgent the need of health service readjustment for this social segment and the promotion of better sociopolitical support.

Keywords: Tuberculosis; Homeless Persons; Women; Gender Analysis in Health.

Resumo
Objetivo: Descrever o perfil dos casos de tuberculose notificados em mulheres brasileiras em situação de rua (MSR) e a relação desse adoecimento com as dimensões de gênero. **Métodos:** Pesquisa quantitativa descritiva com base em dados do Sistema de Informações de Agravos de Notificação (SINAN) do Brasil no período de 2014 a 2019, registrados por meio do Departamento de Informática do SUS (DATASUS). **Resultados:** As mulheres em situação de rua apresentaram altas taxas de reingresso (36,5%) e abandono do tratamento (43,5%). Ao estabelecer uma comparação entre mulheres e homens em situação similar, essas mulheres apresentaram menor percentual de cura (29,7%), maiores percentuais de consumo de drogas ilícitas (68,7%), coinfecção por HIV/AIDS (35,9%) e distúrbios psíquicos (8,4%). **Conclusões:** As mulheres em situação de rua manifestam

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características clínicas peculiares quanto ao adoecimento por tuberculose, o que incita à necessidade de readequação dos serviços de atenção à saúde para esse segmento e maior promoção de aparatos sociopolíticos que garantam outras possibilidades de vida.

Palavras-chave: Tuberculose; Pessoas em Situação de Rua; Mulheres; Análise de Gênero na Saúde.

INTRODUCTION

Life on the streets, while it invokes sociopolitical negligence, also brings together the diverse coping skills and empirical knowledge that result in a culture of survival. It is certain that the street situation phenomenon does not have a single root, and its relation is not only linked to the issue of work, income, and capitalist logic of production, but also to the weakening of family ties, trauma, and addictions. Moreover, it is relevant to consider that staying on the streets can constitute an exercise of autonomy that seeks to deviate from social norms of insertion in society. It is necessary to recognize that the absence of regular conventional housing constitutes a defining factor on such social condition, but it can be a lacking point in the debate in case the homeless individual has his/her existence reduced to this.

Being homeless assigns to the individual a standard of living characterized, in most cases, by distinct dimensions of extreme poverty and insecurity. In this sense, there are numerous conditions of vulnerability in which the homeless person is, among them, the lack of access to adequate nutrition, water and hygiene, exposure to violence, stigmas, marginalization and abuse of alcohol and other drugs. To a greater or lesser extent, these factors prevent the care and integration of their health, which makes the streets a space of great exposure to disease. In this context, it is known the strong relationship between the street situation and tuberculosis, which involves problems from the diagnostic phase of the disease to the treatment outcomes. A study with national data obtained in the period from 2014 to 2019 with homeless people with tuberculosis reveals an increase in the proportions of deaths from the disease and high rates of recurrence and relapse after treatment abandonment[1]. Such work confirms the findings of a previous study conducted in São Paulo between 2009 and 2013[2] and makes visible the application of insufficient and/or inappropriate actions to reduce this problem.

Although advances have been made in tuberculosis control strategies, this infectious disease is still a challenge in global health. According to the World Health Organization, in 2019, approximately 10 million people became ill with tuberculosis, which reflected, in this same year, in about 1.4 million deaths from the disease[3]. In Brazil, in 2019, approximately 4,500 deaths from tuberculosis were recorded, revealing a mortality coefficient of 2.2 deaths/100,000 inhabitants. The following year, in 2020, the country reached the mark of 66,819 new cases of the disease[4] with an incidence coefficient of 31.6 cases per 100,000 thousand inhabitants, which keeps the country among those of high burden for tuberculosis in the world.

Studies[5-6] point out that socioeconomic differences amplify the burden of disease in society. This is confirmed because there is a distinction in the way in which illness occurs in a social group, being directly associated with environmental factors and determinations of sex, race/color, age, and income. Consequently, an explicit social determination in the onset and course of tuberculosis is delineated. Therefore, the analysis of the influence of impoverishment on tuberculosis has made necessary and supports the relevance of studies and interventions directed to people in these conditions, among them, homeless people.

