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Living on the streets: An integrative review about the care for homeless people

O viver na rua: Revisão integrativa sobre cuidados a moradores de rua

El vivir en la calle: Una revisión integrativa sobre cuidados a los habitantes de la calle

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ABSTRACT

Objective: To identify essential elements in care practices for the Homeless Persons in the context of Primary Health Care and verify evidence and strength of recommendation for health decision-making. **Method:** Integrative literature review, using Health Descriptors, keywords and "MeSH terms" in the databases: LILACS, PubMed Centre and Web of Science. **Results:** Twenty-two scientific papers were selected and grouped into three categories: *Understanding of the Other, Support Network* and *Emancipatory Care*. The study identified important elements for the development of care, such as understanding Homeless Persons, valuing network care and *Emancipatory Care*. **Conclusion:** There was a need for further studies and research on the subject, which would make it possible to construct more equitable and inclusive health policies and actions for this population that needs very unique elements in care practices.

Descriptors: Homeless Persons; Primary Health Care; Health Vulnerability; Public Health; Review.

RESUMO

Objetivo: Identificar elementos essenciais nas práticas de cuidado à População em Situação de Rua, no contexto da Atenção Primária à Saúde e verificar evidências e força de recomendação para tomada de decisão em saúde. **Método:** Revisão integrativa de literatura, com uso dos descritores em saúde, palavras-chave e "*MeSH terms*" nas bases de dados: LILACS, *PubMed Central* e *Web of Science*. **Resultados:** Foram selecionados 22 artigos científicos que foram agrupados em três categorias: *Compreensão do Outro*, *Rede de Apoio* e *Cuidado Emancipador*. O estudo identificou elementos importantes para o desenvolvimento do cuidado, como a compreensão da pessoa que vive na rua, a valorização do cuidado em rede e do *Cuidado Emancipador*. **Conclusão:** Verificou-se a necessidade de novos estudos e pesquisas sobre a temática, que possibilitem a construção de políticas e ações de saúde mais equitativas e inclusivas a esta população que necessita de elementos muito singulares nas práticas de cuidado.

Descritores: Pessoas em Situação de Rua; Atenção Primária à Saúde; Vulnerabilidade em Saúde; Saúde Pública; Revisão.

RESUMEN

Objetivo: identificar los elementos esenciales en las prácticas de cuidado a la población en situación de calle, en el contexto de la Atención Primaria en Salud y verificar las evidencias y la fuerza de recomendación para toma de decisión en salud. **Método:** la revisión integrativa de la literatura, con el uso de los descriptores en la salud, palabras clave y "*MeSH terms*" en las bases de datos: LILACS, *PubMed Central* y *Web of Science*. **Resultados:** han sido seleccionados 22 artículos científicos que se agruparon en tres categorías: La Comprensión del Otro; La Red de Apoyo; y El Cuidado Emancipador. El estudio identificó elementos importantes para el desarrollo del cuidado, como la comprensión de la persona que vive en la calle, la valorización del cuidado en red y del cuidado emancipador. **Conclusión:** se verificó la necesidad de nuevos estudios e investigaciones sobre la temática, que posibiliten la construcción de políticas y acciones de salud más equitativas e inclusivas a esa población que necesita de elementos muy singulares en las prácticas de cuidado.

Descriptores: Personas en Situación de Calle; Atención Primaria en Salud; Vulnerabilidad en Salud; Salud Pública; Revisión.

INTRODUCTION

The street becomes a "permanent residence" for a long period of time for some people, remaining for weeks, months and years in the same place, often depending on the tolerance of citizens domiciled in the surroundings[1]. The problem of living on the street has several factors that favor staying on the streets. From the demographic point of view, they integrate people of all ages and sexes, some are even born and live the "whole" life on the street, without contact with the family of origin and without stable work[2]. Several factors exacerbate this situation, such as social inequality and prevailing social prejudice, bringing to the debate of public policies and health, the different needs and health care of this population.

Homeless Persons (HP) is understood as a heterogeneous population group with characteristics related to extreme poverty, family ties interrupted or fragilized, without regular conventional housing, using public places and/or degraded areas, temporarily or permanently, such as housing and livelihood, and may or may not use accommodation units for overnight or temporary housing[3].

The problem of living on the streets is the agglomeration of people, the proliferation of diseases, violence, stress and hostility. The illness on the streets has its own characteristics in the health-disease process, such as the spacing of meals, climate change and other factors that predispose this group to share specific health needs[4].

