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# The routine of the street outreach office team: weaving networks for health promotion

## *Quotidiano de equipes de consultório na rua: tecendo redes para a promoção da saúde*

## *El día a día de los equipos consultores de calle: tejiendo redes para la promoción de la salud*

Selma Maria da Fonseca Viegas[1]
Rosane Gonçalves Nitschke[2]
Lucas Andreolli Bernardo[3]
Adriana Dutra Tholl[2]
Maria Aurora Rodriguez Borrego[4,5]
Pablo Jesús López Soto[4,5]
Daniela Priscila Oliveira do Vale Tafner[6]

1. Universidade Federal de São João del-Rei. Campus Centro-Oeste. Divinópolis, MG, Brasil.

2. Universidade Federal de Santa Catarina, Curso de Enfermagem. Florianópolis, SC, Brasil.

3. Prefeitura Municipal de Bombinhas. Bombinhas, SC, Brasil.

4. Universidad de Córdoba, Instituto Maimónides de Investigación Biomédica de Córdoba. Córdoba, España.

5. Hospital Universitário Reina Sofía de Córdoba. Córdoba, España.

6. Universidade Federal de Santa Catarina, Programa de Pós-Graduação em Enfermagem. Florianópolis, SC, Brasil.

**Corresponding author:**
Selma Maria da Fonseca Viegas
E-mail: selmaviegas@ufsj.edu.br

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## Abstract

**Objective:** to understand the powers and limits for promoting the health of homeless people in the daily life of the Outreach office team. **Method:** a holistic-qualitative multiple case study, based on Comprehensive Sociology of Everyday Life, conducted with two key informants and 20 outreach office team professionals from two Southern Brazilian Capitals. We used the technique of thematic content analysis. **Results:** the powers for health promotion of homeless people come from the articulation of the intrasectoral and intersectoral network by the Outreach office team, in addition to bonding and harm reduction. The limits faced to develop health promotion actions are faced in the specificity and characteristics of this public, in the outsourcing of social assistance, in management, in politics. **Conclusions and implications for practice:** health promotion is still a challenge for the team to be overcome before demands of injuries, treatment of illness and biomedical logic. Intrasectoral and intersectoral strategies can be established to achieve network actions and effectively promote health, contemplating fundamental rights to the lives of homeless people, even in a daily life with unfavorable conditions of living and living.

**Keywords:** Homeless Persons; Health Promotion; Intersectoral Collaboration; Delivery of Health Care; Nursing.

## Resumo

**Objetivo:** compreender as potências e limites para a promoção da saúde de pessoas em situação de rua no quotidiano da equipe de Consultório na Rua. **Método:** estudo de casos múltiplos holístico-qualitativo, fundamentado na Sociologia Compreensiva do Quotidiano, realizado com dois informantes-chave e 20 profissionais de equipe de Consultório na Rua de duas capitais do Sul do Brasil. Utilizou-se a Análise de Conteúdo Temática. **Resultados:** as potências para a promoção da saúde de pessoas em situação de rua advêm da articulação da rede intrasetorial e intersetorial pela equipe de Consultório na Rua, além do vínculo e da redução de danos. Os limites enfrentados para desenvolver ações de promoção da saúde se deparam na especificidade e características desse público na terceirização da assistência social, na gestão, na política. **Conclusões e implicações para a prática:** a promoção da saúde ainda é um desafio para a equipe a ser superado perante as demandas de agravos, o tratamento do adoecimento e a lógica biomédica. As estratégias intrasetoriais e intersetoriais podem ser estabelecidas para alcançar ações em rede e efetivamente promover saúde, contemplando direitos fundamentais à vida de pessoas em situação de rua, mesmo em um quotidiano com condições desfavoráveis de viver e conviver.

**Palavras-chave:** Pessoas em Situação de Rua; Promoção da Saúde; Colaboração Intersetorial; Assistência à Saúde; Enfermagem.

## Resumen

**Objetivo:** comprender los poderes y límites para promover la salud de las personas que viven en las calles en la vida cotidiana del equipo de Consultório na Rua. **Método:** estudio de caso múltiple holístico-cualitativo, basado en la Sociología Comprensiva del Cotidiano, realizado con dos informantes clave y 20 profesionales del equipo de Consultório na Rua de dos capitales en el sur de Brasil. Se utilizó el análisis de contenido temático. **Resultados:** las competencias para promover la salud de las personas que viven en la calle provienen de la articulación de la red intrasectorial e intersectorial por parte del equipo Consultório na Rua, además del vínculo y la reducción de daños. Los límites que se enfrentan para desarrollar acciones de promoción de la salud se enfrentan en la especificidad y características de este público, en la externalización de la asistencia social, en la gestión, en la política. **Conclusiones e implicaciones para la práctica:** la promoción de la salud sigue siendo un desafío para el equipo a superar ante los problemas de salud, el tratamiento de la enfermedad y la lógica biomédica. Se pueden establecer estrategias intrasectoriales e intersectoriales para lograr acciones en red y promover eficazmente la salud, contemplando los derechos fundamentales a la vida de las personas que viven en la calle, incluso en una vida cotidiana con condiciones desfavorables para vivir y convivir.