In Brazil, it is estimated that the incidence of tuberculosis in the homeless population is 56 times higher than the risk in the general population. From a cross-sectional perspective that values aspects of sex and gender, getting sick with tuberculosis finds other aggravating factors, such as the fragility of personal relationships and the echo of a patriarchal society that exacerbates the quality of female life on the streets[7]. Even if the proportion of women who are homeless is smaller[8], it must be considered that its existence is not dissociated from the gender issues experienced by this group. In the context discussed here, its condition strengthens, in the same way as the invisibility of the reflections on tuberculosis in homeless women whose occurrence can be even more impaired due to the various situations of violence faced by this group.

Given this problem, the knowledge about sociocultural differences and the set of risks faced by women who were homeless, it becomes relevant to investigate the characteristics that tuberculosis can present in the same socially marginalized segment, so that new strategies to control the disease can be employed.

Thus, this study aims to describe the profile of reported cases of tuberculosis among Brazilian women who were homeless and the relationship between this illness and gender dimensions.

METHOD

This is a descriptive quantitative study that aims to identify the sociodemographic and clinical profile of tuberculosis cases occurring in Brazilian women who were homeless between the years 2014 and 2019. It is a study guided by the RECORD (Reporting of studies Conducted using Observational Routinely collected Data) tool, an extension of the STROBE (Strengthening the Reporting of Observational studies in Epidemiology) guidelines that guides the construction of studies using routinely collected health data.

The data came from the Notifiable Diseases Information System (SINAN- in Portuguese), which was last updated in February 2021[9]. Data access occurred on April 19, 2021. We included only cases of tuberculosis in homeless people under all entry modes according to year of notification.

The variables selected for the study were: federal unit (UF) of notification, sex; age group; race/color; education; clinical form; type of entry; treatment outcome; presence of comorbidities; gestational status; and immigration. For comparison purposes, the data on tuberculosis in men and in the total homeless population were also analyzed.

The variables "education" and "outcome" were recategorized. Regarding education, the original SINAN variables were aggregated: Elementary School I Complete/Complete; Elementary School II Complete/Complete; Higher Education Complete/Complete. As for the treatment outcome, no distinction was made between the primary condition and the dropouts.

After extraction, the data were analyzed by means of the elaboration of double-entry tables in the Excel program, for the purpose of percentage comparisons between the variables chosen. A descriptive analysis was made of the absolute and relative frequencies of all variables stratifying by sex.

A map was created using Quantum Geographic Information System (QGIS) software to analyze the distribution of tuberculosis cases among homeless women in Brazil.

Only secondary data from the public domain were used. Thus, there was no need to submit the research to the Ethics Committee.

RESULTS

OOf the 17,713 homeless individuals notified with tuberculosis between the years 2014 and 2019, 3,385 (19.1%) occurred among women, showing slower growth than men in the same situation.

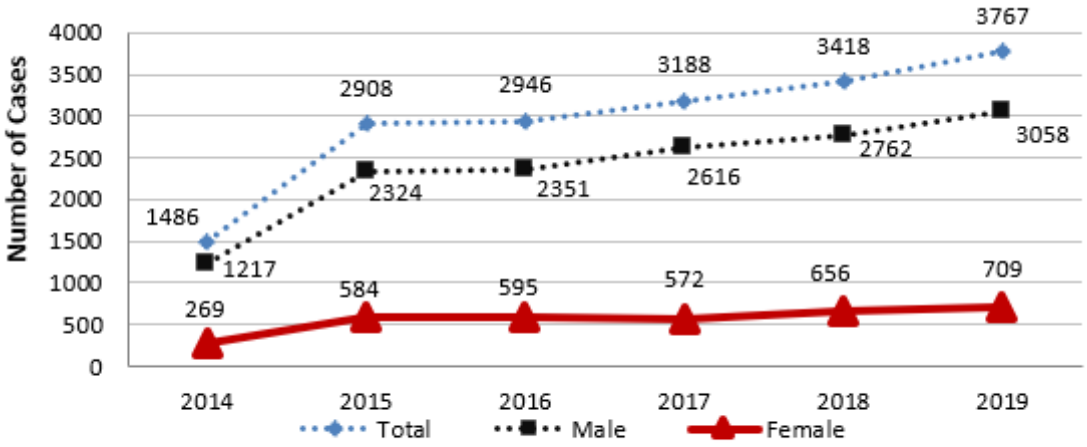

Figure 1: Annual distribution of tuberculosis cases reported in homeless people, according to sex, in the period 2014-2019, Brazil

