

Manguinhos, Rio de Janeiro, Brazil, “Street Clinic” team: care and health promotion practice in a vulnerable territory

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Abstract *The structuring of care to the homeless people through Primary Health Care (PHC), standardized in 2012 is a challenge to the Brazilian Health System. This article discuss the practices of a Street Clinic (eCnaR) team for the homeless and alcohol, crack and other drugs users in order to provide comprehensive care implemented according to PHC and health promotion conceptions. A qualitative analysis of an eCnaR of the Municipality of Rio de Janeiro in the period 2011-2013 was performed, considering PHC essential attributes, with the following analytical categories: the territorial approach; open-door reception services; the complexity of care to vulnerable groups and the coordination of the health and intersectoral network. As theoretical framework, we systematized the concepts of care provided for in Brazilian policies/standards, considering health needs, as well as alcohol, crack and drug dependence in the homeless. As a PHC team for vulnerable populations and territories, the eCnaR was powerful in promoting access, building longitudinality, providing comprehensive care from the perspective of harm reduction and extended clinic. There are challenges to achieve effectiveness of care, such as the multi-professional education and composition; logistical and specialized support to address complex cases and also, the fragility of the network.*

Key words *Primary Health Care, Homeless people, Vulnerability, Care, Harm reduction*

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Introduction

Universal access to health care is a guaranteed constitutional right for all Brazilian citizens, but there are still extremely vulnerable people, such as the homeless, who are prevented from access and health care and, thus, remain invisible to the system. Contrary to the provision of equity in care, this population has difficulty in accessing the Unified Health System (SUS) and its main gateway, namely, Primary Health Care (PHC). This group generally uses emergencies in acute situations or imminent risk to health and life. PHC implemented in its attributes of *first contact, longitudinal link, comprehensiveness and coordination* of care should be able to provide comprehensive care to vulnerable populations such as the homeless. Health systems with a strong reference in PHC are more effective and suitable to the population; they have lower costs and are more equitable, even in contexts of great social inequity.^{1,2} The homeless are a *heterogeneous population group, consisting of people having the common feature of ensuring survival through productive activities developed in the streets, with broken or weakened family ties and no regular home address*.³

Although Brazil has several censuses and information systems, the homeless are not accounted for in these statistics and do not even appear in the register of the Primary Care Information System (SIAB), whose analysis unit basis is household. The National Homeless Survey⁴ conducted in 2008 by the Ministry of Social Development in 71 municipalities identified 31,922 people over 18 years of age living in the streets (children and young people not accounted for). Added to this figure were 10,399, 916 and 888 adults, respectively, in the cities of São Paulo, Belo Horizonte and Recife, of which 70.9% performed some type of paid work; 51.9% had a relative in the city where they stayed; 19% could not even have a meal a day; 29.1% had gone to the streets because of family quarrels; 35.5% because of the use of alcohol and other drugs and 29.8% due to unemployment.

Government health policies aimed at specific care for this population are recent and started in the field of mental health, with the “Street Clinics” (CR). This proposal was inspired by the first CR created in 1999 by the Center for Studies and Drug Abuse Therapy, as a response to the problem of homeless children and drug use⁵. From this experience, in 2004, in Salvador, the CR was linked to a mental health arrangement, namely,

the Psychosocial Care Center for Alcohol and Drugs (CAPS-AD), inaugurating such scheme in the institutional network. In 2009, the Ministry of Health recognized the CRs as one of the strategies of Emergency Plan for Increased Access to Treatment and Prevention of Alcohol and Other Drugs in the SUS (PEAD)⁶. Their teams offered more limited health care options to users at their places of residence, referencing them, when necessary, since they aimed at providing greater accessibility to institutionalized network services, comprehensive care and promoting social ties to the socially-excluded. Successful experiences of staff working with the homeless were conducted in some Brazilian cities such as Salvador, Recife and Rio de Janeiro. In a seminar held in 2012, these experiments were discussed and systematized in a publication of ENSP/Fiocruz⁷, demonstrating the diversity of practices and implementation process of the first “Street Clinic Teams” (eCnaR), care mechanisms for crack and other drugs users among the homeless.

