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Research Article

Perspectives on the health care of homeless people

Perspectivas acerca do cuidado com a saúde das pessoas em situação de rua

Perspectivas sobre la atención de salud de las personas en situación de calle

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Abstract

Introduction: Homeless people (HP) are daily subjected to significant risks, among which those related to health stand out. Objective: To discuss the main issues related to the health care of HP. **Methods:** Theoretical research was carried out based on the reading and assessment of current texts and documents concerning the topic, in order to highlight (1) the key concepts presented and (2) the developed argumentation. **Results:** This endeavor considered (1) the concept of health-disease and the health needs and demands of these populations; (2) public policies and the role of services in the health care of HP; and (3) the role of Primary Health Care (PHC), with emphasis on the work of the Outdoor Clinics Program. **Conclusions:** This reflective-critical systematization sought the delimitation of elements of the legal-social and ethical-political apparatus that involve the processes of expansion of health care to such users.

Keywords: Homeless persons; Health services needs and demand; Primary health care; Health policy.

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Resumo

Introdução: As pessoas em situação de rua (PSR) estão submetidas, cotidianamente, a significativos riscos, entre os quais se destacam aqueles atinentes à saúde. **Objetivo:** Discutir as principais questões relativas ao cuidado à saúde das PSR. **Métodos:** Realizou-se investigação teórica a partir da leitura e apreciação de textos e documentos atuais dirigidos ao tema, a fim de destacar (1) os conceitos chave apresentados e (2) a argumentação desenvolvida. **Resultados e discussão:** O caminho percorrido em tal empreitada considerou (1) a concepção de saúde-doença e as necessidades e demandas de saúde dessas populações, (2) as políticas públicas e o papel dos serviços na atenção à saúde da PSR e (3) o papel da Atenção Primária à Saúde (APSD), com ênfase no trabalho dos Consultórios na Rua. **Conclusões:** A sistematização reflexivo-crítica empreendida buscou a delimitação de elementos do aparato jurídico-social e ético-político que envolvem os processos de ampliação do cuidado de tais usuários.

Palavras-chave: Pessoas em situação de rua; Necessidades e demandas de serviços de saúde; Atenção primária à saúde; Políticas de saúde.

Resumen

Introducción: Las personas sin hogar (PSH) son sometidas diariamente a riesgos significativos, entre los que destacan las relacionadas con la salud. **Objetivo:** Discutir los principales temas relacionados con la atención de la salud del PSH. **Métodos:** Se realizó investigación teórica a partir de la lectura y apreciación de textos y documentos actuales dirigidos al tema, con el fin de resaltar (i) los conceptos clave presentados y (ii) la argumentación desarrollada. **Resultados:** El camino emprendido en esta tarea consideró (1) la concepción de la enfermedad-salud y las necesidades y demandas de salud de estas poblaciones, (2) las políticas públicas y el papel de los servicios en la atención sanitaria del PSH y (3) el papel de la Atención Primaria de Salud (APSD), con énfasis en el trabajo de las clínicas de la calle. **Conclusiones:** La sistematización reflexiva-crítica emprendida buscó la delimitación de elementos del sistema jurídico-social y ético-político que implican los procesos de expansión de la atención a dichos ususrios.

Palabras clave: Personas sin hogar; Necesidades y demandas de servicios de salud; Atención primaria de salud; Políticas de salud.

INTRODUCTION

The present essay results from a research carried out in the Graduate Program in Public Health of Universidade Federal Fluminense (PPGSC/UFF), aimed at reflections on the health care of homeless people (HP), especially within the context of Primary Health Care (PHC). In order to ponder about such reflections, it became necessary to direct the discussions to the subjects' perceptions of:

1. Their healthcare practices;
2. The meanings of health and illness; and
3. The needs for access to health services.

In fact, from the perspective of *recognizing the place in the world of these users* of the Brazilian Unified Health System (SUS) — in this case, the HP —, their own notions of health care must be taken into account, consisting in an element of analysis of health practices and a resource for the legitimation of public policies.[1] The search for this new configuration stems from the to affirm the human being as the center of ethical-political initiatives, manifested as a dimension of health care.[2]

The realities of HP are marked by numerous social vulnerabilities, related to a continuous historical process of social exclusion. Therefore, new configurations for health services must be sought, which correspond to the genuine commitment to providing health care for these oppressed subjects.[1,3] Thus, pondering about new references requires a recovery of the constitution of public policies, laws, guidelines, and service organizations that provide for healthcare practices in such a way to meet the demands of HP, in addition to deepening the analysis of the concepts of health care of this population as a way to assess the potency of this dimension.

