

The invisible urban dwellers: the stigma of People Living in the Streets in Rio de Janeiro

Os invisibilizados da cidade: o estigma da População em Situação de Rua no Rio de Janeiro

Mirna Barros Teixeira¹, Pilar Belmonte², Elyne Montenegro Engstrom¹, Alda Lacerda²

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ABSTRACT People living in the streets, many of whom are crack users, are on the rise in Brazil and other Latin American countries. Such a population suffers from stigmas linked to a perception of fragile character, such as weak willpower to stop drug use, and a dangerous individual feared by society because perceived as an aggressor. The consequences of those stigmas are social isolation, loss of self-esteem, difficulty in accessing health services, which make users withdraw from social and health support, deteriorating their living conditions. Forty-eight interviews were conducted with workers and users of the Street Clinic (Consultório na Rua), which revealed the stigma internalized by people recognized as carriers of the negative traits assigned to them, as well as health professionals' perception of the stigma suffered by such population. The unveiling of stigmas and their analysis can reorient a set of care practices to ensure fundamental rights in health, education, housing, and work, which underpin citizenship, to promote the democratization and social inclusion process of the stigmatized people living in a situation of extreme vulnerability.

KEYWORDS Homeless persons. Crack cocaine. Social stigma. Empathy.

RESUMO Evidencia-se, no Brasil e em outros países da América Latina, o aumento da população de rua, muitos dos quais são usuários de crack. Essa população sofre de estigmas vinculados a uma percepção de fragilidade do caráter, como vontade fraca para interromper o uso da droga e como pessoa perigosa na medida em que é temida pela sociedade, visto que é percebida como agressora. Isso traz consequências como o isolamento social, a perda da autoestima, dificuldade de acesso aos serviços de saúde que provocam o afastamento da busca de suporte social e de saúde por parte do usuário, agravando suas condições de vida. Como metodologia, foram realizadas 48 entrevistas com trabalhadores e usuários das equipes de Consultório na Rua nas quais foi possível reconhecer o estigma internalizado pelas pessoas que se reconhecem como portadoras das características negativas que lhes são imputadas, assim como percepção dos profissionais de saúde da estigmatização sofrida por essa população. O desvelamento dos estigmas e sua análise podem auxiliar na reorientação de um conjunto de práticas de cuidado que garantam direitos básicos de saúde, educação, moradia e trabalho constituintes da cidadania, de modo a fomentar processos de democratização e de inclusão social dessa população estigmatizada em situação de extrema vulnerabilidade.

PALAVRAS-CHAVE Pessoas em situação de rua. Cocaína crack. Estigma social. Empatia.

¹Fundação Oswaldo Cruz (Fiocruz), Escola Nacional de Saúde Pública Sergio Arouca (Ensp) - Rio de Janeiro (RJ), Brasil.
mirna.teixeira@gmail.com

²Fundação Oswaldo Cruz (Fiocruz), Escola Politécnica de Saúde Joaquim Venâncio (EPSJV) - Rio de Janeiro (RJ), Brasil.



Introduction

An increase in the population that occupies the streets as a space for shelter and housing is a reality throughout the Brazilian territory. Although it is not possible to make a correlation between life on the street and the use of drugs, it has been observed that many people end up using alcohol and other drugs as a coping strategy to bear life on the streets¹.

The Population in Homeless Situation (PSR) is a social group that experiences different situations of multiple vulnerabilities, processes of marginalization and prejudices². It is a population marked by processes of social exclusion and who live with experiences of disrespect and absence of social recognition in their daily lives. Stigma permeates access to public goods, and some health services refuse to offer care due to the absence of documentation or registered home. Here, stigma is understood as a social construction that represents a mark on the individual, delegating the person a devalued status in relation to the other members of society.

The National Policy for the Population in Homeless Situation proposes to overcome the stigma of the 'street dweller' by considering the 'homeless population' as a heterogeneous population group that is below the poverty line, with its broken or fragile family ties and without regular housing, using public places and degraded areas to live and stay or making use of reception units for overnight, permanently or temporarily. Such a definition is still insufficient given the complexity of these modes of existence, which are marked by the multiplicity of an itinerancy that is, at the same time, material and symbolic³.