Therefore, the concept of care for the homeless is recent and was realigned to the guidelines of the National Policy of Primary Care (PNAB) in 2011⁸ when, in the face of Brazilian heterogeneity, it recognizes the need for a wider range of modeling of primary care teams, among which those for the homeless. As a result, in 2011, eCnaR teams were standardized with a PHC model flexible with the various realities of the country, whose benchmarks were based on Basic Healthcare Units of the Unified Health System (SUS)⁹. Thus, the eCnaR should serve as the main gateway of this population to the network services and must work in integrated fashion with the Health Care Network (RAS), as well as other inter-sectoral networks. In line with the PHC model adopted in the country, it is proposed that the eCnaR develop individual and collective health actions, health promotion and protection, disease prevention, diagnosis, treatment, rehabilitation, harm reduction and health maintenance⁸ while considering the life context of the population. Therefore, the eCnaR, as other ESF teams, is designed as PHC gateway to the SUS. Three types of eCnaR were created through standards⁹, varying according to professional composition: i) with 4 members, with 2 high-level and 2 mid-level professionals; ii) with 6 professionals and mode; iii) with the addition of a doctor. Various professional categories may be part of the eCnaR, namely: Nurse, psychologist, social worker, occupational therapist, physician, social agent, nursing technician or assistant and oral health technician,

all giving an interdisciplinary character to team performance⁹.

The systematization of Brazilian policies and standards related to the implementation of the eCnaR enables us to highlight those related to Health, such as PHC, mental health, alcohol and drugs (AD) and other sectors, represented by different ministries. As from the year 2000, these launched powerful policies to extend care to this vulnerable group, given its intersectoral and interdisciplinary nature. We can highlight, through the Ministry of Health, the comprehensive care policy to users of alcohol and other drugs (2003)¹⁰ and the Emergency Plan for Increased Access to Treatment and Prevention of Alcohol and other Drugs (PEAD)⁶, which are part of the PNAB⁸ and other regulations that strengthen the Street Clinic's role under the PHC. The Ministry of Social Development and Fight against Hunger, through the census of the homeless produced information relevant to the formulation of public policies⁴. It is worth noting the leading role of the Civil House of the Presidency of the Republic, with the enactment of Law N° 11.343 in 2006, which specified the difference between drug user and trafficker, and the establishment of the National System of Public Policies on Drugs (SISNAD)¹¹, and the Ministry of Justice, whose National Secretariat on Drug Policies (SENAD) launched, in 2011, "*Programa Crack é Possível Vencer*" (free translation: "Crack We Can Win this Battle" Program)¹².

These documents express advances in homeless-targeted policy and legislation. Among them, worth outlining is the design of eCnaR as intersectoral policy scheme also geared for users of alcohol and other psychoactive substances, such as marijuana, crack and solvents, homeless clusters diseases, whose approach is complex and for whom damage reduction is the main care strategy^{9,10}. To increase access and qualify psychosocial care, the Psychosocial Care Network (RAPS)¹³ was established, whose eCnaR is a care mechanism. In this new setting of the network, eCnaR and CAPS-AD are the main gateways of the homeless to the SUS, with the role of integration with health and intersectoral network, becoming thus territorial arrangements for a comprehensive and resolute care.

Health Promotion (HP) has been strong in its endeavors to tackle the challenge of intersectorality, in so far as it recovers health as socially constructed practice, understood within an institutional and strategic approach that considers the contexts where social agents are inserted¹⁴.

The eCnaR thus purports the reorientation of health services¹⁵ for vulnerable groups, working in prevention, promotion and care focused on the comprehensiveness of health actions and the perspective of extended care with respect to the socio-political context in which they operate, as well as local cultural peculiarities. Reducing the abuse of alcohol and other drugs is one of the priority areas of the National Health Promotion Policy revised in 2014, with one of its operational lines being territorial and inter-agency coordination¹⁶.

The eCnaR is a privileged PHC instrument for the development of health promotion practices / actions covering empowerment, social participation, seeking equity, quality information, communication and health education in order to expand care and effectiveness of its practices.

Apart from some theoretical reflections inspired by the policies of this century, there is much to be learned from practical experiences of eCnaR who are leading new work processes in the care of the homeless.