Based on these preliminary considerations, the scope of this manuscript is:

1. To present the concepts related to the health-disease-care processes — with emphasis on the population's health demands and needs; and
2. To discuss the ways in which these factors are related to the production of health care and the organization of services and networks for articulating healthcare practices.

To do so, the following aspects are discussed: the role of healthcare services; the implementation of public policies that guide them; and the theoretical elaboration concerning the practices of the services of *Consultório na Rua* Program (Outdoor Clinics Program – CnaR, which provides healthcare assistance for the street population), at the core of PHC.

Concepts of health-disease and health needs and demands

Concepts of the binomial "health-disease" and health problems and needs, which consist in conditions and conditioning factors in this area, vary depending on the contexts in which they take place. In addition to its etymologies and meanings, there must be a broad perspective that considers the phenomenon expressed in its most diverse aspects simultaneously.[4]

The understanding based on the anthropology of health and disease can be considered particularly significant, as:

1. It enables dialogue about the multiplicity of elements that involve this event; and
2. It provides an opportunity to discuss health policies that are less segregationist and more suited to the needs of economically disadvantaged classes, understanding individuals and their displacement through healthcare sectors:[5]

> The concept of health reflects the social, economic, political, and cultural circumstance. In other words: health is not the same thing for everyone. It will depend on the time, the place, the social class. It will depend on individual values, on scientific, religious, philosophical concepts. Similarly, this can be applied to diseases. What is considered a disease greatly varies.[5] (Free translation)

The term "health" also involves a scientific and philosophical bias, as it constitutes a complex object — conceptually elaborated and empirically apprehended —, analyzable and perceptible, in view of its effects on the subjects' living conditions. As an object of knowledge and enabler of transformations, it presents several recognized facets: phenomenon, metaphor, measure, value, and praxis.[6]

Such characterization concerns the analyses that include reflections on the term. One of them is the contribution of Santos,[7] an author who assesses the existence — or not — of the concept of health. When this author states that "seeking health is not only a matter of survival, but rather of qualification of existence"[7] (free translation), it becomes evident that beyond contextualization, at the core of social logic, health must be conceived upon a focused perspective:

a) the proper meanings — that is, beyond the foundation of the cure or the mere relief of some discomfort; and
b) the adversities of the very existence deemed healthy and possible for different subjects.

The complexity of the term "health" is closely associated with that expressed in the word "disease." Both concepts involve, in their meanings, the social and individual spheres; moreover, they concern the biological dimension of existence, but also the reality historically constructed by different actors.[8] Indeed, it is imperative to reflect on the ways in which people experience health and disease and on the formulation of meanings and of the practices related to such binomial. Therefore, the individuals' narratives, their subjectivities, and the polysemous character of the discourses on illnesses must be considered.[9] Thus, thinking about the health-disease process implies, firstly, analyzing the living conditions of the subjects, their biographies, the historical-social-environmental determinations, and the contextual influences that interfere in their ways of perceiving their own body. Furthermore, it presupposes the identification, or not, of the healthy elements and the determinants of illness. This observation takes into account the consideration of the social production of health and disease, whose attention is focused on the relationships between the conditions in which it is manifested.[10]

This questioning is aimed at configurations that do not consider health problems in their entirety — made "visible" in the individuals' narratives — according to their different conditions.[11] It is, therefore, the hegemonic logic, based on the biomedical model, according to the which, for all intents and purposes, health and disease are reducible to the organic domain.[10] Otherwise, thinking about the health-disease binomial should encompass the scope of people's living conditions, beyond the manifestations inherent in the physical body.[9] Thus, the need to establish contact with the individuals' living subjectivities, relationships, and contexts is evidenced. This is only possible when approaching these perceptions and genuinely understanding the representations of each person's experiences about themselves, as well as their ways of being and being-in-the-world, considering the complex articulation between individuality and collectivity.[12]

Moreover, one must acknowledge that the manifestation of subjectivity permeates a certain expression invoked by the idea of normativity, according to which the relationship with the body is subsumed into a set of rules and lifestyles, which does not allow the subject to autonomously take action.[13] In other words, pondering about concepts of health and disease requires considering the social standards to which people are continually submitted.