Source: Notifiable Diseases Information System - SINAN

The Southeast region presented the states with the highest proportions of cases, making up 48% of all cases of tuberculosis reported in homeless women. The states of São Paulo and Rio de Janeiro had, respectively, 842 (24.9%) and 604 (17.8%) cases of TB in homeless women. In the Southern region, the state of Rio Grande do Sul reported 482 (14.2%) of the cases.

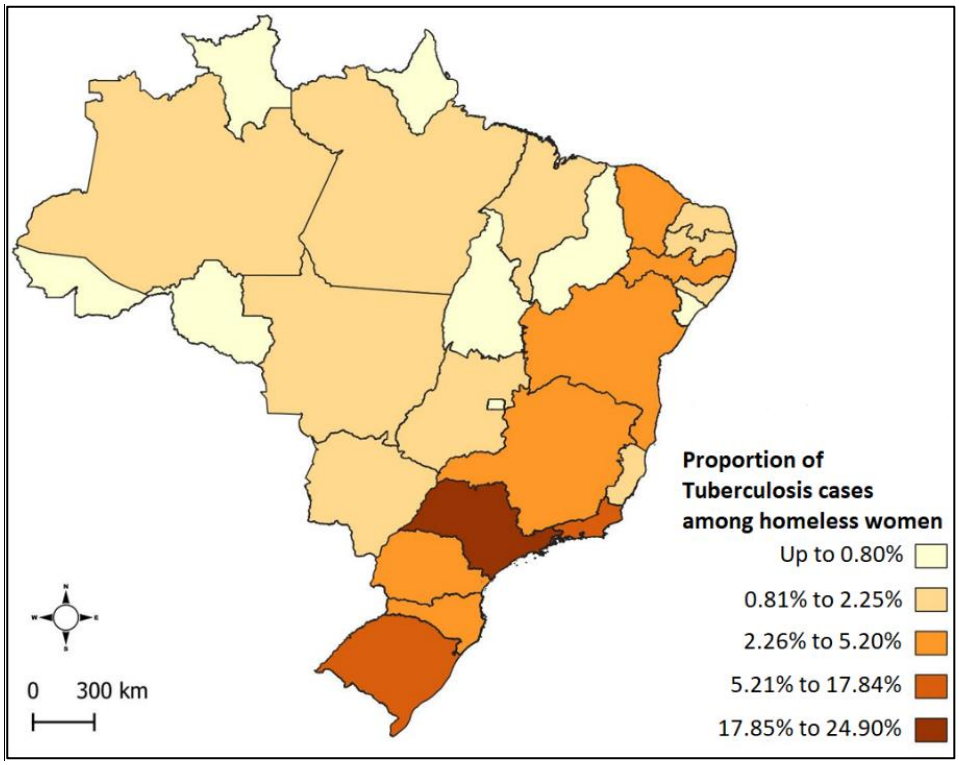

Figure 2 - Percentage distribution of tuberculosis cases reported in homeless women between 2014-2019, according to reporting UF**. Source:** Notifiable Diseases Information System - SINAN

Of the group studied, 114 women were migrants, with the states of Rio de Janeiro and Bahia having the highest numbers of migrations: 27 and 14 respectively (data not shown).

The homeless women diagnosed with tuberculosis showed quite varied ages, but the age range between 25 and 34 years (37.0%) stands out. It is possible to analyze, however, that younger women are on the streets with tuberculosis, since in men, the age range of 35 to 44 years is more expressive (34.2%).

As for race/color, 44.1% of the women declared themselves as brown and 23.8% as black, totaling 67.9% black. For men, 44.3% declared themselves black and 19.2% declared themselves brown, totaling 63.5% black. With a higher frequency (27.9%), although most of these women had completed Elementary School II, 33.6% reported that they did not know or did not answer the question (table 1). The finding was similar among men with a concentration of 26.7% of men with complete Elementary School II and a large portion of ignored data (36.6%). In addition, 105 (3.1%) homeless women with tuberculosis were pregnant during the period studied.

