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Experience reports

Rua na rede: a device for care in the context of the Street Clinic

Rua na rede: um dispositivo para cuidado no âmbito do Consultório na Rua (abstract: p. 13)

Calle en la red: un dispositivo para el cuidado en el ámbito del consultorio en la calle (resumen: p. 13)

Sarah Brito Saminêz[a]
<sarah.saminez@grad.ufsc.br>

Iacã Machado Macerata[b]
<i.macerata@ufsc.br>

Lívia Maria Fontana[c]
<consultorionaruafloripa@gmail.com>

(a) Graduanda do curso de Psicologia, Universidade Federal de Santa Catarina (UFSC). Departamento de Psicologia, Centro de Filosofia e Ciências Humanas, Universidade Federal de Santa Catarina, *campus* Universitário, Trindade. Florianópolis, SC, Brasil. 88040-970.
(b) Departamento de Psicologia, Centro de Filosofia e Ciências Humanas, UFSC. Florianópolis, SC, Brasil.
(c) Psicóloga, Equipe Consultório na Rua, Secretaria Municipal de Saúde, Prefeitura de Florianópolis. Florianópolis, SC, Brasil.

The aim of this experience report is to present the Rua na Rede (Street in the Network) device, created by the Street Clinic team (SCT) in Florianópolis, as a strategy for building comprehensiveness and longitudinal care for SCT users during hospitalization and after discharge. The authors' experience of building the device was analyzed through their field diary, in dialogue with the scientific literature on the subject. The report underlines that Rua na Rede is guided by the Harm Reduction paradigm and faces an important challenge for the Brazilian National Health System: the link between Primary Care and Hospital Care. A nodal point for integrality and longitudinal care for homeless people.

Keywords: Device. Street Clinic. Comprehensiveness. Care. Harm reduction.

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Introduction

This article is aimed to present a device for care in the context of the Street Clinic teams (SCT), created by the SCT of Florianópolis: *Rua na Rede* (Street in the Network). This device has the power to be, at the same time, a care, clinical management and network-building device, affirming an important guideline of *Consultório na Rua* (Street Clinic -SC): caring for the user and caring for public policy networks. According to Ministry of Health Ordinance No. 2488/2011, this is a service that is part of the Primary Care component of the Psychosocial Care Network (RAPS) and develops primary care and psychosocial care actions aimed at people living on the streets.

Due to the complexity of the health situations, it deals with, SC has the potential to develop new care technologies that can respond both to local realities and build technical references for other services and spheres of action. We understand that the creative potential of the service depends on the relationship it builds with the street territory. We start from the assumption that the dynamics of the street demand flexibility in the SC's technical work, posing challenges to the knowledge of the health field and demanding a radicalization of the principles of the Brazilian National Health System (SUS), especially comprehensive care, since the links between social, subjective and biological determinants in the health issues of the people living on the streets (PLS) are especially evident[1].

The "Street in the Network" device was created in 2018 as a tool to accompany SC users in Florianópolis in health and intersectoral network services, specifically in hospital admissions. Its follow-up consists of supporting the user's adaptation to the institution, and vice versa, seeking to ensure that hospital discharge does not constitute a break in the continuity of care. Gaps of care after discharge are very common phenomenons[2]. In the case of homeless people, this discontinuity is exacerbated by the fragility of their community support network. The device is therefore an organizer of the flow of the network, but also a proximal care device, which includes the uniqueness of the case in care, both within the hospital and post-discharge. As well as caring for the user, we can say that Street in the Network helps with care between the network: the link and flow between services and teams.

The aim of this report is to state that Street in the Network, as a technical device, is guided by the Harm Reduction (HR) paradigm and links primary care and hospital care, fostering and expanding the PLS support network. The aim is also to state that it is an instrument of continuing education for both the professionals who work in the hospital and the SCT itself, as they become capable of meeting the specific needs of street users, and the latter become competent to articulate their actions with the hospital institution. Street in the Network would thus have multiple valences: care, clinical management and continuing education. To demonstrate this, we analyzed the experience of one of the authors as an SCT worker, by analyzing his field diary over a period of one year. We selected two analyzers[3] that support the assertion that Street in the Network is a strategy for tackling the problem of hospitalization in the context of SCT care.

