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Fragilities and potentialities of care practice in public policy on street consulting

Fragilidades y potencialidades de la práctica de cuidado en la política pública de consultoría en la calle

Fragilidades e potencialidades da prática do cuidado na política pública do consultório na rua

ABSTRACT
The homeless person is a public health problem in Brazil and with the complexity of this assistance, the Consultório na Rua is an important device in the care of this population. The care practices carried out by the teams are guided by weaknesses and potential. Objective to identify in the scientific productions the weaknesses and potentialities of the practice of care within the Public Policies of the Consultório na Rua. This is a descriptive, exploratory, qualitative study, type of integrative literature review, the time frame was established between 2012 to 2019. After the selection process, the articles were analyzed using the Laurence Bardin Method. Weaknesses related to access to the network, lack of material and human resources, prejudice and resistance in assisting people living on the streets were identified. Regarding the potential, the bond, the multidisciplinary team and self-care, having the nurse as a professional in the planning of actions. We conclude that there is a need for continuing education, deconstruction of the social imaginary and availability of resources about weaknesses. The nurse is inserted in this public policy as a motivating agent and articulator of changes.
DESCRIPTORS: Homeless People; Nursing; Primary Health Care.

RESUMEN
La gente en las calles es un problema de salud pública en Brasil y con la complejidad de esta asistencia, el oficina de la calle es un dispositivo importante en el cuidado de esta población. Las prácticas de atención realizadas por los equipos están guiadas por debilidades y potencial. Objetivo identificar en las producciones científicas las debilidades y potencialidades de la práctica asistencial dentro de las Políticas Públicas del oficina de la calle. Esta es una revisión de literatura descriptiva, exploratoria, cualitativa e integradora, el marco de tiempo se estableció entre 2012 y 2019. Después del proceso de selección, los artículos se analizaron utilizando el Método Laurence Bardin. Se identificaron debilidades relacionadas con el acceso a la red, falta de recursos materiales y humanos, prejuicios y resistencia para ayudar a las personas que viven en las calles. Respecto a las potencialidades del vínculo, el equipo multidisciplinario y el autocuidado, contando con la enfermera como profesional en la planificación de acciones. Se concluye que existe una necesidad de educación continua, deconstrucción del imaginario social y disponibilidad de recursos con respecto a las debilidades. La enfermera se inserta en esta política pública como agente motivador y articulador de cambios.
DESCRIPTORES: Personas Sin Hogar; Enfermería; Atención Primaria de Salud.

RESUMO
A pessoa em situação de rua constitui-se um problema de saúde pública no Brasil e com a complexidade dessa assistência, o Consultório na Rua é dispositivo importante no cuidado a essa população. As práticas de cuidado realizadas pelas equipes são pautadas por fragilidades e potencialidades. Objetivo identificar nas produções científicas as fragilidades e potencialidades da prática do cuidado dentro das Políticas públicas do Consultório na Rua. Trata-se de um estudo descritivo, exploratório, qualitativo, tipo revisão integrativa da literatura, o recorte temporal foi estabelecido entre 2012 a 2019. Após o processo de seleção, os artigos foram analisados através do Método de Laurence Bardin. Identificou-se fragilidades relacionadas ao acesso à rede, falta de recursos materiais e humanos, preconceito e a resistência na assistência a pessoa em situação de rua. Em relação as potencialidades o vínculo, a equipe multidisciplinar e o autocuidado, tendo como o profissional enfermeiro no planejamento das ações. Conclui-se que há a necessidade de educação continuada, desconstrução do imaginário social e disponibilidade de recursos no que concerne as fragilidades. O enfermeiro está inserido nesta política pública como agente motivador e articulador de mudanças.
DESCRITORES: Pessoas em Situação de Rua; Enfermagem; Atenção Primária à Saúde.

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INTRODUCTION

With the development of capitalism and technological advancement, we experience the negative consequences generated by globalization, among them are the reproduction of social inequalities and exclusions[1]. And the context of the homeless population is old and started with the rise of pre-industrial societies in Europe.

