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Primary health care in health care for homeless people

Cuidados primários em saúde na atenção à população em situação de rua

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Resumo

Introdução: o fenômeno situação de rua constitui-se um desafio para sua compreensão, dimensionamento, diagnósticos diversos e para a definição de estratégias para enfrentar as condições de vulnerabilidade, entre elas as de saúde. **Objetivo**: descrever as ações desenvolvidas pelos profissionais de saúde e as dificuldades vivenciadas no atendimento à população em situação de rua. **Métodos**: pesquisa qualitativa, a partir de entrevistas com profissionais de saúde de uma Unidade Básica de Saúde de Belo Horizonte-MG, referência para atendimento a essa população. O conteúdo dos depoimentos foi analisado pelo referencial de Bardin. **Resultados**: os profissionais identificam ações realizadas, a partir do acolhimento sistematizado com vistas à criação de vínculos e abordagem dos principais problemas de saúde. Realizam ações preventivas necessárias e encaminham ou acionam outros serviços, como albergues ou centros pop. Sentem-se satisfeitos e gratificados, apesar de perceberem a necessidade de maior articulação com outros pontos da rede assistencial diante de atendimentos mais complexos ou específicos. Também enfrentam dificuldades para a redução de danos em várias dimensões como vacinação, saúde bucal e geral, saúde mental e prevenção e tratamento de doenças crônicas e infectocontagiosas. Emergiram duas categorias: Identificando ações desenvolvidas pelos profissionais da Atenção Primária e Enfrentando dificuldades e desafios no atendimento a essa população. **Conclusões**: é preciso ultrapassar preconceitos e conhecer a situação de rua para sua implicação nos cuidados prestados na Atenção Primária, apesar dos dificultadores. Capacitação dos profissionais e planejamento multi e interdisciplinar, em rede, concorrem para qualidade na captação dos indivíduos e sua inserção efetiva nos serviços de saúde.

Palavras-chave: atenção primária à saúde; pessoas em situação de rua; pessoal de saúde

Abstract

Introduction: the street situation phenomenon is a challenge for its understanding, dimensioning, various diagnoses and for the definition of strategies to face the conditions of

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vulnerability, including health conditions. **Objective:** to describe the actions developed by health professionals and the difficulties experienced in the care of the homeless population. **Methods:** qualitative research, based on interviews with health professionals of a Basic Health Unit in Belo Horizonte-MG, a reference for the care for this population. The content of the statements was analyzed by Bardin's reference. **Results:** the professionals identify actions performed, based on the systematized welcoming with a view to creating bonds and addressing the main health problems. They carry out necessary preventive actions and route or trigger other services, such as hostels or pop centers. They feel satisfied and gratified, despite noticing the need for greater articulation with other points of the care network in the face of more complex or specific care. They also face difficulties in reducing harm in various dimensions such as vaccination, oral and general health, mental health and prevention and treatment of chronic and infectious diseases. Two categories emerged: Identifying actions developed by primary care professionals and facing difficulties and challenges in serving this population. **Conclusions:** it is necessary to overcome prejudices and know the street situation for its implication in the care provided in Primary Care, despite the difficulties. Training professionals and multi- and interdisciplinary planning, in a network, contribute to the quality in the capture of individuals and their effective insertion in health services.

Keywords: primary health care; homeless persons.; health personal

Introduction

The phenomenon of homeless population (HP) refers to a group neglected in relation to public policies and strategies for facing it, a fact that is a challenge for several countries[1-2].

The difficulties for understanding this phenomenon begin in the definition itself, accepted worldwide and, at the same time, adapted to regional scenarios. Conceptual alignment is fundamental for HP censuses, analyses and data comparisons that allow the proposition of public policies[1-2]. In 2015, the Institute of Global Homelessness defines HP as a 'population without access to minimally adequate housing', a broader conceptualization that covers a larger universe of people[3].

The United Nations estimates 100 million people on the streets (PS) in the world[4]. Most of the PS is composed of men in their 50s, with low schooling, single and divorced, with health problems involving self-inflicted injuries, head injury due to loss of consciousness, epilepsy, tuberculosis (TB), mental disorders, alcohol abuse, tobacco and other drugs[5-7].

In Brazil, there is a significant increase in the PS composed of individuals excluded from society, without social rights, in poverty or poverty and in a degraded state of health[8]. The official counting at the national level is not performed, which reinforces the invisibility of this population and hinders the planning and establishment of public policies directed to their real needs. Nevertheless, the data can be known from estimates obtained by compilation, analysis and statistics of official figures collected by more than 5,500 municipalities. A study of the PS, conducted in 2020 by the Institute of Applied Economic Research revealed a growth of 140% from September 2012 to March 2020, something around 222,000 people, most of them (81.5%) is in municipalities with more than 100,000 inhabitants, mainly in the Southeast (56.2%), Northeast (17.2%) and South (15.1%)[9].