Table 1 - Sociodemographic aspects of confirmed cases of tuberculosis in the homeless population: gender comparison - 2014 to 2019, Brazil.

Variables		Female (n=3.385)		Male (n=14.328)	
		n	%	n	%
Age group (in years)					
	0 to 14	31	0.9	47	0.3
	15 to 24	354	10.5	870	6.1
	25 to 34	1254	37.0	3393	23.7
	35 to 44	1095	32.3	4903	34.2
	45 to 54	443	13.1	3234	22.6
	55 to 64	152	4.5	1490	10.4
	65 and +	54	1.6	379	2.6
	Ignored/white	2	0.1	12	0.1
Race/Color					
	Brown	1.494	44.1	6.343	44.3
	Black	805	23.8	2.746	19.2
	White	787	23.2	3889	27.1
	Yellow	27	0.8	59	0.4
	Indigenous	26	0.8	57	0.4
	Ignored/white	246	7.3	1.234	8.6
Education					
	Illiterate	155	4.6	718	5.0
	Elementary I	696	20.6	2611	18.2
	Elementary II	945	27.9	3824	26.7
	High School	368	10.9	1674	11.7
	Superior	55	1.6	235	1.6
	Not applicable	27	0.8	71	0.5
	Ignored/White	1139	33.6	5195	36.6

Source: Notifiable Diseases Information System - SINAN

According to the data presented in table 2, approximately 92% of the women presented only the pulmonary form of the disease and 50.7% were notified as new cases. The re-entry after abandonment was also remarkable, indicating 36.5% of the total of diagnosed women, surpassing the re-entry rate of men (28.2%).

Table 2 - Clinical form, mode of entry and treatment outcomes of tuberculosis cases in the homeless population: gender comparison - 2014 to 2019, Brazil.

Variables		Female (n=3.385)		Male (n=14.328)	
		N	%	n	%
Form					
	Pulmonary	3,104	91.7	13,276	92.7
	Extrapulmonary	148	4.4	539	3.8
	Pulmonary + extrapulmonary	133	3.9	510	3.6
	Ignore/White			3	~0

Type of entry				
New Case	1716	50.7	8080	56.4
Reentry after abandonment	1234	36.5	4045	28.2
Recidivism	244	7.2	1326	9.3
Transfer	134	4.0	524	3.7
Post-obit[1]	35	1.0	250	1.7
Don't know	22	0.6	103	0.7
Outcome				
Abandonment	1473	43.5	5490	38.3
Cure	1004	29.7	5050	35.2
Transfer	342	10.1	1248	8.7
Death from other causes	245	7.2	809	5.6
Tuberculosis Death	148	4.4	1030	7.2
TB-DR[2]	51	1.5	193	1.3
Scheme Change	16	0.5	52	0.4
Failure	2	0.1	15	0.1
Ignored/White	104	3.1	441	8.0

Notes: [1]The "post-obit" entry refers to cases that were not registered in SINAN in a timely manner, being identified after the death of the individual. [2]TB-DR: Drug-resistant tuberculosis**.**
Source: Notifiable Diseases Information System - SINAN

Regarding the treatment outcomes, 43.5% of the women abandoned the treatment and 29.7% were cured. A comparison between these women and the male group shows that the percentage of dropouts was 1.13 times higher, while the percentage of cures was 1.18 times lower.

As for comorbidities (Table 3), drug use proved to be very significant: 44.6% of the homeless women with TB were alcoholics, 43.8% smoked, almost 68.7% used illicit drugs and 8.4% had mental illnesses. In three of the six comorbidities compared, the percentages found exceeded those of men in the same situation. In relation to AIDS, for example, the occurrence of co-infection in women exceeds almost 16% in relation to the male group analyzed.

Table 3 - Diseases and associated aggravations among tuberculosis cases in the homeless population: gender comparison - 2014 to 2019, Brazil.