**Palabras clave:** Personas Sin Hogar; Promoción de la Salud; Colaboración Intersectorial; Prestación de Atención de Salud; Enfermería.

## INTRODUCTION

Health is the greatest resource for social, economic and personal development, as well as an important dimension of quality of life, needing "to be seen as a resource for life, and not as an objective of living".[1:1] However, there are still populations in situations of extreme vulnerability, such as the homeless population, for whom barriers to access and health care persist, keeping it invisible to the public health system.[2] This population segment, vulnerable by the structure of daily life on the street, has the right to citizenship and health care, and the outreach office team (OOt) becomes a reference for meeting these people's life and health needs. Street life exposes those who live in it to risks that require a specific approach from OOt.[3]

This team, in their daily lives, makes assistance, care and health promotion happen to homeless people, in an itinerant practice that runs through the intersectoral health and solidarity network "mixing with them, not infrequently sometimes, under tension, seeking articulation for the care of those who, until then, were invisible in/in the scenarios of the Unified Health System (SUS – *Sistema Único de Saúde*) in Brazil".[4:253] Being with the street population in different scenarios makes this team a presence in the real, identifying and prioritizing the various health problems and needs for network actions on a daily basis.

Thus, OOt carries out its activities *in loco*, developing actions shared and integrated with Primary Health Care units (PHC), and, when necessary, also with the teams of Psychosocial Care Centers, Emergency services and other points of attention of the network,[5] guaranteed the right and access to homeless people.

The right to health provides for the enjoyment of physical and mental health by all people in their entirety and need, implying health promotion through intrasectoral articulation and intersectoral collaboration through the formation of the Health Care Network (RAS – *Rede de Atenção à Saúde*), seeking to integrate actions with other social protection networks, with broad participation and social control, as proposed in the Brazilian National Health Promotion Policy (*Política Nacional de Promoção da Saúde*).[6]

Health promotion aims at equity and the improvement of conditions and ways of living, expanding the potential of individual and collective health, reducing vulnerabilities and health risks arising from social, economic, political, cultural and environmental determinants. Health and life promotion and defense propose to reduce systematic, unjust and avoidable inequalities, with respect to differences in all dimensions for the universal right to health.[6]

When treating the right to health, from the perspective of human rights, its full exercise also depends on the right to life, freedom, education, political participation, adequate housing, food, among others. However, the guarantee of these rights does not take place in an equitable way for all people, as for the homeless, which can produce situations of inequities and rights violations. Strategies to reduce inequities in guaranteeing the right to health as a fundamental human right are part of the principles and values of universality, accessibility, integrality, quality and inclusion in health in a cohesive and integrated way, in order to achieve health promotion. When human rights are denied, they harm us as individuals and society as a whole, which will develop less and have lower levels of security and well-being.[7]

As an emerging field, inclusion in health needs to provide integrated social and health services to overlap marginalized groups. The ability to have health and social policies to respond to the needs of marginalized populations is a key indicator of quality. The extreme health inequality that persists in high-income countries is evidenced in a systematic review study, highlighting as resolvability that the inclusion health policy must be based on the evidence that trigger exclusion in order to increase the social and economic benefits and avoid social exclusion due to poverty, marginalization and multimorbidity.[8]

Studies that analyzed people's health who make the street their home mostly have an epidemiological profile, comorbidities, including mental illness and use of legal and illegal drugs, the greatest risk of communicable diseases due to various factors and increased exposures such as lack of access to hygiene and health. They point out the advances in specific public policies and the challenges of guaranteeing comprehensive care with effective care strategies to respond to the basic needs, health demands and dignity of these people.[9-12]

Among the RAS points, the use of emergency services and hospital admissions[13,14] was more significant among homeless people with comorbidities and substance use.[15,16] The frequency of emergency care and hospitalizations can sometimes be avoided when homeless people receive high-quality primary care, guidance, social benefits and long-term support services for answers basic needs, thereby reducing spending on preventable health interventions.[13]

Other studies advance health promotion actions by working with smoking cessation counseling and pharmacology for smokers,[17] harm reduction,[18] interdisciplinary intervention after hospital discharge,[19] physical activity practices with health improvements mental, social and reintegration into the community.[20] However, much remains to be done to ensure health and its promotion, for people's quality of life, even on the streets,[10,20] which justifies the relevance of this theme.

