Evaluation of the implementation of the Clinic on the Street: a case study

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Abstract: We aimed to understand the adaptations of the Clinic on the Street Program (CoS) to the territorial context, from the normative bases, carried out by a team working in the city of São Paulo, which offers health care to people experiencing houselessness (PEH). We conducted an analysis of its implementation, through participatory research and evaluative case study, which involved participant observation, interviews and document analysis. The fieldwork and subsequent discussion with the team subsidized the elaboration of the logic model and the elaboration and completion of the evaluation matrix. The results indicate an advanced degree of implementation of the case studied, with the exception of the assistance to users of psychoactive substances and the logistic guarantee to the Clinic on the Street Team's (CSt) itinerancy. The program faces challenges due to management restrictions and limitations of the municipality's service network, which prevent the achievement of equity.

➤ **Keywords:** Primary Care. People experiencing houselessness. Harm reduction. Evaluation of health programs and projects.

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The Problem

The Clinic on the Street (CoS), a program established by the Ministry of Health to care for people experiencing houselessness (PEH), inspired by various municipal initiatives and the result of the demands of social movements, has been the subject of studies of various natures. Researches have been conducted that addressed the analysis of ideological and instrumental knowledge that may eventually be present in some teams (KAMI *et al*., 2016); others addressed the practices implemented by Clinic on the Street Teams (CSt) in health care (ENGSTROM; TEIXEIRA, 2016; LONDERO; CECCIM; BILIBIO, 2014; MACHADO; SIMAS, 2017).

Furthermore, the construction of the care offered by a CSt and the health care network (HALLAIS; BARROS, 2015) is the focus of inquiries and studies. However, there are gaps in the deeper understanding of the work processes, especially considering the articulation between the proposal, the resources allocated to the teams and the care effectively offered. The restricted number of evaluative studies of the CSt (FERREIRA; ROZENDO; MELO, 2016; MEDEIROS, 2016) is remarkable and, within these, none directed to analyze convergences and discrepancies between the content of the proposal and its implementation in specific realities. A study on the implementation of CSt did not proceed from the perspective of evaluation, merely describing the processes, without confronting them with the initial plan (PAULA *et al*., 2018).

The transposition of political guidelines to the operational plan involves the confrontation between reality and the plans and intentions contained in normative documents (FURTADO; CAMPOS, 2005). Such a reality would not be different in relation to the CSt, for which reason we proposed to analyze how a specific CSt deals with the health care of the target population from its normative bases, checking possible adaptations to the context in which it operates, through evaluative case study, supported by a matrix implementation proposal for the Clinic on the Street.

Health care for PEH presents challenges to the public service network. Life on the streets, considered a situation of extreme devaluation by society in general, intensifies difficulties of socialization (GRAEFF, 2012), also raising difficulties in access to goods and services (MENEZES, 2012). There are limitations of some health workers in dealing with the specificities of this clientele, expressed

in bureaucratic obstacles to care, in the allegation of personal, professional and institutional unpreparedness (BORYSOW; FURTADO, 2014).

To the National Policy for Social Inclusion of PEH, established in 2008 after several claims by social movements, were added other more specific claims for health care, which coincided with the dissemination of projects aimed at the care of psychoactive substance users, and projects aimed at the reclusion of this public, especially crack cocaine, at a time of electoral dispute in the federal government. All this led the Ministry of Health (MH) to approach and be inspired by somewhat successful municipal initiatives in this direction, and develop the CoS proposal for the public primary care network (BORYSOW, 2018; BRASIL, 2012). The Clinic on the Street teams (CSt) were outlined as a gateway for this population segment to the Health Care Network (BRASIL, 2012, 2014). The study of the genesis of the CoS (BORYSOW, 2018) revealed the complex process of formulation of this public policy, marked by the expression of demands and pressure for rights in the federal government's decision-making bodies. This diversity is reflected in Ordinances 122 and 123 of 2012, and 1029 and 1238 of 2014.

