

# The dimension of care by the ‘Street Clinic’ team: challenges of the clinic in defense of life

*A dimensão do cuidado pelas equipes de Consultório na Rua: desafios da clínica em defesa da vida*

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**ABSTRACT** The study aimed to analyze the production of Primary Health Care to people living in the streets, provided by Street Office (eCR) teams in the context of a Brazilian metropolis, identifying potentialities and difficulties. This is a qualitative case study considering the universe of the seven teams in the 2016-2017 period, with direct observation of the work and conducting semi-structured interviews with professionals from various categories (n=34), with thematic content analysis. We observed that the eCR operated with an enlarged and comprehensive scope of actions, clinical and intersectoral care, in street spaces and services, through integrated teamwork. They were organized with flexibility, low demand, active search in the territories, in an itinerant way, timely, and immediately, with the construction of shared therapeutic plans, which promoted autonomy, based on harm reduction. Difficulties were inherent to the vulnerabilities and complexities of the cases, the fragmentation of the health care network, the quality of the instruments for health registration and the lack of structural resources (transportation and inputs for health promotion actions). We concluded that care was sustained in the ethical-political, user-centered dimension, in solidarity and in the defense of life.

**KEYWORDS** Comprehensive health care. Primary Health Care. Homeless person. Health vulnerability.

**RESUMO** O estudo objetivou analisar a produção de cuidados primários à saúde à população em situação de rua, prestados por equipes de Consultório na Rua (eCR) no contexto de uma metrópole brasileira, identificando potencialidades e dificuldades. Estudo de caso, de abordagem qualitativa, considerando o universo das sete equipes no ano 2016/2017, com observação direta do trabalho e realização de entrevistas semiestruturadas com profissionais de várias categorias (n=34), com análise temática de conteúdo. Observou-se que as eCR atuavam com escopo ampliado e integral de ações, cuidados clínicos e intersetoriais, nos espaços das ruas e nos serviços, em trabalho de equipe integrado. Organizavam-se com flexibilidade, baixa exigência, busca ativa nos territórios, de forma itinerante, no tempo oportuno, imediato, construção de planos terapêuticos compartilhados, que promoviam autonomia, baseados na redução de danos. Dificuldades eram inerentes às vulnerabilidades e complexidades dos casos, à fragmentação da rede de atenção, à qualidade dos instrumentos para registro em saúde e à carência de recursos estruturais (transporte, insumos para ações de promoção da saúde). Concluiu-se que o cuidado se sustentava na dimensão ético-política, usuário-centrado, na solidariedade e na defesa da vida.

**PALAVRAS-CHAVE** Cuidado integral de saúde. Atenção Primária à Saúde. População em situação de rua. Vulnerabilidade em saúde.

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## Introduction

The growing number of People Living in the Streets (PLS) is a reality throughout the national territory, with an estimate of more than 100,000 PLS in 2015, mainly in large cities, such as São Paulo, Rio de Janeiro, and Belo Horizonte<sup>1</sup>. PLS is a heterogeneous group of unemployed people, former inmates of the penitentiary system, immigrants, among others, who share poverty, poor living conditions, difficult access to primary care services, and other citizenship rights<sup>2</sup>. Living in the streets is a condition of extreme vulnerability that must be understood in its multifactorial dimension and as a result of neoliberal policies that increase the gap of deep social inequalities, unemployment, unstable work, poverty, among other situations of inequalities. Therefore, it cannot be attributed to a simple choice of individuals, often blamed and stigmatized by a large part of society for being in this situation<sup>3</sup>.

The structural vulnerability of the PLS leads us to poverty, which includes the deprivation of personal freedom and the ability to make choices<sup>4</sup>. Having options to choose from is often a difficult task given the lack of perspective in life, pessimism, suffering, and daily life adversities. PLS is perceived as marginalized, invisible, or of negative visibility to society<sup>5</sup>. Such invisibility is an essential element of vulnerability, for which the formulation and implementation of public policies that promote equity, social protection, and care to guarantee life and health are urgent.

