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Information and confidence of the homeless population in fighting COVID-19

Informação e confiança da população em situação de rua no enfrentamento à covid-19

Información y confianza de la población sin hogar en la lucha contra el covid-19

ABSTRACT

Objectives: Describe the main means of access to information and trust in public authorities regarding the fight against Covid-19 by the homeless population. **Method:** Cross-sectional study carried out with 356 homeless individuals, over 18 years of age. A questionnaire was applied and descriptive analysis of the data was performed. **Results:** The prevalent characteristics were: age between 30 and 39 years, male, non-white, religious, unemployed, low level of education, no income and receive government assistance. The sources of information most used by the homeless population were news and social networks and distrust prevails in relation to public authorities. **Final remarks:** The main means of access to information about the COVID-19 pandemic were news reports and social media, drawing attention to the low access to information provided by health professionals, as well as the low trust in government measures to combat the pandemic.

Descriptors: Ill-Housed Persons; COVID-19; Access to information; Disinformation.

RESUMO

Objetivos: Descrever os principais meios de acesso a informações e a confiança no poder público sobre o enfrentamento da covid-19 pela população em situação de rua. **Método:** Estudo transversal realizado com 356 indivíduos em situação de rua, maiores de 18 anos. Realizou-se aplicação de questionário e análise descritiva dos dados. **Resultados:** As características prevalentes foram: idade entre 30 e 39 anos, sexo masculino, não brancos, têm religião, sem ocupação, baixa escolaridade, sem renda e recebem auxílio governamental. As fontes de informações mais usadas pela população em situação de rua foram os noticiários e redes sociais e a não confiança prevalece em relação ao poder público. **Considerações finais:** Os principais meios de acesso a informações sobre a pandemia de covid-19 foram noticiários e redes sociais, chamando a atenção o baixo acesso a informações dadas por profissionais de saúde, bem como a baixa confiança nas medidas governamentais de enfrentamento à pandemia.

Descritores: Pessoas mal alojadas; Covid-19; Acesso à informação; Desinformação

RESUMEN

Objetivo: Describir los principales medios de acceso a la información y la confianza en las autoridades públicas respecto a la lucha contra el Covid-19 por parte de la población sin hogar. **Método:** Estudio transversal realizado con 356 personas sin hogar, mayores de 18 años. Se realizó un cuestionario y se realizó un análisis descriptivo de los datos. **Resultados:** Las características predominantes fueron: edad entre 30 y 39 años, sexo masculino, no blanco, religioso, desempleado, baja nivel de educación, sin ingresos y recibiendo asistencia gubernamental. Las fuentes de información más utilizadas por la población sin hogar fueron las noticias y las redes sociales, y prevalece la desconfianza en relación a las autoridades públicas. **Consideraciones finales:** Los principales medios de acceso a información sobre la pandemia de COVID-19 fueron los informes de noticias y las redes sociales, llamando la atención sobre el bajo acceso a la información proporcionada por los profesionales de la salud, así como la baja confianza en las medidas gubernamentales para combatir la pandemia.

Descriptores: Personas con mala vivienda; Covid-19; Acceso a la información; Desinformación.

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INTRODUCTION

The COVID-19 pandemic in 2020 has raised concerns about the disease, its ways of spreading, control, and its impacts on everyday life, which has mobilized the world in the search for information about something hitherto unknown[1]. The pandemic has led to crisis and emergency situations, with social, economic, physical, and mental health repercussions for populations, especially the most vulnerable[2]. In addition, health systems have been overloaded, with the need for new hospital beds for serious cases, as well as professionals trained to diagnose, treat, and provide correct guidance on care related to the disease, promoting the dissemination of safe information[3].

Technological advances in a period of globalization have allowed society to organize itself into a dynamic network, interconnected with different social actors (people, institutions, organizations) and with rapid dissemination of information[4]. However, the materials and data are not always true, with content often linked to individual beliefs and ideologies, which characterizes fake news[5]. Fake news has circulated rapidly and multiplied in Brazil during the COVID-19 pandemic: from January to June 2020, 339 were identified[5]. This aspect characterizes an infodemic, i.e. the distribution of excessive, fast, and often unreliable information, without clear sources and containing unreliable guidelines[6].