Hospitalization and primary care: interruption and opportunity

The SUS is made up of a wide-ranging network and encompasses various health actions and services, covering different levels of complexity: from basic care to hospital care. In order to encompass this broad spectrum, it is essential that the services are articulated and integrated into a network, for the SUS to function better. One of the biggest challenges is the relationship between hospitals and primary care, in order to enhance and add resolubility, strategically contributing to comprehensive care at its different levels of complexity[4].

In many cases, this relationship is fragile or even non-existent, creating a problem that is not restricted to individualized care, since this good articulation and integration depends on users' health situations not worsening and the consequent overload of high complexity[4]. We found a scarcity of scientific articles on the problem of the relationship between primary care and hospitals, especially with regard to PLS. This points to a blind spot in the network, both in terms of care and the production of health knowledge. Hospitals are part of networks that are set up by regulatory systems, through hierarchical, fragmented flows that end up not prioritizing user demand.[2] If hospital care is operated too rigidly, it can weaken the network and produce discontinuity of care[2].

A specific problem faced during hospitalization is the failure to consider the uniqueness of the lifestyle of homeless people, which is one of the main aspects to be valued in care. It is important that the health professional is engaged to the point of being sensitive to the user, but also responsible and enabling interventions based on this relationship[2]. Haddad & Jorge[2] point out that maintaining trust and the bond between professional and user are fundamental to sustaining continuity of care and ensuring that the specific demands of the subjects are fully addressed.

Our experience shows that the period of hospitalization, as a critical moment, can be a turning point in the case, an opportunity to think about and plan new possibilities, if it is part of a larger follow-up process. If there is continuity of care, the moment of hospitalization can function as a moment of respite, where care can be rethought. Thus, longitudinal care is central, as it enables not only curative actions, but also promotion, prevention and rehabilitation actions through multi-professional monitoring and networking[2].

Comprehensive care for the user implies making available and guaranteeing a diversity of available health technologies, which can improve quality of life and create a safe and comfortable space for hospitalization, and should be the subject and interest of hospital management[5]. Care in this context is necessarily multidisciplinary, in other words, the work of various professionals needs to be articulated, but also of different services, especially primary care.

Too much centralization in the hospital institution means that comprehensive care cannot be achieved. This can only be achieved through networking. When one area of knowledge or one service centralizes the process too much and has a monopoly on diagnoses and treatments, this vertical relationship compromises a comprehensive approach and intervention that takes into account the complexity and multi-determination of the health situation. Thinking about clinical management

from the point of view of comprehensive care is essential if users are to be less divided up by divisions that are typical of the formation of health knowledge and that go against vital functioning, in which the biological, sociocultural, institutional and subjective dimensions are inseparable and require a comprehensive approach.

According to Cecilio & Merhy[5], properly coordinating a diverse set of knowledge and care actions is one of the greatest burdens of the hospital management process and should be a central aspect of discussions on integrality and management. The line of care must be a transversal one that cuts across different health services. The hospital should be considered one of the components for comprehensive care, since this period of hospital downtime can be a gateway to achieving the necessary comprehensiveness, recognizing that urgent and emergency services (such as hospitals) are also gateways for the population that needs access to the SUS[5]. It is in this context that we understand the relevance of Street in the Network. It is important to democratize and decentralize health knowledge and actions in the context of hospital admissions, enabling a universal and comprehensive public health system, so that acts of care take place from a non-vertical relationship both between professionals and between professional and user[5].

The SC teams are multi-professional and carry out activities on site, in an itinerant way, developing shared and integrated actions with the Basic Health Units, the Psychosocial Care Centers, the Urgency and Emergency services and the other points of the intra and intersectoral networks[6]. The Street in the Network device is a strategy for sharing and integrating the SC's actions, since it means that the SC is inside the hospital, carrying out active searches for users who have not yet accessed the service for some reason, as well as accompanying those hospitalized who are already SC users.