In the present study, we seek to identify differences between the program developed by the MH and the intervention actually in operation based on a case study. The greater or lesser success of the implementation can subsidize understanding about both the legal frameworks and the contexts for which it is intended, and the greater or lesser protagonism of the professionals in charge of taking the proposal literally down to street level.

Method

We conducted participant research (GRIEB *et al*., 2015) through a case study (YIN, 2015), with an evaluative focus to understand the performance of CSt in its context and the influence of these contextual elements on CoS practices. We analyzed in depth a single case to highlight the adjustments, adaptations, subtractions and additions made by a team to its daily practice (the actual work), based on the standards established for the national plan (the prescribed work), and thus propose an implementation analysis methodology.

The defined CSt is part of the primary care network of the Municipal Secretariat of Health of the municipality of São Paulo – SP (MSH). The CSt in

this municipality began to be implemented in 2013, when the municipality and the federal government were under the management of the same political party that proposed the CoS program. In 2016, the municipality had 18 teams of this nature, ten of them managed by a social organization and the others by a philanthropic entity (SÃO PAULO, 2016), which is the case of the CSt that constituted the present study. The approached team was chosen by the regional health coordination, based on the criterion of stability of the professional staff that integrated it. In the CSt's area of operation there were: 2 Primary Health Units (PHU), 1 Psychosocial Care Center - PCC level III (Centro de Atenção Psicossocial – CAPS) for adults and another focused on children, 1 Psychosocial Care Center for alcohol and drug addicts – PCC AD (CAPS AD), 1 Family Health Support Center – FHSC (Núcleo de Apoio à Saúde da Família – NASF), and social welfare services focused on PEH. The CSt approached was classified as type III and composed of: 6 Community Health Workers – CHWs (Agentes Comunitários de Saúde – ACS), 3 Social Agents – SA (Agentes Sociais – AgS), 1 administrative assistant, 1 driver, 1 nurse, 2 nursing assistants, 1 doctor, 1 psychologist and 1 social worker.

The approach and execution of the fieldwork took place in three stages:

1) Reading of medical records and other registers; participant observation of the on-street routine of several professionals; and semi-structured interviews with four professionals who participated in the CSt implementation process and eight service users.

2) Systematization and legitimization of the logic model (CHAMPAGNE *et al*., 2013), developed based on the work of the first stage. This model was presented and refined with the CSt and then analyzed by a team of evaluators.

3) Preparation of a criteria matrix to assess the degree of implementation of the CSt, which was adapted from the proposal developed by Vieira da Silva (VIEIRA-DA-SILVA, 2014). The matrix was constituted by the guidelines indicated in the federal proposal, in addition to elements identified in the participant observation and in the meeting with the team. Scores were assigned to these elements, linked to the classificatory tertiles: ≥ 0 and < 33.3% of the maximum score indicates intervention not implemented; ≥ 33.3% and < 66.6%, intervention partially implemented; ≥ 66.6% of the maximum score indicates advanced degree of implementation. We held two final meetings with the team, due to their scheduling difficulties, and proceeded with both in the following way: presentation of the matrix without filling

it out, in order to discuss with the workers the content of the classificatory items and the weight of each one; filling out of the matrix by each worker; and presentation of the score established by the research team and a conversation comparing this result and the results brought by each member, which led to the establishment of a final score considering most of the scores given (Table 2). The methodological path, executed from October 2016 to May 2017, was permeable to the participation of the team workers as informed above; however, the participation of service users only took place in the interviews and participant observation.

The material coming from the three phases was analyzed by the authors through the proposal of evaluation of the degree of implementation, according to Vieira da Silva (2014) and Champagne *et al*. (2011).

This study was approved by the Research Ethics Committee (Comitê de Ética em Pesquisa - CEP) of the Municipal Secretariat of Health of São Paulo and by the Research Ethics Committee of School of Medicine of the University of São Paulo, Certificate of Ethics Appreciation Submission (Certificado de Apresentação de Apreciação Ética – CAAE) number 45553015.2.0000.0065.