The main explanations for sharing fake news are a lack of technical-scientific knowledge and low critical analysis of the veracity of content[7]. In the context of the infodemic, a critical individual has media literacy, a capacity for discernment that contributes to their well-being[8]. To build this criticality, the individual must be continually stimulated, mainly by family, school, and health professionals, with initiatives that lead to learning and information competence[9]. Despite this, the majority of vulnerable populations, such as the homeless population, have broken family ties, low levels of education, and difficulty accessing health services, which impacts their ability to attest to the veracity of information[10].

Information competence is part of the educational process and thus one of the fundamental rights of the individual in society[9]. To ensure quality and effective education, governments must strengthen education systems by composing and improving inclusive governance and accountability, quality assurance mechanisms in education, and information management systems. Information and Communication Technologies (ICTs) should be used to strengthen education systems and the dissemination of knowledge, provide access to information, and offer services more efficiently[11].

Educational instruction directs the individual, as well as brings more value to society, positively influencing social determinants such as access to services, occupation, and income. However, PIH, characterized by low educational attainment, faces significant challenges in accessing information and obtaining basic rights and services[12]. Despite these barriers, there are formal and informal mechanisms that provide this population with access to essential information, such as social services, non-governmental organizations, community support networks, local media, and educational activities in drop-in centers[13].

The inconsistency in the application

of public health policies, coupled with the lack of adequate resources to support HP during the pandemic, has exacerbated the perception of ineffectiveness and lack of equity in government measures[14]. The disparity in access to care and social protection not only worsens the living conditions of these individuals but also undermines society's trust in public institutions, highlighting the need to strengthen public health strategies to ensure a more inclusive and fair response in future crises[15].

In this sense, we ask: what is the perception of the homeless population about measures to deal with the COVID-19 pandemic and what are the main means of access to information used by the homeless population during the pandemic? To understand how vulnerability affects access to information and trust in measures to control COVID-19, this study aims to describe the main means of access to information and trust in public authorities regarding the fight against COVID-19 by the homeless.

METHODOLOGY

This is a descriptive study with a quantitative approach carried out in the municipality of Belo Horizonte, in two Reference Centers for Homeless People located in the south-central region. This study was reported under the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guidelines.

Belo Horizonte has 5,344 homeless people, 58.5% of whom are not from the capital. To meet this demand, the city has services such as the Reference Centers for the Homeless, the Street Clinic, and the Popular Restaurant, which guarantee access to rights for these individuals.

For this study, 356 homeless individuals who used social assistance services in the central region of Belo Horizonte, aged over 18, were selected for convenience. The criteria for non-inclusion were people who did not use the services for this population.

Data collection took place between August 2021 and March 2022, using a questionnaire from the larger "Brazil Social Thermometer" survey. The collection was conducted by trained health professionals and students. The questionnaire sought to analyze the social, economic, and health impacts of the Homeless Population (HP) in Brazil, as well as the governmental public health measures adopted to contain the disease, such as vaccination and social distancing actions. The study used sociodemographic variables (age, sex, race, religion, occupation, schooling, income, and government aid), variables on access to and use of information sources (health professionals, religious institutions, news, social networks, and social support networks) and variables on the reliability of government measures to combat COVID-19 (Federal Government, State Government, and Municipal Government).

The data collected was organized using Microsoft Excel. Descriptive analyses with absolute and relative frequencies were carried out using the Statistical Package for the Social Science (SPSS) software.

The study was approved by the Research Ethics Committee of the Federal University of Minas Gerais (Coep-UFMG) under Opinion No. 3.508.404, in compliance with Resolution No. 466/2012 of the National Health Council and the guidelines and regulatory standards for research involving human beings.