In the process of creating the necessary conditions for the capitalist population. In the context of the so-called primitive accumulation, the peasants were expropriated and expelled from their lands and not all were absorbed by the nascent industry. This caused most of these peasants to experience the bitter experience of wandering the streets exposed to the violence of the oppressive society, which had just been born. Thus came the pauperism that became widespread in Western Europe, at the end of the 18th century, and forged the phenomenon of homeless people[2].

In Brazil, this phenomenon started after the abolition of black slavery. Where after the completion of this well-deserved process, the majority of this population was abandoned, without possibilities of housing, work and food, a large part of these people started to occupy the street spaces[3]. The concepts of social inequality and exclusion complement each other; social inequality is revealed in how the distribution of wealth is made in a given historical-social context and the possibility of identifying the social values that guide this distribution; social exclusion relates to putting a particular social group on the sidelines and the difficulty of recognizing rights that belong to them in the other[4-5].

The transformations generated by the globalization process have produced different groups, more or less marginalized, among them is the social phenomenon of People in Street Situation - PSR[6]. In the 90s, the number of people in the centers of large Brazilian cities increased considerably, but only in 2008 did the Federal Government expose a document of guidelines of the National Policy for the Social Inclusion of the Homeless Population (PNPR), with the ultimate goal of guiding the construction and execution of Public Policies[7].

In accordance with the proposed objective, it was stipulated via Decree No. 7,053 / 2009, to the Intersectorial Committee for Monitoring and Monitoring of the National Policy for the Homeless Population (Ciamp-Rua), together with the National Policy for PSR, requested the Brazilian Institute of Geography and Statistics (IBGE) to include the street population in the 2020 Census[8].

According to this decree, which establishes in its Art. that uses public places and degraded areas as a space for housing and sustenance, temporarily or permanently, as well as reception units for temporary overnight stays or as temporary housing[9].

Also from this decree, the Coordination of Integration Monitoring (CIM), of the Secretariat for Integration and Promotion of Citizenship (SUBIPC), in partnership with the Pereira Passos Institute (IPP), carried out on January 23, 2018 the survey of the PSR of Rio de Janeiro, where 4,628 people were accounted for in this situation[10]. And from the context presented by the PSR, difficulties arose related to the care and reception by the model followed by Primary Health Care (AB) in Brazil, considering that the work organizations of these teams were based on fixed homes, where we didn't think about the dynamics of the subjects who had the streets as home[11].

However, the dilemmas that involve the work process in the AB, such as the requirement for documents to be attended, limits of intersectoral action and restrictions in meeting spontaneous demand, create obstacles to the PSR assistance process and, above all, do not establish a link[12]. In 1997 in Salvador / Bahia, the coordinator of the Drug Abuse Study and Therapy Center - CETAD / UFBA identified that users of Psychoactive Substances (SPA) were young and that they did not continue the treatment, and few arrived at CETAD[13]. In 1999, CETAD created the first Street Clinic (CR).

In 2009, the CR was recognized by the Ministry of Health as one of the strategies of the Emergency Plan to Expand Access to Treatment and Prevention in Alcohol and other Drugs in SUS - PEA(14). The Street Clinic was under the Coordination of Mental Health, with the objective of providing assistance to the Population Street situation with mental disorders[15]. In the city center of Rio de Janeiro, in September 2010, the project "Saúde em Movimento nas Ruas" (Health in Movement in the Streets), also known as ESF POP RUA, was created. Living on the streets is directly correlated to health, social and legal vulnerabilities.

And the deprivation of access to services and health promotion increases the risks of multiple clinical comorbidities[16]. In this regard, in 2011, the CR was linked to the National Primary Care Policy (PNAB), changing its nomenclature to Consultório na Rua (CnaR). The changes go far beyond nomenclature; primary care with its comprehensive and inclusive view, and the congruence of psychosocial care with its proposal to work on Harm Reduction (RD), establishes one of the principles of the Unified Health System (SUS): equity[17].