Results

Structuring and practice of the Clinic on the Street team

The PHU headquarters of the CSt researched had a primary care team for PEH before 2013, through the so-called We on the Street Program - WSP (A gente na Rua – PAR), consisting of teams of nurses and CHWs which, for the most part, were former PEH. The MSH adapted these teams of WSP, putting them in the format of the Family Health Strategy - FHS (Estratégia Saúde da Família – eSF) and, later, in the CSt model. Employees from the old FHS for PEH were hired to join the new CSt.

If, on the one hand, this previous registration, represented by WSP, facilitated the process - since there were similarities between the latter and the FHS – on the other hand, they also raised some confusion among the workers. According to the CSt coordinator:

> I even remember the manager himself questioning 'well, but what has changed?' He clearly said at that time 'I even think the strategy is better than the clinic on the street, but if the proposal is different, why don't we change the strategy?' And there were several attempts of meetings like, well, it is only the clinic on the street that will attend (the PEH), how was the strategy? (E1)

Eight of the eighteen teams in the municipality continued to be associated to the same philanthropic organization that was the author and executor of the first municipal proposal. For the members of the CSt under analysis, the main changes that occurred with the advent of the new proposal were in the composition of the teams and the availability of vehicles to cover the territories. In addition, the CSt were the object of efforts to achieve more integration with other services, and were invited to health network management meetings.

The CSt main activity was the active search for people with health needs on the streets and in social equipments. The clientele was composed through the host in the PHU by the CHWs, in spontaneous searches, as illustrated in the statement of a user: "I met them in the cafeteria. Then, I got a referral, came here to the doctor" E2. It should be noted that spontaneous searches, in the PHU, are initially motivated by oral health emergency, mostly, according to the report of the monitored team. In addition, the PHU offered two weekly group activities with a psychosocial focus, for people with mental disorders, and two harm reduction groups in squares in the operational area, in collaboration with PCC AD.

It was possible to follow the approach of workers to the PEH's on the street, which begins with informal conversations and invitations to participate in activities that include playful tasks and approach of personal aspects, such as problematic drug use. According to the psychologist, "The groups bring the opportunity to explore more emotional issues" (T1). Among some CHWs, we observed a concern about taking alcoholic substances from the users during group activities. At first, the CHWs explained this was a strategy to favor the focus on the activity and promote what they called harm reduction. However, later, they said that such attitude was inspired by their own life trajectories and the religious treatments they had undergone, based on abstinence.

The team as a whole develops health education campaigns, in addition to vaccinations and application of female contraceptives. There was no supply of material for the safe use of psychoactive substances. There were no specific searches by the team for cases of mental disorder and harmful use of psychoactive substances. When mental disorders were suspected, the psychologist held at least one individual consultation in the PHU and incorporated users to the so-called psychosocial group. These cases were also referred to the FHSC psychiatrist. In cases of severe mental disorder (SMD), the collaboration of the territory's PCC was required. We found

with some regularity that difficulties in dealing with intrinsic characteristics of the clientele (users with confused speech, delusions, symptoms indicative of depression) were largely interpreted as demands to the psychologist of the team.

During our fieldwork, the matrix support actions by PCC were suspended. Divergences between the management of the PHU and PCC, related to strategic mismatches arising from different management models, led to the interruption of collaboration. The contact between CSt and PCC, in this context, was restricted to the referral and sharing of cases and to joint street visits once a month. FHSC professionals attended weekly CSt meetings to discuss common cases.

There was a vehicle available to the team for transferring users unable to move independently to the PHU and other services, and for the team itself to move around the territory, but its use was allowed under management review. According to team members, there was constant encouragement for users to go to the PHU, which seemed to have been successful, since a management report indicates more frequent visits by the users to the accompanied CSt when compared to others. In addition to the vehicle, the transfer was supported by means of urban transport cards for the CHWs to go around the territory with users when necessary. During the scheduled visits, if a given user was missed in his or her place of circulation, the CHWs would have to extend the planned route in search of the patient. When necessary, the database of the Municipal Secretariat of Assistance and Social Development, which gathers the registry of people assisted by social assistance services, was consulted.