RESULTS

The sample consisted of 356 individuals whose prevalent sociodemographic characteristics were: average age between 30 and 39 years (27.8%), male sex (89.04%), non-white (88.5%), religious (76.3%), no occupation (72.8%), low schooling (61.24%), no income (65.1%) and receiving aid (69.9%).

Information on COVID-19 was accessed by HP through various means, with health professionals having little access to information (6.2%). The main means of accessing information was through the news (radio, newspapers, and TV news) (73.9%). The other sources of information were religious institutions (8.1%), social support networks (21.1%), and social networks (28.9%).

The sources of information most used by HP were the news and social networks, especially in the 30-49 age group and those with low levels of education. Health professionals, on the other hand, are less frequently used by HP to obtain information, with negative information being prevalent in all variables, as described in Table 1.

Table 1 – Sources of information accessed by HP during the COVID-19 pandemic (Belo Horizonte, Brazil, 2024).

Variables	Health professionals		Religious institutions		News		Social networks		Social suport network	
	Yes n (%)	No n (%)	Yes n (%)	No n (%)	Yes n (%)	No n (%)	Yes n (%)	No n (%)	Yes n (%)	No n (%)
Age group										
18-29 years	4 (5,9)	64 (94,1)	6 (8,8)	62 (91,2)	44 (64,7)	24 (35,3)	18 (26,5)	50 (73,5)	20 (29,4)	48 (70,6)
30-39 years	6 (6,1)	93 (93,9)	1 (1,0)	98 (99,0)	77 (77,8)	22 (22,2)	34 (34,3)	65 (65,7)	18 (18,2)	81 (81,8)
40-49 years	7 (7,4)	87 (92,6)	13 (13,8)	81 (86,2)	72 (76,6)	22 (23,4)	28 (29,8)	66 (70,2)	17 (18,1)	77 (81,9)
50-59 years	5 (7,6)	61 (92,4)	5 (7,6)	61 (92,4)	50 (75,6)	16 (24,2)	14 (21,2)	52 (78,8)	16 (24,2)	50 (75,8)
> = 60 years	-	29 (100,0)	4 (13,8)	25 (86,2)	20 (69,0)	9 (31,0)	9 (31,0)	20 (69,0)	4 (13,8)	25 (86,2)
Sex										
Male	19 (6,0)	298 (94,0)	23 (7,3)	294 (92,7)	237 (74,8)	80 (25,2)	89 (28,1)	228 (71,9)	66 (20,8)	251 (79,2)
Female	3 (7,7)	36 (92,3)	6 (15,4)	33 (84,6)	26 (66,7)	13 (33,3)	14 (35,9)	25 (64,1)	9 (23,1)	30 (76,9)
Race/color										
White	2 (8,3)	22 (91,7)	1 (4,2)	23 (95,8)	22 (91,7)	2 (8,3)	7 (29,2)	17 (70,8)	5 (20,8)	19 (79,2)
Black/brown	20 (6,0)	312 (94,0)	28 (8,4)	304 (91,6)	241 (72,6)	91 (27,4)	96 (28,9)	236 (71,1)	70 (21,1)	262 (78,9)
Yellow	-	-	-	-	-	-	-	-	-	-
Indigenous	-	-	-	-	-	-	-	-	-	-
Not reported	-	-	-	-	-	-	-	-	-	-
Religion										
Has	16 (6,1)	248 (93,9)	19 (7,2)	245 (92,8)	203 (76,9)	61 (23,1)	78 (29,5)	186 (70,5)	55 (20,8)	209 (79,2)
Does not have	6(7,3)	76 (92,7)	10 (12,2)	72 (87,8)	53 (64,6)	29 (35,4)	23 (28,0)	59 (72,0)	19 (23,2)	63 (76,8)
Occupation										
Has	6 (6,2)	91 (93,8)	7 (7,2)	90 (92,8)	71 (73,2)	26 (26,8)	29 (29,9)	68 (70,1)	18 (18,6)	79 (81,4)
Does not have	16 (6,2)	243 (93,8)	22 (8,5)	237 (91,5)	192 (74,1)	67 (25,9)	74 (28,6)	185 (71,4)	57 (22,0)	202 (78,0)
Education										
Elementary	10 (4,6)	208 (95,4)	13 (7,3)	202 (92,7)	159 (72,9)	59 (27,1)	49 (22,5)	169 (77,5)	40 (18,3)	178 (81,7)
Secondary	9 (8,0)	103 (92,0)	10 (8,9)	102 (91,1)	86 (76,8)	26 (23,2)	45 (40,2)	67 (59,8)	30 (26,8)	82 (73,2)
Higher	2 (10,5)	17 (89,5)	2 (10,5)	17 (89,5)	14 (73,7)	5 (26,3)	9 (47,4)	10 (52,6)	4 (21,1)	15 (78,9)
None	1 (14,3)	6 (85,7)	1 (14,3)	6 (85,7)	4 (57,1)	3 (42,9)	-	7 (100,0)	1 (14,3)	6 (85,7)
Income										
Has	6 (4,8)	118 (95,2)	7 (5,6)	117 (94,4)	86 (69,4)	38 (30,6)	38 (30,6)	86 (69,4)	21 (16,9)	103 (83,1)
Does not have	16 (6,9)	215 (93,1)	22 (9,5)	209 (90,5)	177 (76,6)	54 (23,4)	65 (28,1)	166 (71,9)	54 (23,4)	177 (76,6)
Assistance										
Receives	114 (5,6)	235 (94,4)	24 (9,6)	225 (90,4)	187 (75,1)	62 (24,9)	81 (32,5)	168 (67,5)	56 (22,5)	193 (77,5)
Does not receive	8 (7,5)	99 (92,5)	5 (4,7)	102 (95,3)	76 (71,1)	31 (29,0)	22 (20,6)	85 (79,4)	19 (17,8)	88 (82,2)