Goffman⁴ calls social stigma the recognition of difference, of the 'mark', plus a demotion of the holder of that 'mark'. The term stigma was created by the Greeks to refer to "body signs with which one tried to show something extraordinary or bad about the moral status of those who presented them"⁴⁽¹¹⁾. Thus, the use of the word stigma refers to a brand, visible or

invisible, physical or social. Currently, it has been used in a more subjective way than the necessary body evidence.

It is important to note that the term stigma is used in reference to someone, in a language of relationships, and not of attributes itself: "An attribute that stigmatizes someone can confirm the normality of others"⁴⁽¹³⁾. It is understood that a stigma is a special type of attribute and stereotype relationship, when there is a discrepancy between virtual social identity (the character that we impute upon the individual) and his/her real social identity (the attributes that the individual actually has). According to Goffman⁴⁽⁶⁾:

Such a characteristic is a stigma especially when its effect of discredit is very large - it is sometimes also considered a defect, a weakness, a disadvantage - and constitutes a specific discrepancy between virtual social identity and real social identity.

Thus, stigma refers to a profoundly disparaging attribute. The term 'beggars', 'vagabond', 'smelly', 'crackhead' are stigmatizing terms used by society, and reinforced by the media, which highlights aspects considered negative, associating PSR with crime, and 'crack land' with a space very dangerous.

Goffman⁴ reports three types of stigma: 1. the abominations of the body; 2. the faults of an individual character; and 3. the stigmas of race, nation and religion. The second type is represented in the case of people on the street or in harmful use of alcohol and other drugs, as they are stigmas linked to the personal individual, to a perception of character fragility as a weak will to stop using the drug; vagabonds because they did not get a job and also dangerous because they are feared by society as they are perceived as aggressors. The term 'crack land' is full of stigma. In crack lands, we see, in addition to the stigma of drugs, the stigma of the homeless population. According to Goffman⁴⁽⁷⁾:

An individual who could have easily been received in the daily social relationship has a trait that can impose itself on attention and alienate those he encounters, destroying the possibility of attention to other attributes of his. It has a stigma, a characteristic different from what we had predicted. We and those who do not deviate negatively from the particular expectations in question will be called normal by me.

He adds:

by definition, we believe that someone with a stigma is not completely human. Based on this, we make several types of discrimination, through which, effectively, and often without thinking, we reduce their chances of life⁴⁽¹⁵⁾.

A moralistic, negative and prejudiced view of the living conditions and behavior of drug users or vulnerable groups interferes with access and continuity of care offered to these groups, as this generates consequences for the user, such as social isolation, the worsening of their quality of life and the loss of self-esteem. This stigma is, often, internalized by the person who ends up moving away from social and health services, further aggravating his/her living conditions. On the other hand, health professionals are also influenced by this social imaginary that interferes with the care to be offered to this population. The 'National survey on the use of crack'⁵, carried out by the Oswaldo Cruz Foundation (Fiocruz), confirmed that most users had already experienced situations of social discrimination within health and social assistance services and were at greater risk for infectious and transmissible diseases, with low adherence to vaccination and disease screening programs.

Thus, the discussion about stigma is an extremely relevant topic as it interferes with the user's adherence to health services, as well as with the care offered by professionals, thus having implications for the clinic of homeless people and users of drugs living on the streets.

Due to the identification of the difficulty in accessing PSR to primary care services, the Ministry of Health created, in the scope of primary care, teams of Street Clinics (CnaR) as a policy to guarantee the access of this population to health services⁶.

These teams are responsible for welcoming this population and serve them in partnership with the social and health facilities present in the territory. They act in an itinerant way, based on the specific needs and demands of this vulnerable population and the context in which they live, taking into account health inequities. One of the main characteristics of the work is the direct approach to the users in the place they are, which allows an expanded perception of their living conditions and their most urgent needs. The production of comprehensive care includes mental health care within the logic of harm reduction⁶.

The opportunity for closer contact between the street population and health professionals, with an offer of care that promotes the minimum guarantee of some rights, are actions that bring to the debate not only the topic of drugs, but care for basic attention to vulnerable groups, which until recently were not objects of attention, and the reduction of stigma.

Therefore, the objective of this article is to identify, in the speeches of the professionals of the CnaR teams, how stigma interferes with the care offered to people on the street, creating barriers to access to health.