In Brazil, political mechanisms have been created to implement health policies and actions for HP, such as the *Política Nacional para a População em Situação de Rua* (freely translated as National Policy for Homeless Persons) (2009)[3] and the *Manual sobre Cuidado à Saúde junto a População em Situação de Rua* (freely translated as Handbook on Health Care with Homeless Persons) (2012)[5], both seeking to expand access and quality of health care, with specific public policies and mechanisms of care, such as Street Outreach (SO)[5].

The OS follow the foundations and guidelines defined by the *Política Nacional de Atenção Básica à Saúde* (PNAB- freely translated as National Primary Health Care Policy), acting on several specific health problems and needs for this population. The activities are developed in an itinerant way and with actions shared and integrated to the Basic Health Units, formed by multiprofessional teams, including the nurse in all modalities of Street Outreach teams (SOt)[5]. However, HP's own implementation of the policy faces obstacles of various dimensions, such as the dynamics of life of this population, fragmented and non-solidarity social relations, fragile intersectoral articulations and lack of capacity of public management, requiring the State efforts to overcome this reality[6].

Studies show that health services and professionals have little experience and knowledge in "embracing" Homeless Persons and meeting their needs, generating precarious reception. It may occur due to stigmatizing characteristics of this population, such as odor and use of drugs and alcohol, difficulty of access to scheduling appointments and inflexibilization of schedules, difficulties in the Support Network for hospitalization, thus increasing their invisibility[7].

Taking into account the problems of living on the streets, the increase of this population in the cities and the recent creation of public policies with specific services, the authors bring to the discussion the practices of care for Homeless Persons, offered in Primary Health Care (PHC). The choice of PHC but other devices in the care network was due to the understanding that this level of health care is the gateway to health services, acting as the first contact. Allied to this, the most recent HP care policies in Brazil are focused on care by the OS, which integrate the PHC network.

OBJECTIVE

To identify essential elements in the care practices of Homeless Persons in the context of Primary Health Care and to verify evidence and strength of recommendation for health decision making.

METHOD

Type of study and methodological procedures

This is a qualitative study, using the Literature and Integrative Review (LIR) method, in order to allow a synthesis of the studies and generate knowledge about the subject.

The LIR is a research method developed in evidence-based medicine, which permits the incorporation of evidence into clinical practice. Its purpose is to gather and systematize research results on a given topic or issue, contributing to deepen the theme. The LIR has in its course 6 different stages (steps) and complementary to its stages of development[8].

Because it is an integrative literature review, the study was not submitted to the Research Ethics Committee. However, all the ideas of the authors contained in the analyzed articles were maintained, being cited at all times.

Work stages

The study followed the 6 steps proposed for integrative review[8], with elaboration of the research question, the search for the primary studies, extraction of the data, analysis of included studies with interpretation of the results and presentation of the review.

In the first stage, the theme was chosen (care practices for the Homeless Persons in Primary Health Care); the delimitation of the questions: "What is the scientific evidence about the care for Homeless Persons in the perspective of Primary Health Care?" and "What essential elements are present in the practices of care for the Population in Street Situation?"; and the choice of keywords and terms in Portuguese through the Health Descriptors (DeCs – *Descritores em Saúde*) and the English terms through Medical Subject Heading (MeSH). In the second stage, the sites that were searched and the criteria for inclusion and exclusion of the studies were established. In the third stage, the categorization was based on the elements related to the care practices that emerged from the studies, based on the careful reading of the articles' *corpus*, establishing points of convergence and divergence. The 4th and 5th stages were performed concomitantly, where analysis and interpretation of the results occurred. The 6th stage, which occurred the presentation of the review and synthesis of knowledge, was fulfilled throughout the discussion of the categories, along the textual body.

Setting, sample and criteria of inclusion and exclusion

The bibliographic survey was carried out by means of consultation in the databases: LILACS, PubMed Centre (from the National

Library of Medicine of the USA - NLM) and Web of Science. In order to arrive at the publications on this subject, it was searched to select studies using the keywords, in Portuguese: "*População em Situação de Rua*", "*atenção primária à saúde*", "*cuidado*" and "*consultório na rua*". The Health Descriptors (DeCs – *Descritores em Saúde*), in Portuguese, were: "*pessoas em situação de rua*" and "*atenção primária à saúde*". The MesHs were: "homeless person" and "primary health care". We used the crosswords of the search terms, with the keywords and the descriptors in LILACS and in the other databases, associated the MeSh terms, all with the use of the Boolean operator AND.

The search for the studies comprised the period between 2003 and July 2016. It was decided to use only scientific articles, objectifying as a criterion of exclusion, publications that in the format as theses, dissertations and other materials obtained in the databases. The choice for articles published since 2003 was due to be the year of beginning of the occurrence of scientific production on this subject in Brazil.