Excluded from national demographic censuses and other household-based health information records, except sparse municipal initiatives, information on the magnitude and health conditions of the PLS is scarce, fragmented, obsolete, and hinders decision-making, monitoring, and evaluation of effective interventions. It is a population with high morbimortality, comorbidities of the most varied conditions, such as tuberculosis, sexually transmitted

infections, mental health problems, alcohol, and drug abuse, among others, conditions that are also burdened by stigma and violence of living in the streets<sup>2,6</sup>.

Developing public policies that minimize such inequalities is a significant challenge for the country, particularly within the Unified Health System (SUS), so that they promote comprehensive care to the PLS, with PHC as the main gateway, integrated into the Health Care Service Network (RAS) or the Psychosocial Care Network (Raps), to respect the specificities of this population. It can be said that advances have been made in Brazil in the formulation and implementation of policies and actions, from different sectors, which acted synergistically for the protection of PLS, especially between 2008-2009 and 2015. Some examples are the guidelines found in the National Policy for People Living in the Streets<sup>6</sup>, which reaffirmed the principles of equity, humanization, universality, the right to social coexistence and respect for dignity and citizenship, and within the Ministry of Health, the National Policy for Primary Care (PNAB)<sup>7</sup>, with the creation and financial induction of a specific type of primary care team, called the 'Consultório na Rua' ('Street Clinic') (eCR) team, and the Policy for the Promotion of Equity in Health<sup>8</sup>, which included PLS as one of the vulnerable groups and reiterated the importance of the work of these types of teams.

Federal regulations<sup>7-9</sup> state that eCRs aim to increase PLS access to public services and ensure comprehensive health care actions, with proposals from three types of multi-professional team, with variations in the incorporation of professional categories – physician, nurse, social worker, psychologist, dentist, nursing technician, and social action workers – which are articulated with the Family Health Strategy (ESF), RAS and Raps, and other social facilities in the territory. Several eCRs of different modalities were created in Brazil in 2011, in line with the growth and strengthening of

the ESF-centered model, a movement that suffered inflections and tensions after the review of that policy in 2017<sup>10</sup>. In Brazil, in 2019, 155 teams were accredited in the National Register of Health Establishments (CNES)<sup>11</sup> to develop health promotion, prevention, and care actions, as well as urgent and emergency care, both in public spaces and in PHC units.

It can be assumed how intricate comprehensive care is for people in extreme vulnerability, such as PLS, and health practices should include both the technical dimension of care, clinical and managerial skills, attitudinal dimensions, such as reception, attentive listening, respect for life stories, to strengthen autonomy and relieve or minimize suffering<sup>12,13</sup>. The complicated nature of eCRs' work suggests the adoption of models centered on an expanded vision of care, considering people's singularities, their needs, and life contexts, which would imply the construction of shared and flexible Unique Therapeutic Projects (PTS)<sup>9</sup>.

Eight years after the standardization of eCRs in Brazil, some local experiences on the daily work of the teams have gradually been the subject of studies in our reality<sup>5,14-17</sup>, or in comparison with other countries<sup>18</sup>. More in-depth analyses of these practices are justified, like the one proposed in this study, which aimed to analyze the production of PLS care by eCRs in a sizeable Brazilian metropolis, identifying their strategies, potential, and hardship. To this end, the Municipality of Rio de Janeiro (MRJ) was selected as the study scenario, with an estimated 14,279 people living in the streets<sup>19</sup> in 2016. It should be noted that, in 2009, the municipality started a movement to change its health management and care model, increasing ESF coverage from 5% to 60% between 2009 and 2016. There were also financial and structural investments, construction of new health facilities, and expanded scope of services offered<sup>20</sup>. In this context, seven eCRs were implemented in several territories of the city, whose practices were analyzed in this paper from the perspective of professionals.