The work of the CSt followed the definition of area and assigned population, similar to the two reference PHUs. The team rarely went beyond the perimeter of the formally defined territory, except in the case of missed appointments with users. For the PEH, the delimitation of the coverage area was a challenge in the continuity of care. According to a user: "They go to the shelter, then they said 'You have to go to the PHU, because your region is here', I can't look for another (service) because of the street, it is bad, right? (E4) Another user was concerned about the impossibility of remaining linked to the CSt:

> E6: What can I do? It complicates, it got complicated, that the only person who was understanding my illness was her (doctor), and now I don't know where I'm going anymore.
>
> Researcher: And is it far from here where you are now?
>
> E6: No, I am getting just an overnight stay, I get an overnight stay in a shelter, an overnight stay in another shelter, just an overnight stay.

In one of the PHUs in its area, the CSt had a team room and a office, and collaborated with the FHS by providing dental care and exams. But, only the PEHs that had resumed living at home were registered by the FHS. On the other hand, the other PHU's teams did not perform any services and referred the PEHs to the CSt. The CSt's working hours followed the PHU's working hours, with adaptations only during winter and in specific situations, such as when people with SMD had to attend consultations outside the team's working hours.

In addition, clinical care was offered in the unit, by one or more professionals from the CSt – doctor, nurse, nursing assistants, and psychologist. The higher education professionals also provided care on the street, after the first approach by the CHWs, only in cases that involved severe apparent mental disorders, dressings, and administration of medication when necessary. On this occasion, there could be tests to detect tuberculosis, pregnancy, syphilis, hepatitis, and HIV, among others.

Also in the team's daily routine, referrals were made to various services and other PHU teams with the accompaniment of the SAs, who are responsible for helping to ensure the care and protection for people at personal and social risk, and bring the teams closer to the PEH's ways of life (BRASIL, 2012). In turn, the social worker prioritized initiatives traditionally linked to the core responsibility of the profession, such as issues related to housing or shelter, as well as those linked to obtaining documents and access to services in general, always seeking to articulate such actions with the support of the team. The team's daily effort and the scope of its actions, which ranged from clinical to social assistance, seemed to satisfy some of the users' expectations. As stated by a patient of the service:

> They are people that give me strength, when I was lying on the floor. I used to live here on Quatorze Bis [Square], I've always lived here. So they took me off the street, today I live in a shelter. I have nothing to complain about, because it took me out of the hole.

Besides the general and intersectoral approaches, the specific and on-site action taken by the team is also recognized, as another user explained:

> They arrive, they are very good, they are very attentive, these health agent boys, [...] they really go after even, the person may be there in the tent, may be there on the floor [...] they get together if the person is stinking, is this and that other, smells, they go there, if the person is in a bad, dirty invasion they enter, they examine, you know.(E4).

The schedule of visits is organized by the CHWs based on the priorities defined by the municipality's management from the Primary Care Information System (Sistema

de Informação de Atenção Básica - SIAB), which determines the preeminence of people with hypertension, diabetes, pregnancy, puerperium, tuberculosis, and HIV/AIDS. People with at least one of these conditions should be visited monthly and monitored regarding the frequency of appointments and adherence to prescribed treatments. The relatively easy access to the team by users facilitates adherence and observation of treatment by users:

> So I always come here (PHU), but sometimes I lose the prescription, talk to the doctor, talk to the PHU staff that circulates here in the region that provides assistance. With me at least what I see, the professionals have always been on the street with professionalism (E5).

The actions developed and services offered, which we have characterized, add up to hundreds of cases every semester. Below, we summarize the services provided by the monitored CSt in the last semester of 2016 (Table 1).