The motivating issue was to gain an understanding on how and what arrangements the eCnaR can develop in its daily care activities in order to conduct a comprehensive care implemented according to PHC and health promotion attributes¹. Therefore, this study aimed to describe and reflect on the health care and promotion practices of a Street Clinic team working in a vulnerable territory in a major urban center.

Method

This is an exploratory study with a qualitative approach that brings the systematization of an experience and associated reflections, bounded in context and time, aiming at interpreting the assumptions designed and their expression in the practice of services. The case study of a given experience can be considered a strategic methodology to health management by describing in depth and detail the object in its context¹⁷.

From the report of this experiment, directly experienced and observed by authors in their role of managing and supporting the actions of a team – Manguinhos eCnaR, and using management documents (public access technical material)¹⁸, we sought to grasp in an analytical component the various dimensions of the implementation of the eCnaR process in the light of benchmarks of Primary Care Policy and Health Promotion which considered care to vulnerable

groups such as the homeless. Thus, the review of PHC team practices for the homeless becomes relevant due its innovative, contemporary component of standardizations from public policies, actions that bring challenges and solutions that may be applicable to other health care settings, especially in urban centers.

We studied, then, the eCnaR working in the Manguinhos neighborhood, located in the northern part of the Municipality of Rio de Janeiro (RJ), and its care practices developed in the 2010 period, the year of its implementation, until 2013. The analyzed territory has a population of about 37,000 dwellers¹⁸, it is a place of extreme poverty, violence, armed conflict and drug trafficking, with a significant number of homeless people and drug users. In 2010, in line with increased PHC activity in Rio de Janeiro, the community witnessed an ESF scale-up (13 teams, divided into two Health Units) and, in its core, in September 2011, the eCnaR presented in this article was established. This process was monitored by authors since inception until May 2013, as direct observation and field diary recording by authors in their daily local management duties^{18,19}. It should be noted that this experiment was a shared construction with health professionals, managers, institutional backers and local community.

The strategies used for the development of the empirical material were systematization of documents and thematic content analysis in the light of theoretical assumptions that pointed to eCnaR as a device for redirecting services according to the PHC and health promotion guidelines. The following analytical categories were constructed with the thematic analysis of the content: territorial approach; open-door service; complexity of care for vulnerable groups and coordination with the health and intersectoral network, whose findings are described below.

Results and Discussion

Territorial approach

One of the first activities of the eCnaR is the street approach through systematic visits to the territory to be familiarized with it, not only in terms of its geographic size but also its environmental and health features, as well as areas of risk and violence. In this experiment¹⁸, the homeless were located in areas of poor quality environmental structure, without electricity, hidden un-

der the viaducts, on the edge of large ditches, surrounded by piles of trash, disposable mineral water glasses which were used as crack consumption paraphernalia, which was highly prevalent in the area. It was important to note social organization dynamics, whether there were large homeless clusters (some with up to 80 people), composed of families or small groups (“street father and mother”) or even if they lived in isolation.

Regarding the approach, this had to be scaled with the team marking their presence in the territory and proving to be accessible. The eCnaR, uniformed and identified as health professionals, circulated in the environment and wrote down in field diaries the characteristics of these areas (bedrooms, hygiene and drug use). Large clusters of drug users, especially crack, called “drug scenes” were identified, revealing that, in this context, the collective use of space might be justified by reason of safety and protection among peers. Thus, the eCnaR introduced itself to users, informed them about the possibility of care – in the street or at the basic health unit – clarifying information confidentiality issues and non-requirement of identification documents, initially establishing trust and bond ties.

The street approach was carried out by more than one member of the eCnaR and, whenever possible, by a community agent, a nursing technician and at least one top-level professional. Type III team^{9,19} was adopted in Manguinhos, characterized by the presence of a physician and counting with a nurse, psychologist, social worker, dentist and three social agents and a nursing technician. This approach was able to identify dynamic boundaries of use scenes and perform the registration of users either on a preliminary basis (counting groups, how they organize – “families built in the streets”) or in full fashion, depending on the opportunity and the user’s availability to provide information. One year into the implementation, the number of registered homeless arrived at 200¹⁹ and this practice enabled work measurement and planning. The eCnaR made available its contact (phone) to the user in case of health needs, situations requiring their relocation to shelters, emergency situations and even cases of migration to other areas of the city.