The Multiprofessional Teams of the Offices on the Street are characterized in three types of care, where according to the Brazilian Code of Occupations (CBO), the following professions may compose the Offices on the Street teams: Nurse, Psychologist, Social Worker, Occupational Therapist, Physician, Social Agent, Nursing Technician or Assistant and Oral Health Technician, with a weekly workload of 40 hours[17,18].

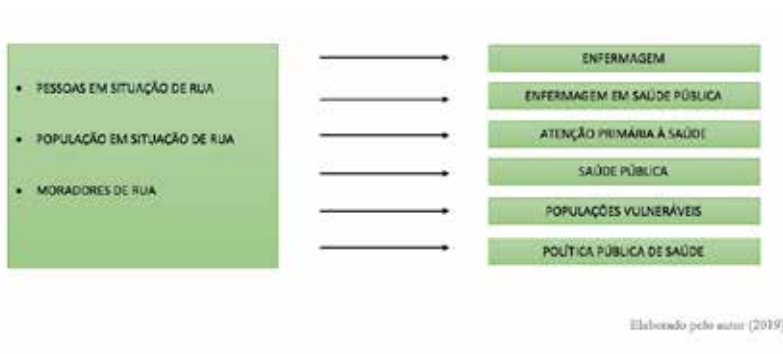
The responsibility, as professionals and academic researchers, is to contribute to the dissemination of this Public Policy, be it an instrument for students and professionals to improve their knowledge with the data discussed. And the question that guides the study: What are the weaknesses and potential of the practice of care in the Policy of the Consultório na Rua, according to scientific productions? Thus, the present study has as main objective to identify in the scientific productions the weaknesses and potentialities of the practice of care in the Policy of the Consultório na Rua. To contribute to the purpose of the research, the following specific objective was outlined, relating the strategies of nursing care in the policy of the Consultório na Rua.

METHODOLOGY

This study was classified based on its technical procedures and adopted a qualitative approach, since it deals, in Social Sciences, with a level of reality that cannot or should not be quantified. This level of reality is not visible, it needs to be exposed and interpreted, in the first instance, by the researchers themselves[19]. Qualitative research arose with the objective of giving an account of the side that is not perceptible and cannot be captured only by equations and statistics, that the foundation in mathematics alone is not sufficient for the formation of the social subject, who relates to others and the world[20]. The study is characterized as exploratory, according to its objectives; it is defined as a preliminary study carried out with the purpose of better adapting the measurement instrument to the reality that one intends to know[21]. And through the integrative literature review it has a broad methodological approach, with which it is possible to include experimental and non-experimental studies, bringing together the incorporation of several purposes of a referenced theme[22]. To survey the articles in the literature, a search was carried out in the following databases of the scientific search sites: SciELO (Scientific Electronic Library Online); VHL (Virtual Health Library); Capes journals. To carry out the bibliographic survey in the databases, the following Health Sciences Descriptors (DeCS) were used: "People in Street Situation"; "Nursing"; "Primary Health Care"; "Public Health Nursing"; "Vulnerable Populations"; "Public Health Policies" and "Public Health". To expand the search, we have included two synonyms in Portuguese for "People in Street Situation": "Population in Street Situation" and "Street People". For all the above descriptors and synonyms, the combinations described in Figure 1 were used, with the assistance of the Boolean operator: "AND".

The search for the articles was carried out from August to October 2019. The inclusion criteria established for this study were: articles available, with full texts, language in Portuguese, articles that portrayed the theme and with a period starting in 2012, year in which PNAB linked CnaR as a strategy Regar-

Figura 1. Ilustração da combinação de descritores e do operador booleano AND para a busca de artigos científicos. Rio de Janeiro, RJ, Brasil, 2019.



ding the established exclusion criteria, were: articles that did not appear in full, in other languages, outside the established period and articles that did not present the theme related to the theme.