According to a survey of homeless people carried out by the Ministry of Health, 43.8% of those interviewed said that they first seek out hospitals and emergency services when they are ill[7]. In this sense, the device functions strategically, responding to the SC's guidelines of operating longitudinal health care, promoting access to services and guaranteeing rights, as well as acting towards network articulation and intersectoral work, in line with the guidelines of the National Policy for the Homeless Population (decree 7.053)[8] . The moment of internment, being a period of fixation, is an opportune time for the user and the services to build new possibilities and reorganization plans, such as the acquisition of civil documentation, access to social assistance benefits such as *Bolsa Família* (conditional cash transfer) and/or *Benefício de Prestação Continuada* (minimum income allowance for non-formal retirees), as well as the recovery of family ties, among others.

Street in the Network

Although the Street in the Network device began earlier, for the purposes of this report we are taking this time frame: the year 2023, beginning at the Nereu Ramos Hospital (NRH) in Florianopolis, a referral hospital for the treatment of infectious and pneumological diseases, where most users are admitted for treatment of

tuberculosis, but also HIV/AIDS, pneumonia and other diseases that are aggravated by their social conditions and life dynamics.

Before starting to check upon those in the beds, a visit is made to the hospital's Social Services to collect information from the users: Are they still in hospital? If discharged, where did they go? Did any relatives pick them up? Did they leave with any medication? Have they escaped? It was also investigated what requests were made to the Social Services team and what information was passed on, etc. At this point, we also discuss what can be done between SCT, NRH and other services in the network. The location of the beds where the users are is then identified and the visits are carried out. It is at this point that the clinic becomes transdisciplinary: there is a meeting and mutual affectation of the various professional perspectives and services, which work together in the same situation[9].

The visits were carried out every Monday from 2pm, by the SC team with the psychologist, psychology trainee and, in general, other professionals from the team. Once the users have been identified (some of them they already know, others they get to know at that moment), they are asked about their health status, how they have been feeling, how they have been spending their days, what has happened to make them want to be there, if there is a discharge forecast, what their post-treatment and discharge plans are. From these meetings, networking becomes more targeted and moves are made to provide whatever is needed at the time. At the start of the visits during the period under analysis, SC had 16 inpatients. This was a considerable number, which fluctuated over time. Of this group, fifteen were men, and there was only one woman whom we met twice. Soon afterwards, she was discharged and later the team got news that she had found a home and left the streets.

In addition to mapping out the needs of inpatients, these first meetings were occasions to strengthen bonds and also to show users that they are not alone at this time of great fragility. Most of them have lost contact with their families or have come from another state, city or even country. This act of being present is what Macerata et al.[10] called the methodology of creating a reference, which has multiple meanings: the service becomes a point of reference for the user, whether they are on the street or in hospital, and becomes a reference for the network with regard to homeless people. Bonding and referral show the user that there is a professional there who is co-responsible for their care, together with them. This approach is also positive in terms of adherence to the proposed treatment, based on respect for the individual's right to choose and autonomy.

Bonds are built through a process of attunement with users and their moment in the care process. What makes this construction possible is the welcoming process, which is done in a double movement: legitimizing the situation experienced by the person, whatever it may be, and also advocating in favor of the unique way in which the individual deals with their situation. In other words, if the subject is in a certain situation that is considered difficult, that state of affairs had its reason for being, and there is, in the specific way in which they deal with it, a singularity that marks that existence and that must be affirmed. It is through this singular way that care strategies can be built. This does not mean accepting a certain condition of violation of rights, but legitimizing and defending the person's unique experience instead.

Under these directions, the aim is to confront both modeled and idealistic answers and solutions that come from the outside and do not dialogue with their reality and their territory of life. The bond is the basis for continuity and accompaniment. Accompaniment is about being close to each user's process in relation to their existential landscape. The process is made up of comings and goings, differences, repetitions and constant openness to the new, even when they seem to be just a repetition of the same. The so-called "relapses", returns and regressions are all part of the transformation process. Accompanying is therefore about being by their side and avoiding solutions that are too quick, being able to sustain their presence for the duration of the encounter. This approach allows us to build interventions that really make sense for the user in their context, taking into account the fact that we are dealing with sensitive issues such as drug abuse, isolation, health and weakened family ties.