In order to offer opportunities for access to goods and services for all, the promotion of citizenship and access to basic human rights is essential. In view of this, it is necessary to recognize homeless people's needs and to promote co-responsible actions in intrasectoral and intersectoral networks that seek to answer them. There is, therefore, the imperative of all those involved, especially management, to be involved with the set of elements that determines the offer of assistance, care and health promotion actions in the organization and in the management of services and teams.[21]

Given this context, the question arises: how do OOt professionals plan and develop health promotion actions considering the singularities and needs of people in street situations? How are the powers for promoting the health of people in street situations contextualized in daily life? How are the limits for promoting homeless people's health?

This study aimed to understand the powers and limits for promoting homeless people's health in the daily life of OOt.

Understanding the daily life as "the way of life of human beings that is shown on a daily basis, expressed by their interactions, beliefs, values, symbols, meanings, images and imagination. Thus outlining its process of living, in a movement to be healthy and get sick, punctuating its life cycle".[22:8]

## METHOD

This is a holistic-qualitative multiple case study,[23] based on Michel Maffesoli's Comprehensive Sociology of Everyday Life.[24]

This study contains two cases, defined by the scenarios, which are two capitals in the south of Brazil. The delimitation of these multiple cases was made by analyzing each case individually, under a single unit of analysis that relates to the research questions and proposition "health promotion of homeless people in the daily lives of the outreach office team"; Therefore, it constitutes a holistic-qualitative multiple case study and the definition of data collection in all existing OOt in the municipalities, interviewing professionals until data are saturated by literal replication. The logic of literal replication predicts similar results, not sampling, i.e., after revealing significant evidence through the first case, the immediate objective of this study was to replicate this evidence, leading the second case.[23]

The Comprehensive Sociology of Everyday Life proposes an understanding of social phenomena, highlighting a sensitive reason, which seeks to value everyday knowledge and common sense. Therefore, it becomes opportune to cast this look on the object of study, since it refers to everything that concerns daily life, the lived experiences, subjects' beliefs and actions in their relationship environments,[24,25] in specific cases/scenarios of everyday and real life in OOt, to be a concrete manifestation of the abstraction of the contemporary phenomenon studied.[23]

The research participants were 20 professionals from five OOt and 02 key informants, national/municipal managers, whose participation was voluntary. The study included professionals who work in OOt in the two capitals of southern Brazil for a minimum period of six months. The participation of key informants is justified for having contributed accurate information about the researched object and was indicated by the participants in this study. Professionals on vacation or away from work during the data collection period were excluded. As for people who did not meet the inclusion criteria, only one had less than six months of experience at OOt. Only 3 (13.6%) refused to participate in the research. Data collection ended when data saturation was verified, i.e., when a sufficient number of replicated information was obtained, configuring literal replication for similar results in both cases[23] without neglecting the new and significant information for this study.

As sources of evidence for the data, intensive open individual interviews were used, with a semi-structured script, and records in field notes. The interview was conducted by the researcher, recorded digitally, transcribed in full and validated by the participant's reading. The average interview time was 39 minutes and nine seconds. The field notes were used for operational purposes: directed to the operational procedures of the research, describing characteristics of the municipalities and OOt; the organization of OOt's work; logistics; the support points in the reference institutions and the RAS, in addition to the relevant facts of data collection.

Data analysis was carried out by means of thematic content analysis,[26] obeying the analytical technique of the cross synthesis of cases.[23] It was defined by the semantic criterion, i.e., by the analysis of "meanings" according to pre-analysis, material exploration, treatment of results, inference and interpretation,[26] considering the theoretical framework of Comprehensive Sociology of Everyday Life.[24] This article presents the category "Outreach office and care network in promoting homeless people's health: powers and limits in their daily lives".

Ethical precepts involving studies with human beings have been met. All participants signed the Informed Consent Form. To maintain the confidentiality of information and anonymity of research participants, alphanumeric codes were used to describe the results. This study was approved under Opinion 2,766,046 (Proposing Institution) and under Opinion 2,837,324 (Co-Participating Institution).

## RESULTS

Of the 22 participants in this study, 18 (81.8%) are female. The age ranged from 28 to 57 years, with an average of 43.3 years. As for education, six have high school technical training, 16 have higher education and 11 have post-graduate degrees, among which 02 have specialization in Outreach office. The average time at OOt was four years and eight months.