The selection of articles was carried out in two moments with inclusion and exclusion criteria, both being part of the LIR stages. First, included studies published from 2003 to July 2016, which were available online ("free") and in full version, in Portuguese, Spanish and English; and to address care practices (selected from reading the study summaries). Exclusion criteria were: Care practices linked only in the approach to Mental Health and/or Hospital Care, studies that did not comply with the objective of the study, in addition to those repeated in more than one database.

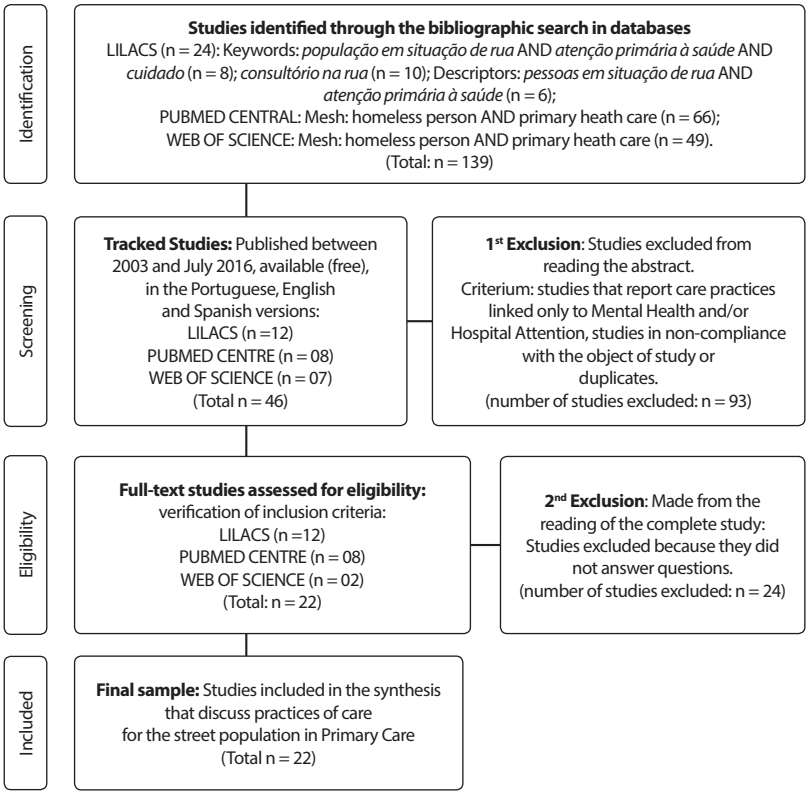

Figure 1 - Flowchart for selection of health care articles with Homeless Persons, Rio de Janeiro, Brazil, 2016

After the first exclusion, the articles were retrieved in full and after reading the material, those who did not respond to the study questions were excluded. The *corpus* of analysis was characterized in 22 scientific papers that discuss care practices related to Homeless Persons: Twelve (12) from LILACS, eight (08) from PubMed Centre and two (02) from the Web of Science. The Flowchart (Figure 1) presents the process of selection of studies.

Collection and organization of data

Printed articles were organized by data manager and references Zotero, where each study received a numbering (E1 to E22). In order to organize and summarize the information, a table was created (Chart 1), which served to visualize the data, allowing analyzing the characteristics and level of evidence of the selected articles. It also allowed the construction of categories by grouping studies with similar analysis, which were prepared and presented in three tables (Chart 2, Chart 3 and Chart 4).

Data analysis

The essential elements of care practices for Homeless Persons in Primary Health Care were presented by grouping the articles into three thematic categories: *Understanding of the Other*, *Support Network*, and *Emancipatory Care*. These categories were produced from the synthesis of each study included in the integrative review and comparing the findings on differences and similarities.

In order to determine the level of evidence, the Grading of Recommendations (Grading of Recommendations, Assessment, Envelopment and Evaluation) was adopted, which is based on a system of methodological guidelines for grading the quality of evidence and the strength of recommendation for decision-making in Health. The level of evidence represents confidence in the recommendation of the information, classifying in four levels of quality: High, moderate, low and very low. However, it does not only evaluate the type of study, other factors can raise or reduce the level of evidence. The force of recommendation expresses the emphasis that a certain conduct is adopted or rejected[9].

Data collection and analysis were performed from November 2015 to July 2016.

RESULTS

Synthesis of Selected Studies

Among the publications found, we selected 22 articles that passed the criteria of inclusion and exclusion, based on the theme "care for Homeless Persons". These articles were presented in Chart 1, containing the publication characteristics (year, journal, authors, title, city and country) and study design.