An example of this is the case of the user J.B., followed-up by Street in the Network. J.B. was a 49-year-old white man from João Pessoa-PB who was homeless in Florianópolis. He had been admitted to the NRH for pulmonary aspergillosis, a disease whose treatment consists of medication and surgery. He was hospitalized awaiting surgery. J.B.'s family ties were very weak, he had no contact with close or even distant relatives, so the SCT was his strongest link. During this period of hospitalization, he expressed his desire to leave the hospital if his surgery didn't take place soon. He had been in hospital for over a month waiting for the procedure. Based on this desire, the Street in the Network began to organize a foster placement for the user, so that he wouldn't return to the streets when he left the hospital. After quite a lot of work and coordination between the SCT and the social assistance service, J.B. was offered a place in Florianópolis' municipal hostel, where he was taken in after leaving the NRH and accompanied by the SCT outside the hospital. While still in the hostel, J.B. returned to the NRH and underwent the expected surgery which, at first, was only to remove part of his lung. However, it turned out to be a total removal of one side of the organ, a procedure with high morbidity and mortality. During this pre- and post-operative period, JB continued to be cared for by the SCT, but the user had some complications after the surgery and had to be intubated, which made his state of health even more delicate, and unfortunately, he died after a cardiorespiratory arrest. So far, the exact cause of this arrest is unknown, as the user had no heart problems. The last information given to SCT was that the cause of death would be investigated.

At the Governador Celso Ramos Hospital (HGCR), the same step-by-step procedure is carried out as at the NRH before visiting the beds. The HGCR is an emergency service, which results in a smaller number of people being admitted to hospital, where the stay is generally short. This makes the bonding process difficult, as it is not possible to achieve continuity in the visits. However, Street in the Network responds to this particularity, seeking to enhance care even in a shorter period, in which care processes can be very impersonal. In addition to the fragility of the bond with the user, the bond with the service in these cases is also weakened, as the demands need to be resolved and done quickly, considering the context of PLS.

The user identified here as P.R., a 40-year-old white man from Florianópolis, was a registered SC user and was identified during one of the visits to the HGCR. There,

he was hospitalized for a short time until he was transferred to the NRH. His state of health was quite fragile, as were his community ties. He was and continues to be monitored by SCT through Street in the Network. Although delicate, his health has improved over time, thanks to the hospital care and treatment conditions that this environment can provide, but also to the bond that we were able to work on during his hospitalization.

Weekly visits to the user were made possible through networking, hearing his demands and future plans, while work was done to make them viable. For example, P.R. wanted to finish his treatment at the Santa Teresa Hospital (HST), which has a Backup Unit for medium- and low-complexity patients transferred from other hospitals. A backup unit is a place where you can receive long-term, personalized treatment outside of a regular hospital. The HST is a place with more space and that enables/provides other daily activities such as: a place to exercise, green space with vegetable gardens, activities that the user believed could help them in the recovery process and acquire new habits. Through coordination between the SCT, Social Services and Medicine at the NRH, the user's wishes were met. Today he is at the HST finishing his treatment. As a result of this work, P.R.'s family ties have been re-established and strengthened. His brother and girlfriend visit him and he has re-established contact with his mother by cell phone. Today he is waiting to be discharged and has the help of his family and girlfriend in this process, showing the power of building a network in a broad sense: a network of public policies but also a community network, networks of life and affection.

Another noteworthy point regarding Street in the Network is that most of the people who are accompanied make harmful use of alcohol and other drugs. The time of hospitalization can also be seen as a necessary break from drug abuse: rest for the body, strengthening, food, hydration and shelter. In addition, it is a period for possible organization: making plans for the future, sharing your life projects and discussing their viability. Considering the seriousness of some cases, this abrupt interruption in the use of a substance, made possible by hospitalization, can be seen as an HR strategy. However, it should not be avoided problematizing and reiterating that the compulsory nature of hospitalization cannot be the foundation of treatment[11].