Source: Prepared by the authors (2023).

The HP's trust in the Federal, State, and Municipal Governments and their measures to tackle COVID-19 is 26.4%, 31.2%, and 40.2% respectively. Table 2 describes HP's trust in the federal, state, and municipal governments and their measures to tackle COVID-19. Non-trust prevails in all spheres of government.

Table 2 – HP's confidence in public authorities' measures to tackle COVID-19.

Variables	Federal Government		State Government		Municipal Government	
	Yes n (%)	No n (%)	Yes n (%)	No n (%)	Yes n (%)	No n (%)
Age grouo						
18-29 years	12 (22,6)	41 (77,4)	12 (22,2)	42 (77,8)	15 (27,8)	39 (72,2)
30-39 years	24 (25,0)	72 (75,0)	30 (31,3)	66 (68,8)	34 (35,4)	62 (64,6)
40-49 years	35 (38,5)	56 (61,5)	42 (46,2)	49 (53,8)	56 (61,5)	35 (38,5)
50-59 years	13 (20,6)	50 (79,4)	16 (25,4)	47 (74,6)	25 (39,7)	38 (60,3)
> = 60 years	10 (37,0)	17 (63,0)	11 (40,7)	16 (59,3)	13 (48,1)	14 (51,9)
Sex						
Male	83 (28,3)	210 (71,7)	100 (34,0)	194 (66,0)	128 (43,5)	166 (56,5)
Female	11 (29,7)	26 (70,3)	11 (29,7)	26 (70,3)	15 (40,5)	22 (59,5)
Race/color						
White	9 (25,0)	27 (75,0)	10 (27,0)	27 (73,0)	14 (37,8)	23 (62,2)
Black/brown	81 (29,1)	197 (70,9)	96 (34,5)	182 (65,5)	122 (43,9)	156 (56,1)
Yellow	3 (50,0)	3 (50,0)	4 (66,7)	2 (33,3)	4 (66,7)	2 (33,3)
Indigenous	-	3 (100,0)	-	3 (100,0)	-	3 (100,0)
Not reported	1 (14,3)	6 (85,7)	1 (14,3)	6 (84,7)	3 (42,9)	4 (57,1)
Religion						
Has	77 (30,2)	178 (69,8)	92 (35,9)	164 (64,1)	117 (45,7)	139 (54,3)
Does not have	15 (22,4)	52 (77,6)	18 (26,9)	49 (73,1))	24 (35,8)	43 (64,2)
Occupation						
Has	24 (27,0)	65 (73,0)	29 (32,6)	60 (67,4)	35 (39,3	54 (60,7)
Does not have	70 (29,0)	171 (71,0)	82 (33,9)	160 (66,1)	108 (44,6)	134 (55,4)
Income						
Has	34 (28,6)	85 (71,4)	40 (33,6)	79 (66,4)	60 (50,4)	59 (49,6)
Does not have	60 (28,4)	151 (71,6)	71 (33,5)	141 (66,5)	83 (39,2)	129 (60,8)
Education						
Elementary	56 (28,1)	143 (71,9)	66 (33,0)	134 (67,0)	81 (40,5)	119 (59,5)
Secondary	33 (30,8)	74 (69,2)	38 (35,5)	69 (64,5)	51 (47,7)	56 (52,3)
Higher	3 (17,6)	14 (82,4)	5 (29,4)	12 (70,6)	9 (52,9)	8 (47,1)
None	2 (28,6)	5 (71,4)	2 (28,6)	5 (71,4)	2 (28,6)	5 (71,4)
Assistance						
Receives	72 (30,1)	167 (69,9)	86 (35,8)	154 (64,2)	111 (46,3)	129 (53,8)
Does not receive	22 (24,2)	69 (75,8)	25 (27,5)	66 (72,5)	32 (35,2)	59 (64,8)