In accordance with the inclusion criteria, it was established that only scientific productions with at least one nurse among the interviewees and/or one nurse as one of the researchers, were selected to compose this study. The use of this criterion has as main objective to expose the nurse's vision and contribution in scientific productions on the theme.

After the pre-selection, a detailed reading of the studies was carried out, where only the productions that presented the theme remained. The presentation of the study selection process in numerical form is exposed through the flowchart in Figure 2.

Figura 2. Fluxograma do quantitativo inicial de artigos encontrados nas bases de dados científicas. Rio de Janeiro, RJ, Brasil, 2019.

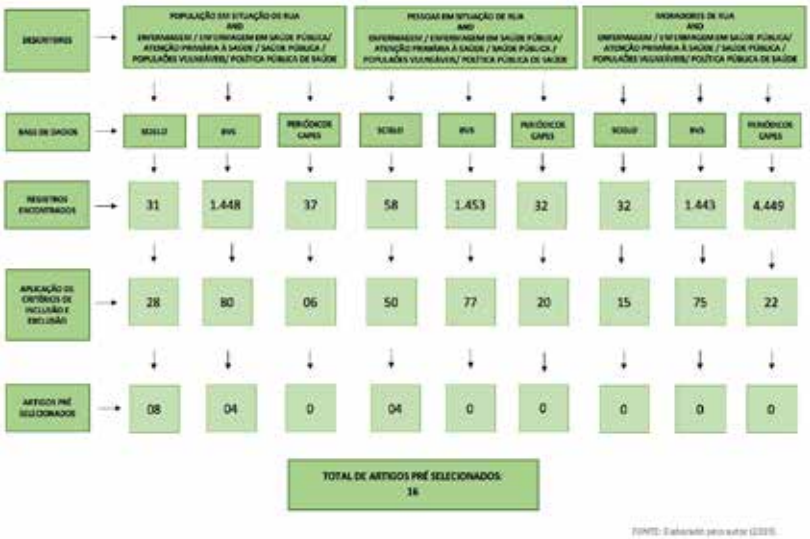


Figura 3. Características dos artigos selecionados para compor os objetivos da presente pesquisa. Rio de Janeiro, RJ, Brasil, 2019.