Taking this into account — and resorting to the initial discussion —, it can be considered that health and disease represent a binomial that cannot be explained solely by the biological dimension, nor by philosophical, scientific, and existential perspectives. It especially and also refers to cultural events, historically constructed in different ways, in different societies, in such a way that this pair of concepts must be necessarily analyzed from a social point of view, that is, as a fact that occurred in society and that was experienced by the individual.[8]

Indeed, the present investigation is based on a multiplicity of views to think about the current phenomenon of health care for HP. It is worth highlighting some of the elements that compose the determinants of the health-disease process in this population. In fact, some situations should be considered as "participants" of such a binomial, such as the circumstances of unemployment, family destructuring, low level of education, limited access to public services, low level of community articulation, and lack of opportunities (perhaps, hopelessness).[14] These are aspects that can be identified in most HP. It becomes paramount, then, to dimension the health needs that shall be addressed/met for the proper organization of services.

Furthermore, it is essential to use these aspects as guiding elements for investigating how the concepts of HP interfere in their lives, especially in terms of the impacts on the performance of health services, in the context of public policies and the SUS. Ultimately, it is about organizing health care in order to guarantee the exercise of citizenship, ensured by the current legal system. These reflections are extended — and complemented by — to the question regarding the perception of health problems, their peculiarities and influences, as these elements intervene in the explanatory capacity of the phenomena, related to the health-disease process, which allows greater effectiveness in seeking greater attention to the needs of the population.[15]

In this context, the problematization of what can be considered a health issue and how its understanding encompasses considerable complexity is highlighted:

> “[...] what is a problem for some people may not be considered a problem for others. The perspective of health problems, therefore, varies depending on the position of different subjects in the structure of social relations, being part of their ‘worldview,’ their culture, their political projects, their utopias [...] In this sense, the identification of the population’s health issues and needs has to assume, or intend to assume, a ‘polycentric perspective,’ identifying the several subjects and their position in the ‘power structure’ of health.”[16] (Free translation)

This statement points to the subjects’ autonomy — while true experts in themselves and their health care —, in addition to demonstrating how it is necessary for them to be recognized, regarding their abilities, as the ones who can indicate what their health problems and demands are. In this case, it is assumed that health needs are represented by the culture, values, projects, and desires of individuals who seek services (for example, those offered by the SUS).[15] This is a perspective that must necessarily consider the encounter between those who demand and those who provide care in addition to the meanings developed in this process.

In the context of Public Health, this perspective is consistent with the composition of SUS, as considerations about the determinants and conditions involved in the health-disease process are circumscribed in health practices. These are elements that substantiate the exclusion of a considerable part of the population from the economic system, with the production of social interactions nuanced by individualism, consumption as the achievement of social status and prestige, and competition.[17]

Concepts of health are also established based on human-human and human-environment relationships.[18] In other words, both the exchange between subjects — their life experiences and the relationships they establish with others — and the territory to which they relate and that significantly influences the individual and collective ways of life, allow the composition of aspects that interfere in their health-disease status. In this domain, a factor inherent in the logic of health care is the contact with their realities, their individual and collective conditions of existence, their ways of being and being-in-the-world. For this reason, thinking about health care ratifies the existence of broadened needs, considering complex actions, in addition to merely curative ones.[19]

This analysis instigates thought by continually re-signifying conventional and protocolar healthcare modes, in favor of expanding the perception of the health-disease-care process as an element that dialogues with real healthcare needs, and not only with actions aimed at “compulsory and immediate improvement” of a given illness. Thus, the analysis takes on a new meaning, one that comprises health care longitudinally and carefully carried out in a welcoming way in relation to what each individual and the collective demand.