## Methods

This is a qualitative, exploratory case study<sup>21</sup> considering the universe of the seven eCRs in the MRJ during the data collection period (2016/2017). Although with work processes varying according to the different health needs and vulnerabilities of the territories, all the eCRs were complete, modality III, and three teams had a dentist and oral health technician. Some teams had a car to transport professionals and users and were linked to one or more Family Clinics, depending on the size of the territory covered by the team, many times larger than the PHC facility's coverage area.

Different data collection techniques were employed to capture the diverse eCR work process, and the care actions developed, such as direct observation of the teams' daily work, the analysis of the team's registration records, and the staging of interviews with a semi-structured script. Thirty-four professionals (from a universe of 69 professionals) were included for interview to ensure the participation of at least two higher education professionals (doctor, nurse, psychologist, social worker, dentist) and one mid-level professional (social worker or nursing technician) of each of the seven teams, on a voluntary adherence and availability basis, or to consider different categories. A group of two researchers and two supervisors alternated in the participation of the activities of the eCRs, staying about one month in each one, attending meetings, individual clinical attendance, groups, actions in the streets and other external actions in the territories, with notes in field diaries and audio recordings.

The interviews with professionals were held at the health services at a scheduled and appropriate time and place, and were recorded and transcribed in full. The systematization of the analyses was carried out in the Atlas.ti program, and the empirical

material was processed from the thematic content analysis<sup>22</sup>. Thus, the categories emerged from the real work in the production of care, considering the strategies, potentialities, and difficulties in the performance of the eCRs. No mention was made of the team or professional category to ensure confidentiality and secrecy of the participants' information. The study complied with the ethical precepts of human research and was approved by the Research Ethics Committee of the Sergio Arouca School of Public Health (Ensp)/Oswaldo Cruz Foundation (Fiocruz) in 2015, under CAAE No. 45742215.6.0000.5240.

## Results and discussion

Many convergences in practices related to the production of care by eCRs were apprehended in field observations and interviews with professionals – actions of the most diverse settings in the field of health promotion, prevention, and management of clinical diseases within PHC, albeit still with difficulties in integrating with other equipment in the health network. Actions were also identified in the field of intersectoriality, social support (Bolsa Família – Family Grant, urban transport card, continuous cash benefit (BPC), approximation with families), and citizenship – carried out either in the internal spaces of the Family Clinics or directly through the street approach.

Specificities in the organization of the work process were due to the characteristics of the territories and their users, with strategies to allow access, care resolution, and even safety of professionals and users. Of the seven teams, five worked in places of extreme violence and poverty, and four of them, in territories marked by the ostensible presence of drug trafficking, where an essential portion of drug (such as crack) users was found.

The teams visited the territory regularly, and this is essential for approaching and

receiving users, referred to as 'meeting and listening spaces', which are imperative for building therapeutic bonds.

*We gather around the cashew tree every Tuesday, and everyone already knows... this routine in the streets organizes the demand. People end up knowing that we will be there, and they count on it [...], so some procedures are possible in the streets, while for other types, people are better served at the clinic.*

Another convergent potential identified was the articulation between shared management of the work process and the production of comprehensive care, as pointed out in other studies, such as by Vargas and Macerata<sup>16</sup>, in which the logic of integrated teamwork is essential. According to Peduzzi<sup>23</sup>, 'teamwork' emerges in a context consisting of three aspects, related to integrated actions, with the approach related to the biopsychosocial health-disease model, as opposed to the biomedical model, and to changes in work processes to expand interventions, with joint organization and planning. The typology described by the author as an integration team, not a cluster, was still perceived in the work of eCRs due to the valuation of the work of all professional categories, communication and collective construction of collective or individual care projects, in the streets or services, agreed on regular activity meetings (daily, in the morning, to discuss the day's priorities; besides a weekly, more in-depth meeting). Such practices are essential to overcome the social and technical division of labor<sup>23</sup>.

