'Street Outreach Teams': care in the territory at the interface between HIV/AIDS, drugs and Harm Reduction

Consultório de Rua: cuidado no território na interface entre HIV/Aids, drogas e Redução de Danos

Pollyanna Fausta Pimentel de Medeiros[1,2], Rossana Carla Rameh-de-Albuquerque[3,4], Renata Barreto Fernandes de Almeida[5], Alda Roberta Lemos Campos-Boulitreau[4,6], Naíde Teodósio Valois-Santos[7], Ana Lucia Marinho Marques[8]

DOI: 10.1590/0103-11042023136201

ABSTRACT This article aims to present the experience of implementing 'Street Outreach Teams' in the city of Recife-PE as a strategy for HIV/AIDS prevention and Harm Reduction (HR) associated with the use of alcohol, crack, and other drugs. Although the review of the history of this process reveals tensions, volatility, and alternations in the care models implemented by the city management, the analysis points out the importance of reaffirming, in the current context, the practices and experiences in that field, anchored in HR and in the defense of civil and human rights. Street outreach teams have been found to help strengthen the practice of HR in the Unified Health System, as a public health strategy to reduce vulnerabilities to Sexually Transmitted Infections (STI) and AIDS associated with the use of alcohol, crack, and other drugs. The experience has expanded the promotion of the line of care for people who use alcohol, crack, and other drugs and reduced the vulnerabilities of STI/AIDS associated with such use. However, it seems that it is necessary to invest and maintain permanent training processes, in addition to epidemiological studies and research demonstrating the results achieved in different contexts.

KEYWORDS HIV. Health policy. Harm Reduction. Psychotropic drugs.

RESUMO *Este artigo teve como objetivo apresentar a experiência da implementação dos Consultórios de Rua na cidade do Recife-PE como estratégia de prevenção ao HIV/Aids e Redução de Danos (RD) decorrentes do uso de álcool, crack e outras drogas. Ainda que o resgate da história desse processo apresente tensões, impermanências e alternâncias nos modelos de cuidado implementados pela gestão municipal, sua análise aponta a importância de reafirmar, no contexto atual, a proposição de práticas e experiências nesse campo, ancoradas na RD e na defesa da cidadania e dos direitos humanos. Observa-se que os Consultórios de Rua contribuem para fortalecer a prática de RD no Sistema Único de Saúde (SUS) como estratégia de saúde pública, assim como reduzem as vulnerabilidades às Infecções Sexualmente Transmissíveis (IST) e Aids associadas ao uso de álcool, crack e outras drogas. A experiência do CR ampliou a promoção à linha de cuidado para pessoas que usam álcool, crack, e outras drogas, reduzindo também as vulnerabilidades das IST/Aids associadas a esse consumo. No entanto, vê-se que é preciso investir e manter processos formativos que sejam permanentes, além de estudos e pesquisas epidemiológicas que demonstrem os resultados alcançados nos diferentes contextos.*

PALAVRAS-CHAVE *HIV. Políticas públicas de saúde. Redução de Danos. Substâncias psicoativas.*

[1] Centro Universitário Maurício de Nassau (Uninassau) – Recife (PE), Brasil.

[2] Faculdade de Ciências Humanas ESUDA (FCHE) – Recife (PE), Brasil.

[3] Instituto Federal de Educação Ciência e Tecnologia de Pernambuco (IFPE) – Recife (PE), Brasil.

[4] Tessituras Psicologia e Saúde – Recife (PE), Brasil.

[5] Centro Universitário UniFBV (UniFBV) – Recife (PE), Brasil.

[6] Espaço Trilhares Psicologia – Recife (PE), Brasil.

[7] Fundação Oswaldo Cruz (Fiocruz), Instituto Aggeu Magalhães (IAM) – Recife (PE), Brasil.

[8] Universidade Federal de Pernambuco (UFPE) – Recife (PE), Brasil.
ana.mmarques@ufpe.br

Introduction

In Brazil, when hundreds of AIDS cases had been discovered, the Ministry of Health (MS) recognized the infection as a public health problem in the 1980s and created the National AIDS Program with Decree No. 236/1985, with the aim of defining guidelines and strategies to combat the epidemic in the country[1].

In 1989, the city of Santos, SP, was the first city in Brazil to introduce Harm Reduction (HR) as a public health strategy, given the high HIV transmission rates associated with injection drug use. In the 1990s, the first specific HIV prevention interventions for injecting drug users (IDUs) were developed in other Brazilian municipalities, with a focus on Salvador, BA, which implemented the first syringe exchange program (Programa de Troca de Seringas – PTS) – a HR strategy that informed and counseled IDUs about HIV prevention measures and suggested that they not share needles and syringes[2,3]. In Recife, PE, the Harm Reduction Program was introduced in the 2000s and targeted people who use alcohol and other drugs.