It is from a HR perspective that the SCT works on the issue of alcohol and other drugs. In other words, the focus is not on abstinence from a particular substance, but on changing the subject's relationship with it. HR understands that the substance is not a problem in itself. Torossian et al.[12] state that "we are living, desiring and thinking human beings who signify and act upon substances." (p. 84). It is based on these factors that the individual establishes and creates their relationship with alcohol and other drugs. The moment a drug user is hospitalized, they are placed in compulsory abstinence and the substances they use are replaced by drugs with a high potential for dependence, as a way of easing the withdrawal symptoms, creating other problems. In view of this, it is necessary for these drugs to be administered responsibly and aligned with other activities that are of interest to the individual and that promote a relationship of well-being with other non-drug practices. The focus should not be on abstinence from the drug or the desire to use it, as isolation can significantly contribute to the centrality of the substance.

The HR paradigm is not against abstinence. But it defends the importance of contemplating and thinking about other paths beyond detoxification/abstinence, considering the unique relationship that each individual establishes with the drug as a socio-historical-cultural-chemical artifact. Aiming to improve quality of life, recognizing the drug also as a substance that can amplify pleasures and seeking to understand how the individual relates to these valences in a given context[13].

P.R. was a heavy user of alcohol and other drugs. The period of hospitalization was also an important break from this abuse, and consequently from abstinence (using medication), with the exception of cigarettes, which are allowed in the NRH. This can be considered a HR strategy: the fact of being able to smoke during hospitalization influenced the user's adherence to treatment and was important for a while. However, it later ceased to be part of their habits, by the individual's own choice.

The subject's autonomy is the central object of HR and needs to be legitimized, because as well as being the protagonist of their story, they have fundamental knowledge: knowledge about their own life and what the substance has done to them at that time[14]. The HR paradigm instrumentalizes care in a way that this empirical knowledge, this knowledge of experience can be included in treatment. It's important that health professionals don't assume a position of knowing about the other person's life, telling them what they should or shouldn't do. Rather, they should try to promote reflection so that attention to the relationship with oneself awakens the desire for care, both for oneself and for the group[11].

The contemporary drug experience is not separate from the capitalist mode of production[15]. Lancetti[11] points out that "it is the constant generation of lacking, an experience in tune with the consumer society, the imperative of enjoyment and it is also a message to society to show 'look how we are failing'. '' (p. 75) The fight should not be against drugs but for people, for their freedom and for other important aspects of life. Fighting against a substance does nothing for notions of care, on the contrary, it harms the subject, especially those who are in a context of extreme social vulnerability, as is the case with homeless people[11]. We know that the war on drugs isn't about drugs, it's about specific bodies: those considered dangerous, degraded and enemies of "order", like PLS.

The knowledge of the territory that the subject occupies beyond the hospital is also part of the care strategy. It increases the possibility of continuity of treatment, follow-up and bonding. From a territorial rationale, we can think about activating the resources that the community offers, to add to the care strategies and also plan new possibilities[16]. Territory goes beyond a geographical space and goes beyond home referencing, where only people living in homes would belong to a given territory. Inhabitants who are not domiciled belong to the territory. The territory is a space of resources, dynamics, actions and the production of subjectivity[17].

It is in the relationship with and from the territory that "care is carried out as a collective, democratic and inclusive practice, following the guidelines of an expanded clinic"[17] (p. 2). The hospital, as a biomedical institution, tends to isolate the subject and the territory, which causes them to lose their specificities and singularities. Hence the need for Street Clinic teams to aim to get closer to the territory, but also to bring

other services closer to the street. It is not the hospital that goes to the street, but that the logic of the street can be understood in the hospital. Care management is built with, in and for the territory, respecting its singularity, its subjective and objective aspects[17].

The street, as a territory where people live, has its own particularities: the circulation of people, people we meet more often, as well as others we see only once or sporadically; the presence of the police, businesses. There are diverse forms of relationship with the street. It is essential for the SC to experience the territory of the street that these people inhabit, so that they have the sensitivity and capacity to understand that the period of hospitalization is also a moment of destabilization: it generates a suspension of this territory of life, of everything that it marks and means for the user. This has a major impact on the subjective experience[17]. Street in the Network is a device that helps users to sustain themselves in this destabilization. But it also brings the specificities of the street territory into the hospital territory, in order to contribute to the singularization of care. We have observed this during our time in the facility. There is the potential that, on coming into contact with the device, professionals will become more sensitive and receptive to SC users, imposing fewer barriers to their access and helping to make the hospital environment one to which the user can briefly belong.