This picture composes a complex, multifaceted phenomenon, inserted in the capitalist logic and related to the social inequalities of distribution of income and social goods and to the exclusionary and inefficient economic policy. As a result, a history of hospitalizations in recovery and detention homes, orphanages and psychiatric hospitals is revealed, for mental suffering, TB, epilepsy and drug use. Therefore, 44% of individuals in street situation (SS) seek hospitals and

emergency services for their demands and 27% seek basic health units (PCU)[8,10-12].

A study conducted in Minas Gerais by the Citizenship Center of the Federal University of Minas Gerais, in 2020, based on data from the Single Register for Social Programs of the Federal Government, identified 18,011 people in SS, and 12 municipalities concentrate 70% (12,804) of this population, in a total of 853 municipalities[13]. In Belo Horizonte, 9,114 people were identified in the same situation, or 50.6% of the total state, which shows a significant increase when compared to the data of the third census conducted in 2013, in which there were 1,827 people in this situation. Most men (88%), aged between 31 and 50 years (67%) and brown or black (80%), which reveals the racial inequality present[13-14]. Among the main reasons that led this population to homeless conditions are unemployment (29.8%), family conflicts (29.1%) and alcoholism/drugs (35.5%)[15].

The conditions of vulnerability, in addition to psychosocial conditions that produce physical and emotional suffering, but inseparable from each other, represent a challenge for the implementation of health policies[4,11]. These conditions demonstrate that illness is a dynamic process and a reflection of the interaction between biological, social, cultural, economic, political and social determinants of health (SDH)[4].

Strategies adopted by some Brazilian municipalities for the health care of the PSR were the implementation of some policies, services and actions, such as popular street education and damage reduction projects (DR), at the end of 1980, in the city of Santos. The "*A Gente na Rua*" Program was added in São Paulo and Salvador in 1990[11,14].

In other municipalities, family health teams (FH) were established, based on the implementation of the FH Strategy (FHS), as a model of care recommended for the level of Primary Health Care (PHC), the gateway to the Health Care Network (HCN). This was the case of the municipality of Belo Horizonte, which implemented, in 2002, the first team of FS for PSR (FH-HP), followed by São Paulo, Rio de Janeiro, Porto Alegre, Curitiba and Recife[11,14-15].

In 2009, the National Policy for the HP (PNPSR in Portuguese), a national initiative for the recognition of the rights of the then defined group of individuals in economic, family and social vulnerability, without delimitation of a space of survival, was established and, in turn, uses public or welcoming places for their temporary and/or permanent stay[8,11,15].

The PNPSR, in addition to universality, equality and equity, proposes as principles respect for the dignity of the human person, the right to family and community coexistence, the valorization and respect for life and citizenship, humanized care and respect for social conditions and differences of origin, race, age, nationality, gender, sexual and religious orientation, with special attention to people with disabilities. It is also emphasized the various guidelines of this policy, which in addition to determining the promotion of civil, political, economic, social, cultural and environmental rights of this population, under the responsibility of the State for its elaboration and financing, requires that each level of government articulate and integrate public policies in its management scope.

Other important guidelines involve encouraging and supporting the organization of this population and its participation in the various instances of formulation, social control, monitoring and evaluation of what is implemented, respecting the specificities of each territory and taking advantage of the potentialities and local and regional resources in planning, implementation and monitoring of the respective policies, in addition to implementing and expanding educational actions to overcome prejudices and empower workers to qualify the care of this population[8].

The principles and guidelines provided for in the PNPSR are intended to guarantee the rights of individuals in SS such as broad, simplified and secure access to health, education, social assistance, housing, security, culture, sport, leisure, work and income services and programs. To this end, it must ensure the training and permanent training of professionals and managers to develop intersectoral, cross-cutting and intergovernmental public policies aimed at this situation, produce data and indicators that reflect the reality and that support concrete and objective proposals aimed at the needs detected. It should also be emphasized the importance of articulating the Unified Social Assistance System (SUAS in Portuguese) and the Unified Health System (SUS in Portuguese) to qualify the provision of services, its temporary reception structure and the implementation of specialized reference centers to this public[8].

The institution of social services and equipment such as temporary institutional reception and Pop Centers are also configured as achievements in SS, implemented from public policies. Hostels, shelters and crossing houses, members of the special social protection of high complexity of SUAS aim to offer comprehensive care and ensure conditions of stay, conviviality and reference address to welcome the HP, migrants and/or people from areas of geological risk[11,15].