Therefore, the analysis of contexts is broadened in terms of a dimension that encompasses the encounters of the population — and their cultures — with healthcare providers in health services; that is, the issue of health care is recognized beyond the quality of diagnosis and treatment. Indeed, it is about developing actions that allow reaching a level of depth that includes the worldview of those who need support.[20] Furthermore, the unpredictability of what shall be disclosed as an event in these encounters is inevitable. To remedy it, the constant articulation between those who dialogue with users and other actors who are also involved in this process becomes necessary. Therefore, it is essential, for this process to be sensitive to what is produced in these encounters, to find ways of cooperation between health and other government policies, in such a way that an intersectoral action takes place.[15]

Public policies and the role of services in the health care of homeless people

Thinking about the health system and the provision of healthcare services to the population requires evaluating the way in which the concepts of health and disease — and the associated health needs — are connected with the broadened health care that is expected and recommended by the principles and guidelines of the SUS. Hence, there is a relationship between the health system and the social dynamics that constitute the social values regarding health protection, which is broadened according to the social understanding of ways of coping with the illness process.[21]

Taking this into consideration, it is possible to understand that, for the consolidation and legitimacy of this system, a political-legal circumstance is necessary, which establishes the need for the implementation of public policies that guarantee the fundamental social rights of any citizen in addition to providing support to socially-excluded individuals. This is a category understood by the process of distancing and weakening the participation of such people in social relationships, given the difficulties in effectively exercising their citizenship, in their contexts, in terms of rights, duties, and participation in political-social decisions.

Nevertheless, the focus of Public Authorities on HP is still very recent and results from several struggles that took place in favor of social aspects and rights. The disinterest in these populations, still present in the State, demonstrates the contradiction of both actions and public opinion on the subject, in positions that alternate between pity, concern, and welfare and repression, prejudice, and indifference.[22] These nuances precisely demonstrate this neglect and lack of social protection initiatives, on the part of the State, that satisfactorily address HP subjected to different vulnerabilities and risks.

The National Policy for the Homeless Population (*Política Nacional para a População em Situação de Rua* – PNPSR) was established by Presidential Decree No. 7,053 of December 23, 2009, and it was implemented in a decentralized way as an action to legitimize the existence and guarantee the rights of HP. This policy ensures the health care of HP, including assistance and accommodation services present in the territory.[23] There was also the advance brought by the Intersectoral Monitoring Committee, with the same decree, in addition to achievements arising from the publication of the Health Operational Plan for the Homeless Population (*Plano Operativo de Saúde para a População em Situação de Rua*) and the implementation of the Outdoor Clinics Program, which provides for, in Section 4 (which guides the objectives of this study), the establishment of strategies to strengthen participation and social control as essential for defending the rights of HP.[24]

In light of this reality, the implementation of the Organic Law on Social Assistance (Law No. 8,742 of September 7, 1993) ratifies the task of the Public Authorities, given the recognition that social assistance is a citizen's right and a State's duty. Indeed, healthcare services and programs aimed at HP must be maintained, providing the social minimums through actions of public initiative and society.[25] Thus, social projects and other initiatives focus on addressing the growing demand of this population.

It is worth considering that the National Health Promotion Policy (*Política Nacional de Promoção da Saúde* – PNPS), established by MS/GM Ordinance No. 687, of March 30, 2006, represents:[26]

> "[...] a transversal articulation strategy in which visibility is given to the factors that put the population's health at risk and to differences between needs, territories, and cultures present in our Country, aiming at creating mechanisms that reduce situations of vulnerability, radically defend equity, and incorporate social participation and control in the management of public policies."[26] (Free translation)

In addition to the legal apparatus — and associated with it —, social movements play a significant role in the discussion on human rights and other aspects linked to HP citizenship. The protagonism of this discussion takes on new meanings with the advent of the Homeless Workers Movement (*Movimento dos Trabalhadores Sem Teto* – MTST), which inaugurates a social movement with solid political achievements in terms of popular housing, through the occupation of public spaces and the struggle for regulation.[27] In 1990, homeless people were recruited by the Landless Workers Movement (*Movimento dos Trabalhadores Rurais Sem Terra* – MST) to participate in their camps and rural occupations and gained support from civil society entities.[28] Later, according to the booklet on the formation of the National Street Population Movement (*Movimento Nacional da População de Rua* – MNPR), the protagonism in this struggle for rights focuses on the emergence of this movement, primarily in the cities of São Paulo and Belo Horizonte, with subsequent repercussions in other Brazilian regions. In 2008, it found representativeness in the National Council for Social Assistance (*Conselho Nacional de Assistência Social* – CNAS) and its organization and political practice are guided by the following principles: democracy, appreciation of the collective, solidarity, ethics, and groundwork; and its agendas are: retrieving citizenship by means of decent work, sufficient wages for supporting oneself, decent housing, and health care.