The results, presented in topics, consider the analysis subcategories of the thematic category "Outreach office and care network in promoting homeless people's health: powers and limits in their daily lives".

Health promotion is referred to as a challenge to be overcome in the daily life of OOt before demands of diseases, treatment of illness and biomedical logic. The results show how the actions to promote health promotion are planned and developed, focusing on the powers and limits in daily life. They point out the need to restructure services and articulate with the other components of the care network to advance the promotion of better quality life for people on the street, overcoming the institutional exclusion still experienced by the stigmatizing characteristics that these people experience (Field Notes).

### Promoting homeless people's health: how OOt plans and develops actions

The health actions carried out in the daily life of OOt seek to identify homeless people's demands in a comprehensive and articulated approach to the basic health network and the intersectoral network (Field Notes).

The search to overcome difficulties for an expanded dimension of health care, which includes the social determinants of living and falling ill in the space and time of the street, with a view to

promoting homeless people's health, has been present since the implantation of OOt:

> *Since the beginning, we have always tried to see what the needs of these people are in relation to the services that already existed. The Outreach office has six years in the municipality, but the Social Approach has 20, the SOP Center* (Specialized Reference Center for Homeless People) *has been in existence for 15 years. So, they are services that they already knew and could bring what needs that population had. Of course, in the first moment of the creation of the outreach office, there were a number of patients aggravated by the lack of care that this population had, but we did not want to be alone in the healing part* ($E_4$).

The reduced opportunities for health promotion actions and how OOt (does not) plan and (does) develop these actions on a daily basis were reported:

> *There is already a very consolidated work process, so they do not stop to plan health promotion actions. I have been doing this and trying to bring them more through practice. It is not just a matter of "oh, let's do a permanent education and talk", it is not only through discourse that I will be able to change, but show how to do* ($E_2$).
>
> *I, as a physician, very little! But I run after the loss of what I work with health promotion. From my specific work, I see that I am always in demand for treatment, treatment... who has succeeded, and I believe, is our psychologist, who has brought this possibility of this look of promotion.* [...] *as a team, is still very much in demand for the disease. The promotion is more in the individual, in which it is possible to work on harm reduction* ($E_6$).
>
> *We are more in treatment than in promotion. Do a lot of quick tests and have a lot of non-reactive patients, we do guidance, but you can't keep up with these people.* [...] *takes the patient already affected by the condition and treats the condition* ($E_3$).

## The street as a space for housing and support for homeless people: unequal distributions of health determinations

Promoting health permeates Non-Governmental Organizations (NGOs) and entities, which leads OOt to reflect on the street as a space for housing and support for homeless people and on the solidarity action of helping to fight hunger in these human beings in face of the unequal distribution of health determinations:

> *When I was a little girl, I would knock on the door and ask for old bread. Hunger is not a problem! There's lots of food! If you go out at night, there are people sleeping in the square with three lunchboxes, NGOs and churches leave. The penalty that moves people to want to help is a lot for the food. So, there would have to be a project where people would take their donations to a central* [...] *would have to have a renovation, a lot goes through the Christian conscience of wanting to help. With this kind of help, people remain even more on the street and speaking ill of the shelter. Because, of course, on the street they have freedom, in the shelter they have rules* ($E_7$).

Housing, drug addiction and pain are unique and legal approaches in a daily life with an open door to the homeless:

> *I address the housing issue, why is the person here? Do you have an addiction? Would you like to interrupt or reduce? Do you want to accompany us? I try to cover everything, if the person gives this freedom too, because there are a lot of people who arrive "I am in pain, I want this, the other day I come back and see if I want to", and we try to keep the door open* ($E_5$).

## Potentials in promoting homeless people's health

The powers to promote homeless people's health come from the articulation with the intra-sector and inter-sector network, carried out by OOt professionals. The network actions are aimed at individuals with a health problem (s) or facing social determinants that go beyond the priority demands of these people:

> *A power is networking, because health promotion is not done alone. As much as there is health in the name, but it is not only in the area of health. Mainly thinking about health in the expanded concept, leaving this biological clinical area. If health is having a job, if health is having a home, if health is accessing public services, I have to access the network. So, for me, it is the network articulation, it would be the maximum! Because thinking about difficulties, institutional limits, precariousness.* [...] *then, the network is the main power that we have in our hands, both because of the very effect of the union, of the qualification, but because we are united by the difficulties too. Unites in precariousness, unites by necessity* ($E_2$).

The organization of health care in the street scene is seen as a powerhouse for OOt for knowing homeless people's reality, *in loco,* and building the bond:

> *It is difficult to speak of powers for health promotion. But, the fact of being more on the street, ends up managing to talk to people and have a coexistence for a longer period. The bond of being in the place closest to where he is* ($E_6$).