The specialized reference centers for HP, also called 'Pop Centers', mentioned above, are municipal social assistance units that are part of the special social protection of medium complexity of SUAS, should operate on weekdays, but can extend their hours on holidays, weekends and night time. The 'Pop Centers' aim to meet some of the pressing needs of people in such a situation, i.e., the preservation of integrity and autonomy, the reduction of violations of social assistance rights, their aggravations or recidivism and DR caused by situations that violate rights. From qualified listening, it seeks to understand the social, cultural and historical context of each person, in addition to elaborating the individual and/or family follow-up plan.

These centers, as a reference space for group, social and the development of relations of affection, respect and solidarity, intend to contribute to the construction of new life projects, respecting the choices of users, enabling conditions of welcome in the social assistance network and promoting actions for family and/or community reintegration. Moreover, basic issues are also ensured, such as food, space for personal hygiene and the custody of belongings, when considering the identity and subjectivity of people to strengthen their role and social participation[11,15].

In addition to the PNPSR, we highlight the creation of the Intersectoral Committee for Following and Monitoring of the PNPSR, a space for dialogue between representatives of this population and those from various sectors of the State, as well as the establishment of the HP Technical Health Committee and the teams of street clinics (SCt) to improve the capacity to respond to existing needs. Likea, multidisciplinary support teams were defined, linked to the Mental Health Coordination (MH) and primary care, created to perform activities such as active search and care, in a itinerant way, to users of alcohol, crack and other drugs. All actions or activities must be carried out in a shared and integrated manner to the PCU and, when necessary, with psychosocial care centers, emergency and emergency services and other points of the Social Assistance Network (SAN)[11,15-18].

It is observed that, in some way, the HP is welcomed by the SUS, even in the face of supposed difficulties for care and follow-up by health or social care professionals and for the development of daily practices directed to such individuals.

It is essential to make emerge, from the health professional's view, the actions directed to the HP when considering their

singular characteristics, social vulnerability and health itself, in addition to identifying the possible difficulties experienced in this approach.

The results will enable discussions and propositions of health strategies and care directed to this group and may contribute to the qualification of teams with a view to greater articulation of the SAN, based on strategies aimed at this phenomenon. Finally, they will be able to optimize available resources, as well as identify other needs.

In view of this scenario, the study aimed to describe the actions developed by health professionals and the difficulties experienced in the care of the HP, from the perspective of the workers.

Methodology

Qualitative research on the actions developed by health professionals in HP care in a PCU. This approach considers the dynamic relationship between the real world and the individual, with emphasis on subjectivity, which does not translate into numbers[19-20].

The scenario was a reference PCU for HP care, located in the South-Central region of the city of Belo Horizonte, MG. The professionals of the FHt-HP and Oral Health (OH) for HP (OHt-HP), SCt and the FH supporting teams for this group were participated, such as psychiatrists, social workers, psychologists and nurses.

The collection of the statements occurred between May and June 2015, after approval by the Research Ethics Committees of the Medical Sciences College of Minas Gerais and the City of Belo Horizonte, under the numbers 954,096 and 1,041,652, respectively. Health professionals from this health unit with at least one year of experience in the care of the HP were included. Those on vacation or leave, or absent for any reason, were excluded during the information collection period. The selection of participants was intentional, because in qualitative research it is possible to select people who can contribute to the study, considered key informants and rich in information[20]. The sample consisted of 16 participants identified by letters and numbers, from P1 to P16.

A semi-structured interview script that allowed the free expression of ideas was used and included, in its first part, data related to the profile of the participants. The proposed leading questions included information on the health and intersectoral actions developed with the HP, the difficulties faced in daily life and that other professionals would be involved in the care of the specific public, in addition to the discrimination of the role played in such actions.

After the approach of the researcher to the PCU and the participants, the Free and Informed Consent Form was signed, in meetings scheduled by the manager in the unit, for the appropriate explanations about the project and its objectives. In these opportunities, the place and time for the recorded interviews were defined in the health service itself. Three students from the last year of the Nursing Course were present in the meetings that collected the statements under guidance and training of three teachers, two masters and a doctor, respectively. At each meeting, with an average duration of 20 minutes, only one student and the interviewee were in the room for data collection. Then, the statements were transcribed in full, parallel to the collection, and analyzed by the group of researchers, which allowed us to verify the saturation of the data in the interview of the 16th participant, not being necessary the inclusion of new professionals[20].

At the end, the material was read and reread in order to seek the convergence of what was exposed. The emerging themes for content analysis were identified, performed in the light of Bardin's[21] reference, a method that allows the study of what is contained in the messages expressed. For this, the initial

evaluation was made for the organization of the following steps, through the first contact with the statements. Next, the step of choosing and clipping the registration units, called the exploration phase of the harvested material. The third stage included inference and interpretation of the results obtained[21]. The steps described occurred with the presence of all researchers.

