Access barriers: Analysis based on the perception of Street Clinic workers

Barreiras de acesso: uma análise a partir da percepção das trabalhadoras do Consultório na Rua

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ABSTRACT The present study aimed at understanding the access barriers of homeless people (HP) in Belo Horizonte city to health services as well as to analyze the employed care strategies from the Belo Horizonte Consultório na Rua (eCR), street clinics' team view. We report a qualitative study by means of semi structured interviews with 10 workers from two eCR. The investigated HP face protocol and symbolic discriminatory barriers that hamper and impede their rights of access to the health system, besides the Brazil Unified Health System (SUS) equity guidelines. These barriers are related to the social exclusion process to what the homeless people are submitted, marked by multiple and overlapping violences, restricted access to basic rights that are escalated when the use of drugs is reported. Among the strategies to overcome the access barriers are the need to qualify public data on HP, institutional dialogues on the HP access to the SUS, a more permanent education attitudes to demystify thoughts and prejudices, the need to elaborate different flows that take into account the HP's ways of life, the need of outgoing primary care actions that promote inclusion of the Belo Horizonte HP, as well as strategies that strengthen them with active social participation.

KEYWORDS Ill-housed persons. Health services accessibility. Health equity. Vulnerable populations. Qualitative research.

RESUMO *O presente artigo visa analisar as barreiras de acesso aos serviços de saúde da População em Situação de Rua (PSR) e as estratégias de cuidado na percepção das trabalhadoras das equipes de Consultório na Rua (eCR) de Belo Horizonte. Trata-se de um estudo qualitativo, realizado por meio de entrevistas semiestruturadas com 10 trabalhadoras de duas eCR. A PSR possui barreiras de acesso discriminatórias, protocolares e simbólicas que impedem a efetivação do acesso ao direito à saúde, apesar da diretriz da equidade ser norteadora para o Sistema Único de Saúde (SUS). Essas barreiras se relacionam com o processo de exclusão social ao qual a PSR está submetida, marcado por múltiplas e sobrepostas violências, pelo acesso restrito aos direitos básicos e se agravam quando há relatos de uso de drogas. Dentre as estratégias de superação das barreiras de acesso estão a necessidade de qualificação de dados públicos sobre a PSR, alinhamentos institucionais sobre acesso da PSR ao SUS, ações de educação permanente para desmistificar mitos e preconceitos, elaboração de fluxos que considerem os modos de vida da PSR, atuação extramuros da atenção primária para vinculação da PSR do território e estratégias de fortalecimento da PSR com participação no controle social.*

PALAVRAS-CHAVE *Pessoas mal alojadas. Acessibilidade aos serviços de saúde. Equidade em saúde. Populações vulneráveis. Pesquisa qualitativa.*

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Introduction

The Homeless Population (HP) is a heterogeneous group that has in common extreme poverty, the weakening or rupture of family ties, the lack of conventional housing and the use of public places as housing and sustenance[1].

The large number of HP in Brazil is the result of the worsening of social issues, especially the rapid urbanization that occurred in the 20th century, with migration to large cities, the formation of large urban centers, social inequality, poverty, amongothers[2]. The HP lives in a permanent state of vulnerability, either because they do not have documents (which is indispensable for citizenship), or because they do not have a home, money, fixed employment, caused by not having access to education or because they find it difficult even to receive healthcare[3].

There is a shortage of updated public data that quantify and characterize the HP in Brazil, and they are not included in the census data of the Brazilian Institute of Geography and Statistics (IBGE), because it is not a domiciled population. The Institute of Applied Economic Research (IPEA) estimated that, in 2022, there were 281,472 homeless people in Brazil[4]. In May 2023, there were 204,244 homeless people registered in Cadastro Único (CECAD)[5].

To obtain a national overview of the reality of homelessness in Brazil, a national survey on homelessness was carried out in 2009, which identified 31,992 people over 18 years, living on the streets. According to the research, homeless people have difficulties in accessing health services, and more than half of the interviewees said they had suffered discrimination and maltreatment in health services, where they are sometimes considered to have 'social pathology', avoiding entering certain spaces because they understand that they will probably be expelled[1].