Nº DE ARTIGOS	BASE DE DADOS	TÍTULO	AUTOR / ANO	REVISTA	MÉTODO
1	SCIELO	O VIVER NA RUA: REVISÃO INTEGRATIVA SOBRE CUIDADOS A MORADORES DE RUA	KOOPMANS et al.,2018	REBEn	QUALITATIVA – REVISÃO DE LITERATURA
2	SCIELO	CONSULTÓRIO NA RUA: AS PRÁTICAS DE CUIDADO COM USUÁRIO DE ALCOOL E OUTRAS DROGAS EM MACAPÁ	BITTENCOURT et al, 2016	CEAN	QUALITATIVO – PESQUISA DE CAMPO
3	SCIELO	A IMPLANTAÇÃO DO CONSULTÓRIO NA RUA NA PERSPECTIVA DO CUIDADO EM SAÚDE	HERMES et al, 2018	REBEn	RELATO DE EXPERIÊNCIA
4	SCIELO	SABERES IDEOLÓGICOS E INSTRUMENTAIS NO PROCESSO DE TRABALHO NO CONSULTÓRIO NA RUA	KANI et al., 2016	REEUSP	QUALITATIVA E EXPLORATÓRIA
5	SCIELO	CONSULTÓRIO NA RUA: VISIBILIDADES, INVISIBILIDADES E HIPERVISIBILIDADE	HALLAIS; BARROS, 2015	CADERNO SAÚDE PÚBLICA	OBSERVAÇÃO SISTEMÁTICA E ANÁLISE INTERSETORIAL
6	BVS	DETERMINANTES SOCIAIS, EQUIDADE E CONSULTÓRIO NA RUA	PINTO et al., 2016	REUOL	QUALITATIVA – RELATO DE EXPERIÊNCIA
7	SCIELO	EXPERIÊNCIA DOS PROFISSIONAIS DE SAÚDE NO CUIDADO DA PESSOA COM TUBERCULOSE EM SITUAÇÃO DE RUA	ALTORIM et al, 2016	REEUSP	QUALITATIVA, EXPLORATÓRIA E DESCRITIVA
8	SCIELO	PESSOAS QUE VIVENCIAM SITUAÇÃO DE RUA SOB O OLHAR DA SAÚDE	PINO; SANTOS; ROSA, 2017	REBEn	REVISÃO INTEGRATIVA DE LITERATURA
9	SCIELO	O CONTROLE DA TUBERCULOSE NA ÓTICA DE PROFISSIONAIS DO CONSULTÓRIO NA RUA	IANO et al, 2018	RLAC	QUALITATIVA, EXPLORATÓRIA E DESCRITIVA
10	SCIELO	PRÁTICA DE CUIDADO E POPULAÇÃO EM SITUAÇÃO DE RUA: O CASO DO CONSULTÓRIO NA RUA	SILVA; CRUZ; VARGAS, 2016	SAÚDE DEBATE	QUALITATIVA – ESTUDO DE CASO
11	BVS	PRÁTICA DE SAÚDE DAS EQUIPES DOS CONSULTÓRIOS DE RUA	SILVA; PRAZERES; LINHARES, 2014	CADERNO SAÚDE PÚBLICA	QUALITATIVA, EXPLORATÓRIA E DESCRITIVA
12	SCIELO	EQUIPE "CONSULTÓRIO NA RUA" DE MANGUINHOS, RIO DE JANEIRO, BRASIL: PRÁTICAS DE CUIDADO E PROMOÇÃO DA SAÚDE EM UM TERRITÓRIO VULNERÁVEL	LINDERTHOM; TEIXEIRA, 2016	CIÊNCIA & SAÚDE COLETIVA	QUALITATIVA: RELATO DE EXPERIÊNCIA
13	SCIELO	TRABALHO NO CONSULTÓRIO NA RUA: USO DE SOFTWARE (WEBQUALITEQ) NO APOIO À PESQUISA QUALITATIVA	KANI et al., 2016	CEAN	QUALITATIVA – PESQUISA DE CAMPO
14	SCIELO	MISSÃO E EFETIVIDADE DOS CONSULTÓRIOS NA RUA: UMA EXPERIÊNCIA DE PRODUÇÃO DE CONSENSO	SIMÕES; COUTO; DELGADO, 2017	SAÚDE DEBATE	RELATO DE EXPERIÊNCIA

FONTE: Elaborado pelo autor (2019).

After the selection process was completed, and in order to summarize and organize the selected articles, a table was created (Figure 3), with the purpose of analyzing the characteristics of the selected studies.

To analyze the data of the selected studies, Laurence Bardin's Content Analysis (CA) methodological framework was applied, which is defined by a set of communication analysis techniques aiming to obtain, by systematic procedures and objectives of content description messages, indicators (quantitative or not) that allow the inference of knowledge related to the conditions of production/reception of these messages[23].

RESULTS AND DISCUSSION

Regarding the characteristics of the productions, 06 studies carried out field research, 05 used the experience report, 01 research as a case study and 02 used the integrative literature review.

According to this criterion, the presence of the nurse is pointed out that, 05 (35.71%) studies have nurse researchers and interviewed nurses in the same study, 04 (28.57%) researches as the nurse the interviewee and 05 (35.71%) %) publications present the nurse as a researcher.

In this perspective, there is little scientific production carried out on the theme and, mainly, the difficulty in finding productions performed by nurses. It emphasizes the need to increase research with a focus on these subjects, aiming at the dissemination of politics, as a means of exploitation for new public

policies, and that the professional nurse is inserted and is a motivating agent in this achievement. After reading and critically analyzing the results and discussions of the studies that make up this research, three categories were identified for carrying out the discussion.

