

Implementation of the Street Outreach Office in the perspective of health care

A implantação do Consultório na Rua na perspectiva do cuidado em saúde
La implantación del Consultorio en la Calle en la perspectiva del cuidado en salud

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ABSTRACT

Objective: To report the experience of implementation of a clinical equipment of health care production to homeless people, denominated Street Outreach Office. **Method:** Experience report in the city of Rio de Janeiro, Brazil. **Results:** The Street Outreach Office implementation resulted from a demand for health care practices for homeless people. This implementation had intersectoral articulations, causing health professionals to carry out street care practices, which led them to strive for public policies, to rethink their actions in order to increase the resolution of care to this population. **Conclusion:** We should emphasize the importance of health professionals to reinvent their practices, daily, seeking partnerships and acquisition of new knowledge in order to achieve results that can reduce the demands of these individuals throughout their life routes.

Descriptors: Homeless Persons; Health Management; Primary Health Care; Health Vulnerability; Comprehensive Health Care.

RESUMO

Objetivo: Relatar a experiência da implantação de um equipamento clínico de produção de cuidado em saúde à População em Situação de Rua, denominado Consultório na Rua. **Método:** Relato de experiência ocorrido no município do Rio de Janeiro, Brasil.

Resultado: A implantação do Consultório na Rua partiu de uma demanda de práticas de cuidado em saúde para pessoas em situação de rua que se encontravam desabrigadas. Esta implantação contou com articulações intersectoriais, fazendo com que os profissionais de saúde, na realização de práticas de cuidado à População em Situação de Rua, fato que os levam a almejar por políticas públicas, repensassem suas ações para que ampliassem a resolutividade da assistência a essa população. **Conclusão:** Salienta-se a importância dos profissionais de saúde reinventar suas práticas, cotidianamente, buscando parcerias e aquisição de novos saberes a fim de lograrem resultados que possam minimizar as demandas destes indivíduos ao longo de suas trajetórias de vida.

Descritores: Pessoas em Situação de Rua; Gestão em Saúde; Atenção Primária à Saúde; Vulnerabilidade em Saúde; Assistência Integral à Saúde.

RESUMEN

Objetivo: Informar la experiencia de la implantación de un equipo clínico de producción de cuidado en salud a la población en situación de calle, denominado Consultorio en la Calle. **Método:** Relato de experiencia ocurrido en el municipio del Rio de Janeiro, Brasil. **Resultado:** La implantación del Consultorio en la Calle partió de una demanda de prácticas de cuidado en salud para personas en situación de calle que se encontraban abrigadas. Esta implantación contó con articulaciones intersectoriales, haciendo que los profesionales de salud, en la realización de prácticas de cuidado a la población en situación de calle, hecho que los llevan a anhelar por políticas públicas, repensaran sus acciones para que amplían la resolutividad de la asistencia a esa población. **Conclusión:** Se destaca la importancia de los profesionales de la salud reinventaren sus prácticas, cotidianamente,

buscando alianzas y la adquisición de nuevos saberes a fin de lograr resultados que puedan minimizar las demandas de estos individuos a lo largo de sus trayectorias de vida.

Descritores: Personas sin Hogar; Gestión en Salud; Atención Primaria de Salud; Vulnerabilidad en Salud; Atención Integral de Salud.

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INTRODUCTION

Homeless People (HP) has historically been inserted in the different societies as a group of great vulnerability and, currently, it is the protagonist in discussions and proposals of public health policies in Brazil. The definition of HP indicates this group as heterogeneous, possessing several means of survival in productive activities developed on the street, with broken or fragile family bonds, without reference of regular housing⁽¹⁾.

The individual living on the street is unique and must be contextualized according to the territory to which it belongs. The complexity of living and health conditions in large urban centers generates many challenges and the possibilities to guarantee equity and the right to citizenship to these vulnerable groups are complex. For this, the work process of health professionals must be creative, innovative, and unique to the needs of this clientele⁽²⁾.

Thus, the *Política Nacional para a População em Situação de Rua* (APA Policy Guide on Homelessness)⁽¹⁾ has as its principles: equality, equity, humanization, universality, the right to social coexistence (family and community), recognition of social uniqueness, and respect for dignity and citizenship.

The articulation between health policies is essential for the implementation of health practices in the follow-up to HP. These include the *Política Nacional de Atenção Básica* (United States National Healthcare Policies), whose activities established in this policy are directed to actions, in the individual, family and collective, and whose focus focuses on the actions of promotion and protection health, disease prevention, diagnosis, treatment, harm reduction and health maintenance, with the purpose of developing comprehensive care that impacts on the health situation and the autonomy of the people and on the determinants and health determinants of communities⁽³⁻⁴⁾.