*We have some group activities, and individual visits, medical, nursing, psychology, with social workers, dental appointments, and, sometimes, users want to be attended to by social workers. Dental care is present in some of the teams and is widely used, not only in emergencies, due to pain, but in actions that improve self-esteem... and the smile.*

The street approach – not necessarily in the first meetings – or in the services allowed the temporary or definitive registration of users, with different characteristics for each team, as the criterion for who would be considered a ‘user monitored by the team’, as evidenced in the statements: “A user monitored by our service is the user who is seen, visited, or approached in the last 3 months” or another team that “only considers a monitored user one with a proposed care”.

While the electronic registration has been accessible in all PHC units since 2010, the teams pointed out that both the registration instrument and the specific longitudinal monitoring forms for the PLS were inadequate, which generated discontinuity and data.

*The registration form was ridiculous when it started [2013/2014] - questions outside the reality of street users... Now [2016] they have evolved into a better format [...], with specific questions - Where one sleeps, what time can one be found if they have to get medication and whether that is the place where he will be found. Where will he be if he is not there for any reason?*

They adopted manuals (diaries) or spreadsheet records, exchanges, and informal contacts with other eCRs and services to overcome this difficulty, “because the patient is itinerant, but medical records are not”, looking for the possible integration to expand care. It is worth noting that there were several electronic medical records in operation in the city’s ESF/PHC, and some areas were in the process of migrating to the national system (e-SUS), causing loss of clinical information.

For the various reasons mentioned, it was difficult to generate information, not allowing to know epidemiological indicators and those resulting from the effects of the care provided by eCRs, essential information for management decision-making – an absolute information void that contributes to this group’s invisibility. Corroborating this finding, a participant observation study in eCR carried

out by Hallais and Barros<sup>9</sup> showed that the historically marginal PLS are hardly able to access health services, making them invisible to the SUS itself.

With data from the users’ register, we observed that most were young adults, although there were older adults and a few children. Most of them were men, but eCRs’ concern with women stands out – women are even more vulnerable due to gender violence, rape, unwanted pregnancy, loss of custody of their children born in the streets. The professionals somehow recognized (and technically organized themselves) to work with the management of acute conditions, in general, infectious or trauma, given the imminent threat to life, using several strategies for rapid diagnosis, in the point-of-care logic, such as serological tests for syphilis, HIV, hepatitis, pregnancy test and smear test for tuberculosis and, consequently, immediate care, with pain medications, antibiotics, psychotropics, dressings, and other supplies. The eCRs worked in the first aid of urgent/emergency care, in the aggravation of chronic conditions, those related to violence, trauma, or even of a psychiatric nature, situations that demanded the intense mobilization of the team and integration with the network. Such practices show, in the face of extreme complexity, the need for quick and timely responses. As described in the literature, pulmonary tuberculosis is a significant condition in PLS, about 60 times higher in PLS compared to the rest of the population; as well as other chronic conditions, such as hypertension (10.1%), psychiatric/mental problems (6.1%), HIV/Aids (5.1%), and vision/blindness problems (4.6%)<sup>9,24</sup>.

Living in the streets is not necessarily a temporary or short process, some live there for many years, grow old there, get sick (and sometimes die) due to infectious, chronic conditions, or external causes, violence, lack of food, despondency, and discouragement in the struggle for survival. Being prepared to deal with the PLS illness and suffering process,



aggravated by the situation of vulnerability and extreme poverty, is no simple task. On the other hand, the care of users with chronic conditions was also complicated due to difficulties in diagnosis and treatment. Because these conditions demand continuous, longitudinal monitoring, with difficulties in strategies to keep them monitored due to the great geographical mobility, as highlighted by the professionals' reports: *"we lose track of them [...] We have the first contact, and then we lose them", or "the PLS cannot stay in the territory, they go elsewhere"*.