Weaknesses of care: a practice under construction

The construction of this category was guided by the principles of SUS: Universalization, Equity and Integrality, where the most persistent weaknesses were identified. Universalization brings health to us as a citizenship right for all people, as well as access to actions and services, and it is up to the State to guarantee this right. The concept of equity is linked to that of universality, where it concerns the needs, diversities and specificities of each person or social group; it also considers the health impacts of different forms of prejudice.

People on the streets to access the services available in SUS face several barriers. Care for this population is characterized by innumerable challenges, where some of these prevent or delay the access of these users. Among these barriers/challenges, the following stand out: prejudice, discrimination, absence of necessary documents for identification, difficulties in relation to the teams' work processes, the lack of preparation of the teams in the care of these subjects, access to the network health and lack of resources[24-26].

Going against the principles of SUS, prejudice appears as a barrier to inclusion. For this, there are four aspects: from the health teams to the people on the street, from the teams of the various health equipment to the teams of the Consultório na Rua, from the general population to the PSR and from the general population to this practice of carried out by the teams[25].

Detailing the first aspect named above, the teams' prejudice is shown as a barrier that ends up interfering and/or recommending the assistance. Health concerns refer to the construction of hygienist views by professionals in relation to PSR, and denounce prejudice as: "work is a lost investment", "it is drying ice", "what they do will not get anywhere some "and that" is a frustrating job"[25-28].

The stigma created by the social imaginary and that permeates the health teams were/are built from the prejudiced and discriminatory look given to the PSR. The presence of prostitution, the use of drugs and alcohol in the context of PSR is seen by professionals as a character flaw, and not as a health and social problem, thus blaming this population for their current situation[29].

In view of the second aspect, the team itself is a target of prejudice for working with this social group. The prejudice identified on the part of the population is both with the PSR and with the teams of Consultório na Rua[30,31].

Comprehensiveness, one of the principles of SUS, concerns the articulation of health and intersectoral and the integration of health actions, and was pointed out in the studies as a weakness in the care of PSR[24,32]. Access to the Psychosocial Care Network (RAPS) and the Health Care Network (RAS) was identified as a weakness. In relation to the equipment that is made available in the territories for the operation of these connections, the fragile integration of sectors and services and the user's difficulty in accessing when he is not accompanied by a member of the Street Clinic teams[25,30,33,34].

Regarding the Psychosocial Care Centers for Alcohol and Drugs (Capsad), the lack of this device was mentioned in some areas covered by the Street Clinic teams, making it difficult for the PSR to access this equipment. Regarding the inefficiency of the reception, the Psychosocial Care Center (CAPS) was referred to as one of the barriers of access[25,28].

Primary Care (AB) was an intersector mentioned in relation to work difficulties and, consequently, access. Referring to the fact that even the Consultório na Rua is a health device of the AB, teamwork is not built. Another access reported as inefficient is the Emergency Medical Assistance Service (SAMU), which complicates this access due to the lack of skill and preparedness to attend the PSR[27,28,32]. Were mentioned in relation to the differences in care provided with the Family Health Strategy (FHS) and a conventional UBS, these difficulties became more effective in the conventional UBS[29].

The structural deficit was identified as a weakness in the care of users of alcohol and other drugs. Another point highlighted in this study was the insufficient number of professionals, since many users do not accept going to the UBS to perform the service, as a result of unfortunate previous visits[27].

The non-availability of portable electronic equipment, such as tablets and/or notebooks, is characterized as a hindrance to record activities. It also discusses the infrastructure of the Health Units, where rooms and computers are lacking for care[29].

Some studies have highlighted the weaknesses related to the vulnerability of the PSR itself, showing challenges for the team when putting the practice of care into action. It was noted the difficulty of the Street Clinic teams in maintaining the adherence of the PSR to the proposed treatments. One of the reasons reported is the constant displacement of the PSR, due to conflicts between groups and/or not staying in the same place for a long time in order not to adhere to the treatment.[26]. It was identified that the lack of family structure, education, occupation and the vulnerabilities associated with crack consumption, affect their self-esteem and precarize their self-care, thereby complicating treatment adherence[27,32].