Source: Prepared by the authors (2023).

DISCUSSION

The sources of information most used by HP were the news and social networks, highlighting the low demand or low access to information through health professionals. Non-trust in the government's measures to tackle COVID-19 was prevalent among this audience.

HP's access to information is often limited. The lack of a fixed residence imposes restrictions such as difficulty in keeping documents and belongings, the impossibility of adopting hygiene measures and social stigma, and barriers that compromise access to

basic health services, social assistance, and education, which makes it difficult to obtain information that is critical to their survival and well-being[16]. The study shows that there is little access to information from health professionals, reinforcing the existence of barriers to accessing health services. On the other hand, as there is a greater prevalence of information via the news and social networks, it is considered that this public is often included in media where access is facilitated and where they do not suffer from stigma and prejudice.

The municipality of Belo Horizonte has nine health regions with around 15 Basic Health Units (BHU) per region. Compliance with the principles of the Unified Health System, integrality, equity, and universality, is a basic premise for these services. There are also three Reference Centers for the Homeless, and social assistance services that provide guidance, reception, and referrals. Health services do not require documentation to provide care for HP, however, the study showed that only 6.2% of participants relied on health professionals to access information about COVID-19.

Coping with the COVID-19 pandemic has led to measures of social isolation and the closure of businesses, but it has disregarded the situation of people who live and make a living on the streets. Social isolation has restricted daily activities and domestic activities and hindered access to health services. These aspects may have influenced HP's search for information through the news and social networks, given how easy it is to access information[17]. However, the use of social networks can be an important source of untrue news and information.

Social networks are potential channels for facilitating the spread of fake news[18]. To reduce the impact of fake news, efficient and comprehensive health education is suggested, carried out by health professionals[19], recognizing its importance for the prevention and early detection of the disease, reducing the possibility of injuries and risks of contamination by COVID-19.

Health education practices underpin care practices, generating knowledge that was once unknown or even mystified, especially in vulnerable groups that are distanced from their rights and access to quality information, such as HP. However, according to the Advanced Research Institute (Ipea), specific guidance activities were less recurrent in HP actions during the pandemic[20], which corresponds to the findings of this study, in which the rate of access to information, through health professionals, is low.