One can imagine how challenging it is to care for people with HIV/Aids, hypertension, diabetes, amputees, patients who are discharged from the hospital, pregnant women requiring prenatal and puerperal care, tuberculosis patients, often resistant, or other conditions that require longitudinal care of higher technological density, carried out in public spaces on the streets or shelters. For the population domiciled and covered by the ESF, care for chronic conditions has been an old dilemma since the late 1980s<sup>26</sup>. More radically than thought for the ESF, addressing the countless loads of disease is an expanded challenge for eCRs, requiring a broader offering of services/actions and support from a health and intersectoral network. The possibility of using the 'expanded portfolio of health services' available to all individuals registered at Family Clinics was potential for the care provided and reinforced the dimension of comprehensive care.

After the creation of this specific type of team for PLS, the Ministry of Health<sup>2,8,9</sup> and even the municipal health secretariat<sup>25</sup> published norms that point out guidelines for the work of the eCRs, considering this expanded scope of practices, emphasizing the perspective of harm reduction. The adoption of this perspective was present not only for people with alcohol and other drugs (such as crack) abuse but it was also a reference that permeated other practices in a low-demand care model.

*Harm reduction is a cross-sectional approach, present in several of the activities inherent to physical care and mental health, and therapeutic projects... but we do not have many of the 'classic' damage reduction supplies - such as lip balms, serum for the nostrils that protect from cracks in the mouth due to crack use; we have condoms. [our emphasis].*

Operating under the rationale of harm reduction implied adapting the work to the users' reality, attitudes that explained not only techniques and apparatus, but also an ethical care posture<sup>27</sup>. While the teams recognized the importance of adopting protocols and clinical guidelines, they reported how much such a practice could imprison health care and generate conflicts given the flexibility needs to care for PLS, as explicit in the professionals' narratives:

*Our work demands more availability, more mobility, and flexibility, flexibility with the agenda, with the area covered by the team.*

*If I am very strict in applying and maintaining the protocol, that street person will likely not adapt to the protocol, which is what [also] happens to the family's health. [...] I need flexibility [...] or at least an internal agreement of this protocol, for example, for syphilis treatment.*

We also observed flexibility with the eCRs' coverage area, unlike what was observed for the ESF model, which is home-based and with defined territories. While with geographic territories pre-established by the municipal management, in practice, the territorial limits were smoother, capillary, and reached users regardless of their location – nomadic population-itinerant and flexible team:

*We do a full-time active search [...] for some clinical issue, you know, dislocation, ringworm, mental disorder, or someone who was attacked and had to find it because a colleague gave us a message, we do an active search not only in the streets, but hospitals, shelters, elsewhere outside our area.*

The eCRs often used simple strategies in technological density to facilitate the meeting of users, such as offering a printed card, with a telephone number, in case the user needed a contact in a clinical emergency or was approached to be removed from the streets by other government sectors. It was a simple strategy, but it exceeded what is prescribed in the regulations. Given a comprehensive and expanded care model, health actions should consider the needs of the population, provided to ensure timely care (swift, at the time of diagnosis, or contact with the user, in the street or at the Health Unit), effective and acceptable by the user. From this perspective, time and opportunity were central in this care model; the notion that “*time is here and now*” was reflected in the immediacy of the team response to users’ demands, as reported by one of the professionals:

*The life they lead in the streets is not a simple thing [...], and neither is the work of professionals, in the face of so many urgencies, everything has to be done on the spot.*

Low-demand care strategies, when possible, respecting users’ autonomy and desire, lead us to harm reduction based on the ethics of care<sup>27</sup> and references of the expanded and shared clinic<sup>28</sup>. The therapeutic relationship, concerning users’ preferences, strengthening the autonomy for decision-making on the health-disease-care process, is highlighted in the professionals’ report by signaling that “*their [PLS] autonomy is the most important thing to achieve [with the care of the team]*” or when saying that:

*we perceive that people have a fundamental change in self-care [...] we have little to contribute [...] but the little we have, makes a difference, indeed, in this self-care thing.*