Regarding adherence to the treatment of tuberculosis, the living conditions of these subjects stand out, which are entirely related to the control of this disease. The constant social inequalities and the lack of interest in

taking care of health, since, being aware of their diagnosis, respond with denial or with a little about care, results from ineffective control and a challenge for the team[25,26].

Regarding the weaknesses found in the Street Consultation teams and other health professionals who work with the PSR, there is a lagged qualification. Professionals are poorly prepared to deal with the negative points that will be discovered during the assistance to PSR. They do not have training or are not even encouraged to seek specialization that contributes to the promotion of a diversified view of this population[29]. It emphasizes the disqualification, ineptitude and the inability of professionals to exercise sensitive and qualified listening, where the demands and needs of this population are accommodated[25].

Potentialities of Care Practice: exaltation of a humanized strategy

The practice of care is characterized by several processes, some of which are potentiators for the beginning, middle and end of the assistance provided to these subjects. Some of them are extremely important for the exaltation of this strategy, such as the recognition of the fields of action, the different forms of approach, the bond built, the multidisciplinary teams, the effective communication and the practice of emancipating care.

The opening of the field is one of the main identification strategies, and its central objective is to know these territories, observe the narratives of lives and understand the dynamics of care that will be put into practice. These objectives are intended to deconstruct prejudiced eyes that may be present during the course of care[24,35]. The approaches are carried out in loco, with the objective of aiming and validating the recognition of the place, and visualization of the environmental, sanitary and social characteristics. The approach dynamics is performed with the presentation of the team and the possibilities of care, and is performed by more than one member of the Consultório na Rua[24,33].

The forms of approach are defined by the Street Consultation teams after the recognition, must be performed by more than one member of the Street Consultation teams and have at least one professional with a higher level in the monitoring. In order to carry out this process, the Street Clinic teams identify the risks and vulnerabilities to which the PSR is exposed, and from this first contact, users are offered immediate clinical care (analgesic and curative), rapid tests (pregnancy , syphilis, hepatitis, HIV), and sputum collection for tuberculosis. Once this first contact was established, the Street Clinic teams set out to build the bond[33].

The care strategies carried out by the Consultório na Rua are guided by several processes, one of which is the construction and maintenance of the bond. The bond corresponds to one of the potentialities of the Consultório na Rua, and its actions are related to a humanized approach, in which welcoming, dialogue and qualified listening are practiced[27,34,36].

From the listening and dialogue between the PSR and the Street Clinic teams, it is understood the perspective of comprehensive care, to which this user will be inserted. The bond is identified as a facilitating means that, when built, enhances the care provided by the Consultório Rua teams[25,27,36].

In order to strengthen confidence, it is necessary that the Street Clinic teams clarify to the PSR that these professionals are in that place with the intention of providing care, and not with the purpose of removals to shelters, since the PSR has already experienced approaches for compulsory removals[36]. Evidencing the needs for care, the Street Clinic teams present the rights of the PSR within the health services, maintaining respect in the face of decisions and prevailing autonomy for each choice[25].

The Street Offices are made up of multidisciplinary teams, this represents an empowering element for the construction of care, where different looks and plural knowledge are achieved with the purpose of providing comprehensive care, in addition to this, the strategies that are built by the teams Street Offices need to be focused on the reality of the PSR. With this, workers who practice collective practices become more effective, in relation to the medical-hegemonic model, to which the Street Clinic teams try to distance themselves[29,33,35,37].

The work performed by the Consultório na Rua teams is considered one of the potentialities of the Consultório na Rua, configured between the articulation and the care provided, the teams hold weekly meetings, with the intention of discussing the cases, actions and interventions to be carried out, reinforcing the promotion of collective management and permanent education of the team. This work process is related to the sharing of responsibilities in relation to the care of PSR[25,26,33,37]. One of the strategies for the practice of care provided by the Street Clinic teams is the night actions carried out in order to reach users who were unable to access during the day[27].