Chart 1 deals with a *corpus* of analysis, with national and international publications, both presenting experiences of caring for Homeless Persons at PHC. In relation to the twelve national publications (around 55%) and analyzing the publications by regions of Brazil, it can be seen that 75% of publications in the Southeast region, coming from the states of São Paulo (São Paulo and Campinas) and Rio de Janeiro (Rio de Janeiro and Niterói). It is also worth noting that in Brazil, the city of São Paulo was the one that started the publications on this subject and only in 2012 were articles published in other states. In the Northeastern region of the country, one publication (8.3%), from the state of Ceará (Fortaleza) and the one from the South region, two publications (16.7%) from the states of Rio Grande do Sul Alegre) and Paraná (Curitiba).

In relation to the 10 international publications (45%), six studies were selected (60%) from the United States (Virginia, California, Philadelphia, Alabama, Marrow, Maryland, Pittsburgh and Boston), one (10%) from England (London) and three (30%) from Canada (Toronto and Calgary).

Chart 1 - Characteristics of the selected studies, related to the year, authorship, title, journal, place of study and design, Rio de Janeiro State, Brazil, 2003 a 2016

Nº	Publication Year and Journal	Authors	Title	Outline	City and Country
E1	2016 *Ciência & Saúde Coletiva*	Engstrom EM, Teixeira MB[10]	*Equipe "Consultório na Rua" de Manguinhos, Rio de Janeiro, Brasil: práticas de cuidado e promoção de saúde em um território vulnerável*	Qualitative research, with systematization of an experience	Rio de Janeiro (Brazil)
E2	2016 *Escola Anna Nery*	Kami MTM, Larocca LM, Chaves MMN, Lowen IMV, Souza VMP, Goto DYN[11]	*Trabalho no consultório na rua: uso do software IRAMUTEQ no apoio à pesquisa qualitativa*	Qualitative research, use of interviews, use of IRAMUTEQ software	Curitiba (Brazil)
E3	2016 Patient Preference and Adherence	Steward J, Holt CL, Pollio ED, Austin EL, Johnson N, Gordon AJ, Kertesz SG[12]	Priorities in the primary care of persons experiencing homelessness: convergence and divergence in the views of patients and provider experts	Qualitative research, using interviews	Marrow, Maryland, Pittsburgh, Alabama (USA)
E4	2015 BMC Family Practice	Campbell DJT, O`Neill BGO, Gibson K, Thurston WE[13]	Primary healthcare needs and barriers to care among Calgary´s homeless populations	Qualitative research, using interviews and Focus Group	Calgary (Canada)
E5	2015 *Cadernos de Saúde Pública*	Hallais JAS, Barros NF[7]	*Consultório na Rua: visibilidades, invisibilidades e hipervisibilidade*	Qualitative research, using participant observation	Campinas (Brazil)
E6	2015 *Saúde Debate*	Silva CC, Cruz MM, Vargas EP[14]	*Práticas de cuidado e população em situação de rua: o caso do Consultório na Rua*	Qualitative research, Case study	Rio de Janeiro (Brazil)
E7	2014 MedCare	Kertesz SG, Pollio DE, Jones RN, Steward J, Stringfellow EJ, Gordon AJ, Johnson NK, Kim TA, Granstaff U, Austin EL, Toung AS, Golden J, Davis LL, Roth DL, Holt CL[15]	Development of the primary care quality-homeless (PCQ-H) instrument: A practical survey of patients' experiences in primary care	Quantitative-qualitative research, use of interviews	Alabama (USA)
E8	2014 Lancet	Hwang SW, Burns T[16]	Health interventions for people who are homeless	Systematic review	Toronto (Canada)
E9	2014 Rev *Interface: Com Saúde e Educação*	Londero MFP, Ceccim RB, Bilibio LF[17]	*Consultório de/na rua: desafio para um cuidado em verso na saúde*	Experience reporting from field diaries	Porto Alegre (Brazil)
E10	2014 Rev *Interface: Com Saúde e Educação*	Macerata I, Soares JGN, Ramos JFC[18]	*Apoio como cuidado de territórios existenciais: Atenção Básica e rua*	Experience report	Niterói (Brazil)
E11	2014 *Fractal Revista de Psicologia*	Pacheco MEAG[19]	*Políticas Públicas e capital social: O projeto consultório de rua*	Discussion/Reflection Article	Fortaleza (Brazil)
E12	2013 BMC Health Services Research	Campbell JTD, Gibson K, O´Neill BG, Thurston W [20]	The role of a student-run clinic in providing primary care for Calgary´s homeless populations: a qualitative study	Qualitative research, use of interviews and analysis of categories	Calgary (Canada)
E13	2013 American Journal of Public Health	Kertesz SG, Holt CL, Steward JL, Jones RN, Roth DL, Stringfellow E, Gordon AJ, Kim TW, Austin EL, Henry SR, Johnson NK, Granstaff US, O´Connell JJ, Golden JF, Young AS, Davis LL, Pollio DE[21]	Comparing homeless persons' care experiences in tailored versus nontailored primary care programs	Comparative survey	Pensilvania, Alabama, California, Massachusetts (USA)