Comorbidity	**Female (n=3,385)**		**Male (n=14,328)**	
	N	**%**	**n**	**%**
Alcoholism				
Yes	1,509	44.6	7,952	55.5
No	1,672	49.4	5,663	39.5
Ignored/White	204	6.0	713	5.0
Smoking				
Yes	1,483	43.8	6,315	44.1
No	1,630	48.2	6,965	48.6
Ignored/White	272	8.0	1,048	7.3

Illicit drugs					
	Yes	2,314	68.7	7,472	52.1
	No	905	26.4	5,859	40.9
	Ignored/White	166	4.9	997	7.0
AIDS					
	Yes	1,214	35.9	2,875	20.1
	No	1,946	57.5	10,381	72.5
	Ignored/White	225	6.7	1,072	7.5
Mental Illness					
	Yes	284	8.4	839	5.9
	No	2,837	83.8	12,379	86.4
	Ignored/White	264	7.8	1,110	7.7
Diabetes					
	Yes	111	3.3	517	3.6
	No	3,025	89.4	12,805	89.4
	Ignored/White	249	7.4	1,006	7.0

Source: Notifiable Diseases Information System - SINAN

DISCUSSION

The investigation of tuberculosis in women who are homeless is crossed by the need to understand the immense field of social inequities that make up not only the manifestation of this disease, but also, mainly, the different way in which this phenomenon is perceived within the health system and the academia, contributing to achieve a triple burden of neglect on this minority group given their social status, health status, and gender.

Although quite clear, it is pointed out that the singularities presented by women who are homeless are not fully considered at the time of attention to their health[10]. Being a woman and being on the streets are not considered social conditions that are closed in themselves. In different ways, they reveal a range of institutional problems that makes daily minimization of social rights, by gender markers, by neglecting the ways of life presented.

Women going to the streets may be the result of multiple motivations. Family problems, use of psychoactive substances, unemployment, or the simple desire to do so are cited as reasons for leaving home[8]. From a gender perspective, the street experience is constructed differently for men and women. The first assume the streets as the outcome of a terminal condition of rupture and social degradation, while for women, the street situation represented an initial solution against violence and dissatisfaction with the domestic space[7].

In the period of this study, 3,385 cases of tuberculosis were reported in homeless women, with higher prevalence in black and brown women, literate, young and adult, although the level of education found was low. This confirms previous findings that relate such educational profile and age group with higher occurrence of tuberculosis[11-13].

Most homeless women were diagnosed with the pulmonary form of the disease, following the same pattern presented in the general population. Regarding the follow-up of cases, these women showed significant differences as higher rates of treatment abandonment and reentry after abandonment when compared to men also being homeless. This reality can portray the unfair living and housing conditions, which exacerbate a strong scenario of vulnerabilities that the street context has been exposing to women's lives. The existing stigma about this disease can intensify the breakdown of relational bonds, making life on the streets something much lonelier and sickening for women. A study reveals that social representations about tuberculosis generate negative results to the sick person due to the association of the disease with dirt and transmissibility and/or lethality[14]. Moreover, the stigma about tuberculosis negatively impacts the initiation of treatment[15].

The development of tuberculosis within the street life of women displays a very fragile evolution that reaffirms a decadent socioeconomic context. The dynamics of the streets formulates a structure capable of concentrating more strongly the social determinants of tuberculosis, facilitating the discontinuation of treatment, which can be translated into the high rates of treatment abandonment seen in women who were homeless. It is known that the effectiveness of the treatment of tuberculosis is linked to the precise compliance with a six-month therapeutic standard that should be enhanced by improving the living conditions of the patient. Several studies[12,16] have reported, thus, the multifactorial nature of the abandonment of this treatment, which can be induced by issues such as drug use, education, alcoholism, insufficient income, food restrictions and difficulties in access to health services. Such problem hinders the rehabilitation of cases, making the infection more severe and resistant to drugs[16].

The high percentage of retreatment of cases in women, exemplified by cases of relapse and re-entry after abandonment, are reflections of flawed and costly health management and social assistance. The dynamics of being homeless presupposes the existence of health care capable of considering the individual and collective efforts produced daily for the struggle for survival that precedes getting sick with tuberculosis. In this sense, not only the adequacy of therapeutic schemes is indispensable, but also the joint promotion of political supports that enable other ways of living.