Table 1. Monthly average percentages of services provided by CSt in the second semester of 2016

Reasons for attendance	Monthly average percentages in relation to the total number of patients seen in the second semester of 2016	Average number of cases in the second semester of 2016
Hypertension	11,57%	58
Diabetes	2,69%	13,5
Tuberculosis	1,26%	6,3
HIV/AIDS	4%	20,6
Mental Disorders	10,8%	54
People who had problems associated with alcohol use	19,34%	97,5
People who presented problems associated with crack use	8,53%	48,8
People who presented problems due to the use of other drugs	8,24%	41
Pregnant women	3,31%	16,5
Average number of people accompanied per month in the second semester of 2016	100%	498
Monthly average number of people not registered and served by CSt in the second semester of 2016	-	350

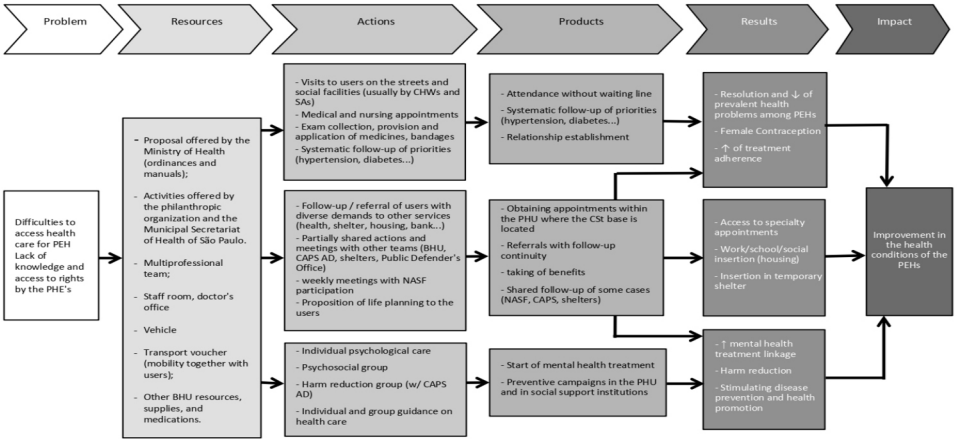
Source: own elaboration.

The data presented in relation to alcohol is restricted to cases whose use triggered other health problems (19.4% of the total monthly attendance). However, the number of people who regularly consume alcohol, according to CSt members, is much higher. This region is characterized by the presence of relatively small attendance (8.53% of total cases attended) of crack users, compared to other areas of the city, according to management reports.

Systematizing the structure and practice of CoS

The elements we have been exposing helped to systematize the correlated resources, actions, and products used in the production of specific results and impacts through the logical model of the CSt (figure 1). In the discussions raised in the process of developing the model, we noticed that the team considered as a priority to overcome the PEH's lack of knowledge about their rights and how to access them – in addition to meeting the health needs properly said. The philanthropic institution to which the team was linked provided the CSt (through an agreement with the Municipal Secretariat of Health of São Paulo) with the salaries, offered the vehicle and training; the Municipal Secretariat of Health of São Paulo, in turn, offered the place for the activities, and the social organization that managed the PHU helped with FHS resources. The CSt tried to articulate them, but some are not always available – such as the infrequency of training courses and the lack of specific rooms in the PHU for group activities and nursing and psychological consultations.

Figure. 1 CSt Logic Model



Source: own elaboration.

Analysis of the degree of implementation

The evaluation matrix of the degree of implementation of the CSt was prepared taking Ordinance 122/2012 as a reference, together with the various subsidies from the fieldwork and the two meetings held with the team, when it was discussed and the scores were revised (Table 2). This revision, arising from the CSt's critics, required new consultations of the material from the observations and interviews for the final definition of the matrix.

For the themes considered most relevant were defined scores of 0 or 5 or 10, according to the increasing implementation condition; those considered less relevant were scored with 0 or 2.5 or 5, according to the increasing implementation condition. In the column destined to the weighting, there are, respectively, the maximum potential scores and the score effectively obtained by the analyzed CSt. The score achieved by the team, in each item, is highlighted in the table. Overall, the team approached presented an implementation level of 75% of the maximum possible, equivalent to an advanced implementation level.

Table 2. Implementation evaluation matrix.