To be continued

Chart 1 (concluded)

Nº	Publication Year and Journal	Authors	Title	Outline	City and Country
E14	2013 *Rev Polis e Psique*	Macerata IM[22]	*Experiência POP RUA: Implementação do "Saúde em Movimento nas Ruas" no Rio de Janeiro, um Dispositivo Clínico/ Político na Rede de Saúde do Rio de Janeiro*	Experience report	Niterói (Brazil)
E15	2013 Journal of the American Board Fam Med (JABFM)	Weinstein LC, LaNoue MD, Plumb JD, King H, Stein B, Tsemberis S[23]	A primary care-public health partnership addressing homelessness, serious mental illness, and health disparities	Experience report	Philadelphia (USA)
E16	2012 Journal of the American Board Fam Med (JABFM)	Price-Stevens L, Goode JVR[24]	Shared Care Model in a federally qualified health care center for the homeless	Experience report	Virginia (USA)
E17	2010 *Revista Saúde e Sociedade*	Junior NC, Jesus CH, Crevelim MA[25]	*A Estratégia Saúde da Família para a equidade de acesso dirigida à população em situação de rua em grandes centros urbanos*	Experience report	São Paulo (Brazil)
E18	2010 American Journal of Public Health	O' Connell JJ, Oppenheimer SC, Judge CM, Taube RL, Blanchfield BB, Swain SE, Koh HK [26]	The Boston Health Care for the homeless program: A public health framework	Document review study	Boston, (USA)
E19	2007 *Revista da Escola de Enfermagem da USP*	Canônico RP, Tanaka ACDA, Mazza MMPR, Souza MF, Bernat MC, Junqueira LX[27]	*Atendimento à população de rua em um Centro de Saúde Escola na cidade de São Paulo*	Experience report	São Paulo (Brazil)
E20	2006 *Revista Saúde e Sociedade*	Junior NC, Andrade MC, Luppi CG, Silveira C[28]	*Organização de Práticas de Saúde equânimes em Atenção Primária em região metropolitana no contexto dos processos de inclusão e exclusão social*	Experience report	São Paulo (Brazil)
E21	2003 *Cadernos de Saúde Pública*	Junior NC, Silveira C[29]	*Organização das práticas de atenção primária em saúde no contexto dos processos de exclusão/ inclusão social*	Experience report	São Paulo (Brazil)
E22	*2003 British Journal of General Practice*	Riley AJ, Harding G, Underwood MR,Carter YH[30]	Homelessness: a problem for primary care?	Discussion/Reflection Article	London (England)

Regarding the distribution of articles on the thematic axis, almost all are linked to the Public Health area, except for two articles published in journals in the area of Psychology and another two in a Nursing journal. Regarding the methodological nature: 20 articles are qualitative (91%), one (4.5%) quanti-qualitative and one (4.5%) quantitative. In relation to the drawing: Eight (36.4%) are researches of several drawings (case study, systematization of experiences) using interviews and/or Focus Group and/or field diary, ten (45.4%) are (9.1%) as a theoretical discussion or reflection on the subject, one (4.5%) as a documentary review and another (4.5%) as a systematic review.

Synthesizing the knowledge produced regarding the level of evidence of the studies analyzed: 64% presented very low level of evidence and 36% level of moderate evidence. Most of the studies that presented very low level of evidence are national studies, because they are in the format of experience reporting and without a more methodological outline. The observational studies outlined, with methodologies and methods more outlined, are in the foreign literature. There was thus a lack of national studies with other levels of evidence (moderate and high), which are well-outlined types of clinical and/or observational trials.