Regarding operational aspects, in addition to two mobile phones, the team had a car to move around in the territory, which was also occasionally used to transport users to the Basic Health Units or even hospitalization and access to other network schemes. The recording of information was done in non-computerized field diaries com-

pleted on every field visit. A detailed description of environmental ethnography, scenes, residents, perceptions and actions taken in the field was subject to discussion in the regular meetings of the eCnaR and enabled a better organization of the work process and planning of team actions.

Unlike the ESF, which works with predefined territory and households, such scheme was more imprecise under the eCnaR and was agreed and revised according to the social dynamics, considering the intense migration of the homeless, where the enrolled area was the whole territory of Manguinhos and surroundings. Thus, this allocation was agreed directly with the user, with flexibility for his possible shift to other areas.

Open doors services: reception rather than collection

The principle of universal access to health is undoubtedly one of the ethical axes that guide the practice of care to the homeless and alcohol and drug users, given their situation of social exclusion. The eCnaR aimed, at first, to intervene by introducing these users in the care network, giving them the constitutional right to health and working as a gateway to the health system to provide positive answers to these users, which may not become simply a bureaucratic and obligatory passing place for other types of services⁷. Receiving and promoting the inclusion of people living in the streets in citizenship, health services and other sectors, is the most important attribute, considering their extreme vulnerability.

Reception always brings a combination of two dimensions, one in the relational field, of the professional's attitude toward the user, qualified listening, humanization; and the other, in the field of organization of work processes, in which reception could be a device that uses the eCnaR to promote access and resolute health care. Health professionals are fundamental to the consolidation of the strategy of inclusion, access and reception to this population, which is required in order to develop the ability to listen without judgment and prejudice by analyzing care possibilities, in a varied range of options offered by the health and intersectoral network.

Therefore, respect for individual autonomy occurred in a perspective of extended health care²⁰ aimed at an approach beyond the physical health needs, including a harm reduction approach that is opposed to user collection practices in shelters or compulsory hospitalization. In a conflicting form associated with police raids, So-

cial Assistance Secretariat agents also performed crack users collection actions, directing them to the compulsory shelter without their consent. This generated a lot of suspicion and fear on the part of the homeless who demanded from the eCnaR not to follow such practices, by not participating in this type of action. This collection practice was the subject of intense political debate in Rio de Janeiro.

Depending on the complexity of cases, the eCnaR became the gateway to other levels of care network, such as emergencies / clinical hospitals or psychosocial care. In addition to street care, it also offered the possibility of specific treatment at Basic Care Units (UBS), where the eCnaR shared space with other family health teams, with scheduled service and self-referral, with the reception made by team professionals, in shifts without restricted hours, observing the needs and possible deliveries. As the unit had electronic medical records for all users, eCnaR records were also computerized and could generate a SUS Card number.

Vulnerable groups care complexity

Providing continuity of care is also saying to the other that we share the responsibility for his life; it is about sharing between professionals and users to protect life and recognizing that health work can be supported by a collective co-management²¹. In establishing the relationship with its customers, the eCnaR sought to coordinate, with a certain level of freedom and singling space, relations between the institutions and the connections between the points of care of the health and intersectoral network.

A dialogic co-managing relationship and the idea of support and coordinated network is what one expects of democracy in labor relations and in the movement of professional engagement with his work^{20,21}. The eCnaR had to build, on a case-by-case basis, the therapeutic projects, respecting the uniqueness of each life story and the complexity of health and disease processes in order to promote self-esteem and adherence to agreed therapeutics²⁰.

The link could be established with any team professional, who could become the case manager, that is, responsible for tracking that user's care plan. In this plan, promotion and preventive health care, treatment and rehabilitation actions were agreed with the user. Immediate clinical care (such as delivery of an analgesic, antibiotic, dressing, dental care) was often the first form of

bonding and the window of opportunity for longitudinality care; other times, a haircut was offered as first care. A greater range of services and technologies was available (vaccination, dressings, laboratory and radiology tests, gynecological preventive care, access to drugs and supplies such as condoms and, also, oral health-focused, among others).