It is important to emphasize that in this period there wasn't yet a public health policy specifically aimed at treating people with problems due to the use of alcohol and other drugs, so they were left to the care of philanthropic, religious or psychiatric institutions, usually an asylum, and dedicated exclusively to drug abstinence. The Ministry of Health's response to this issue wasn't made official until 2003 with the publication of the Policy on Comprehensive Care for Users of Alcohol and Other Drugs[4].

With the decline in HIV infections from needle and syringe sharing and the recognition of the relevance of the HR perspective for addressing problems related to the use of different drugs in different contexts, the MH adopted this perspective in an expanded form for the care of people who use drugs as a public health strategy and in dialog with the Unified Health System (SUS) guidelines. In this context, HR was reaffirmed as a fundamental guideline for care in this area, defined as

> A public health strategy that aims to reduce the harm caused by legal and illegal drug abuse by supporting the user in his or her self-regulatory role without immediately recommending abstinence and encouraging social mobilization[4(27)].

Over the years, HR has become a new paradigm because it brings in the perspective of welcoming people who use drugs as citizens with rights and as political subjects, and including them as protagonists of care actions. By opposing the paradigm of abstinence as the only possible direction of care, HR asserts itself as a strategy for producing health and life[5,6].

In recent decades, the field of public care policy for people living with HIV/AIDS, like other social policies, has been thwarted by various challenges (e.g., freezing of funding, limitation of the role of the state, suppression of social movements, conservative attitudes toward certain issues such as gender and sexuality) that limit the possibility of developing appropriate institutional responses to the profile of the epidemic and the social and health needs of people, and result in policies that reinforce stigma and prejudice[7,8].

This article presents the experience of the Street Outreach Teams in the city of Recife PE, from their creation in 2010 in the context of the Municipal Policy for Harm Reduction and Care for users of alcohol, tobacco and other drugs, called the More Life Program (Programa Mais Vida). It's important to consider that some of the authors were directly involved in the formulation, articulation, and implementation of the Street Outreach Teams (Consultórios de Rua – CR), making this text a live and dynamic report because it's a practice in a field with many complexities and paradoxes. In a period marked by so many difficulties and setbacks, this article hopes to contribute to the strengthening of public policies and promote reflection on indicators and essential elements in the formulation of good practices in this area. It

also aims to highlight the importance of the CR as a public policy for the prevention of sexually transmitted infections (STIs) and their interface with drug use, using HR as an ethical, technical, and political reference and in defense of civil and human rights.

Context

Recife, the capital of Pernambuco, is part of the metropolitan region along with 14 other municipalities; it has an area of 220 km² and an estimated population of 1,661,017 in 2021, the ninth largest in Brazil[9]. The 94 neighborhoods are divided into 6 political-administrative regions, whose spatial configuration expresses the differences created by socioeconomic inequalities that have been entrenched throughout history. According to a study conducted by the Brazilian Institute of Geography and Statistics (IBGE), Recife is the Brazilian capital with the highest inequality index in 2019, where approximately 115,000 people, or 7% of the population, live below the extreme poverty line[10].

Regarding the profile of the municipality in terms of consumption of alcohol and other drugs, the III National Survey on Drug Use in the Brazilian population, conducted in 2015 among the population aged 12 to 65 years, found prevalences above the national average for all Brazilian capitals. The prevalence of people who used alcohol in the last 12 months was 47.4%, for non-prescribed drugs 2.8%, and for illicit drugs 4.8%[11]. A study conducted by Fiocruz Pernambuco on HIV infections in a population that regularly uses illicit drugs, especially crack, estimated HIV prevalence at 17 times the estimate for the general population[12], making this population a priority group for prevention and care interventions.

Within the scope of the municipal SUS, the structuring of HR actions aimed at the population that uses alcohol and other drugs began with the implementation of the CR, based on a letter of invitation from the Ministry of Health to the municipalities that have invested in the care of the population at risk in the field of alcohol and other drugs, using funds from the Emergency Plan to Expand Access to Treatment and Prevention of Alcohol and Other Drugs (PEAD)[13] of 2009 and the Integrated Plan to Combat Crack and Other Drugs (PIEC), 2010[14].