Despite these experiences, there is still a restricted character of agglutinating social movements that were able to give due visibility to the human rights of HP.[22] This can be inferred from the experiences of some movements, which persist in the struggle through social mobilization, in the incessant search for guarantees of rights and citizenship for these people, establishing this social space for dialogue and articulation. However, it is noteworthy that, in the current moment of crisis in the country, the actors who are open to creating these exchanges and negotiations compose a still unusual field of discussion, a factor that discloses the invisibility still linked not only to HP, but also to those who struggle for — and with — these people.

In the core of this social and political context, it is necessary to pay attention to the way in which services play their role in health care, in view of the progress arising from the legitimacy of rights and citizenship historically achieved. And, as they perpetuate, solidify, or dissipate the ways of meeting the health needs of different populations, their actual demands and concepts of health-disease, as well as the consonance or dissonance of the actions of the network in relation to the overlapping of all these issues of interest for the analysis of these attributions.

Indeed, one can analyze the complexity of the healthcare field based on Caponi's statement:[29]

> "[...] evidencing that the scope of statements, the scope of discourses, is in permanent intersection with the non-discursive, institutional scope. That is why the acceptance of a given concept implies much more than a statement, it implies directing certain effective interventions on the subjects' bodies

> and lives, it implies the redefinition of this space from which administrative control of the health of individuals is exercised."[29] (Free translation)

Therefore, it is worth considering the role of services and the work of professionals — aiming at going beyond the biomedical, protocolar, and segmented logic — by making themselves available to users' health care. And, instead of — or in addition to — this —, to strengthen a concept of care that comprises what is established in the subjects' discourse and bodies, in their concepts of health-disease, in their life stories, as well as in what they consider as actual health needs and demands.

Considering what the expression of health care advocates — manifested by health policies, programs, and services — and in line with the principles and guidelines of the SUS, there is a close relationship with health care as a strategy of the system and care practices.[30] It is expected that every system of healthcare services has as its main goals: optimizing the health of the population; indicating the causes of illnesses and disease management; and minimizing disparities between population subgroups (in which HP are inserted), in such a way that there is no systematic disadvantage in terms of accessing and reaching these services. This premise summarizes their responsibility towards their users regarding access priority, regardless of their different conditions.

In this sense, analyzing healthcare services consists in an idea pondered by Almeida-Filho, who stresses that "it is necessary to question the meaning and place of personal, professional, institutional, and social practices that, in an articulated way, shape the spaces in which health is constituted"[6] (free translation). Such practices influence and are influenced by the dynamics of people who need health care — and by all the complexity inherent in them — in favor of access and availability of services, considered from the perspective and concept of users themselves.

The use of these assumptions allows actively listening to people seeking health care, taking into account their needs as the center of interventions and practices. This takes place through the indispensable appropriation of discourses freely presented by users, which are marked by their own concepts, which are not necessarily limited to the logic of specific and merely technical assistance, which can become merely directed to an isolated complaint/demand. These considerations ratify the importance of subjectivity as an inalienable premise of users and health workers, enabling to expand actions of a restricted and technical nature towards a deeply compassionate work of social interaction.[31] The provision of health care implied and permeated by the user's life story is proposed, valuing their authorship and autonomy in their care process and their connection to the service, considering "the decision, freedom, and participation, which are the fundamental elements for the performance of self-care"[32] (free translation).