Criterion	Weighting		Deployment Status		
	total	grade	Not implemented	Partially implemented	Implemented
Minimum composition of the CSt Modality III	10	10	Not having the minimum number of professionals as proposed by the ordinance (0)	Having a minimum number of professionals but no doctor (5)	3 high school professionals + 3 higher education professionals + doctor (10)
Primary Care	10	10	Not offering any primary care actions (0)	Offering only a few punctual actions of primary care (5)	Offering the full range of actions related to primary care (10)
Use of vehicle for the actions	10	10	No vehicle available for the team (0)	The vehicle is shared among other teams, and CSt can only use it for specific actions (5)	A vehicle is available and the team uses it daily for itinerant care of the population (10)
Development of itinerant on-site activities	10	10	Team does not offer on-site activities (0)	The team performs only some on-site actions, and/or only some professional categories perform them (5)	The team performs a great part of its actions on-site, in an itinerant way (10)
Development of shared and integrated actions with the PHU of the coverage area	10	5	The team does not develop shared actions with the PHU teams in the coverage area	The team develops few shared actions with the PHU teams, and/or only with one team in the coverage area (5)	The team develops shared and integrated actions with all the teams of the PHU in the coverage area

continue...

Criterion	Weighting		Deployment Status		
	total	grade	Not implemented	Partially implemented	Implemented
Care for users of alcohol, crack and other drugs	10	5	The team does not provide care for users of alcohol, crack and other drugs (0)	The team offers and provides care for substance users, but searches are not made specifically for this situation (5)	The team performs active search for substance users, and offers health care (0)
Carrying out actions in harm reduction	10	5	Does not perform harm reduction actions (0)	Few harm reduction actions and inputs are offered (5)	Promotes frequent harm reduction actions, with wide distribution of supplies (10)
Development of shared actions with PCC and other services in the health care network	10	10	Does not perform shared actions (0)	Performs actions only with PCC or another health service (5)	Performs shared actions with PCC and other services in the health care network (10)
Social agents acting in accordance with the ordinance (harm reduction)	5	2,5	It has no social agents, or there are social agents who perform functions other than those foreseen by the ordinance (0)	There are social agents, who partially perform the functions foreseen by the ordinance (2.5)	There are social agents who perform the functions foreseen by the ordinance (harm reduction), with experience related to the work with PEH or a life trajectory on the streets (5)

continue...

Criterion	Weighting		Deployment Status		
	total	grade	Not implemented	Partially implemented	Implemented
Hours of operation adequate to the demands of the PEH	10	5	The opening hours are shorter than those of the PHU and do not meet the demands of the PEH	The working hours are the same as those of the PHU, occurring, only in specific situations, the attendance of CHWs at different times according to the user's needs (5)	The team's hours of operation were adequate to the demands of the region's PEH (10)
Access to continuing education	5	2,5	There is no team access to continuing education actions (0)	Education processes are infrequent and do not address the needs of the team (2.5)	The team has constant access to continuing education processes (5)
Total	100 = 100%	75= 75%			

Source: own elaboration.

The meeting for the presentation of the scored table was awaited with curiosity by the team. According to its members, the process was positive as a moment of reflection on the work developed by them. There was agreement with the defined scores (according to the exposed criteria). Some team members were unaware of some norms and were able to approach these guidelines, while others were able to review their performance and become aware of the adaptations made according to the reality of the territory. This exercise provided important discussions for the team's analysis and proposals for action.

Discussion

From the evaluation process using the implementation matrix, we were able to analyze internal and external processes to the team from the standpoint of the SUS principles.

The monitored team presented complete training, and acted by partial integration of knowledge of each professional category, expanding, in a sense, the possibilities of

care according to the proposal of interdisciplinarity (CAMPOS, 2000). The work of CHWs and SAs contributed to the linking of users with the team and PHU, enabling agreements with users to start and continue treatments (ENGSTROM; TEIXEIRA, 2016). However, the active search and systematic monitoring of users ended up being the sole responsibility of the CHWs and SAs. The rest of the team centralized most of their care in the PHU, which precisely affected the principle of interdisciplinarity, and reproduced the logic of an FHS team, in the sense that the other professionals centralize their activities in the PHU and go to the territory outside the PHU in specific situations, causing restrictions on access to higher-level professionals.