Results

The study scenario has 23 health professionals directly involved in the care of the HP. The criterion of data saturation involved 16 workers, 75% female and 69% with higher education, especially nurses and psychologists. Of the total, 50% of them have, on average, one to five years of work with individuals in SS.

Two nursing technicians, two community health agents (CHA) and a general practitioner participated in the FHt-HP. This team, at the time of the research, was out of date in relation to the professional nurse who retired and to two CHA who requested dismissal from the position. The OHt-HP is composed of a dentist, an OH technician, an OH assistant. Only the assistant did not participate in the research, because he was on medical leave. The other professionals participating in this study make up the FHt-HP support team, that is, two nurses, two psychologists, a social worker, a psychiatrist. The social worker, nurse and psychologist participated in the SCt. The damage reducing agent and the art educator did not show up on the days scheduled for the interview.

From the process of analysis of the collected statements emerged two categories: Identifying actions developed by PHC professionals and facing difficulties and challenges in serving this population.

Identifying actions developed by PHC professionals with the HP

Some actions highlighted by the interviewees are of general scope, others, more specific, according to the professional category or the team.

The professionals highlighted the identification and registration of the user, the monitoring and attendance of the HP during visits in the street territory as the moment when it is possible to perform preventive actions, verify the needs and identify the situations for referrals or activation of other services and equipment:

"We accompany the homeless person, register, send him/her to hostels, support houses and, when we come up with a patient, we call the ambulance and try to route to the UPA (referring to the Emergency Care Unit)." [P14]

"... disease prevention actions. Monitoring, diagnosis, data collection, identification for team monitoring. Need for clinical, dental, psychiatric or psychological care." [P5]

"We have support from the street approach, the Street Office, the Military Police." [P15].

Several actions carried out at PCU and other services were cited as the hostel and pop centers. Professionals perceive welcoming as the main strategy for building bonds. They investigated the past and present vaccination status and respiratory symptoms for the early detection of TB, as well as tests for the diagnosis of HIV and hepatitis:

"Visits ... to the hostel, the pop center, active search and approaches on the street." [P15]

"Reception, health education, rapid testing for HIV, syphilis and hepatitis B. Pre- and post-test counseling. Tuberculosis... happens a lot in street situations, because they are vulnerable, malnourished and live in clusters. When diagnosed, many abandon treatment. They are welcomed into the unit, we evaluate the demand and forward them. Social and

mental health issues are referred to the social worker. We also looked at the vaccination status." [P13].

"The team works hard with tuberculosis. We are aware of this fact." [P6]

The participants affirm that the form of reception of the HP enables dialogue, reflection and sharing the desire to leave the street. For the professional, it is necessary the ability to listen and sensitivity to the situation:

"This welcome allows people to reflect on the best quality of life. Many seek treatment clinics to get rid of drugs or employment to get out of the hostel, return to normal life and not get homeless. Because it's very sad." [P13]

One of the professionals of the FHt-HP emphasized the satisfaction for the care provided, for the possibility of helping, hearing and following life stories, in addition to gratification through the results:

"We accompany adolescents, pregnant women and the elderly who talk about their lives, it is satisfying to talk, to listen. It's gratifying to work with the homeless when you see the results." [P14]

However, the need to articulate the intersectoral network, due to the specificity of the HP and the demands beyond the health sector, was highlighted by the professionals:

"We work on intersectoriality. It's not just any population that has a health problem! It has issues linked to the social, associated with other services. You don't work separately." [P4]

The respondents revealed that identifying the demand of the HP and the necessary care actions makes it possible to activate professionals according to their competencies, in addition to multiprofessional interventions, in the face of more complex or specific care, in other points of the SAN:

"In more delicate processes that require medical follow-up, we trigger the doctor or nurse." [P14]

"

"We approach users, analyze demand. If the nurse is injured, he/she will bandage or refer her to the UPA, Health Center or Hospital." [P2]

The OHt-HP related oral illness and health in general, besides emphasizing care actions to reduce harm:

"We do all kinds of action inherent to dentistry. Health education, prevention, clinical practice and oral health promotion. Supervised brushing, prostheses.... we re-established the masticatory function. For them it is a possibility of social insertion. They say, 'I want to put on a prosthesis.. They want that, they want to leave the street, the drug, the alcohol, they seek social insertion and work. They seek odontology in this sense." [P3]

"I do oral hygiene of them, removal of tartar and polishing of teeth. I advise on health, personal and oral hygiene. I give a lecture and host." [P10]