Unique actions, when working to reduce damage in the context of the street, configure health promotion considering

subjectivity, condition and social environment, providing the connection between health care and the expansion of quality of life by reducing damage:

> *Primary prevention? We have a population that is already tertiary on several issues. Thinking about health promotion, we work first on the issue of chemical dependency in the view of harm reduction* ($E_{14}$).
>
> *We already played soccer... music circle, conversation circle. All of this reduces damage, as they are not using drugs, so it promotes health* ($E_{16}$).

Health care and care for homeless people are considered to be of collective scope, since actions and services become relevant to public health, when think of these conditions of living on the streets as an important element within of the dynamic relationship of the health-disease process:

> *One of the greatest potentials is to work on health promotion. Many people do not understand that working for the health of the street population is a job for the whole society, they still think it is very punctual, that it is for that person in itself, and it is not. We know it is something much bigger* ($E_4$).

Of the 22 participants, 10 presented the preventive and educational notion when addressing its meaning in terms of promoting homeless people's health, showing how the prevention of risks and injuries is configured in the daily activities and activities of OOt (Field Notes).

### Limits in promoting homeless people's health

The limits faced to develop actions to promote homeless people's health face the specificity and characteristics of this public, in the outsourcing of social assistance, in management, in politics:

> *There were several buckets of cold water over these six years, because working with health promotion itself is already very difficult! For the homeless, then, it is almost impossible: for what? For this population? Why dismiss a worker to do health promotion for a type of population that is not even seeking health care?* [...] *the limits are the political obstacles that still happen, it is not only for the homeless population, I think it is a really political issue in the country, we are also going backwards. But, I still think it is more difficult with regard to the homeless population* ($E_4$).
>
> *The limits of knowledge, political, institutional, all, of all kinds.* [...] *complain about the institutional limits of working conditions. For example, a cell phone is badly needed to be on the street. Office opening hours are un-ac-cep-ta-ble!* [...] *to street has routine, street has time! In the morning they sleep or have to spend the morning at the SOP center, because they can only have lunch if they are inside. Then those who are not at lunch at POP, their lunch is at two-thirty, because it is after two onwards that they will manage the restaurants, what is left over from lunch. From three to twenty I would say, because it sings well and then, at 8 pm it got dark, there is already another routine, it is already the use* ($E_2$).
>
> *The difficulty is this disruption of social assistance being outsourced, and with difficult communication*. [...] *social assistance deals with a greater need than health, resources, professionals. The fact that we are not able to work so much together, reduces the potential to promote.* [...] *another issue is that the team does not have other professionals, the social educator, the health worker, so it ends up stuck in the biological, in the technical* ($E_6$).
>
> *It is really difficult to work with health promotion with the homeless population other than Primary, Emergency Care* ($E_7$).

There is a mention that health promotion is difficult to articulate in the daily life of services, being interdependent on the network, management and policy:

> *Whether we will be able to do more health promotion depends on whether management is more sensitive to serving this population. If she is not so sensitized, she will keep the team doing the basics. And then, when faced with political issues, we had a project that involved the citizenship of homeless people.* [...] *and which is cut off for political reasons.* [...] *the street population is still very much the focus of this type of politics, making this promotion work difficult. But, the most important thing is to see in professionals' profile, the desire to work with the promotion* [...] *to do it in a big, wide way, it is still very difficult, and when we show up it ends up wanting to be covered* ($E_4$).

Considering multiple analysis of cases, in one of the cases, 66.7% of participants addressed the understanding of health promotion and how the actions are or are not planned and developed in the daily routine of OOt, considering the basic conditions and supplementary the living and coexistence of homeless people. In the other case, health promotion appeared in the descriptions of 14.3% of participants.

However, due to the observant look in the research field and the daily coexistence with OOt for data collection in both realities, health promotion actions are shown in this daily life as a scene and scenario. They were seen when witnessing moments in which people's daily needs who sought attention by OOt, or who was addressed in the breadth of living on the street, turned to the dimension of being and the determinants of living on the streets. Hunger, cold, clothing, lack of body hygiene, sleep on

the street, the abusive use of alcohol and other drugs, violence, illness and psychosocial condition were reversed by humanizing views and in articulated actions in a network. They need to ensure food, a warm body, a shower and clean clothes, sleep in the shelter, harm reduction considering dependence on alcohol and other drugs, relief from pain and suffering in the face of illness, loneliness, or wounds, whether visible or invisible, suffered or caused, which at the time of care and attention were not judged by the team (Field notes).