The approach of eCnaR involves identifying risks and vulnerabilities of individuals and capturing high-risk cases requiring more urgent care. Thus, for example, rapid tests (pregnancy, syphilis, hepatitis, HIV), smear collection for tuberculosis were carried out on the street and at the clinic, at the most timely moment possible, as well as fast interventions. As a link was being established, it was possible to plan therapeutic projects, incorporating educational, health promotion, social support and inclusion actions.

Regarding the provision of care, each professional category had a set of procedures specific to its core expertise, in addition to those relating to the field of work²¹, thus extending care to this extremely vulnerable population. The presence of a physician, provided only in Mode III⁹, was essential to the quality and continuity of care, an improvement over the other modalities for increasing resolute care.

Considering the fundamental interdisciplinary work to approach the homeless, the professional incorporation of oral health (dentist, oral hygiene technician) was fundamental. Users' self-esteem was improved by taking care of the oral health issues of this population, frequent in users of inhalants and contact with the oral mucosa, achieving yet another possibility of expanding the specific care to the homeless. The oral health team participated in field actions with small assessments on street patients, provided guidance, distributed oral health kits and performed clinical treatments. The psychologist working in his specific mental health core was a powerful articulator of psychosocial network schemes in his territory. The social worker was a very active professional in the valuation of citizenship and helped in the collection of documentation, shelter issues, when necessary, and family reintegration, since social vulnerabilities are determinants of the health-disease process.

Demands of mental health care for AD users, as well as health clinical care focused on the harm reduction strategy²², directing the provision of care that minimized the adverse consequences of harmful drug use for both the individual and the society. When users requested drug cessation

treatment, an analysis of the possible conditions of adherence to the treatment was made according to the user profile; access health and intersectoral network (shelters, hospitals, locations for outpatient treatment and hospitalization for drug use), and evaluation of family reintegration.

Actions valued educational and informational activities, using material with policy and practical information on the most recurrent diseases, such as tuberculosis; regarding self-care, with food and hygiene, warning of harm related to drug use, sexuality, condom use, human rights and citizenship, among other issues related to quality of life. Artistic and recreational activities were important strategies of collective intervention – football matches, capoeira gatherings, handicrafts, beauty shops, among others – by intensifying the link and integration of curative, preventive and health promotion actions strongly induced by social agents⁹.

Coordination with the health and intersectoral network

The coordination of care can be defined as the coordination between the various health-related services and activities, so that regardless of where they are provided, they are synchronized and focused to achieve a common goal. In terms of Health Care Networks¹³, care coordination plays a prominent role, since without it the first contact is a purely administrative function, longitudinality loses its potential and comprehensiveness is difficult to achieve. The coordination of care seeks to break with the fragmentation of services, making a difference in integrated health care systems, as these are organized through an integrated network of points of care, providing continuous assistance to a given population, where PHC operates as a communication center, ordering flows.

The implementation of the coordination of care by the eCnaR has been difficult, since it depended on the construction of a network, both in the health sector and the intersectoral networks, such as Social Assistance, which had a different agenda in its service to the homeless. In addition, there was a shortage of equipment available in the territories, so that eCnaR could operationalize links between these points of care of the RAS and RAPS¹³.

The construction of the eCnaR care network occurred through professional team visits to institutions attending the homeless and drug users, which involved the health and intersectoral

network. During these visits, the team built a spoken agenda, described feelings, profiles, characteristics, hindrances and the facilities found in the visited services. With such information, it was possible to create a service catalog built by means of surveys about devices that users already accessed, and also knowledge of the health system by health professionals and other sectors, establishing links between services, respecting the reference processes already formalized in the network and building up others not so official. Another important gain that strengthened intersectorality was the joint monthly meeting with the staff of the Specialized Reference Center for Social Assistance (CREAS), for the development of integrated therapeutic projects as they targeted the same population.

The team sought to operate in a movement that would bring, yet again, users closer to work environments, leisure and culture, taking into account the social and family network. Oftentimes, the homeless in need of health care and other levels and the eCnaR had to have access to other network components, such as the Mobile Emergency Service (SAMU). On the other hand, coordination with the Emergency Unit (UPA) was further facilitated by its geographical proximity to the Basic Health Unit, with management and with the professionals of this equipment, enabling the eCnaR to closely monitor hospitalizations. The eCnaR professional efforts were undertaken for the coordination related to other components of psychosocial care, as well as with the specialized hospitalization hospital. The eCnaR visited patients admitted in this hospital who, on discharge continued to receive treatment in the PHC. A major challenge, given its scarcity in Rio, was access to other RAPS components, such as the Reception Units and Home Care Services¹³.