The statements include the educational actions in health developed in external events that occur in public spaces, common places of permanence of the HP:

"We hold an action/event in Praça da Estação (referring to a public space in the city of Belo Horizonte). We talk about STDs (referring to sexually transmitted diseases), measured blood pressure, addressed health problems, and the dentistry team evaluates and guides." [P6]

Actions carried out by the MS team, such as support for FH-HP and SCt, were listed:

"Matrixing of cases with the teams and the social assistance network, which involves the street approach team. We thought about clinical care and the therapeutic project with the team leading the case, for the best individual intervention." [P1]

"We work intersectorally - social service, medical clinic, nursing, zoonosis and education, all participate in the elaboration of the singular therapeutic project, from each person. Mental health comes to listen to what has determined the

division of ties with each other and the choice to live on the street." [P12]

"I have been working on matrix support and case management with the Office on the Street team. A kind of clinical audit to organize a little and hierarchize care, in addition to setting priorities." [P7]

One of the SCt professionals recognizes its role in describing the work process and the actions developed:

"Our work is itinerant, we come across the individual using the drug, where he usually stays and ask if we can get there, if he agrees to talk. We work with damage reduction." [P8]

Other actions listed were those developed by one of the members of the CSt, the art educator, as a strategy of bond building and resocialization of the HP:

"... recreational activities, painting workshop, drawing and various other activities carried out on the street." [P2]

"... has the art educator who is extremely important as a team member. Assists in workshops on the street, with children and adolescents. I see it as a time to strengthen bond." [P12]

Actions related to the removal of this population to the PCU or emergency services, carried out by the professionals of FHt-HP or SCt, when visiting the HP in the street territory, were mentioned:

"Route to the health center..., in case of urgency and emergency we send him/her to Emergency Care Unit (UPA in Portuguese), we evaluate vital data ... we make small dressings." [P8]

The actions were related by workers from reception, identification, evaluation, to the most specific and others that permeate any of them, such as health education. However, even aware of the activities carried out, the difficulties that make greater the challenges to be faced were highlighted.

Facing difficulties and challenges in attending HP

Most interviewees revealed aspects of the HP profile that impact care, due to the difficulty in locating individuals and the pressure for immediate care:

"Difficulty of where to find the person and to continue the treatment. Sometimes he/she starts treatment and the person changes places." [P4]

"Another difficulty: they are immediate. They know they won't be here tomorrow, at that point, they want everything at the same time and they're always high or drunk. So if you set up another day... will come the difficulties of service." [P3]

"Tuberculosis has a higher incidence in this population. It is a great difficulty the profile, because it has little commitment to themselves. So being able to medicate daily and observe, for six months, is almost a miracle." [P11]

One of the professionals emphasizes that understanding the complexity of this population and the specificities of each case is crucial for care, but requires creativity and adaptation:

"Everything in the street population is specific, there is no standard for working. We deal with creativity because each one is unique. You have to discuss the case and see what best way to work with that person." [P4]

Difficulties pointed out by some interviewees are related to the existing barriers in the care of the HP, such as the understanding of professionals regarding the complexity of SS, moral discourse and interprofessional relationship, in addition to the organization of the service:

"We have difficulties with intersectoral work, the perception of other sectors about individuals in this situation... they have their own moment and don't give the same answer that someone else would give. Sometimes the network doesn't understand. And for the singular therapeutic project it is necessary to tune

in the team. Matrixing does not always occur as it should, or as we wish." [P1]

""Sometimes it is lack of professional profile or even the insensitivity of some areas. Sometimes it is a lack of more constant maintenance of teams, since the turnover of human resources is high. In addition, the service hours of some areas, eventually, do not coincide with that of the HP. It takes the connection of the two teams (referring to FHt-HP and SCt)." [P7]

"The greatest difficulty is the moral discourse that goes through care... we have to get past that to see the individual who needs care, without a pre-concept." [P12].

"The way this user is received at the health center, it is also a difficulty. If he/she thinks he/she hasn't been well received, he doesn't want to come back." [P8].

The difficulties listed involved from the location of individuals in HP to the pressure for care, which requires creativity, adaptation and understanding of specificities. Obviously, it is necessary, in the view of the respondents, to free themselves from prejudices to overcome the barriers to health care.

Discussion

At the time of the study, 1031 people in HP were linked to FHt-HP. Of the total, 946 (92%) men and 943 (91%), aged between 20 and 59 years. In the experience of health professionals who serve this population, the most common issues highlighted involve mental health, use and abuse of licit and illicit drugs and infectious diseases. Government data corroborate the findings by pointing out that the main problems of illness in the HP are mental disorder, alcoholism, smoking, TB and AIDS[15].