Assistance to vulnerable groups, such as HP, is a constant challenge for the practice of health professionals who work in Primary Care. Imbued with the need to carry out decisive care actions that included this vulnerable group, the Ministry of Health, in line with the *Política Nacional de Atenção Básica* and the *Política Nacional para a População em Situação de Rua*, created the clinical equipment called Street Outreach Office (SOO), with its respective Street Outreach Office teams (SOOt). The SOO was created as a clinical equipment that aims to promote HP care with different health problems and needs, developing shared actions and integrated with the Basic Health Units⁽⁴⁾.

Notwithstanding this, in 2010, the *Unidade Municipal de Reinserção Social* (Municipal Social Reintegration Unit) was created in the city of Rio de Janeiro. This unit is a social equipment specializing in the care for vulnerable adults whose purpose is to meet the demands of HP. The construction of this unit occurred in Programmatic Area 5.3 (PA 5.3) located in the western zone of the municipality.

In this territory, as well as in the entire municipality of Rio de Janeiro, it is quite common to find homeless people. However, with the implementation of this shelter unit, it was evidenced the exponential growth of this group around the health unit, which points to the need to remodel and create new public policies that contemplate the real needs and also a plan qualification of the professionals who work in the direct care for these individuals.

Although HP's policy is to ensure health care, shelter and care services generally do not have the structural and human resources to meet social health needs. In this sense, it is pointed out as a challenge the implementation of an intersectoral policy that can contemplate the several areas, such as housing, social assistance and health⁽⁵⁾. Attempting to establish this articulation, the SOO was created in 2013 in PA 5.3, with the proposal to reorganize health care for HP in this territory.

OBJECTIVE

Reporting the experience on implementing a clinical equipment of health care production to Homeless People, called Street Outreach Office.

METHOD

This is a descriptive study, describing the path of implementing health care equipment at HP: Street Outreach Office (SOO), in Programmatic Area 5.3, west of the city of Rio de Janeiro, comprising the districts of Santa Cruz, Sepetiba and Paciência. This implementation experience occurred in the period from 2013 to 2014, from professionals involved in the support, coordination and implementation of SOO. The territory served is part of a setting of high social vulnerability, with characteristics related to poverty and the process of social exclusion. The three districts occupy the 147th, 146th and 144th positions, respectively, of the Social Development Index⁽⁶⁾.

This territory has, in its history, an increasing elevation of HP and numerous actions of punctual compulsory gatherings, whose return of the individuals to the streets occurs of fast way and without any change in the conditions of life. In view of this fact, SOO is a creative and important strategy of care that, together with the actions carried out by the health units and shelter institutions in the territory, produce a differentiated care to this population.

RESULTS

The experience of implementing care practices in Street Outreach Office

Knowing the HP of this setting was the initial challenge, in which the direct observation and the subsequent interaction with this population was launched as strategy. At this time, it was necessary

to identify the magnitude of HP in the territory, how they related to the passers-by and how they organized in public spaces.

The mapping carried out by the FHS (Family Health Strategy) team was then essential for the recognition of the disposition of this population in the territory. From this action, it was understood that the territory was configured as a temporal space and the geographical migration was not constant, which allowed the location of individuals to the health care concretization. However, conceiving the existence of a permanent physical space to reach HP is always challenging and not always effective given the migratory culture that predominates in this population.

The approach with HP was a matter of collective discussion given the difficult interaction of these individuals with the health teams, which made it difficult to build the link. It was observed that, for the most part, these individuals had histories of suffering, abandonment, weakening of family ties and violation of social rights due to physical or psychological violence.

In this process of building the bonds, the approximation has gradually taken place. The individuals most open to the approach of the team were often those who made the disclosure of the work and who outlined the ways to stay in the places where they lived or used as a scene of drug use.

The practice of street care should incorporate knowledge, experience and culture of the people involved in this process and must be built on an interpersonal relationship based on bonding, welcoming, dialogue and qualified listening. Listening and dialogue are human beings' own abilities and essential tools for the user to be cared for in the perspective of comprehensive care, providing respect for diversity and uniqueness in the encounter between caregivers and cared for people.

The trust and bond between the health team and the users was also built gradually. It was necessary to demonstrate to the group that the professionals that circulated in their places of residence were not evaluating them and did not aim to practice shelter removals. They were reticent, above all, that they had already experienced a history of compulsory removals. The interpersonal relationship based on daily care practices with these individuals was essential for the interaction and establishment of a trust relationship.