Despite avoiding the paternalistic posture, the autonomy-heteronomy relationship was sometimes a delicate balance in the

care process, especially in conditions that threaten the lives and physical integrity of users. Because it deals with complex cases, the construction of Unique Therapeutic Projects (PTS) – as proposed in the literature and regulations of the Ministry of Health<sup>9,28</sup> – was present in most cases, albeit with greater flexibility of goals and agreements. Shared care projects, sometimes with little structure, were built for all users to improve the clinical or social condition, as highlighted in the professionals’ report:

*we elaborate the PTS more systematically for more complex cases, usually in team meetings, but in all cases, we have an established proposal and monitor how it evolves, although the user has a leading role because all these proposals are built together with the user.*

When including the PLS in the construction of PTS, with the definition of actions and strategies that respect their specificities, singularities, and demands, the eCRs develop a care practice centered on the subjects and guided by an ethical-political dimension of care. This dimension can be better understood if we think of care guided by the concept of ‘value’, as the thought by the philosopher George Canguillen (1904-1995), in work revisited by Ayres<sup>29</sup>. In this dimension, practices transcend norms. They are implicated in and concerned with human value, in defense of life. The ethical dimension of care, as presented by Boff<sup>30</sup>, also reveals the intersubjectivity, affections, and recognition of the subjects in the act of caring, which, in turn, is inseparable from the political dimension of care, as a field of dispute in which conflicts, power relations, mediations, partnerships, the struggle for rights emerge, among others. In this sense, user-team shared care responsibility, respect for stories of illness and suffering, and the opportunity for these users to set goals, make choices, and make decisions are essential<sup>13</sup>.

It is worth mentioning that a certain tension in the act of sharing care seemed to be present in the distribution of responsibilities as the eCRs considered that there should be greater involvement of the other professionals of the Clinic, for example, in meeting the self-referred demand, at times when the doctor and nurses were engaged in street care. When reaffirming that they were not specialists in 'Pop Rua' (PLS Reference Center), the eCRs sought to reconstruct meanings, reduce prejudice, stigma in serving this population and sensitize other professionals, such as those from the ESF and managers to the inclusion of PLS in the routine of the units.

*Our care is shared... we are not specialists in the street population, and that is not even what we want; but we can bring to all the professionals of the clinic [of the ESF] a shared responsibility around that care [...], that the territory outside the area was also theirs, and we started to see that the work was shared.*

On the other hand, working in the same physical space as the health unit allowed strengthening the relationship with other professionals, as eCRs could collaborate in the development of therapeutic plans, referred to as 'multidisciplinary support', in cases of mental health, alcohol use, family/social violence, non-adherence to therapies or even when attending emergencies of users domiciled under the care of the ESFs. This sharing was a recognition of eCRs' work.

The intricate care of the PLS implied a plurality of actions and strategies challenging to implement, which, many times, caused an inevitable work process disorganization or fragmentation, attributed to itinerancy, immediacy, but also some inadequate structural resources, such as supplies, transportation for professionals and users, personal hygiene material, financial aid or public support for users to participate in events in the city. One of the challenges of caring for teams is to develop

strategies that promote the social inclusion of PLS and allow its free circulation in cultural activities and public spaces in the city, which, in turn, although fundamental, exceed the attributions of the health sector and imply intersectoral articulations. We had the opportunity to follow extreme, powerful practices. We can say that they were moving and surprising in strengthening citizenship and inclusion in urban spaces, such as, for example, joint visits by eCR and users to a gastronomic social event, a dinner offered by a restaurant in the city center ('Refettorio Gastromotiva' project) to PLS, decent space and meals, with respectful table, cutlery, and menus, which were unique moments for the participants<sup>3</sup>.