The results showed the actions performed in the territory/domicile-street, through the "street visit", and this space is pointed out by the literature as the place of permanence of individuals, point of fixation and where they are found[10-11]. In these places, the actions of disease prevention and identification of more complex situations with proper referral were highlighted, when necessary. It is perceived that the professionals consider the place of fixation of individuals as a starting point for health care.

In the service of the HP identify and register are essential tasks that enable information and knowledge of the social context and such activities have the support of other teams or institutions such as the art educator and the military police, for example. Health problems, access to services and institutional reception emerge, in addition to the scarce material and human resources that allow a diagnosis about this population. Such actions, recommended in the FHt, are performed by the CHA, which links users/families to the FHteams[11,15,22-23].

Other actions on the street are carried out by FHt-HP, SCt and MS team, with emphasis on Involuntary Driving for Examinations and Care (CIEC in Portuguese), approach strategy and referral to a reference service for people with acute clinical or mental picture at risk of life. The actions are discussed and programmed and the responsibilities for each professional/service are defined, according to the case in question[11], as can be evidenced in the results.

The reception was emphasized for the reach of the HP and his/her linkage. It is a technology of relationship and qualified listening, either in the PCU or in the street territory to start the follow-up, understanding the demand of individuals and their insertion in the SAN, with a view to care resolution. Welcoming enhances the therapeutic process by the relationship of affection, trust and bond and requires a professional profile and willingness to such ability[11,15,22-23]. The results also showed that welcoming, as a strategy of linking and consolidating the therapeutic process, in the professionals' view, enables dialogue

and reflection on being on the street or the desire to leave the street.

In relation to the most common pathologies, concern with TB in HP and its early identification emerged. Health professionals identify the low self-esteem of individuals in SS and the little commitment to it that could sustain treatment adhering. In fact, the incidence is higher in this population, with 48 to 67 more times more likely to get sick compared to the general population[11,15]. Identification, follow-up and treatment until the cure of the disease are the actions recommended by the Ministry of Health, with PHC being the gateway and privileged place for its execution[11,24].

The proposed goals for TB control in Brazil are 85% of cure of new cases of the pulmonary form, dropout rate below 5% and detection rate above 70%, so that it is possible to reduce the incidence around 5% to 10% per year. However, for the specific group, they are difficult goals to be achieved by irregularity and treatment abandonment[25-26]. However, even in view of the difficulties to find individuals during the time necessary for the use of tuberculostatics and for their own treatment support, the teams, in the researched scenario, bet on the desire and commitment of the HP in the search for health, which has made it possible for some to discharge for TB cure, recognized as 'almost a miracle'.

Studies show the potential of integrated and coordinated teamwork, with the exception that management support regarding human and material resources is fundamental, in addition to training for care[23,26]. The results showed the importance of such support, both by the PCU manager and the institution itself in promoting continuing education, with professionals, which includes themes related to the specificities of the HP, that develops the creativity necessary for health services to reach the population in their place of fixation and that consider the specific social and epidemiological profile. This would represent the effectiveness and efficiency expected for the public thing regarding the care of individuals in SS.

Perhaps for this reason, the personal satisfaction and gratification of professionals in the care of the HP were revealed by the empathy and bonds established due to a humanized and affectionate relationship that positively impacts the results of health actions. For some authors it would be the axis of the care process focused on the specificities of the individual. This is due to listening, dialogue and support, in addition to the willingness to welcome and meet needs, with the appropriate and resolutive direction in the SAN. A challenging and rewarding experience[23,26]. Helping, hearing and following life stories involved the care provided to individuals in SR and were perceived as a reward for the respondents who, in one way or another, have their work recognized not only by themselves, but by the assisted population.

For professionals, however, networked work is fundamental considering the SDH that impact on the health of this population and other demands, in addition to health issues, with emphasis on economic and social issues. Alignment of health, education and social care strategies and resources has been considered potentiating care, given the complexity of the demands of the HP[22-27]. It becomes possible to intervene in a problem-solving way on health problems and promote a greater integration of this population in the service network[12,22,27-28.] In fact, the results indicated flaws in the articulation of the intersectoral network in the care of the population with so many specificities. It would be necessary, in addition to the muti, interdisciplinarity, in order for the competencies to return to a common objective.

It is substancially defended to consider the importance of a primary care provider, a health service and professionals in the reference PHC, who are coordinators of care as provided for in the National

Primary Care Policy, the attributes of PHC and the FHS itself and, especially in the case of the HP, when considering that such level of health care should be the user's entry into the SAN. The experience of the participants, in this study, points in this sense, and it should be considered that with the decentralization of actions aimed at HP, provided for in national and municipal policies, people in SR should be assisted by professionals from the PCU of the street territory where they settled. The referral of individuals to other points of the network should be based on an articulated and integral care vision[7,11,27,29]. Health professionals consider that HP is not just any group that can be worked on 'separately'. The actions should be thought, organized, planned and interconnected between PHC teams as well as other points of the SAN.