As presented by the participants of this study, a power in the daily life of OOt is *"the network articulation, because health promotion is not done alone".* Figure 1 shows how the care network for homeless people, intra and intersectoral, and solidarity is organized. This diagrammed presentation was suggested by the study participants and validated in a workshop, carried out in both scenarios, to return the results to the researched realities.

## DISCUSSION

The Outreach office was implemented as a public health policy to historically fill the existence of a healthcare gap for homeless people, privileging the approach of these people in their life contexts and on the street scene. Living on the street involves risky situations and behaviors, the unequal distribution of social goods and the culmination of social exclusion.

"Health Promotion is a field under construction and coexists with a plurality of concepts (ways of thinking about it) and acting (intervention)".[28:191] The promotion of health "as a power deals with the transition from passivity to activity, from heteronomy to autonomy, from technique to ethics, from reason to emotion, from the instituted to the instituting".[28:193] This "does not mean putting each of these concept words in antagonistic positions and having to decide for one or the other pole. On the contrary, it means the recognition of dynamic interrelationships that are, at the same

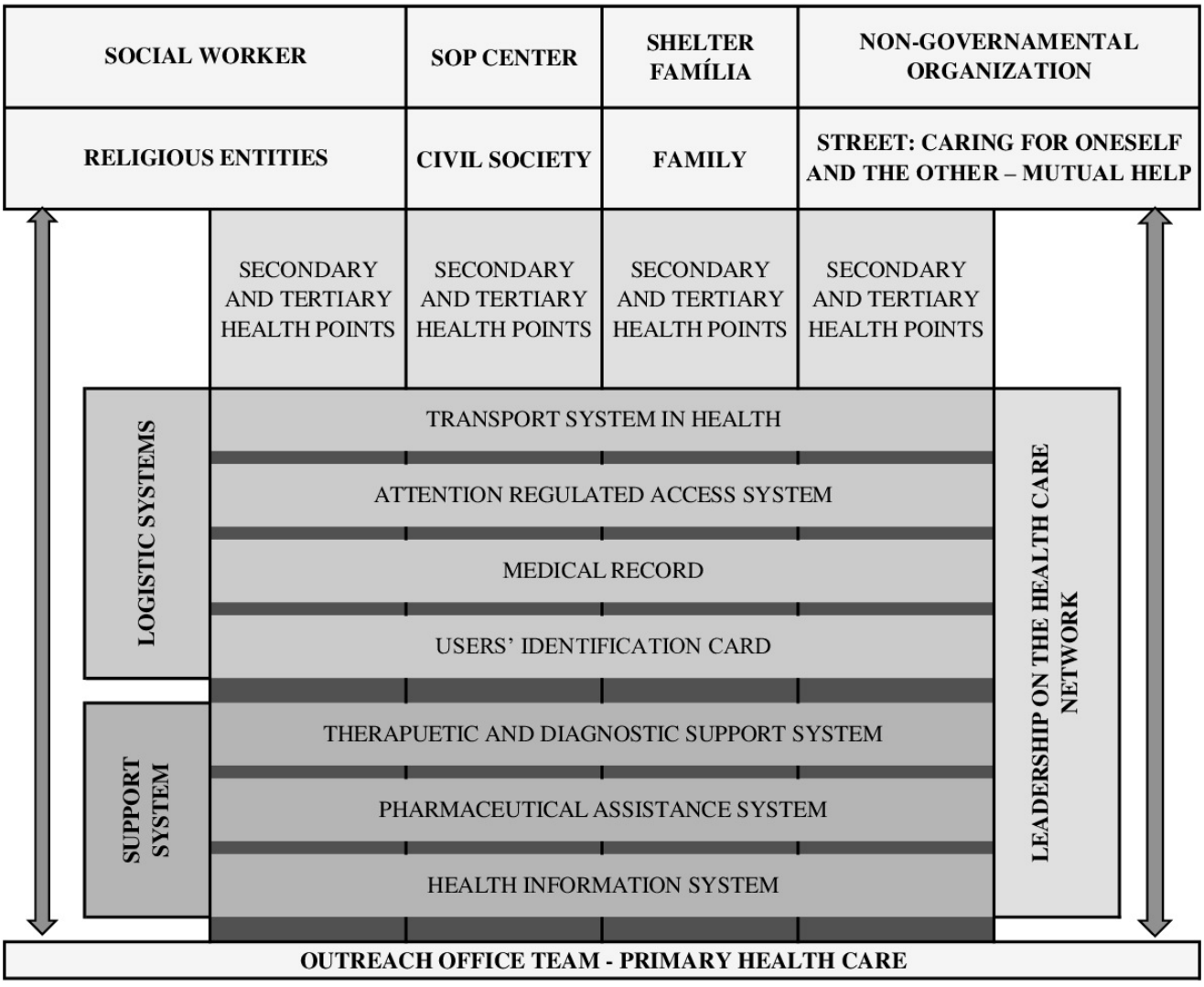


**Figure 1.** Street Outreach: health care for homeless people organized in intrasectoral, intersectoral and solidarity networks.
Source: Adapted from Mendes.[27]

time, objective and subjective, that there are tendencies now to intend them, now to place them side by side".[28:192-194]