It is based on the premise that, (re)knowing them as people with rights, it will be possible to reorient a set of care practices that can guarantee basic health rights, education, housing, work, among other constituents of citizenship, in order to stimulate the processes of democratization and social inclusion of this stigmatized population and in a situation of extreme social vulnerability².

Material and methods

This article is part of a qualitative research

carried out to analyze the practices of the CnaR teams of the Municipality of Rio de Janeiro (MRJ), approved by the Research Ethics Committee of the National School of Public Health Sergio Arouca (Ensp)/Fiocruz under opinion CAAE number 45742215.6.0000.5240.

MRJ has seven CnaR teams: two in downtown, one in Antares (Santa Cruz), one in Bangu, one in Realengo, one in Jacarezinho and one in Mangueiras. 34 interviews were conducted with CnaR professionals, including: 6 social workers, 3 dentists, 6 nurses, 6 doctors, 6 psychologists, an occupational therapist and 7 social action agents. This article highlights the analysis of the care of professionals from CnaR teams that identify the stigma of health professionals in relation to people on the street.

The interviews with the professionals were carried out in rooms of the family clinics in which the CnaR teams are allocated. The Management of the Municipal Health Secretariat of Rio de Janeiro brokered contact with the teams. The interviews were recorded, with the participants' authorization and transcribed for analysis, which is presented below. The interviews were coded as professionals (Prof 01 to 34) to guarantee the confidentiality of the participants.

Results and discussions

Although the Unified Health System (SUS) advocates universal access to health, this, even today, presents itself as one of the challenges to be overcome. The testimonials in the interviews corroborate this fact, having been mentioned the behavior of health professionals as a barrier to access to health care of the PSR.

So, this access [before the creation of the eCnaR] was a very compromised access, very complex, because first of all, when they tried most of the time they couldn't do it or when they did it was very poor service, right? (Prof 5).

Both the issue of prejudice and bureaucratic issues, even of asking for documentation of this population, there is not, this [documentation] has been lost throughout life or never existed. So there are many access barriers that still exist today. (Prof 26).

The difficulty of getting access often makes the PSR not take care of itself: *"There are so many negative attempts that the person gives up on going to get his rights"* (Prof 14).

The difficulty of access becomes more evident when the PSR seeks care at other levels of care with greater complexity. The workers of the CnaR team reported that many professionals from other sectors, such as diagnostic services, hospitals and Emergency Care Units (UPA), only serve a person on the street when they are accompanied by the CnaR team. The professional reports the experience of one of his users going to one of these services alone: *"[...] When some homeless people arrive at the UPA, it has already happened to me, they push us, hit, throw outside and we are not assisted"* (Prof 9).

So most of the time we follow the user to this other level of health, be it secondary or tertiary, so that his care is guaranteed, because many times this user goes to this consultation that was scheduled at that secondary level and he is not attended or then he is attended, but he is not given due attention, so many times we need to follow up to his consultation so that this quality consultation is really carried out, understand? (Prof 8).

I already got at the hospital with a patient, who got there and they told me to let her in the corner. She 'there, only you'. They even say they stink. They don't like, sometimes, to assist people who are so dirty. (Prof 32).

So, I think this problem is in the professionals who work in the network and who cannot see this person the way they should be seen, so, access has always been very difficult for these people

and this is undeniable, it is not a coincidence that CnaR exists. (Prof 5).

Health service professionals create barriers to access PSR from the requirement of documentation to be attended to the requirement of abstinence for consultation, which keeps this group, many times, excluded from health care.

Sometimes the professional is going to assist and does not have the right care for these people. They have a prejudiced glance and it is difficult. I think the big problem is the people who work on the network. (Prof 25).

In addition, homeless people are stigmatized for their physical appearance, and are often linked to their dirty and smelly appearance. The promotion of care by the CnaR team promotes self-care in users who organize themselves to go to the consultation in the Basic Health Unit, according to the words of a CnaR professional

There is something that is physical: you see that the person took a shower and got dressed, they got dressed to come for the consultation day, we get p. off because we are in a hurry in the car and the patient, '- but no, I'm just going to take a shower and then he takes half an hour to come', '- no, but we don't care, He may have come dirty', but that's it, getting ready to go to the consultation, then someone lends the slipper for the other to go, there is this movement that is cool and a feeling of having a right to health like all people. (Prof 5).