In fact, the insertion of OHt in the FHS, for example, for HP care is fundamental, especially, with users of inhalant drugs. Activities performed in the PCU or in the squares, such as oral hygiene guidelines, distribution of oral care kits, prophylaxis and clinical treatment allow the rescue of self-esteem and self-care[30]. These were activities evidenced in the results for DR, a clear concern of professionals when considering the human being in its integrality.

The interviewees recognize the relationship between OH and general health, especially in view of the high social vulnerability and precarious hygienic conditions and use each opportunity for health education in general, in addition to tooth care, tartar removal and use of prostheses, when indicated. In fact, the deficiency in self-care and knowledge about OH reflect on the non-ownership of toothbrushes and reveal once again the cruel face of social exclusion[31-32]. On the other hand, oral rehabilitation, which includes the restoration of masticatory function, was pointed out and recognized by professionals as a demand of individuals for social reintegration and abandonment of drug use. In this sense, some publications indicate that the search to improve the OH condition is related to self-perception about one's own state of health and the desire for reconstructed functional dentition for the 'resumption of life'[32-33]. It is still an occasion for the examination of socioeconomic and psychosocial issues that are related to the intentions of this population to take care of themselves. In addition to creating bonds, contributing to the citizenship and social reintegration of the PSR and expanding access to OH services[11,32].

Educational practices, as a strategy to promote health and prevent diseases, were cited and should promote access, provide opportunities for the participation and protagonism of the HP, besides enabling the discussion of important topics to its context and needs[30]. The educational actions described included lectures, measurement of vital data and approach on various health problems that occurred both indoors, in the PCU, and in public squares and other places, used to stay in the HP. It is clear the perception of the participants that health and health education should leave the PCU and meet with individuals in HP in the place where they are fixed, usually. Therefore, it is necessary to incorporate methodologies adapted to the complexity of social life, capable of promoting discussion about SDH, which favor protagonism and empowerment[34].

The respondents of the MH team revealed actions that go beyond clinical care and support to FHt and SCt, which include matrix support, case discussion and elaboration of a singular therapeutic project (STP) carried out by professionals from various sectors (health, education, surveillance and social assistance). Again, multi and interdisciplinarity were highlighted.

The STP refers to a set of proposals for articulated therapeutic actions for an individual, a family or a group, elaborated from the collective discussion among professionals of interdisciplinary team, in

matrix support activities. It is a tool of co-management and shared care, based on the definition of common objectives and the establishment of correlated tasks and agreed as a team. It develops in four moments, namely: diagnosis, goal setting, division of responsibility and reassessment, usually proposed for the most complex cases[35-37].

Matrix support, also called matrix support, beckons for an 'organizational arrangement technology' that enables technical support of specialized areas with PHC teams. It is characterized by the multi-interdisciplinary relationship between FH teams and support, and is configured in the technical-pedagogical and care dimensions. The first includes joint actions between professionals of the teams and support that can occur during the discussion of topics and/or from individual, home, collective activity and actions in the territory, in a shared way. The care dimension refers to the direct interventions of the support teams with the users, according to the specificities of the category, which can occur individually or collectively. In addition, matrix support can be an important strategy of continuing education, considering the opportunity to share knowledge and practices that stimulate learning-to-do together[35-37].

Thus, matrix support occurs from joint and shared care between a supporter/specialist and a reference team, as a transformation tool that expands the integrality and co-management of care, universal access and individualized treatment, in addition to increasing the scope of actions and the problem-play capacity of PHC[35-37]. Expressions such as 'individual' and 'from each person' could be observed in the statements and denote the respondents' view of singular care.

Thus, matrix support favors overcoming the fragmentation of knowledge, expanding the capacity for analysis and the action of professionals towards the co-production of health and the autonomy of the matrix teams and the target individuals of care[35-37]. Specifically, the participation of the MH team brought about subjectivities of the life context of the HP, from listening, with the help of the street approach team and understanding about what would have determined or contributed to the division of ties, motivations and the choice of life on the street.

The SCt, in turn, are the bridge between the HP and the PHC teams, in the face of actions for DR and that strengthen autonomy in various scenarios on the street, especially in relation to drug use[11,16,17]. Reducing harm, a role recognized by participants, represents a strategy for people who want and fail to reduce/stop drug use, in order to minimize the damage generated by abuse. Aspects inherent to drug use and its influence on health, the resumption of self-care and social life, with a shift of focus from the drug to the focus of life, are worked.