Even without daily use of the vehicle, we observed the presence of CHWs and SAs in the territory, establishing trust and mutual accountability in the treatments. However, the restricted use of the vehicle reduced the distance traveled by the agents, hindering coverage, a fact also verified in another CSt (FERREIRA; ROZENDO; MELO, 2016). For itinerant PEHs, this limitation of team displacement can cause disruptions in follow-up and hinder equity, in Vieira da Silva's perspective (VIEIRA-DA-SILVA, 2014). The insertion of equipment and supplies for rapid tests and dressings in the vehicle could enhance the care actions in the streets. We also understand that the restriction of the CSt operation period to business hours used to prevented the recognition of potential users of the service whose location and meeting would only be possible at night, making the team less adapted to the target audience.

Acting on the streets in cases of mental disorders or clinical complications ensures a care that breaks the walls of services and allows greater interaction between the health system and the living conditions of the PEH (LONDERO; CECCIM; BILIBIO, 2014). Cases involving mental disorders and other complexities are the moments that seem to justify the team meeting in the street actions.

The team can build a bond with people who abuse of psychoactive substances, using relational tools, such as non-judgmental reception, qualified listening, among others (MACHADO; SIMAS, 2017). The experience of CHWs and SAs with life on the streets offers them knowledge of the norms of psychotropic territories (FERNANDES; PINTO, 2002), i.e., the spaces of marketing and consumption of psychoactive substances that have varied rules of coexistence, facilitating the approach and mutual trust. But, by not offering inputs to ensure safety in this

use, the pragmatic principle of harm reduction is affected, as well as health equity. Harm reduction aggregates diverse actions to mitigate the harms associated with the use of psychoactive substances. But, to really succeed, this strategy depends on the articulation of relational and pragmatic tools (SOUZA, 2013).

Moreover, the conformation of the CoS in primary care policy and the *modus operandi* used by WSP influenced the organization of the team under study, with regard to the reproduction of the dynamics of traditional primary care teams. In addition, the reproduction of the biomedical logic by some team members, especially when they act restricted to the priorities listed by SIAB, prevents the effectiveness of integral care.

The influence of Christian missionary logic also seemed to permeate the dynamics of part of the team under study. The CSt performance beyond health needs and in the approach to alcohol consumers seemed to be not only based on the guarantee of rights, but also inspired by the posture of bringing help to those in need and freeing them from the harmful use of psychoactive substances. If we consider the entire history of charity of the Catholic Church for unassisted groups since the brazilian colonial period, the presence of representatives and/or people influenced by this institution in the formulations of the CoS (BORYSOW, 2018), the management of the CSt, analyzed here, by a philanthropic group with a Christian background, and the history of some of the CHWs in treatments promoted by Christian institutions, it would not be surprising to identify this missionary logic among the team components. This seemed to favor the dedication of the workers in the assistance, but caused a hybrid care composed of health care, guarantee of rights, and charitable, moralistic, and controlling postures about the PHEs, derived from Christian values, especially regarding the use of psychoactive substances.

Regarding the interdepartmental and intersectoral articulation, which occurs through meetings and sharing of some actions between the CSt and other health and social assistance teams, an attempt to overcome inequity is identified, enabling the adequacy of care to the needs of its target audience (BORYSOW; FURTADO, 2014; ENGSTROM; TEIXEIRA, 2016). However, there are barriers in the service network: the inflexible organizational structure in relation to schedules and users' ways of circulation, and the restricted contribution of permanent education hinder the achievement of improved access to health care for PEHs. The CSt needed to pressure for the PEHs to be registered as users of the PHU where it is based, even

without proof of residence, as determined by the ordinance MH 940/2011, a fact also verified in the work of an other CSt (FERREIRA; ROZENDO; MELO, 2016; KAMI *et al.,* 2016). Such situation, unduly justified by the fact that the PEHs have no housing and therefore do not belong to the "territory", affects the principles of universality and equity of the brazilian Unified Health System - UHS (Sistema Único de Saúde – SUS) (BORYSOW; FURTADO, 2014; VIEIRA-DA-SILVA, 2009) reinforcing the invisibility of this population (HALLAIS; BARROS, 2015; KAMI *et al*., 2016). The monitored CRC feels pressured by the extent and diversity of the demands coming from its clientele and by the fragile dialogue with other teams.