The encouragement, for example, of strategies such as the directly observed treatment (DOT) facilitates the approach of tuberculosis in the homeless population by strengthening the professional-patient bond and monitoring of cases. It is known that the instrument has great influence on the promotion of better outcomes and disease management[17]. The DOT contributes to treatment adherence through a more humanized and integrated care.

Conditions such as diabetes and smoking found similar frequencies among homeless people notified with tuberculosis, regardless of gender. However, when we consider alcoholism, homeless women with tuberculosis have a lower prevalence for the habit. Inequalities are also demarcated with the identification of the lowest percentage of cure for the female segment (29.7%, in contrast to 35.2% of the male group), leading us to question the possibility of greater social barriers in reaching and adhering to treatment by such women.

The coinfection with HIV/AIDS was revealed as the most frequent condition affecting homeless women notified with tuberculosis. The susceptibility of TB/HIV/AIDS association in such women reflects the weakening of their social supports as a reflection of a patriarchal and inconsistent public system. Women who are homeless find it more difficult to withdraw oral contraceptives and female condoms in health clinics, a fact that becomes a strong obstacle in the production of female autonomy over their sexual health, especially when it is verified that men find it easier to access condoms in the same services[18]. However, it is worth noting that access to such resources is not able to eliminate the problems related to the practice of sexual activity on the streets.

Issues such as prostitution and sexual violence also enter as facilitators of the vulnerability of women on the streets in relation to the usual occurrence of sexually transmitted infections. The sexual practice on the streets for women is constantly performed in an imposing way, sometimes by the need for survival, sometimes by forced subjection by other street dwellers or passing strangers[10,18]. Such reality calls for reflection and debate on the character of passivity and objectification of the female body. About this reality, a study[7] reveals that for women crack users, situations of violence are enhanced and the concern about access to basic needs such as hygiene, food and rest is reduced.

Regarding information on illicit drug use, the data reveal a higher occurrence among homeless women. Approximately 70% of these women presented continuous use or not of drugs other than alcohol or cigarettes. Drugs are used by women as escape valves from their reality on the streets[19]. It is observed that many of them are aware of the damage but continue to use illicit substances to ease the facing of their situation, especially in the face of a routine of violence.

Research has shown that diseases that affect the immune system, such as HIV/AIDS, alcoholism, malnourishment, and drug addiction, delay a positive prognosis, since they intensify the infectious picture of tuberculosis[6,20]. In another study, the use of illicit drugs is indicated as a factor in the progression of tuberculosis in the community due to the lifestyle of users and the sharing of materials[21].

More tenuously, the prevalence of mental illness was higher among homeless women with tuberculosis. Mental suffering was identified as an important point in the understanding of women who are homeless, sometimes as a cause and sometimes consequently for this life situation. It is important to remember that both the street situation[14] and tuberculosis[22] are processes marked by prejudice and stigma. Moreover, for women, the breakdown of family relationships can promote unhappiness, and, in many cases, it is the desire to re-establish emotional ties or the creation of other ties that directs their efforts to get off the streets. Women who are homeless expose a state of guilt and loneliness due to the distance from their children and family[10], a situation that can lead to damage to their mental health.

The constant state of alert required by living in a scenario of great and distinct violence can also contribute to the precariousness of women's quality of life. It is known that staying overnight on the streets is characterized as a great challenge for women living on the streets and hardly shows itself as an opportunity for real rest for such people due to the fear of aggression[7,10]. Living on the streets generates fear, insecurity, loneliness and anguish for women[19].

It is feared not only a greater exposure to sexual violence, but also to aggressions resulting from simple intolerance to the street situation, such as those derived from hygienic actions that seek to keep these people away from public or private environments by the desire to make the space something more pleasant[7].

The confrontation of violence against homeless women requires both new political apparatuses and the fight against social stigmas. The Maria da Penha Law does not reach the streets and society rejects the woman on the street, relating her to profanity for not belonging to the domestic[23].

Still on the siege of obtaining their rights, women assume that the street is a place that makes it difficult to meet the basic needs, especially regarding the menstrual period[24]. In this sense, the housing in shelters, squats, and abandoned places promotes greater safety for the realization of personal care such as bathing, regular meals, and resting[10,24,25]. However, even so, the strong standardization of the hostels shows itself with an impediment for many of these women to recognize their role as a welcoming service.