The scenario of performance of SCt can be both where the HP stays most of the time on the street, considered as a place of fixation, and the circulation of this population, and several actions often need to be articulated with other points of the SAN and/or with institutions of education, work and social promotion[10-11,16-17,28,38-39]. This scenario of fixation of the HP was recognized by the professionals as the best place for the itinerant performance of the FHt-HP and SCt, which allows to approach those who wish to at least talk. From there, bonds can be formed in this form of welcoming.

However, there are weaknesses when seeking DR, as it implies integrated commitment and preparation of health workers, involvement of the individual and financing for team maintenance[30,38,40]. The results show the activities performed, such as games, painting and drawings that require a certain logistics and training of instructors to achieve the objectives. Research shows that painting, games, dance and music are resources that make it possible to work on unexplored emotional

content. In addition, incentives to new perceptions in relation to the environment and to him/herself are added, the collective construction of meaning that enhances individuality, stimulates autonomy and empowerment, and contributes to social inclusion[41-42]. Although the activities mentioned can be developed by the team in general, in the scenario of the present study, they are performed by the art educator.

The results found and corroborated by the literature, in relation to the health services most sought after by the HP, highlight those related to urgent and emergency care. However, there are difficulties in serving this population due to the lack of training and prejudice. Deficient infrastructure and inadequate locations for post-hospital discharge are also evidenced[7,11,43]. In order to face the situation, it is urgent to invest in multi-professional and intersectoral primary care actions. The literature also demonstrates positive impacts on the health of the HP, with reduced use of emergency services, in the face of ease of access to services, establishment of bonding and engagement to care and self-care actions[27,29,43]. While recognizing possible prejudices, the interviewees emphasized the need to break certain paradigms to universalize health care in its true sense.

Among other difficulties, the results highlighted those related to the follow-up of the HP, due to their specific profile and the desire for immediate care. The professionals, in turn, realize that in the face of the delay in meeting the demands, the opportunity for health promotion and disease prevention is lost. The same problems are mentioned by other researchers as lack of fixed address, high mobility and displacement and absence or low treatment adhering, which are challenges for care[11,22,44]. There is no single way of approach and follow-up, and it is essential to understand its specificities, discuss as a team and share possibilities. It is noteworthy that the care process should not be cast and standardized, and adaptations are necessary, in addition to creativity, as evidenced in the results.

On the other hand, different perceptions of participants in relation to the HP contribute to the difficulty of engagement and accountability for care to this population. It is pointed out the existence of many personal and structural barriers that hinder or prevent access of marginalized groups to primary health care[22,44]. Inadequate profile to work with HP, the high turnover and moral discourse that guide the practice of health professionals in various services hinder the matrixing and effective construction of STP. Other studies also add the difficulty in building bonds, the precariousness in the organization of the service, the requirement of documentation and the non-recognition of the HP as individuals with rights like any person[22,28,44]. The participants recognize the actions performed, but, at the same time, identify the personal, team and managerial difficulties to achieve the proposed objectives and greater effectiveness in the responses to the individuals attended.

Finally, it is important to shape a profile for those who serve individuals in SS that includes ability to form bonds, comprehensive vision, ethical guidance, willingness to listen, sensitivity and dexterity for communication. Competencies capable of identifying the real needs of the person from the perspective of comprehensive care[22-23,26], highlighted in the results found.

This is said to be the importance due and required in relation to knowing each place of action and the population served to establish care that makes a difference in the individual context and in the health of the population as a whole. The clearer and broader the diagnosis and the more permeable the SAN, the deeper the scope of actions and the more easily difficulties will be overcome.

Conclusion

Knowing the actions developed anywhere in the world where there are people in street situation has, as implication for the practice of health care, the look that considers the differences, respects autonomy and individual demands. The actions developed were recognized by professionals, even in the face of difficulties that exist and will always exist, but the adequacy of work processes is now claimed in relation to the professionals training and optimization of the actions performed.

The planning of what needs to be carried out with a view to disease prevention should consider integrated, multi- and interdisciplinary care and, most relevantly, always in network. It is emphasized that the approach in the context of life is an experience that facilitates the bond.

Although the results of this study point to positive aspects, successful in the care of HP, built over years of experience with this population, there are still problems to be faced, clearly described and that demand its management, preferably shared.

The study has limitations because it was carried out in only one PCU, although it is a reference unit for the HP, however, qualitative research does not seek the generalization of results. What was sought was the experience of health professionals in the care of individuals in SS. However, new studies that address more specific issues related to SS, such as the individual perception of those involved, their family relationships for health care or, even, the central axes of network training could contribute to other strategies of care, capture, insertion and linking of these individuals in health services around the world.

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