Analyzing the strength of the recommendations of the studies, also by the GRADE System[9] - which relates the studies to factors that can raise or lower the quality of evidence, expressing the emphasis to be adopted or rejected a certain conduct, considering the balance between the advantages and disadvantages, the selected studies present factors that increase the quality of the evidence. These factors are the high magnitude of effect with benefit to PH, and the beneficial effects of improving the quality of life can be considered as advantage, without presenting in the studies risks of adverse effects, such as the psychological load for the patients and the cost to the society. In addition, the studies present recommendations for health policies, positive interventions for patients and professional conduct favorable to the target public, analyzing the implications of the degrees of recommendation in relation to the target audience (managers, patients and health professionals). It establishes, therefore, a balance in the relation between advantages and disadvantages, demonstrating benefits for the care for Homeless Persons, being able, then, to have a strong force of recommendation.

From the reading of the *corpus* of the articles and analysis of its results and discussions, it was evidenced that the construction of the link as an instrument of care with HP is very important. In order to facilitate the determination of essential elements related to the practice of care for Homeless Persons, we sought to group similar discussions into the following categories: *Understanding of the Other*, *Support Network* and *Emancipatory Care*, which we analyze.

Understanding of the Other

Nine studies were grouped in the category *Understanding of the Other*: E4, E6, E8, E11, E13, E14, E16, E19 and E21.

In this category, the studies pointed out essential elements for the care of Homeless Persons (Chart 2). The care goes through the construction of a bond, through a qualified listening by the reception[7,14,22], with a break in the prescriptive[14] and punctual care, serving as an instrument to rescue the value of life and health, citizenship, of the dignity and of the affective-intellectual of the individual[29] and starting from the necessity of each individual[13,21,24] . Care practices based on the analysis of the different *habitus* of these individuals[19] favor the interpersonal relationship between Homeless Persons and health professionals[16].

Chart 2 - Essential elements pointed out in the studies of the category *Understanding of the Other*, Rio de Janeiro, Brazil, 2016

Category *Understanding of the Other* - Essential elements pointed out in the studies	**Studies**
- Positive interpersonal relationship between HP and healthcare professionals (respect, mutual trust, acceptance and care)	E8
- Bonding and reception (qualified listening)	E6, E19, E14
- Access and individualized care to the needs of each individual	E13, E16, E4
- Disruption of prescriptive care	E6
- Non-punctual care, with redemption of citizenship, dignity and affective-intellectual	E21
- Understanding the *habitus* of each individual	E11

Support Network

Seven studies were grouped in the category *Support Network*: E1, E2, E10, E15, E17, E20 and E22.

Studies grouped in the Support Network category bring the articulation as an essential element to promote care with Homeless Persons (Chart 3). The articulation of the health and intersectoral network as a referential north for the promotion of care: articulation with all health services and other sectors[10,18, 23,25,30,28] as shelters ("Housing First")[23,30] and to articulation with other offices[25]. The articulation presents itself through the work process, and it may occur the creation of a catalog of services: through device surveys and establishment of connections between services, respecting the processes of reference and articulation between therapeutic projects[10]. This method of support would function as a methodological north for joint actions in the territories, as a methodology of approximation, housing, composition and care[18].

The articulation also comes from the approximation and contamination of the territory, working in the perspective of expanded health care, which contrasts the practices of compulsory collection of street users in shelters or compulsory hospitalization, and is still a practice present in some social work services[10]. The articulation as a proposal of work is also presented as a partnership between public health services, health schools and "shelters", becoming essential for the evolution of the purposes of integration to housing centers and other public sectors[23], as well as such as the importance of teamwork for an articulated attention of different knowledge and practices[11].

Chart 3 - Essential elements pointed out in the studies of the category *Support Network*, Rio de Janeiro, Brazil, 2016

Category *Support Network* - Essential elements pointed out in the studies	**Studies**
- Articulation of the health and intersectoral network as referential north for care	E1, E10, E17, E15, E22, E20
- Housing Coordination	E15, E22
- Articulation between government Offices (inter-office)	E17
- Catalog of services with connection to each other and articulation with therapeutic projects	E1
- Approximation of territory and understanding of the ways of living of the population	E1
- Care based on the reception and not the recollection	E1
- Teamwork with an emphasis on the articulated attention between the different knowledge and practices	E2

Emancipatory Care

In the category *Emancipatory Care*, five articles were grouped: E5, E3, E7, E9 and E18.

The term *Emancipatory Care* for this category was based on the work of Hallais and Barros[7] who in his study used this term. These authors bring *Emancipatory Care* to recognize the diversity and autonomy of the subjects, allowing their participation in the process of care, also called as a political act of care. To enable and enhance this form of care, the relationships between professionals and users should be reconfigured, preserving life histories and knowledge of individuals, thus building empathy and links[7].