Sometimes, the stigma is internalized by the group itself, stigmatized by society, which recognizes itself as having negative characteristics attributed to it:

[...] but the homeless person kept this stigma because he thought '-ah, I am poorly dressed, smelly, the person looked cross-eyed at me, looked like this, cross-eyed'. (Prof. 32).

An important point raised in Goffman's work⁴ is that stigmatized individuals tend to have the same beliefs about identity that we have. This generates the perception that, in fact, they are not accepted and the others are not willing to maintain contact with them on an 'equal basis'. This can provoke a feeling of shame, that the individual has fallen below what he really should be. This feeling of self-deprecation is very common among people on the street: "*whoever lives on the street is run over, lives on the sidewalk*" (Prof 12).

In this case, when stigma is internalized, individual or work group with this population are also necessary⁷.

Often, PSR does not recognize himself/herself as a person with the right to access to health, which is clear in the speech of a professional when he says that many users are extremely grateful for the care by the CnaR team and that they call them 'angels':

It happens all the time, they think we are doing them a favor, they thank a lot, they say we are angels, so when the person treats us like that it is not because we are very nice, but also understanding that I am not saying that ... anyway, of course the person can be very grateful for that professional, but that also speaks of a lack of understanding of the service as a right, of thinking that, anyway, the person is doing a favor and we are here upholding SUS. (Prof 19).

Bearing in mind that social stigma is a strong disapproval of personal characteristics or beliefs that go against current cultural norms, these social stigmas often lead to marginalization, understanding it as a social process of becoming or being made marginalized; relegate or confine someone to an inferior social condition, on the verge or on the brink of society⁸. To be marginalized means to be separated from the rest of society, forced to occupy borders or margins and not to be in the center of things. Marginalized people are not considered part of society.

'He's on the street, because he is shameless, because on the street he gains everything'. You hear it 24 hours a day, and then you make other people, not those who are with us, but make other people notice it; realize what led to that condition and that nobody is rid of it. (Prof 12).

Stigma is a social construction that represents a mark to the individual by delegating him/her to a devalued status in relation to other members of society. Goffman⁴ calls the recognition of the difference a social stigma, the 'mark'. He also addresses the issue of groups, using the term 'category' to situate most of the individuals who include themselves in a certain category of stigma, for example, 'homeless persons' or 'crack users'. Members of a particular category of particular stigma, such as 'beggars', 'crackhead', tend to come together in small social groups whose members all derive from the same category, these groups being subject to an organization that encompasses them in greater or lesser extent. The 'crack lands' are spaces or scenes of use that aggregate several users of crack and other drugs whose stigmas of this category of users are related to the use of the drug, associated with a devaluation of the bearer of that 'mark'⁹.

It is worth mentioning that economic problems, rupture of family ties and social exclusion are, in general, what lead people to the harmful use of alcohol and other drugs, and not the other way around, that is, it is not the drugs that take people to the streets, but it is the vulnerabilities of the street context that lead to the use of drugs to make this situation more bearable¹⁰. Currently, crack is the drug of the day, which attracts more visibility due to the form of organization, since the consumption space is, at the same time, the place where the drug is commercialized, creating great scenes of use that were called 'crack lands'. The very name 'crack land' was strongly criticized by Carl Hart¹⁰ when he signaled that there is racism associated with the term. According to the author, the term crack land

is horrible, you have to stop using it, because that is not the land of crack; and when people use that term, it exempts people from doing something. Because crack is not the problem, the problem is poverty, mental health, racism is the problem¹⁰.

According to the professionals' reports, it is evident that users often incorporate the stigmas attributed to them for the use of drugs and for living on the street, according to the following statement:

Around the street population there is a stigma that everyone uses drugs, everyone is illiterate, everyone is thief, everyone is crackhead, so it is very difficult to stay in a job when you say you are a street dweller or enter any environment. (Prof 9).

Another important term in the work of Goffman⁴⁽²⁷⁾ is that of 'informed' defined as

marginal men before whom the individual with a weakness need not be ashamed or self-controlled because he knows he will be considered an ordinary person.