The bureaucratization for the reception of PEHs in shelters and hostels leads the CSt to act as mediator with the social assistance teams, especially in cases of mental disorders and patients with severe chronic problems. The especially exclusionary logic that affects people with SMD in public services (BORYSOW; FURTADO, 2014; VIEIRA-DA-SILVA, 2009) is reproduced here. Thus, the team assumes responsibility for some determinants of the health/disease process, extrapolating its actions (LONDERO; CECCIM; BILIBIO, 2014), even when it initiates processes for the access of PEHs to shelters, housing and social benefits which could be of shared responsibility with Social Assistance. Despite the constant attrition, when dealing with social reintegration, the CSt acts as a promoter of intersectorality and trans-sectorality (JUNQUEIRA, 2000).

Conclusion

The evaluation of the degree of implementation allowed us to identify the relevance of the team in providing care in primary care, in the bond with users, in the dialogue and inter-service and intersectoral work, and in supporting demands that go beyond what is traditionally recognized as the health sector, but that are fundamental in this population segment. However, there are aspects to be developed in order to ensure equity for this population, especially in ensuring the mobility of the team through the territory, interprofessional work on-site, and improvement of the flow between the CSt and the PHU teams, as well as ensuring the necessary supplies for harm reduction.

These elements can be seen as important weaknesses as in the case of the Covid-19 pandemic, which has challenged health and social care services to develop strategies

to maintain care for this social segment facing the complications of the disease and the risk of contagion (BORYSOW; MANAIA, 2021). If this fact already strains the teams to remodel their activities, the lack of structure for on-site care will further hinder the work facing Covid-19.

The use of the implementation analysis matrix was validated by the team here under analysis, in the sense of helping to systematize the information coming from the daily work and provoking reflections for the improvement of the team's processes.

It became evident that the proposals made at the central levels of UHS inevitably suffer adaptations, resistance, and new elaborations based on local conditions and history. The problems identified with the monitored team seem to stem less from its degree of implementation and much more from a paradox of the health policy itself and of the other services in the network.

The success of the CoS seems to be precisely when the PEHs will be able to waive it to obtain health care in the UHS, without barriers.[1]

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Note

[1] I. da C. Borysow: project conception, data analysis and interpretation; writing of the article; final approval of the version to be published; responsible for all aspects of the work in ensuring the accuracy and integrity of any part of the work. W. Y. Oda: analysis and interpretation of data; relevant critical review of intellectual content; final approval of the version to be published. J. P. Furtado: analysis and interpretation of data; writing of the article and relevant critical review of the intellectual content; final approval of the version to be published.

Resumo

Avaliação da implantação do Consultório na Rua: um estudo de caso

Objetivamos compreender as adaptações do programa Consultório na Rua ao contexto territorial, a partir das bases normativas, realizadas por uma equipe atuante na cidade de São Paulo, que oferece cuidado em saúde para as pessoas em situação de rua. Realizamos análise de implantação da mesma, por meio de pesquisa participativa e estudo avaliativo de caso, que envolveu observação participante, entrevistas e análise documental. Os trabalhos de campo e posterior discussão com a equipe subsidiaram a elaboração do modelo lógico e a elaboração e preenchimento da matriz de avaliação. Os resultados indicam avançado grau de implantação do caso estudado, com exceção do atendimento aos usuários de substâncias psicoativas e da garantia da logística à itinerância da equipe. O programa enfrenta desafios diante de restrições da gestão e limitações da rede de serviços do município, que impedem o alcance da equidade.

➤ **Palavras-chave:** Atenção Básica. Pessoas em situação de rua. Redução de danos. Avaliação de programas e projetos de saúde.