The multidisciplinary teams of the Street Clinic (eCR) were created to deal with the different problems and health needs of the HP, given the recognition of the difficulty of access to primary care services[6]. The eCRs correspond to a type of extramural care, which seeks to provide comprehensive care, offering on-site healthcare assistance to guarantee care for PSR. The teams make up Primary Health Care (PHC) and circulate in the territories in a vehicle, offering health care adapted to the specificities of a population with important complexity[7].

This article aims to analyze the barriers of access of the HP in the SUS, as well as the possibilities of construction of care from the perception of the workers of the eCR. The results presented are part of a master's thesis[8] that sought to understand the role of eCR in the street space and public scenes of drug use.

Material and methods

This is a qualitative study, considering that this research format allows a deeper understanding of certain social phenomena, favoring the subjective aspect of social action in view of the configuration of society's structures. Thus, qualitative methods emphasize the specificities of a phenomenon in terms of its origins and its reason of being[9].

Semi-structured interviews were conducted with workers from two eCR. The researcher contacted each team during work meetings where she presented the research and invited them to participate. The selection criterion of the workers was to integrate one of the teams that work in the territories of the studied scenes of drug use. Refusal or absence from work during the collection period were defined as exclusion criteria.

Ten interviews were conducted, from October to December 2021, with an average duration of forty minutes. Two professionals from each category (social worker, nurse, harm

reducer, art educator and psychologist) of two eCR, who work in the studied scenes of use, participated. The audio of the interviews was recorded, later transcribed, and the material was archived on the institution's servers.

The names used in this article are fictitious to preserve the anonymity of the participants. The data were analyzed using the Thematic Content Analysis technique[10]. Content analysis can be understood as a communications analysis tool that makes use of systematic procedures to describe the content of messages.

Initially, the transcribed content was organized by thematic axes; then, the analysis was carried out according to the frequency with which these themes were mentioned and, in a third moment, the cross-sectional analysis was carried out, in which the transcribed content is cut and grouped into the thematic axes initially organized. Among the thematic axes identified, here we intend to discuss an axis that was presented as central: the perception of the workers about the access of the HP to the SUS network.

The interviews aimed to understand the performance of the device with the HP in the scenes of use. During the analysis, it was noticed that access barriers were a recurring theme in the interviews. This topic has become an important element of research, considering the privileged extramural view of the eCR in relation to HP with its on-site performance and its ability to look intramural within public health policy. As health workers, they have a different approach to the HP, based on their prerogative to be a low-demand service, that operate in the street space, which brings a more specific look at this reality. In contrast, they also have a look within the institutionality of the SUS/BH network, considering that they are part of it.

The research was guided by Resolution No. 466/12[11], of the National Health Council (CNS), which regulates the guidelines and standards on research involving human beings, approved by the Research Ethics Committee of Fiocruz Minas/Instituto René Rachou (CAAE 46888821.0.0000.5091) and by the Research Ethics Committee of the City of Belo Horizonte (CAAE 46888821.0.3001.5140) under registration 4,084,770.

Results and discussion

The eCRs that were part of the research are mostly composed of black women (black and brown). At the time of the interviews, 7 workers had one to two years of experience in the service, as shown in the *table 1* below.

Table 1. Research participants

Name	Gender	Age	Race/Ethnicity	Education	eCR working time
Iris	Cis Woman	20 a 24 years	White	Completed Higher Education	From 1 to 2 years
Amarilis	Cis Woman	30 a 34 years	White	Completed Specialization course	From 1 to 2 years
Margarida	Trans man	25 a 29 years	Asian	Completed High School	From 1 to 2 years
Dália	Cis Woman	30 a 34 years	White	Completed Specialization course	From 1 to 2 years
Tulipa	Cis Woman	35 a 39 years	Brown	Completed Specialization course	From 3 to 4 years
Lírio	Cis Man	25 a 29 years	Black	Completed High School	From 1 to 2 years
Violeta	Cis Woman	30 a 34 years	Black	Completed Specialization course	From 1 to 2 years
Camélia	Cis Woman	35 a 39 years	Black	Completed Higher Education	7 years or more
Azaleia	Cis Woman	30 a 34 years	Black	Incomplete Higher Eduaction	From 1 to 2 years
Antúrio	Cis Man	20 a 24 years	Brown	Completes Secundary School	From 3 to 4 years

Source: Self elaborated.