Conclusion

The "Street in the Network" device arose precisely because it understood that SC practices go beyond what is done on the street and inside health centers. It allows us to see the network's services as spaces for caring for its users, and those spaces that need to be built. It is essential that SC is present in hospitals for PLS. The way in which hospitalization is experienced has a direct influence on what the post-discharge period will be like, which is an important moment for guaranteeing comprehensive care, understanding that hospitalization - short-term, non-asylum - can be seen as a "privileged period for collectively thinking about and producing continuity of care and access to other services in the health system"[5] (p. 6). It is understood that a care space is made up of various aspects, one of which is the way in which the processes and workflow are organized, taking into account the reality of the subject and their territory. In other words, it is necessary to occupy institutional spaces in order to overcome the barriers that homeless people encounter in health services[17].

It is possible to think that the emergence of the Street in the Network was born out of the questioning of how welcoming/service spaces can accommodate the logic of the street, in the sense of equity. Also, how the ways of intervening, listening, referring and networking can include the demands of PLS. Building equity seems to point to a process of facilitating the relationship between SC users and health professionals from the wider network, as well as institutional rules. These relationships, in general and at first, are conflictual, permeated by prejudices and stereotypes about homelessness, and a lack of recognition of users' rights. This has conspired against their wellbeing, since historically they have been the weakest link and the ones who suffer directly from the consequences of managing this space.

It is possible to affirm that Street in the Network is a device for comprehensive care, but also for promoting equity, which works as a close presence, as a mediator and promoter of health, both for users and for institutions. As soon as these coordination activities are carried out, the chance of success in the case is greater, because as well as providing care, it also manages the active search and once again directs resources and services to what is really needed, optimizing results. All of this involves micro-political work[16] that Street in the Network can do: changing sensitivities, including the uniqueness of cases in inpatient care processes, and supporting hospital staff in this process, which also involves transforming their perspective on PLS.

Authors' contribution

All authors actively participated in all stages of preparing the manuscript.

Conflict of interest

The authors have no conflict of interest to declare.

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O presente relato de experiência objetiva apresentar o dispositivo Rua na Rede, criado pela equipe de Consultório na Rua (eCR) de Florianópolis, SC , como estratégia de construção da integralidade e longitudinalidade do cuidado do usuário da eCR, especialmente no momento de internação hospitalar e pós-alta. Para isso, analisou-se a experiência vivida pelos autores, operando o dispositivo por meio do diário de campo e em diálogo com a literatura científica sobre o tema. O relato aponta que o Rua na Rede é orientado pelo paradigma da redução de danos e enfrenta um importante desafio para o Sistema Único de Saúde: a articulação entre Atenção Básica e atenção hospitalar, ponto nodal para a integralidade e a longitudinalidade do cuidado da pessoa em situação de rua.

Palavras-chave: Dispositivo. Consultório na Rua. Integralidade. Cuidado. Redução de danos.

El presente relato de experiencia tiene como objetivo presentar el dispositivo Calle en la Red, creado por el equipo de Consultorio en la Calle (Consultório na Rua - eCR) de Florianópolis (Estado de Santa Catarina), como estrategia de construcción de la integralidad y la longitudinalidad del cuidado del usuario de las eCR, especialmente en el momento del ingreso hospitalario y después del alta. Para tanto, se analizó la experiencia vivida por los autores, operando el dispositivo por medio del diario de campo y en diálogo con la literatura científica sobre el tema. El relato señala que el Calle en la Red está orientado por el paradigma de la Reducción de Daños y constituye un importante desafío para el Sistema Brasileño de Salud: la articulación entre la Atención Básica y la Atención Hospitalaria, punto nodal para la integralidad y la longitudinalidad del cuidado de la persona sin hogar.

Palabras clave: Dispositivo. Consultorio en la calle. Integralidad. Cuidado. Reducción de daños.