Some practices are carried out in the street spaces, such as the distribution of inputs for the prevention of Sexually Transmitted Infections (STIs) and AIDS, guidance on health problems, practices on self-care (hygiene and food), information on the recurrent diseases of tuberculosis and the drug use, condom use, measurement of capillary blood glucose, prenatal care and nursing, psychology, medical and social work appointments[28,33,35,36].

In addition, when care cannot be provided in street spaces or when more elaborate assistance is needed, the articulation between networks is referred to as fundamental. In some cases, this articulation takes place through knowledge and communication between professionals. In others, the articulation occurs through health equipment, such as: the Psychosocial Care Network (RAPS),

the CAPS and the Family Health Support Center - NASF[24,27].

The Consultório na Rua shares space with family health teams at the UBS, where care can be scheduled or spontaneously demanded, with professionals available to welcome and care. The availability of electronic medical records for the records of the Street Clinic teams is highlighted, thus generating a number of SUS Card for the user, aiming at the better access of the PSR to the network[33].

These articulations happen in partnerships between public services, health schools and shelters, enhancing the articulation in extended care and between professionals. It appears that these partnerships must be encouraged and consolidated by the team[s][34,36].

Regarding the incentives that are given to the PSR for adherence to treatment, the Consultório na Rua promotes the donation of basic baskets, transportation vouchers and some UBS offer a bath. Even though the basic baskets are not appropriate under the conditions presented by the PSR, the donation causes well-being and allows the user to use it as a means of exchange to support their needs[26].

Nursing care strategies: a holistic view of the homeless

The role of the nurse can be identified in social relationships, as this professional can move through different spaces of care. This performance is observed in the questions in which the nurse proposes agreements with the other health equipment for the best access of the PSR to the network[30]. Qualified listening to nurses is a care strategy for these professionals. PSR's speeches are built on stories of violence, family breakdowns, hunger and a history of illness; in this sense, the sensitive listening and the biopsychosocial look of the nurses guarantee a differentiated reception[30].

The nurse's challenge in assisting the user in the use and abuse of alcohol and other drugs stands out in the face of the most varied conditions. The nurse's assistance is identified in the assignments related to the application of bandages and rapid tests, in the promotion of health and in the care with hygiene and food. And the nurse is a professional aggregator who works in a multidisciplinary team.

CONCLUSION

The care to the PSR is marked by several challenges that compromise the practice of care, and these weaknesses found pass through the principles of SUS. Among these challenges are: access to the network, structural deficit, prejudice, outdated qualification, difficulty in adhering to treatment and deconstruction of the social imaginary. It points out the potentialities identified in the practice of caring for PSR, which build within this policy a strengthening of comprehensive and humanized assistance. Among the most cited are the knowledge of the fields of action, the categories of approaches, bonding, multidisciplinary teams, effective communication and self-care.

The importance of combating prejudice and deconstructing the social imaginary of the teams is emphasized, whether they are from the Consultório na Rua or from other health equipment. May this fight be carried out with training, training, specializations and, above all, the construction of a holistic and humanized view of this population. And the material and human resources, not only in the Consultório na Rua, but also in the support network, must have investment. Greater investments and availability in the construction of a method of adherence to the proposed treatments are also considered. The sum of these factors on the weaknesses is in line with the potential developed by the Consultório na Rua. And the knowledge of the place where you will work, this issue favors a positive aspect in reducing the ineffective approach. The emancipatory care placed in such a way that these subjects understand and build possibilities for self-care, and that they understand that this self-care can and should be performed by them.

Nevertheless, the forms of care performed by nurses were emphasized, bringing this professional as an articulator of assistance based on a differentiated reception, a listening associated with a biopsychosocial look, the autonomy of this professional before the established protocols, the professional of choice in planning and executing team actions and, mainly, motivating agent of change in the deconstruction of the social imaginary, that we can build views and actions for inclusion and that this research is an information tool for academics and professionals from different health spheres to discuss and rethink the your knowledge. ■

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