For analysis purposes, the barriers were categorized into three types, although sometimes they intersect: discriminatory barriers, protocol barriers and symbolic barriers, which are addressed in each section respectively. Then, results that are not related to the central categories are presented, but are important to think about the possibilities of care found in the topic of building bridges.

Discriminatory barriers: 'left there and fell, no one saw, only saw at the end of the shift'

Butler points out in her work 'Precarious Life' that some lives are "highly protected", however "other lives will not find such rapid and fierce support and will not even qualify as bereavable"[12(52)]; the framing makes some lives more or less bereavable. For the author, all life is precarious, however she distinguishes the intrinsic precariousness of life from another that is the product of a policy, acting unevenly in some populations.

> It is what could be called the differential distribution of precariousness, which is linked to the differentiated distribution of health and goods, and which is also related to the aspect of human life exposed to hunger, violence or destruction[13(69)].

Pinheiro relates Butler's idea of framing with the dehumanization of the bodies of sex workers, with emphasis on the denial of the pains experienced by them, since "their pains are not perceived as violence, but as consequences of what they are — women sex workers"[14(75)].

Regarding the notion of framing, the author explains:

> When we take a photograph, we remove from it what is not desired for the other to see, what should not be printed. Angle is also a choice and determines a priori what the photographer wants to highlight or discard from the frame

boundary. Associated with the idea of framing, the limit of the frame corresponds to its margins, or edges. The frame chosen for a photograph — as well as its production —, or for a situation, carries a discursive intention and a choice of what fits within the frame and what does not exist in front of that frame, meaning what will not be seen[14(80)].

Under the logic of framing, when faced with the person in a street situation, the subject who sees him decides (by a conscious choice or not) to direct his gaze to these subjects by placing them at the angle of the framing or at the margin of it, outside the edges. Relating the reality presented about sex workers with the HP, a similar context of marginalization and discrimination is perceived when the precariousness experienced is associated with vagrancy, laziness or choice, causing them to be outside the framing of the beings that should be cared for.

It stands out here, according to Pinheiro[14(80)]

> That seeing 'these subjects' is much more than looking, because it is a political choice. Everything that is seen is delimited by edges that exclude from the captured image what should not be inside the frame. [emphasis added].

The notion of racial discrimination used by Almeida, that is "the attribution of differentiated treatment to members of racially identified groups"[15(32)], has as a "fundamental requirement the power, without which it is not possible to attribute advantages or disadvantages on account of race"[15(32)].

In this text, the word discrimination is represented as the action of intolerance and prejudice that separates and segregates people or groups, culminating in disadvantages or privileges for individuals depending on the group to which they belong, whether by race, ethnicity, gender, sexual orientation, religion, social situation, disability, among others, recognizing that such practices in health services are known to be factors that hinder health access and care[2].

In this sense, it was used to define as discriminatory barriers the actions developed by public actors that prevent or disqualify offers to the HP driven by prejudices, such as reports of refusal of care; distancing at the time of examining; inadequate care; not touching the subject during the clinical evaluation; demanding that the user return cleaner; failing to indicate a therapy for discrediting adherence[8].

In the interviews, several cases were reported that can be related to the notion of discriminatory barriers because they are homeless, however a situation arouses attention due to its severity and negative outcome: the time that the eCR took a user to hospital, later the team received a call from a professional from the Emergency Care Unit (UPA), informing: "*there is a man who is here at the door that you brought yesterday, he does not want to stay, he is here at the door, but he cannot stay here at the door*". And Amarilis, one of the interviewees, responds: "*No! He can stay wherever he wants. But is he okay? What's going on*?" The UPA professional informed that he could not walk, but had signed a "*term of evasion*".