This term 'informed' leads to a reflection on the work of health professionals who make up the CnaR Teams who need to have their prejudices placed 'in parentheses' so that they can offer care to people on the street, to some extent, drug users.

Could the CnaR professionals be called 'informed'? Goffman⁴ goes on saying that a type of informed person is one whose information comes from his/her work in a place that takes care not only of the needs of those who have a particular stigma, but also of the actions taken by society in relation to them. In this sense, working with the stigmas of homeless people in the health field is necessary to promote adequate care. This author also stresses that the stigmatized can be evaluated by others differently. A small action can be considered remarkable. He exemplifies it with the acts of

a blind person when walking alone, eating alone that can be considered remarkable acts and causing the same kind of admiration that you have of a magician who takes rabbits out of his hat.

Goffman⁴ will deal, as well, with the issue of 'mixed contacts', that is, the moments when the stigmatized and the so-called normal are in the same social situation, that is, in the immediate physical presence of each other. He suggests, then, that visibly stigmatized individuals – which we can consider vulnerable groups, PSR and drug users in this situation – will have reason to feel that mixed interactions – cause anguish in the interaction with other individuals. There is a malaise in the relationship between stigmatized and non-stigmatized or the ones called normal. Perhaps that is why it is not common for people on the street to seek health services spontaneously. As the professionals of the CnaR team go to the territories, present themselves offering a space for listening and care, it is possible that this malaise is less and tends to disappear with the promotion of the bond and that people feel more comfortable to reach the CnaR. Reports from professionals of the CnaR demonstrate that other health professionals are uncomfortable in serving people on the street:

Users needed to go up the stairs, use the elevator, sometimes, not everyone can shower every day, there are wounds that sometimes have a very strong smell. And then we know how much these characteristics, especially the smell thing... So it is also an issue that people have that the person, this fear of danger, that they will steal, that they will do... and then we know how uncomfortable it was for the unit. (Prof 27).

He got there and waited 6 months to get that place, specialized service. Then we witness situations of prejudice, stigma with the population. Sometimes even disrespecting us professionals, of thinking that we are guarding that person, as if he were a... ' - Ah, now the city hall is also

providing Uber'. Something like that, in that sense. Although we also find many professionals who are delighted. ' - Wow, how good this service is, that the person can access it, that you bring'. (Prof 32).

The manager of the Family Clinic, even today she calls to say that there is a homeless person at the door of her clinic needing assistance, right? 'So why doesn't she provide care, right? It is her duty regardless of being a homeless person', then we try to reinforce that they have to be assisted on the network, right? (Prof 48).

The difficulty of intrasectoral health care leads us to a strategic function of the CnaR, which is to perform the matrix support of professionals in primary care and the health network referring to the care of this population, to prevent situations like those previously reported from occurring again. There are already some good experiences with services that received matrix support and that, in a process of shared construction, have been building intervention proposals.

So they [the network professionals] also began to understand that it is not a seven-headed hydra to serve the street population, but we did not let that go. (Prof 34).

We know that there is stigma, bad smell, badly dressed, drunk, getting rid of the use of the drug, look for the health unit, so the proposal was made by the professionals of the office to sensitize the professionals of the reception to these homeless people to health units. (Prof 22).

Another central issue in PSR care is intersectoriality. In relation to work, the stigma of society in relation to people living on the streets, whether by appearance or subjective issues, often makes it difficult or even prevents their social reintegration.

Sometimes, they are unable to enter the market because of prejudices, you know, if we could talk,

right, and look at these people differently we could help a lot more. (Prof 25).

A professional from one of the CnaR teams reported the importance of teeth for insertion in the labour market:

About my area, oral health, one thing is the person with a tooth another is the person without a tooth, so this is something that totally changes the lives of these people, the way they are, the way they act, it is very common here for us people arrive with this demand. 'Wow, I almost got a job, as a waiter at the bar, but the guy said that you can't work with food without teeth, because it gives an impression of dirt, precariousness'. Anyway... (Prof 29).

When humanized care occurs – provided by the CnaR team – it promotes the subject's recognition as a legal entity, a person who deserves to be cared for, and this generates an increase in self-esteem and has an important effect on the promotion of self-care. Thus, the principle of equity is more evident in the care for PSR⁶ because it promotes care for those who need it most, understanding this population as a vulnerable group subjected to issues such as physical violence, stigma of professionals, unhealthy environment, deficient diet, among other aspects.