Final considerations

The complexity of health and living conditions in major urban centers brings immense challenges to the SUS with regard to achieving equity, the structuring principle of public policies, such as Health Promotion and Primary Health Care. Vulnerable groups, such as the homeless are entitled to citizenship, as well as the assurance of health care. The implementation of PHC attributes requires that eCnaR develop work processes that, in a way, should be creative, innovative, radical and tailored to its customers' needs. It is

considered that the experience described herein has brought advances in the consolidation of comprehensive PHC, especially regarding intersectorality. Similarly, there are virtuous experiences in other areas of Rio de Janeiro (such as the eCnaR located downtown and the neighborhood of Jacarezinho), and in other Brazilian cities, which must be disclosed^{7,23,24}.

The work of the eCnaR is a step forward from the perspective of construction of a humanized care, considering users as subjects of rights and duties and favoring their autonomy. It can be said that it is necessary to advance the construction of more integrated and increasingly inclusive policies that meet the needs of different social sectors and consider reception instead of punishment and criminalization of drug users; increased access to goods and services and citizenship, eliminating repressive, judgmental and punitive practices, promoting harm reduction practices that include health care diversity, advancing health legitimacy as a constitutional right.

Due to its historical background and living conditions, diseases and poor access to health services, clientele served by the Street Clinic is a high-vulnerability group. The multidisciplinary and interdisciplinary service setting enables its views and plural knowledge to address the biological, psychological and social needs of this fragile segment of society, working to promote equity in health care^{8,9}. It is necessary to nurture in these professionals the ethical and political commitment to protect life, empathy and solidarity, clinical and relational skills required to work with the population of such vulnerability.

Regarding drug abuse, Brazil has advanced enough in the formulation of a policy for these users, while care was no longer based on abstinence as the only solution. Harm reduction has become a guiding care strategy, a new ethical, clinical and political paradigm²², a Ministry of Health¹⁰ strategy that offers comprehensive care to the user's health by reducing aggregate losses due to the use of drugs and preventing those not yet installed, not necessarily interfering with the use of drugs.

With the institution of care organized from Health Care Networks (RAS) and the PHC system, this basic level of care had to provide an effective alternative care to this population, instead of just adopting a critical stance toward collection and involuntary hospitalization of crack users and the homeless. As a RAS device and, more specifically, of the RAPS, we concluded that the eCnaR can promote access to and qual-

ity of care to the homeless and provide quality care according to PHC attributes. Choosing to invest in health care and social cohesion, and not in coercive freedom restriction measures for the homeless are options that dialogue with inclusive public policies, such as health promotion, in line with the guidelines of the psychiatric reform.

The appreciation of the “subject” and his uniqueness radically changes the field of knowledge and public health and clinical practice by seeking a shared care construction between users and professionals²¹. New practices tension and promote changes in the organization of services, oftentimes cast in inflexible practices (strict schedules, documents requirements, clothing, hygiene, etc.). The eCnaR experience has shown that people health care is very powerful in the territory where the social and community network can assist in the treatment and relief of suffering.

Within this care logic, care offered to the homeless and alcohol, crack and other drugs users aims not only to control their symptoms, but also the full exercise of their citizenship and social support, as defined by Valla²⁵, as a reciprocal process that generates positive effects for both the recipient and the support provider, allowing both to have a greater sense of control over their lives.

Thus, the organization of open-door user-focused services with the participation of the user, exerting an extended and shared clinic²¹ in the RD perspective is a major challenge for the care of the homeless, as is the construction of intersectoral public policies to promote care, especially for crack, alcohol and other drugs users. We conclude that, while implementing full PHC attributes, the eCnaR is powerful to promote effective and precise care of the homeless and AD users in a life-preserving effort.

Collaborations

EM Engstrom and MB Teixeira work together in the conception and study design, interpretation of the findings, as well as in the writing of the article.

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