When the team arrived at the unit, the patient had already been taken back inside because he had a significant worsening of the condition. After readmission, he was isolated for suspected tuberculosis and, after two days, died after a fall from the stretcher. According to the UPA team, the patient was found "*fallen ... he already had mydriasis, his pupil was dilated, he had no brain response*". And he concludes: "*we understand that it was [...] negligence, of care. They didn't go there, they left him there, and he fell, nobody saw, they only saw him at the end of the shift*" (Amarilis).

The situations above dialogue with the findings in the literature and reveal how this population is socially seen by a stigmatized bias[16], loaded with prejudices[17], with the resistance of some health professionals to serve them[18], revealing themselves as the 'unwanted patient' of many health services, which generates fear and distrust of users[19] – who know the limitations of access and feel discriminated[20]. The

release of the patient after the signature of the alleged 'term of evasion' indicates a lack of responsibility in relation to the patient who is in the unit.

Corroborating the literature, there were reports of discriminatory situations with the HP aggravated when related to drug use, as occurred in an orthopedic emergency care:

The doctor dismissed him, started saying that he cannot use antibiotics because he is a crack user, and talking loudly. He [the user] *is a older man, he was ashamed, he lowered his head [...] he said* [referring to the doctor] *that it is because he uses crack, that he wants nothing to do with life, that he chose this. I intervened, I said 'sorry, what does this have to do with medication? [...] It's not like that, he's a straight-up guy, you're here to take care, it's not your job, he's here to receive care, and we're here to make sure that happens'.* (Azalea).

The marginalization of these bodies is due to the (re)production of the stigma to which the HP is subjected, contributing to the construction of a negative image of these individuals. In situations such as the one described, moral convictions loaded with prejudices are attributed, even before listening to the subject's life story or diagnostic complaints. The aggravation of stigma when it comes to people in harmful drug use comes from a notion of fragility of character, vagrancy or dangerousness[16,17], driven by a 'conceptual slippage' between poverty, madness and dangerous classes that needs to be overcome[21].

Health professionals are also influenced by this imaginary[16] and, often, since the patient's report on drug use there is hostility in the clinical conduct of care. Case of a pregnant woman who sought the health center and the professional of the unit said

Oh, but I will not want to open this SISPRENATAL [referring to the registration of the system for monitoring and evaluating prenatal care and the puerperium monitored by the Ministry of Health]*, becouse then, if I do not find her, if I have*

to answer for her, I do not want to answer for it, I will be sued if the baby dies, if this woman dies on the street, the responsibility will be mine.

Some discriminatory barriers identified in the interviews were the lack of commitment to the care of people, *"when we go to accompany a person in the clinic, the person* [care professional] *talks looking at us* [eCR worker]*, does not look at the person* [patient]*, as if the person were not there"* (Amarilis); they refuse care, saying *"return with the Street Clinic"* (Amarilis), determining the presence of eCR as a precondition for care.

It is noteworthy that these discriminatory actions towards the HP do not concern individual choices of professionals in isolation, on the contrary, they correspond to the social imaginary related to homeless people, the result of a social process of segregation and social exclusion. Such actions are disconnected from SUS' guidelines and go against the technical regulations of the Ministry of Health that provide for equity and guarantee broad, simplified and safe access[22].

Protocol barriers: 'They prefer to go with us, because we arrive breaking some barriers'

Among the situations of denial of access identified in the interviews, there were bureaucratic and protocol justifications, such as: lack of identity document, SUS card, proof of residence, absence of fixed residence, vacancy time in the unit's schedule for divergent service of the ways of life of the HP or a condition to care only with the presence of an eCR[16,18,21,23].

We named as protocol barriers the actions of denials of access of the homeless person in public health services under justifications related to the infrastructure of the services, protocols, flows, routines, registrations, schedules and other motivations related to the organization of the services. We do not intend here to invalidate the need to establish flows and protocols, including understanding the importance of systematizing processes to guarantee access to SUS. However, the difficulty of the network in reviewing the protocol processes to guarantee the right of access of the HP from an equity perspective is questioned.