Of the women studied, 105 were pregnant, a situation that can be a stressor on the quality of health of homeless women, since due to the precarious living conditions and the difficulty in accessing health services, pregnancy can bring considerable risks to the mother and her baby[26-27].

Despite the rare nature of neonatal involvement, vertical tuberculosis infection is possible and has high mortality rates. Although congenital tuberculosis is uncommon, complications such as premature birth, low birth weight and other situations related to maternal health can occur due to the mother's illness by tuberculosis[28].

Thus, we appreciate the need for a timely diagnosis as well as actions that favor the permanence of homeless pregnant women in the treatment regimen for tuberculosis. A clinical suspicion that is sensitive to the different possibilities of life of those being evaluated is a unique tool to promote a more equitable and comprehensive care.

Within reproductive health, it is important to mention the disproportionate care received by pregnant homeless women in relation to other times of life. The requirement of prenatal tests has been seen as the greatest opportunity to link to health services[18,25]. It is during pregnancy that the State is more present in the control of this woman's health, even though its concern is not on her itself, but on the life that is being generated[29]. Such reality points to another problem associated with gender issues, access to services, and the lack of autonomy of the bodies. Added to this context, for women who are homeless, even access to prenatal care is posed as something costly. An integrative review reveals the presence of obstacles of diverse nature as the professional unpreparedness to perform the care, the lack of flexibility and bureaucracy for consultations, lack of social support and drug use[27].

In aid to the emerging study of the relationship between immigration and health, the finding of 114 immigrant street women with tuberculosis allows the questioning of the effectiveness of current policies of reception and access to universal health care. In a study on tuberculosis mortality in Brazilian capitals, higher rates of migration had a positive association[30].

Facing the still inefficiency of the State in subsidizing the reorganization of life and the rescue of citizenship for these women, parallel efforts brought about by the National Movement of the Homeless Population and other social actions prove to be decisive in fighting for the achievement and visibility of their citizenship.

This study presented important limitations in terms of data collection. Being a study that uses secondary sources of information, the authors were aware of the existing fragments in the completeness of the data, given the large number of underreporting and ignored records. Likewise, the lack of exact quantification of the homeless population made it impossible to calculate epidemiological indicators such as incidence and mortality rates.

The discrimination of the SINAN data only on the variable "sex" also prevented the present study from expanding the concept of gender and investigating cases of tuberculosis in transsexual women and transvestites who are homeless. It is known, however, the strong presence of these women in the street context, which does not allow us to disregard the possibility of tuberculosis for the LGBT+ population (lesbian, gay, bisexual, transvestite, transsexual and transgender) in this social context.

Considering the insufficient number of studies on the subject, this paper contributes to the evidence of the development of cases of tuberculosis in Brazilian women who are homeless, characterizing the profile of occurrence of this disease from clinical issues common to the homeless population as well as encouraging a discussion of gender relations in the face of such illness.

CONCLUSION

The simple observation of the attenuated growth of cases of tuberculosis among homeless women or its lower proportion among the total number of reported cases in this segment has obscured the real expressiveness of the disease within the health care of these women.

Tuberculosis infection is a socio-clinical marker of the different ways of life assumed within a society, and the unequal way in which this illness takes hold in the female portion of the street population maps out the different levels of exposure that exist and different therapeutic capacities of everyone based on their social location.

The dimension of tuberculosis for women who are homeless can respond not only to the irregular housing status, but also, similarly, it can be an answer to a precarious life situation that is delivered to the female being in the context of the street. The experience of women on the streets is a theme that goes beyond financial and housing issues and can be understood as the enchainment of sociopolitical failures that concomitantly produce and restrict the possibilities of life to be lived.

The social inequity suffered by women on the streets encompasses problems such as discrimination and violence that invalidate the promotion of a dignified life from the construction of negative and disabling stereotypes. Thus, it is urgent the political planning for the realization of specific interventions for the health care of women on the streets, considering the biological singularities and the different experiences and knowledge of such subjects on the streets.

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