The importance of characterizing these services has some limitations regarding the reception and monitoring of all the health demands of the population served by the services. When thinking about the integrality of the network as a facilitator for the quality and equity of health care, the relevance of PHC is highlighted, whose strategic function is important in the link that is formed between the health system and people; this explains the need to implement an articulated intersectoral policy.[33] In fact, an intersectoral approach, in this sense, represents a genuine possibility to avoid the stalemate of care, allowing a flow of these demands.[33,34]

The role of primary health care

PHC refers to the "[...] set of individual, family and collective health actions that involve promotion, prevention, protection, diagnosis, treatment, rehabilitation, harm reduction, palliative care, and health surveillance, developed by integrated care practices and qualified management, carried out with a multidisciplinary team and aimed at the population in a defined territory, for which the teams assume health responsibility”[35] (free translation). This level of care represents, as a rule, the first contact of individuals, the family, and the community with the national health system, through which care is taken to places where people live and work, being an element of the continued healthcare process.[22] Therefore, PHC is the main gateway and communication with the entire Healthcare Network (*Rede de Atenção à Saúde* – RAS), with the Family Health Strategy (FHS) being the main configuration resource of the PHC and also the main ordering of care.[30,36] In addition to the FHS, the current National Primary Health Care Policy (*Política Nacional de Atenção Básica* – PNAB) — regulated by Ordinance No. 2,436, of September 21, 2017 — ratifies the inclusion of health care for the homeless population with the protagonism of the CnaR, the expansion of the number of municipalities with Family Health Support Centers (*Núcleos de Apoio à Saúde da Família* – NASF) and the creation of fluvial and FHS Primary Health Units (*Unidades Básicas de Saúde* – UBS) for riverside populations.

The articulation that is necessary between the PHC/FHS teams, in order to comply with their resolvability proposal, is directly linked to the concept of integrality. The former takes place through the adequacy of the teams, which are based on the demands and health needs of the population, seeking to comprise their actions, relying on the expansion offered by support teams and articulations related to other points of health care in the network for the continuity of care.[37]

Taking this into consideration, an important characteristic of PHC to be highlighted for the discussion of this study is the aforementioned “first contact,” which concerns access to and use of healthcare services for each new health event or new episode of the same event, considering as the gateway the service identified by the population and the team as the first health resource to be sought when there is a health need/problem.[34,35] In other words, people — whoever they are and regardless of their demands — are expected to be welcomed in a service focused on this “free initiative”, that is, PHC services. PHC uses several healthcare technologies to help managing the health demands and needs of the territory, paying attention to risk, vulnerability, resilience, and the premise of welcoming — with unconditional hospitality[1] — any demand, health need, or suffering.[35] Thus, the organization of work processes in PHC operates through the guidelines of welcoming and bonding, according to which the multidisciplinary team is responsible for the health care.[38]

Considering this composition, these characteristics and objectives, the use of PHC in the Brazilian health system has considerably improved since the creation of the FHS, both by expanding the population’s access to services and by providing greater promotion, prevention, diagnosis, treatment, and rehabilitation initiatives.[39] Nonetheless, there are many challenges to achieving equity and better health outcomes, such as valuing PHC in the RAS, increasing its resolvability, and focusing on population’s needs. In addition to these aspects, the challenges pointed out by Motta and Siqueira-Batista[39] are worth mentioning: “the challenge of understanding and practicing integrality in PHC; the challenge of valuing and adapting the profile of FHS professionals/workers; the training, insertion, and praxis of community health agents; the difficulty of teamwork in the FHS units”[39] (free translation).

In spite of these obstacles, the impacts of PHC on the health of the served population are indisputable. This level of health care is highlighted as a guiding element for analyses capable of identifying the flows present in the RAS altogether; moreover, there is much evidence of its resolvability, despite its limitations. It is, therefore, a privileged place for the provision of health care and the regulation of access — with emphasis on microregulation — regarding professional decisions and prioritization of cases through their analyses. Thus, resolvability is linked to the established bond, to the support and articulation of the network.[37] These are arguments related to the answers about the problematization of the effectiveness and reach of the primary healthcare network through strategies, instruments, services, and norms that compose it, insofar as "in health services there is a multiplicity of networks operating in connections among themselves, in different directions and meanings, building care production lines"[40] (free translation).

Care production lines are extremely important to think about the organization of teams and the work performed by professionals for the effectiveness of what is intended to be achieved with the organization of PHC. This is mainly due to, as previously mentioned, the way in which the encounters between the teams and the users take place, and based on them it is possible to assess this criterion of resolvability and scope of actions.