The legislation provides for comprehensive health care for families and individuals in situations of vulnerability or social and personal risk, and must be given regardless of the presentation of documents[24]. Refusal for health care in these cases is a situation of violation of rights, either by disinformation or deliberately.

In the municipality, there is a guideline for the dispensation of medication for undocumented HP, however, the HP continues to face protocol barriers justified by bureaucratic aspects that reinforce the institutional violence arising from the bureaucracy of health services[25]. An important aspect pointed out by the workers is the need for a differentiated 'calculation' in the clinical conduct of care to the HP, considering their ways of life:

This routine, which sometimes works so well for us, of waking up at such a time, of eating, of resting, […] the way people organize themselves on the street is really different. And if we bring the same parameters, it will always 'go bad', they will always think that the person is not wanting to take care of their health. It's different, because he has several other problems that we can't measure. (Íris).

The relationship of the health professional with the user of the services can be established as a power relationship, where technical knowledge overlaps with the user's knowledge, either in the relationship with the eCR or with the other teams of the SUS network. Sometimes, there is a risk of disregarding the immediacy that permeates the logic of life of the HP[26]. About these behaviors misaligned with the ways of life of this population, Amarilis reports:

You can't think that 'oh, so-and-so will arrive at the health center at seven o'clock in the morning'.

It is a crowd that does not sleep at night because it using all the time, they do not sleep at night because the street is dangerous at night [...] so they always have to be alert. [...] When morning comes is when there is a little more security, and yet it is dangerous, he will not arrive at the health center at seven o'clock in the morning to collect blood. (Amarilis).

The ways of life of the HP are often related to the search for daily survival (what to eat today, where to sleep today, how to protect oneself today). Therefore, their needs and their daily lives need to be guiding in the construction of care protocols, thinking in a health network that knows the needs of this population. The inflexibility of schedules for consultation may be incompatible with living on the street[25], making access unfeasible.

Regarding protocol barriers, the eCR have an important role in mediating the relations between the HP and the services:

We have to convince the subject that he is a subject of rights, and then we have to convince the tip [referring to network services] *that it is the right that he has to be cared for.* (Azalea).

As much as there are differences between protocol barriers and discriminatory barriers, both result from prejudice and disregard of the ways of life of the HP.

Another striking aspect of the interviews are the noises found in the relationship between the eCR and the workers of other services, either by leading the patient considered 'unwanted' – by generating more work demands for the team that receives it – or by the interventions that the eCR need to make at some moments to be able to guarantee the access of the HP to other care.

It is noticed that, even composing the care network of SIS/BH, often the subjects accompanied are seen by other services as 'patients of the Street Clinic', with little commitment to the construction of shared care. It is necessary to demarcate that

the guarantee of comprehensive care must be the responsibility of the health system and not the result of the individual battle, often desperate, of each user, [or in this case, of the eCR][27(122)].

Symbolic barriers: 'We've been waiting for you'

With regard to health care processes, although there is no physical-spatial distance from health services, it is clear that homeless people, especially those who attend the scenes of drug use, have great resistance and avoid approaching territorial-based health services, including in situations of pain and acute suffering[16].

An aspect that causes astonishment is the refusal to seek health services, with several reports of situations in which the subjects expect the return of the eCR on Monday.

When we arrive, people will look for us and say: 'look, so-and-so is like this, we were waiting for you here'. The community is very close to the UPA, of the CERSAM AD [Mental Health Reference Center]*, the health center [...] because there I joke that it is like the hospital area. And yet, sometimes you will arrive on a Monday and someone will say that they have been waiting for you since Friday.* (Íris).

Situations such as this can be considered symbolic barriers to access, when, even before having a denial of access in a specific service, the person deduces that they will not be well served and avoids entering public spaces from an expectation of expulsion[1]. In the literature, there are records of feelings of low self-esteem on the part of the HP, feelings of shame, comparissons to garbage[17], showing the reproduction of stigmas that are internalized and contribute to the distance from health services.