With the link established, it was necessary to unveil the knowledge about the health-disease process that guides the life trajectories. In this way, a semi-structured tool was built, based on the HP data sheet that produced a diagnosis of the health conditions of this population and, later, an epidemiological picture of the territory.

The epidemiological clinical profile of the territory indicated the prevalence of tuberculosis, Sexually Transmitted Infections (STIs - such as HIV, syphilis and viral hepatitis), skin diseases, ulcers in the lower limbs, psychiatric problems, and abusive use of alcohol and other drugs. It was also identified cases of abandonment to the treatment of diseases and health problems, which raised questions about the complexity of the health-disease process and how the inhabitants of the streets and inhabited by them need privacy, dignity and recognition as citizens. Care for this population's health necessarily passes through the understanding of the street culture, in which it is necessary to consider some questions: Who are these people?

How do they survive? What is the meaning they attribute to their existence? Through this picture, we question how public bodies can reach the questions related to the social demands related to the trajectories of lives of these individuals.

After analyzing the health situation, we sought to produce actions that would enhance the SOO care proposals. It was necessary to go beyond walls, create mechanisms so that care could be carried out in the spaces of the street itself, with psychology, nursing, medical and social service consultations. Procedures such as curative, antenatal, rapid HIV testing, syphilis and viral hepatitis, glucose measurement, blood pressure measurement, direct observation of the medication intake for tuberculosis treatment and health education services, among others were offered.

However, it was observed that the services performed did not generate satisfactory results, since the team worked with the logic of previous schedules, which distanced these individuals from the process of care and away from therapeutic possibilities in meeting their health demands.

It was observed that the permanence of these individuals in the unit generated a great anxiety related, above all, concerns related to meal times in shelter units, commitment to informal sources of income and difficulties to adapt to the social norms advocated by the health team.

In this way, it was necessary to modify the work process, guiding access to spontaneous demand. Another transformation carried out in this process was the implementation of the Municipal Office Health orientation about the non-obligatory original HP documentation for health care, requiring only a communication from the manager to the reference units.

It was necessary for the SOOt to remodel its way of acting in this situation, because knowledge for the care with HP was reconstructed and knowledge that professionals brought from the traditional Primary Health Care model or the experience in the Family Health Strategy were allied. Despite being representative, these previous experiences have not always proved sufficient to meet this population in its singularities.

In addition to the difficulties in implementing health care for HP, there was a need to intensify intersectoral actions that could contribute to the resolution and comprehensiveness of the practices performed by health professionals. Thus, in order to consolidate proposals that reached HP, several actors were activated to seek guarantees of the rights of this population, among them: the *Centro de Referência da Assistência Social* (Reference Center for Specialized Social Assistance) and the *Defensoria Pública do Estado do Rio de Janeiro* (Public Defender's Office of the State of Rio de Janeiro).

Reference Center for Specialized Social Assistance has, among other attributions, the provision of services to the individual in situations of threat or violation of rights⁽⁸⁾. The partnership between the Reference Center for Specialized Social Assistance of the locality and SOOt was due to the need for articulation of actions of social assistance and health. For the purpose of this partnership, meetings were held between the professionals of the two institutions for the purpose of discussing and planning a joint working process.

A major concern of the health team regarding the partnership with the Reference Center for Specialized Social Assistance

was the logistics used by these professionals to carry out care actions. The main complication was due to the use of a type of transport for locomotion of employees similar to that used by the *Secretaria Municipal de Desenvolvimento Social* (Municipal Social Welfare and Development Office) for purposes of compulsory collections in several areas of the city.

In relation to the partnership with the Public Defender's Office of the State of Rio de Janeiro, it emerged based on reports about the existence of pregnant women in scenes of drug use, pointing to a situation of extreme social risk whose health care was precarious or nil. This fact led to encounters and discussions with several social actors, among them, social workers and nurses of a Municipal Reference Hospital of the locality, psychologists and social agents of the Psychosocial Care Center for Alcohol and Drugs, among others who participated in this network of protection to HP of the locality.

We should emphasize the importance of institutional partnerships in the success of HP care. In this sense, all the Primary Health Care Units of the territory have a relevant role in the care process. Such collaborations and partnerships should be encouraged and consolidated by the teams. Thus, initially the work was developed through pre-scheduled meetings with the managers of the units to talk about the work to be carried out with this population. In light of this logic, it was argued that health units should be facilitators of HP care and access to health services acting in conjunction with SOO.

Working with a population marked by social stigma and the exclusion of public policies is a challenging activity. Thus, the trajectory of implementation of a clinical equipment of health care production to HP was marked by the participative involvement of the State and informal equipment of the territory.