Although Hallais and Barros[7] have the greatest emphasis on this term, the other studies (Chart 4) also discuss elements of care very close to this proposal, that is, they defend a care that aims at the emancipation of the subjects[7,26]. The challenge of *Emancipatory Care* would be to break the "invisibility" of Homeless Persons to give them real conditions of their participation in society, reflecting, for example, the various processes that are inherent to their movement of being on the street[7,15,26].

The articles point out that in order to break with several issues that hinder and limit access to care, one must instead use listening as a political instrument, recognizing and valuing the subjects' autonomy, knowledge and narratives, in order to *Emancipatory Care*.

It is necessary to deconstruct the stigmatizing and "colonizing" look of health professionals and services, thus breaking with "biopower"[7], absorbing the unexpected, the unscheduled and the non-prescriptive[17,26,15]. However, for this, another study[17] brings the importance of moments of pause between the interventions of the professionals who care for this population, for the very reflection of the care, calling *Care in Composition*.

In the moments of deceleration, the sensitivity emerges and the professionals stand next to what they are taking care of, in a "composition" of care.

An essential element in the care given to the Homeless Persons through emancipation would be the development of new research, new findings and innovative solutions to specific health problems, contributing to the development of participatory policies in this area[12,15,26].

Chart 4 - Essential elements pointed out in studies of the category *Emancipatory Care*, Rio de Janeiro, Brazil, 2016

Category *Emancipatory Care* - Essential elements pointed out in the studies	**Studies**
- Emancipation of the subjects with focus on the political care.	E5, E18
- Recognition of the diversity and autonomy of the subjects, transforming them into participatory agents of the health-disease process.	E7
- Understanding the street as a territory of the Homeless Persons: living on the street.	E5
- Breaking with biopower: care must absorb the unexpected, the unplanned and the non-prescriptive, with the development of new research and innovative solutions.	E5, E9, E18, E7
- Care in composition: moments of deceleration of the caregiver, the caregivers are placed next to who is caring for.	E9

DISCUSSION

This study sought to carry out a review of HP care through the elements identified in the scientific articles, also seeking to base it on the evidence and strength of recommendation. Although some studies, mainly national, present a low degree of evidence, the strength of the recommendations of these studies was considered strong, contributing with elements that can collaborate for the construction of policies and actions related to the care. However, it points to the need for new research with more methodological rigor on the evaluations of these practices, which are directly linked to the professionals who work with HP. The international articles, in great part, with structured methodological delineations have brought to this review, real elements to consolidate the practices of care and rethink the formats outlined in the policies to HP.

The studies grouped in the category *Understanding of the Other* valued, before any practical action of care, the bond and the listening through the reception to the understanding of this subject[16,19,21-22,27,29]. The key elements for the production of care, through this review, as well as this category, permeate the bond built by qualified listening and the disruption of prescriptive and punctual care. The care does not come by appointment, and cannot be punctual and at that moment. Care takes time, partnership; identification of needs, for this becomes a longitudinal care and in the very construction of this care, builds the bond.

Although the host is seen as a device capable of contributing to the reorganization of the work process and the reconstruction of practices, there are still difficulties in incorporating into the health practices the concepts of longitudinality and coordination of care. In the daily practice of health, a pilgrimage of users in search of care is perpetuated[31].

This construction of care can happen at PHC. The studies highlighted the PHC as the essential place for the occurrence of these care practices with a focus on embracing Homeless Persons [15-16]. But for this to happen, another important element present in the set of articles analyzed is the *Support Network*. This support is materialized in a wide way in the work of the present networks of the territory where this population is inserted. The networks are identified and built in the territory, during the production of care.

In the *Support Network* category, they emphasize care based on the appreciation of the articulations of the services. The support is seen in an expanded way, in the work of the institutional networks in the territory and as in the support of the work process of the professionals. Based on the knowledge of the singularities of the person living on the street, the support goes through several ways of conceiving it in care, through links between teams and subjects, intersectoral and even inter-office links, together to enhance the capacity for articulation and connection between the various elements, producing health care in a shared way[18,20,23,25,30].

The construction of the *Support Network* is not easy, representing a major challenge at PHC. In Brazil, the Health Care Network (RAS - *Rede de Atenção à Saúde*) consists of the set of health services and equipment that exist in a given geographic territory, but cannot be restricted. Work with the homeless should not be restricted to a region, as many people move away from their homes, break family ties, and seek out other neighborhoods, cities, and even states[32]. When they build other groups and choose other places of housing they need other services and other professionals to rebuild their care and even to promote access to ensure comprehensiveness and care.

PHC professionals can contribute to this reintegration movement into a new territory. This migration will produce new interaction with other services and professionals, implying the construction and reconstruction of *Support Networks*, requiring the implementation of qualified actions of meetings between different services, specialties and knowledge[32].