Understanding particularity a little, people who are in a more fragile situation, and if SUS is based on the principle of equity, it is not because they are ugly, that is equity, recognizing inequalities. (Prof 10).

The National Equity Policy¹¹ included PSR as one of its intervention groups, recognizing this population as a vulnerable group that needs comprehensive and equitable care.

One of the most effective strategies to reduce stigma is the contact between those who stigmatize and the stigmatized population. Contact is an opportunity to reduce the generalization of opinions and concepts in

relation to specific groups among the general population. It was possible to notice that the CnaR workers, who have daily contact with the PSR, did not manifest prejudice towards this population, but in their speeches they highlighted the perception of stigmatizing situations in other health teams that act directly with the PSR.

Andrade and Ronzani presented tools to face the stigma of health professionals. In the case of people in harmful use in drug use scenes, the first step would be to understand the drug as an inanimate object, therefore, it is necessary to understand how the person relates to the drug within a certain context, for the provision of care to be organized, and not just think of an intervention on the drug itself. Another step would be to bring to light what view professionals have on vulnerable users. They need to be aware of their beliefs, since “to face stigma, it is necessary to talk about stigma”⁷⁽¹³⁾.

In this sense, the discussion of stigma is directly linked to the debate on Human Rights (HD), and should be used in the construction of a work agenda aimed at offering care and protection actions to people on the street who do or do not use harmful drug. Such rights can be imagined as powerful instruments to be used against the institutional and symbolic violence to which these people are subjected; against the non-recognition of them as political holders of rights, in particular, those who are inserted in realities marked by poverty, violence, racism and prejudices of different orders and who have their citizenship status partially recognized by the State, not being, therefore, understood as individuals worthy of enjoying their freedom and autonomy¹².

In view of the analysis of these reports collected by the interviews, it was possible to highlight how much the stigma promotes a barrier of access to PSR care in the health system, in addition to barriers in the process of social reintegration, and it is also important to raise awareness of the health and intersectoral network for the reception and humanized

care in the light of the equity in which all are holders of rights.

Final considerations

PSR in use or not of drugs is the target of stigma that, in the end, excludes him/her from the right to health care. Stigma is present in health professionals, in the very people who internalize the prejudice that falls on them and in society. It is necessary to think about ways to deal with the stigma of health workers and users, with the goal of expanded care.

As already discussed, population in homeless situation, regardless of harmful drug use, are seen as people with a character flaw, and not as a group that needs to be prioritized by public health. This view, with a moralistic, negative and prejudiced connotation about the health conditions and behavior of vulnerable groups, directly interferes with the access and continuity of treatment offered to these groups. For the user, the consequence is social isolation, loss of self-esteem and withdrawal from public services due to the access barrier. In the case of professionals in the intrasectoral and intersectoral network who deal with this reality, the distorted image that they internalize makes the relationship with users, the reception and the bond difficult, preventing them from carrying out an appropriate intervention. On the other hand, it is evident that the CnaR is an important device, not only to guarantee access, but to reduce the stigma of this vulnerable group in

view of the expanded forms of reception, the strengthening of self-esteem and the recognition of users as holders of rights.

It is essential to ensure public policies guided by equity, solidarity and universality with articulation of the sectors of health, education, work, human rights and social assistance. Within this perspective, care needs to be offered based on the notion of respect for the dignity of these users, their autonomy and freedom, as they are citizens with constitutionally guaranteed rights, even if they have made life choices that are not necessarily healthy from the individual and collective point of view.

Collaborators

Teixeira MB (0000-0003-0088-9420)* contributed to the conception, planning, analysis and interpretation of the data; critical review of the content; and approval of the final version of the manuscript. Belmonte P (0000-0001-7674-5867)* contributed to the conception, planning, analysis and interpretation of the data; critical review of the content; and approval of the final version of the manuscript. Engstrom EM (0000-0001-6149-3396)* contributed to the conception, planning, critical review of the content and approval of the final version. Lacerda A (0000-0002-8011-5507)* contributed to the conception, planning, critical review of the content and approval of the final version. ■

*Orcid (Open Researcher and Contributor ID).

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