These symbolic barriers can easily be perceived in the discourses from Íris, who mentions a set of public health equipment in the

territory, with ample hours of service to the public in the open door modality. This includes CERSAM AD (in Belo Horizonte corresponds to the Psychosocial Care Centers for Alcohol and Drugs – CAPS AD), the Health Center and the UPA, located between 240m to 350m from the living space of these subjects who, even so, are unable to access them in order to have their rights to health effective.

There was a report about a critical situation presented with a user who experienced a conflict with trafficking. She was in the park, fingers parted by a machete cut, there was tissue rupture and a deep wound with bone exposure. The user had been tortured after being accused of putting salt in commercialized cocaine. The team tried to mobilize her to be assisted in the UPA 350m from the site, however, even in the face of a serious situation, the user did not accept. Faced with the refusal and severity of the injury, eCR chose to dress and monitor the wound on the street, even though it was aware that the offer of care in the situation was far from ideal, but understood that it was the possible care from the perspective of harm reduction. It is understood that this refusal may also be motivated by the fear of calling the police, as it is an episode of violence and an illicit activity.

The situations reported reveal similarities in the scenes of use in Belo Horizonte/MG with the one portrayed in Cuiabá/MT, where

fear, prejudice and distrust are at the base of the symbolic (but real) barriers that hinder the arrival of subjects in health services that operate in fixed establishments[19(88)].

It is noteworthy that these symbolic barriers are not related to something imaginary. They allude to a refusal or distancing of homeless individuals from health services, an expression of the real prejudice suffered throughout life when accessing public establishments[1]. Repeated access barriers foster symbolic barriers that result in lack of trust, dissatisfaction with services and, consequently, withdrawal

and distancing from public health services.

The access barriers found in the researched context are related to the conception of Filho and Moura[20] about social humiliation as a modality of anguish, resulting from the traumatic impact of class inequality. Humiliation for the poor (here situated in the context of the HP) is a reality felt in daily life as imminent, always lurking, and the feeling of not having rights, of looking despicable and disgusting is imposed on them, as beings that no one sees.

Thus, the access barriers identified from the perspective of the workers sometimes intersect and resemble each other, since the factors that generate them are based on the same basis, the process of social exclusion.

Despite all the impasses presented, there is no intention in this article to fall into a fatalism, as if there were no production of networked health care. Although this article focuses on the critical points related to access barriers, possible outputs built on a daily basis collectively, in a network, were identified for the realization of the right to health of the HP.

Building bridges: 'That's our job, bridging'

The workers pointed out the eCR as "*a service that arrives with the body as no service arrives*" (Tulipa), which arrives in places where other services do not arrive and this arrival becomes possible from the link built by the device with the territories.

It is to arrive, understand, respect that space. But that's it, I think we have to be there, if we are not there, it's not enough. Even the vaccine, currently we are going to vaccinate because there is a link, they are going to vaccinate because they know the team, we are going to vaccinate at the Health Center because we are going to refer them, understand? We are a little fringe, which will arrive first, we have a perspective. For the advancement of other professionals [referring to other services] *it is still necessary to ascertain the expertise of the Clinic.* (Camélia).

Relating the context of the research with the literature on the performance of eCR in the country as a more fluid device, which adapts to the reality of the subjects, it becomes evident "the contrast of the view of those who see the scene from the highway, from inside a car, and those who enter the scene"[28(157)].

The displacement of these teams and the direct approach to the user in the place and the way he is, without prejudgments, allows an approximation of reality that demystifies stigmas and generates a tendency to erase discomforts since the establishment of a bond[16,18,28].

One of the terms used to refer to the functions of eCR is the fact that the service is established as a bridge between the street and the other SUS' devices. As much as many users do not access their rights in territorial-based health services, with the presence of eCR "[they] *have the information, they see the white blouse passing by,* [they know] *that it is city hall equipment, from health and that, if they need it, they will go*" (Lírio). Situations such as those described reveal the importance of the action proposed by the Ministry of Health of a mobile device that serves *in loco* in these historically neglected territories, with the potential to expand users' access to health and other social rights with the health network and intersectoral network.