DISCUSSION

The care for HP is permeated by numerous challenges ranging from the existence of legal devices that guarantee the access of this population to health services until the sensitization of the population and deconstruction of the social imaginary about these individuals.

Several governmental or non-governmental institutions in the same territory have the assistance of HP as a characteristic of their work. It is then the recognition of this network and the reflection on how the efforts can be added to the decisive development of the work process.

In this sense, health teams participating in HP care should be able to observe biological, psychological and social health needs, helping to increase the effectiveness of health rights for the street population⁽⁹⁾.

New forms of care must be considered that surpass the biomedical model, focused primarily on the biological component of illness. This implies the remodeling of some aspects related to care, such as listening and the interdisciplinary therapeutic process, reconstructing the work proposed in manuals, which are considered "standards".

In this setting marked by the invisibility of HP, it is emerging to discuss new forms of interventions that consider people in their individualities and value their experiences and experiences⁽¹⁰⁾. The interpersonal relationship is a positive factor, bringing important elements such as mutual respect, the maintenance

of dignity, the building of mutual trust and the demonstration of welcome throughout the process⁽⁹⁾.

The praxis of the Family Health teams already works on the logic of intersectorality. The multidimensional care requires conditions that surpass those already contained in most of the programs developed. In this way, the action with these subjects has been thought in logic of networks of assistance that articulate diverse social actors.

These professionals must cultivate ethical commitment and in defense of life, with empathy and solidarity, together with the clinical competence necessary to work with this population of great vulnerability⁽²⁾.

It is noteworthy that such barriers and needs are also identified in HP care in other countries, such as Canada. Barriers linked to access to medications and health services, among other variables, affect Homeless People. In this sense, it is urgent to search for means of coping that transcend traditional work processes, building specific strategies and services to HP, guaranteeing greater access to services and thus ensuring greater effectiveness⁽¹¹⁾.

Studies and strategies specific to the street population are also being developed by researchers from several North American universities such as Birmingham, Pittsburgh, Boston, including Johns Hopkins University, Baltimore. These researchers constructed a tool to evaluate street care in Primary Health Care, raising important aspects such as accessibility, relationship between professionals and patients, such as respect, trust and perception of competence, satisfaction of care provided, integration with other services and continuity of care, thus constituting important points for the organization of care⁽¹²⁾.

Another study that compared the structuring of mobile teams of action to the street population also brings the approach of Street Teams (ST), present in Portugal, as a means of approaching, monitoring and referral of HP to the other services of the health network, to provide Primary Care. The authors point to common factors at the end of the comparison of the strategies of action of the three study countries: Brazil, the United States and Portugal. Countries have essential elements that make up positive interventions, such as improved access, establishment of multiprofessional teams, active search and assistance with the problematic use of substances⁽¹³⁾. Based on these national and international experiences, it is necessary to seek a discussion on positive strategies to promote greater access to services and greater comprehensiveness of care for Homeless People.

Study Limitations

The study limited itself to working only with the report of the experience on the implementation of a clinical equipment of health care production, located in the city of Rio de Janeiro, bringing elements related to this territory.

Contributions to the Nursing, Health or Public Policy

We believe that this study can contribute to broaden the debate on the subject as a knowledge tool for nurses and other health professionals, allowing the visibility of HP. The relevance of this discussion is the promotion of actions and debates on the forms of care for this population and the essential elements for its construction, in order to contribute to the formulation of public policies that can meet all the needs of this population.

CONCLUSION

Implementing HP health care policies based on the models proposed by SOOt strategies presents challenges for health professionals and managers, given the complexity of meeting social and biological demands that accompany this social group. In addition, the social invisibility of these individuals is also observed in the inoperability of public policies.

We attempted to report the practices developed to consolidate the SOO modality to monitor health issues for HP in a territory of high social vulnerability, where it is necessary to review the logic of the actions of the Primary Health Care professionals due to the increasing number of HP.

It is necessary that there be joint efforts so that the consolidation of the work with these subjects is not based on individual efforts, because it becomes fruitless to reach the results that

answer not only to the health problems of this population, as several other problems of cultural, political dimension and economic aspects that are configured in the everyday life in trivialization of HP's life, which often consists of sanitary actions of hygienist and punitive character that distract them from health professionals and health services.

In the experience of implementing SOOt's work, it has been demonstrated that it is important that the professionals who work in these teams (re)invent their care practices and, thus, alienate the stereotypes, transforming themselves every day to build a work base aggregator, and surprising rigid and pre-established protocols.

In addition, it is worth mentioning that the implementation of SOO in PA 5.3 has brought benefits not only to HP, but also to professionals who work in the Primary Care of the territory. These professionals came to understand the phenomenon of homelessness with all its dynamics and its own culture.

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