The *Emancipatory Care* expresses, in this category, the movement in defense of the emancipatory political care that inserts and permeates the subject, making him a citizen, bringing this citizen who lives on the street and from the street to articulate and formulate his own care. PHC professionals can thus reconfigure prescriptive care and "re-create" their way of producing care from their experimentation with this other.

In this case, *Emancipatory Care* is one of the important elements, bringing this subject to the center of care, delimiting who this subject is and what needs it points to the construction of health practices. Thus, to include the subject in the center of care represents placing him as the protagonist of his own life and his care.

This category, *Emancipator Care*, is based on the very concept used by the authors Hallais and Barros[7], when they analyzed in their study the visibility of HP, as of another author who worked on this concept in other contexts, such as Pires[33]. *Emancipatory Care* comes as a political act of care, presupposes caring as a gesture and solidarity attitude, assuring rights and citizenship[7,33].

Care, in this sense, comes not only from listening to others and from networking, it comes from recognizing the other as a citizen and as protagonist of his own life, with State responsibility, in determining new participatory policies and new proposals for care in Health with Homeless Persons[7,15,17,26].

It seeks to implement the care in its political form, which means, therefore, to move to public agent of change, formulator and inducer of the same, passing from patient to citizen. *Emancipatory Care* produces autonomy, self-care and self-knowledge[33].

In this perspective, the care for the Homeless Persons cannot be understood and implemented in a punctual and prescriptive way, but rather constructed taking into account the trajectory of the living of these subjects. Recognizing, therefore, the homeless person as the protagonist of their care can be a challenging task for health professionals who often work with rigid, pre-instituted prescriptions and protocols in which the social context and subjectivity are not recognized of these subjects when implementing health actions. The care that is proposed here is anchored in the diversity of needs and demands brought about by them.

Study limitations

We emphasize the limitation of the study because the *corpus* has greater emphasis in the national literature, which had a greater number of reports of experience, restricting the quality of the evidence. Another issue, regarding the limitation of the study, was the fact that other international databases were not investigated, leading to the non-inclusion of other scientific articles.

Contributions to the sectors of Nursing, Health or Public Policy

It is believed that the development of research and the findings in the experience reports serve to review and rethink care practices and policies with this unique group. The present study may contribute to the creation of proposals for care actions in the area of Nursing and Public Health, in general; thus encouraging a more focused care for those who live on the street, understanding this subject, valuing teamwork and *Support Networks*, and bringing the *Emancipatory Care* proposal to the debate. Still, the study may encourage the creation of more proposals aiming at the solution for public policies to the homeless.

Further research on the subject is recommended, especially at the national level, as HP care practices are being implemented. We are, in Brazil, at the beginning of the trajectory of actions and research on this subject and we can guide us through the researches already carried out in international scenarios, such as USA and Canada. These countries conduct health care practices with Homeless Persons and research on the issue since the 1980s with policy consolidation in the form of "projects". In Brazil, studies have only been in progress since 2000.

CONCLUSION

The present integrative review made it possible to analyze the national and international scientific production on the practices of care for Homeless Persons and the generation of scientific evidence about successful experiences of these practices of care in this specific population. It also identified some important elements that should guide these practices, not only for nursing professionals, but for all professionals engaged in these care practices, including managers and professionals from other areas.

The study identified important elements in caring for Homeless Persons, such as understanding the homeless, valuing network care, *Emancipatory Care*, and valuing the caregiver. To understand who this other person is on the street is to look at the other in a non-prescriptive, "bare" way, without prejudice, trying to understand what needs to be held and how care can be performed in the most effective format for needs. The care in *Support Network* goes through the valuation of the various sectors and professionals and defends the work of joint form in the territory, with the strengthening of intersectoral links.

The emancipation of the subjects, making them co-participants of their care project, becomes necessary for all forms of care, conceiving listening as a political instrument, valuing the autonomy, knowledge and narratives of the other. In this sense, the street is not only a place of exit but also of permanence, becoming the territory of care. Care practices must take into account, because this living territory, with its own unique demands of those who live on and off the street: Smells, sounds, narratives, affections, the life of the street.

Based on what was analyzed it was evidenced that care with Homeless Persons has no way to follow a prescription or predetermined actions. The care here is also very unique and is performed on a daily basis, when the professional can perceive and capture how it happens to live on the street and how the individual belongs to it. For this, he must always bring the subject who lives in the street to the center of his care, who will determine the actions of care from the needs identified by him, making this *Emancipatory Care*.

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