The fact that it presents itself as a low-demand service, with a certain informality, which arrives in a friendly way with the offer of harm reduction inputs, escapes the imagination related to health workers in white coats, with formal language, prescriptive conduct and, perhaps, even cold from a relational point of view. The possibility of transit through the territory, the ingenious management skills of the technicians and the expanded offer of care that go beyond only the curative logic (with harm reduction actions and art education), considering the perspective of integrality of the SUS, allows access and care to the extent that users allow.

The relationships established with the network are sometimes complex and generate the need for daily dialogue between the devices of the SUS network.

> The Street Clinic is an important device, not only to guarantee access, but to reduce the stigma of this vulnerable group, given the expanded forms of reception, the strengthening of self-esteem and the recognition of users as subjects of rights[16(100)].

It has the potential to minimize the deleterious effects of the performance of health services, even causing constraints to question the discrimination and lack of assistance of the HP[28].

Bonding, dialogue and listening are important tools for the performance of the service, used as a care and bonding strategy:

> *So, to achieve this bond with the user, we use listening, you know, we show him that we are willing to listen to him, that we are not there to just deliver something, to be able to only offer something, but also to listen to him, to understand him. So, this is usually the strategy that we use in the park, listening to the users and explaining the service to them, you know, explaining about harm reduction too and so that this trust and this bond is established, that we believe that everything comes from there, from the bond with the user, from the trust that he has in us.* (Lírio).

Goldblum[29] discusses the importance of the care actions used by the eCR of Rio de Janeiro/RJ following an inverse logic to promote access according to the specificities of the users, with no expectation that the user adapts their characteristics to the service. Acting in a low-demand and high availability perspective involves being an access service with or without scheduling, with the non-requirement of documentation, as well as the availability to welcome the intoxicated subject, not demanding to be abstainers, presenting itself as a service that facilitates the access of the user who, historically, encounters a lot of barriers when seeking a health service.

The power of the eCR is perceived as a network-articulating health service, which proposes care in an expanded perspective, considering principles such as subjectivity and autonomy. The service has a possibility of adapting to the reality of the HP due to its mobile infrastructure, often subverting the necessary, but rigid, health protocols.

Final considerations

This research, carried out within the scope of SUS, corresponds to an instrument of reflection on the work process, indicating possible improvements to the system, with the possibility of supporting public policies that qualify access from the perspective of equity.

Regarding municipal management to reduce protocol barriers, it is important that there are institutionalized alignments for the situations already provided for in national and municipal regulations, as well as the establishment of specific flows and protocols for the HP, considering their ways of life to guarantee access and timely care, with wide dissemination within the network.

Permanent health education actions can prove to be a strategy to reduce discriminatory barriers, seeking to demystify stigmas and guide workers. The actions need to contemplate the harm reduction guidelines of the SUS (integrality, universality and equity), as well as reaffirm the non-negotiability of the professional performance of the public-servants in line with the guidelines of the Ministry of Health and the National Policy for the Homeless Population.

With regard to symbolic barriers, based on the recognition of primary care as care coordinator, especially in Belo Horizonte, which has 81.2% coverage of the Family Health Strategy[30], it is recommended to build extramural action to recognize this population in its assigned territory. Also, make it possible to link HP with the services, in addition to the working of the eCR. It is also important to strengthen the social participation of the HP – such as the creation of the National Movement of the Street Population in the 2000s, in the face of growing indignation at violence and the denial of rights[2] – and its representation in social control, in Health Councils and Conferences.

Collaborators

Fraga PVR (0000-0001-7252-8574)* contributed to the conception of the work, data analysis, preparation of the article, final approval of the version to be published. Modena CM (0000-0001-7966-9951)* contributed to the study design, analysis and interpretation of the data, critical review of the article. Silva PFC (0000-0001-9553-0036)* contributed to the study design, data analysis, critical review of the study. ∎

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