Outdoor Clinics Program

Health care must be offered to everyone in an equitable way; hence, the responsibility for HP must lie with any SUS professional and service, especially PHC, aiming to expand this reach to the healthcare network. Indeed, this network is evidently a reference for the care of HP, as it considers the territorial and relational dynamics of users for the articulation of healthcare strategies, substantiated in terms of the Outdoor Clinics Program (CnaR).[35]

CnaR is an important service for achieving this health care. It was created by PNAB, which established the guidelines for organizing the CnaR teams. The need for intersectoral integration between health policies and other public policies is highlighted, in such a way to improve the capacity to respond to the health demands and needs of HP.[41]

The CnaR team has "variable composition, is responsible for articulating and providing comprehensive health care to homeless people or people with similar characteristics in a given territory, in a fixed or mobile unit, and may have the modalities and respective rules described in a specific ordinance"[35] (free translation). The actions are carried out on the street, in specific facilities, and are also articulated with the other PHC teams in the territory, the NASF, the Psychosocial Care Centers (*Centros de Atenção Psicossocial* – CAPS), the Emergency Network and the services and institutions of the Unified Assistance System (*Sistema Único de Assistência Social* – SUAS), among other public and civil society institutions. Furthermore, CnaR is a mobile team linked to at least one UBS and that advocates for the establishment of links and the expansion of the access of HP to healthcare services, using a proactive approach that dialogues with the users' movements and territories.[37]The logics of care to which these instruments are proposed have a broader meaning, as the encounter with the population already takes place in the territory, which allows the development of bonds that go beyond the simple provision of health care, in favor of taking actions that enhance health.[42]

Therefore, CnaR consists in a service that is currently linked to the PHC, implemented in its characteristics of first contact, longitudinal bond, comprehensiveness and coordination of health care and, therefore, its formulation presupposes the ability to provide comprehensive health care necessary to vulnerable populations such as HP.[43]

Given the specificities of these users, the CnaR teams compose one of the strategies that provide such care, namely harm reduction (HR). This is considered an important care guideline and a strategy that allows contact and approximation with these people, in such a way to listen to their voices, their silences that translate into prejudice, stigma, suffering, and social exclusion.[44] According to the policy and strategy of HR, it is intended to create forms of care management considering the uniqueness of each user.[45] CnaR is, therefore, a service that aims at serving the place where the user circulates, in its geographical, existential, and relational territory; hence, the intersectoral approach is essential for enabling its work in the network. This perspective of territory follows the consolidation of spaces that carry out these and other care practices and health actions through the prioritization of unique aspects that preserve their specificities.[46,47]

The challenge is to overcome practices that privilege the individual manifestation of health changes without considering them in the light of collective health, which means problematizing health care by creating instruments permeated by multiple knowledge and practices, more resolute to meet the demands that range from subjects to citizenship, from individuals to collectives. Furthermore, there is the principle of universal access to health as one of the ethical pillars that guide healthcare practices for HP, which are subject to a bias of social exclusion.[43] Health promotion is articulated through the uniqueness of each subject in their territory and in the attention payed to the formulation of strategies that facilitate the expansion of the level of health and quality of life, considering the uniqueness of the subject.[42]

Considering the brief contextualization of this instrument[36,42] — and beyond what is based on and established in ordinances and laws —, there is the recognition of the realities and experiences of professionals, users, and family members who are involved in the healthcare logic proposed by CnaR.[48-50]

CONCLUSIONS

Health-disease represents a binomial of explicit complexity, whose meanings, in terms of health demands and needs, have direct implications for the health care of HP. It is worth reflecting, indeed, on the social reality imprinted on the bodies and discourses of these SUS users, in terms of health promotion and the different determinants of illness, which allows for better planning of care initiatives, linked to individuals, their territories and contexts.

Professionals and users must be considered as participants in the process of shared management of health care. The consolidation of this process takes place, to a large extent, through the articulation of networks and integrated services, with emphasis on the CnaR, as the authors sought to demonstrate in this essay. Considering the scope of the principles and guidelines of the SUS, it is necessary to improve the reflective processes aimed at the praxis of health care for HP, continuously constructed in the composition between: 1. the paramount respect for the others' self-determination; and 2. the unconditional hospitality of those who are willing to provide assistance.

CONFLICT OF INTERESTS

Nothing to declare.

AUTHORS' CONTRIBUTIONS

FGF: Project administration, Conceptualization, Writing – original draft, Writing – review & editing, Investigation. RSB: Conceptualization, Writing – original draft, Writing – review & g, Investigation.

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