Thus, health practices, when involving social and philosophical, symbolic and cultural dimensions, must consider the subjectivities that go through the process of being healthy and falling ill.[29] Considering the intrasectoral articulation and intersectoral collaboration, in the daily life of OOt, these practices permeate the expanded clinic in actions that go beyond health demands and are based on the struggle against social exclusion and the configuration of inequity in the distribution of resources and power in society.

However, in a context of vulnerable people, the current crisis proves to be societal by distancing lives, in which life itself is seen as absent, denied by not wanting to see or recognize what has been lived.[30]

The results confirm, in both cases studied, that the daily demand is more focused on disease treatment than on health promotion; however, attention to clinical conditions brings professionals being closer to homeless people, establishing a bond. A study corroborates these findings by showing that OOt identifies risks and vulnerabilities, and people at greatest risk have a more pressing focus on clinical demands. The first form of bonding is the immediate clinical care, creating an opportunity for longitudinality of care, making it possible to plan therapeutic projects, psychosocial care, incorporate educational actions, health promotion, support and social inclusion.[2]

A study carried out with homeless people leads to the understanding that the logic of operation and organization of OOt is directly related to the immediate conditions of existence of these people. Therefore, for this population to be healthy, it is essential to change their conditions of existence.[31] To impact on the conditions of existence of these people, intersectoral actions are necessary to promote health and basic social rights, which are still neglected. Neglect puts the future tense in check for future forms of life[32] by disregarding part of the population that lives with the insignificance of exclusion.

Thus, one lives the present on the street, the here and now, in immediacy, in resolving the need demanded at that moment of pain, illness, hunger, cold. The hermeneutic perspective is methodologically in line with the development of life stories. For OOt, it is necessary to grow along with what is sprouting. The concrete look is attached to the details of everyday life, to the immediate observations, to this theatricality of life, in this space, which is made up of small things, indifferent as such, but which, in an orderly set, make sense, in order to provide access to health and fundamental human rights to homeless people.

Based on the testimony of OOt professionals, housing and hunger are evidenced, fundamental human rights. In this scenario, the hunger supplied by people in the community is revealed, in a solidarity network, which "tends to emphasize the community feeling of belonging, i.e., the process of implication through which each one of us exists in function of the other"[32:121]. In this way, food not only nourishes the body, it also nourishes *being together,* enabling *organic solidarity*, of the Maffesolian common-living, which is not of the order of the instituted, of the mechanic, but rather based on an *ethics of aesthetics,* from *feeling together,* which is expressed by a bond.

When considering the structural elements of human dignity resulting from the convergence of the human being with the human being, the absence of two social rights, food and housing become more noticeable in relation to homeless people. The first ensures biological continuity, the second, a dignified existence.[33] Not having access to housing can be related to intrinsic and extrinsic factors, such as physical disturbance or loss of work.[34]

Although homeless people are heterogeneous in terms of their profile and the causes that led them to this condition, there is one thing they have in common: "extreme poverty, broken or weakened family ties and the lack of conventional housing, their the roof is the sun and the moon, its walls are the cardboard or the viaducts and the bridges ".[35:300]. Vital challenges that are part of this reality on the street and the determinants of the health-disease process, and that demand intersectoral actions.

Thus, it is necessary to be aware of the 'same things' and their internal logic. It is necessary to understand popular culture that maintains a magical relationship with its natural environment, with the world of objects, the interactivity that is established with the material world that constitutes everyday life.[32]

Weighing homeless people, a study carried out in Cheshire, a county located in northeastern England, points out thats experiences that lead people to become homeless should be analyzed considering the social conditions homelessness occurred, such as poverty, interruption of schooling, drug abuse, lack of social and psychological support, physical, sexual and emotional abuse, neglect, dysfunctional family environments and unstable family structures. Becoming homeless is considered to be a process characterized by a progressive decline in resilience created by these incidents, leading them to engage in behavior called (dis) adaptive: substance abuse, alcoholism, self-harm and disruptive behaviors.[36]

One can infer the transfiguration of resilience, adaptation and integration, since it is necessary to adapt and integrate with the world of the street, resisting, insisting, persisting in living, or, better, surviving, since it is always evasion risks, while, in a paradox, it is seen as a nuisance, exposing its own limit.