Seeking to weave intersectoral articulations, despite the difficulties, was one of the tasks of the eCRs given the basic demands and needs of the PLS. There were demands for rights, of daily life, such as help to get documents – birth certificate, identity card – to obtain the Family Grant, retirement, transportation vouchers, among other social rights:

*Users' demands are 'basic' things, which is a document, some demand for wounds, toothache, and demand of life, food, work, and particular demands, some physical health issues... pregnancy test, phlegm, many dressings. Demands for social support, Family Grant, Riocard, Continuous Cash Benefit... require intersectoral work, and the presence of the multi-professional team is important. [our emphasis].*

the importance of intersectoral actions, articulation with other health equipment was also essential for comprehensive and resolute care, but, at the same time, it caused tensions, difficulties, and barriers in the work process of eCRs. An example is care regulation, which manages access to specialized services in the RAS and Raps and hospitalization, which, while necessary to organize the system, had very strict flows, did not consider criteria such as severity, PLS' situation of vulnerability,



and the opportunity of the 'here-and-now' users, not being available for appointments, exams or procedures in specialized services in the future, hence the logic of the users' entry through emergency and critical care services. The strategies that eCRs built to get care were often informal, as mentioned:

*References are often not made by SISREG, but through contact [...]; we follow precisely all the flows, all the rules they impose, but we also agree with management the perversions of this flow.*

Perverting the flow, as the professional points out, was, in fact, a strategy in the production of care so as not to lose the bond with users and ensure their access at the different levels of care in the network, according to their needs and specificities.

Undoubtedly, eCRs' work was, at different times, experienced by professionals as a generator of anguish and suffering when faced with numerous difficulties, such as the lack of supplies and a more articulated health network, discontinuous actions, the difficulties of articulation with other sectors of society and the limits imposed, among others, by the very condition of poverty and extreme vulnerability of the PLS. On the other hand, it was possible to show, at other times, a satisfaction and a particular enchantment, which can be attributed to the characteristics of the health work of the eCRs that allowed the autonomy of professionals to cope with the singularities of users and made the work alive and creative, quoted as one of the powers for the performance of professionals.

We concluded that sharing care between team and users aiming at autonomy, as well as the low demand for building therapeutic bonds, was a robust strategy and denoted an ethical-political dimension of care, with user centrality and respect for their care processes, illness, and suffering. This dimension aims to expand the access of PLS to health and other basic rights, fundamental in the construction of citizenship and the defense of life.

## Final considerations

PLS is a growing phenomenon, especially in large urban centers, with high morbimortality and extreme social vulnerability, which, as such, require differentiated care strategies and specific public policies to reduce social inequalities. Interest in thinking about interventions for floating, temporary populations has been observed even in developed countries, such as health care for immigrants in Europe and the Americas. Brazil has implemented team modalities for specific populations, such as riverine dwellers, rural and forest populations, and, undoubtedly, people living in the streets, in inadequate housing or extreme poverty conditions.

We observed that, through PHC, eCRs promoted access to the SUS (and sometimes to other sectors), working with the needs of users, from those that are more specific or more complex, most requiring the construction of shared therapeutic plans that were developed at the right time and place, because of the immediacy that permeates the PLS' logic of life. Reflecting on the care practices of eCRs, based on primary health care models, of low demand, creative, timely, and comprehensive, considering the needs of the PLS, can bring supporting elements for the formulation and implementation of public health policies to other vulnerable populations. If, on the one hand, several difficulties were evidenced in the daily routine of eCRs, on the other hand, robust care strategies were also observed from the perspective of strengthening the autonomy and expanding user access to health and other social rights. These observations allowed us to recognize that eCR care was based on a model that prioritized users, and was solidary, anchored in its essence, in the ethical-political dimension of care, committed, above all, to the defense of life and citizenship.

The potential of the eCRs' work in the production of PLS care, with its limitations and potentialities, should continue further in other studies, especially given the current situation

of dismantling public health policies. The condition of living in the streets is perverse. It is the result of neoliberal policies that enhance poverty and social inequalities. This condition is even more aggravated by sanitariat and restrictive sectoral policies, such as the actions of removal and involuntary commitment of the PLS, which are a setback to democracy, human rights, and equity and public health policies.

## Collaborators

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