Access to information is a fundamental right provided for in the 1988 Federal Constitution. The law aims to enable clarification and access to data clearly and transparently. As such, health information is a right, and, for this reason, health professionals should be the main source of information dissemination and need to be prepared and willing to offer and communicate according to the individual needs of each user, without sticking to standardized formulas[20]. This attitude encourages and strengthens the creation of a bond between the user and the network, resulting in a scenario of guaranteed rights, information, and dignity.

This study also showed that HP do not trust the measures adopted by the municipal, state, and federal governments to deal with the COVID-19 pandemic. Vulnerable groups, including HP, are at greater risk of being affected and dying from COVID-19. Access to information on the prevention and treatment of the disease has been limited, with restricted access to information by health professionals and the use of news and

social networks. In addition, the impossibility of following prevention and control measures for those who do not have a permanent home or live in extreme poverty exposes them to the disease. Although some emergency measures have been taken, such as welfare benefits and providing a place to treat HP with COVID-19, they have still suffered the consequences of actions that were not in line with their needs.

Research carried out by Ipea (2020) on the measures adopted to deal with the pandemic aimed at HP identified, for example, that access to emergency aid required documents, a cell phone with internet access, and proof of residence, items that HP generally do not have[21]. It is necessary not only to recognize the specificities, diversities, and multiplicities of the issues HP face but above all to develop effective public policies that promote improvements in their living conditions.

One of the guidelines of the National Policy for Homeless People (NPHP) is the articulation of federal, state, municipal, and Federal District public policies, as well as the promotion of civil, political, economic, social, cultural, and environmental rights[22]. To break the history of repression and social invisibility with HP, it is necessary to invest in public services that include integrality as the guiding axis of health actions and social services, aiming for greater social inclusion and opportunities for better living conditions.

Humanization in health must be emphasized by prioritizing the principles of the UHS in everyday care and management practices. The humanization of care for people living on the streets must establish bonds, value the individual, promote their autonomy, and increase their capacity to transform reality; to this end, exchanges of solidarity between different professionals and different services must be constant to build collective spaces for confrontation and resistance[23].

Health is everyone's right and the duty of the state, guaranteed through social and economic policies. The public HP care network is basically articulated around government initiatives within the health and social assistance systems, generally carried out by municipalities[24]. However, the rare guidelines issued by the federal government have not been accompanied by new budgetary contributions. Moreover, it can be seen that most of the initiatives taken in the municipalities are not the result of official guidelines from the municipal government but from the professionals who work with HP, who require the management to provide them with the means to implement the proposed measures[25]. In this way, HP has to deal with neglect and negligence on the part of the state in formulating public policies.

LIMITATIONS

A limitation of the study was the fact that the participants were not followed up longitudinally, and it was impossible to establish causal relationships since it was cross-sectional. The use of a dichotomized questionnaire was also a limiting factor, as there was no room to obtain answers outside the already structured model, reducing the scope of the information collected.

FINAL CONSIDERATIONS

Concerning the objective of describing the means of access to information and trust in public authorities regarding HP's response to COVID-19, it was revealed that the most used sources of information were the news and social networks, with low demand for information from health professionals. Lack of trust in public authorities to deal with CO-

VID-19 was prevalent among this audience.

The results reflect the problem of obtaining information from the news and social networks, which are the most recurrent means of spreading unreliable information, having a negative impact on HP's ability to cope with COVID-19 and access to healthcare. In addition, the low level of adherence of health professionals in disseminating information is worrying, given that popular health education is an essential tool in the care provided.

The low reliability of HP in government can be explained by the lack of a more sensitive approach by the public authorities to HP and their specific demands, especially concerning guaranteeing access to basic rights, which are essential for the implementation of emancipatory public policies that improve the lives of these people.

Identifying the methods of access to information and the level of reliability in government agencies contributes to the development of new studies and, in particular, to the formulation of public initiative proposals aimed at changing this scenario, focusing on providing information and access to health that is consistent with the trajectory of the street. They also contribute to the field of nursing, revealing the importance of caring for vulnerable populations, such as HP, in the context of public health and health education.

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