Considering the homeless people's reality in the city of Palermo, Sicily, Italy, a study carried out shows that, although Article 32 of the Italian Constitution states that for the protection of health, human rights are fundamental for each individual and the interest of the community, little has been done in terms of health planning to improve homeless people's quality of life and reduce health spending. It would be advisable to develop a preventive risk strategy and health interventions aimed at these people to improve their living conditions, in addition to allowing more equitable and accessible access to public health.[34]

Harm reduction was highlighted as an alternative daily practice for the prevention of risks and other diseases, health education and comprehensive care. The recognition of users' uniqueness by the team allows for the tracing of non-exclusive paths/strategies, respecting the freedom and resilience of each one, so that they

are protagonists of their choices, even in unfavorable conditions on the street.[18]

Participants in this study declare that there is only intersectoral action/collaboration and health promotion for homeless people if there is a political management and culture that reconfigures new ways of acting to minimize social exclusion.

The policy is no longer able to face the challenges of the moment, becoming an object of general distrust. Political power is an instance that determines social life, i.e., it limits it, constrains it and allows it to exist. The government has decision-making power that covers many areas of society. However, it is noted that the politician can only be recognized as such if he knows how to influence feelings, desires and collective imagination.[37]

To achieve health promotion of the homeless population, it is necessary to reflect on public policies and their effectiveness, the permanent education of professionals, guarantees of access to health and respect for singularities.[38] There is no way to talk about the right to health and fundamental human rights to life without talking about social justice. Participatory policies are necessary and that the exercise of citizenship is a space for popular participation for decision-making and effective health for all.

Finally, in the daily life announced by OOt, to promote health, it is necessary not only to guide, but, above all, to walk with homeless people, having as a guiding thread the bond, sensitive listening, touch, dialogue, considering limits and their powers, remembering that *while power is in the order of domination, power is in the order of cooperation and liberation.*[39]

## CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

This study points out that, in addition to assisting the demands of illness/illnesses, it is necessary to conceive and intervene in integrated and networked actions for a social, political and technical approach to the health-disease process that effectively promotes health for homeless people, even in unfavorable living conditions. Intrasectoral and intersectoral strategies must be established to minimize risks and damages to which homeless people are exposed.

Thus, thinking about health as access to education, work, transportation, leisure, food, among other determinants, implies overcoming the social exclusion of homeless people and defending the fundamental rights to life.

The daily presence of OOt in the context of the street reflects a policy that regains the autonomy of control over social determinants, being structured in intersectoral policies aimed at impacting on more humane conditions of life for the vulnerable. Finally, it is understood that it is through this way of promoting health, in daily life, that the potentials for operationalization of better health conditions for homeless people reside.

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## AUTHOR'S CONTRIBUTIONS

Study design Selma Maria da Fonseca Viegas.

Data collection or production: Selma Maria da Fonseca Viegas, Lucas Andreolli Bernardo.

Data analysis Selma Maria da Fonseca Viegas, Rosane Gonçalves Nitschke, Lucas Andreolli Bernardo.

Interpretation of results: Selma Maria da Fonseca Viegas, Rosane Gonçalves Nitschke, Lucas Andreolli Bernardo, Adriana Dutra Tholl, Maria Aurora Rodriguez Borrego, Pablo Jesús López Soto, Daniela Priscila Oliveira do Vale Tafner.

Writing and critical review of the manuscript. Selma Maria da Fonseca Viegas, Rosane Gonçalves Nitschke, Lucas Andreolli Bernardo, Adriana Dutra Tholl, Maria Aurora Rodriguez Borrego, Pablo Jesús López Soto, Daniela Priscila Oliveira do Vale Tafner.

Approval of the final version of the article. Selma Maria da Fonseca Viegas, Rosane Gonçalves Nitschke, Lucas Andreolli Bernardo, Adriana Dutra Tholl, Maria Aurora Rodriguez Borrego, Pablo Jesús López Soto, Daniela Priscila Oliveira do Vale Tafner.

Responsibility for all aspects of the content and the integrity of the published article: Selma Maria da Fonseca Viegas, Rosane Gonçalves Nitschke, Lucas Andreolli Bernardo, Adriana Dutra Tholl, Maria Aurora Rodriguez Borrego, Pablo Jesús López Soto, Daniela Priscila Oliveira do Vale Tafner.

## ASSOCIATE EDITOR

Aline Aparecida Monroe

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