The More Life Program was launched in 2004 and the CR was implemented in 2010 as the main strategy for the care of the homeless population under the municipal Harm Reduction Policy for the use of alcohol, tobacco and other drugs. The More Life Program included care services for the population that used alcohol and other drugs – six psychosocial care centers for alcohol and other drugs (CapsAD), four Half Way Houses (Casas do Meio do Caminho), facilities that were precursors to reception centers, and a detoxification unit in the general hospital[15,16].

The CR had six teams of harm reduction officers, one for each health district, linked to a CapsAD, and a roving team of arts educators who carried out activities in the region, visiting communities, conducting dialogs, and intervening through prevention and promotion of health and civility. Recife was the first Brazilian municipality to create the position of Harm Reduction Officer (Agente de Redução de Danos – ARD) under direct administration by Municipal Law No. 17.400/2007, through a public contest process[16,17].

Subsequently, the CR proposal was reformulated at the national level, and in 2011 the Street Outreach teams were introduced as part of the MS National Primary Care Policy, aiming to improve access to care for the homeless population and align with primary care guidelines. In Recife, the two team models – CR and Consultório na Rua – were maintained and linked to the Family Health Teams targeting homeless people[18,19].

In this review, we present the CR, whose main objective was to expand access to health care for people who use drugs in different settings and contexts, such as on the street and at cultural events, and HIV/AIDS prevention

was one of the main strategies developed. The report also aims to highlight the project's potential in terms of its HIV/AIDS interventions and setbacks related to changes in mental health and STI/AIDS policies.

The experience

The CR project was designed considering the territorialization of Recife and its division into sanitary districts. Each team consisted of three ARDs, a position that required a high school diploma, and a technician with a college degree, usually psychologists or social workers. The roving team of arts educators consisted of four professionals and six workshop instructors, who could also have a secondary school or college degree, with the following artistic languages: capoeira, theater, self-care, and percussion. For the management of these teams, there was a CR coordinator of the field actions who supervised the activities carried out, three drivers, and a clinical supervisor who differentiated the problems encountered in the field and aligned the teamwork accordingly.

To build the CR team's work process, including identifying areas and priority times for interventions, meetings were held with primary care managers, CapsAD, and professionals from the Unified Social Assistance System (Sistema Único de Assistência Social – SUAS) network. To structure the interventions based on the realities of the areas, the following steps were taken: (a) mapping of services and/or facilities available to the population in the areas defined for the project; (b) observation and identification of dynamics in these areas related to community organizations and leaders, public safety, prostitution and drug trafficking; (c) in conjunction with the STD /AIDS policy, provision of supplies (male and female condoms, lubricant, and information brochures on STD/AIDS prevention and services) and training of teams for HIV/AIDS counseling; (d) Conduction of joint educational activities with the health network targeting both specific cases reported by CapsAD, Family Health Centers (Núcleos de Apoio a Saúde da Família – NASF) and Family Health Strategy (Estratégia Saúde da Família – ESF) teams, including home visits to people using drugs continuously, e.g., at cultural events, squares, or scenes of drug use; e) referral of specific cases to health and social assistance services; f) record of experiences and perceptions of the area in a field diary and preparation of regular reports.

It's important to emphasize that the actions of the CR took place both during the day and at night, and that the areas for the interventions were selected according to criteria to identify places where people were in a particularly vulnerable situation, consuming psychoactive substances or, moreover, living with HIV/AIDS. In this sense, the street space was a frequent place for interventions and should be understood as a private environment for the people who live there. As Nery Filho, Valério, and Monteiro[16] point out, activities such as personal hygiene, eating, sexual intercourse, and sleeping, which are considered private, are performed on the street in everyday life, making it difficult to access STI prevention and contraception practices, for example.

The use of supplies (plastic bottles that can be exchanged for glass bottles, key chains with HR tips, snacks or cups of mineral water, condoms, etc.) was an important tool for the work in the field, as it facilitated ARD's access to the areas and allowed for rapprochement and bonding with the groups, leading to a more sophisticated approach to drug users. They not only promoted access to these products, but also provided information on the modes of transmission of HIV and other STIs such as hepatitis B and C.

To facilitate entering the field and for their safety, the CR teams wore uniforms (vest and shirts) and a sticker-identified car. The driver also helped teams enter and leave areas with higher risk of violence and coordinated with community leaders before entering the area to conduct field activities.

First, the ARDs explored the site where they'd be working through direct observation in the field to identify its characteristics and dynamics to better guide their work process. They identified patterns of drug use and routes of use, i.e., what drugs were present and how they were used – injected, snorted, smoked – and whether paraphernalia was shared for use. They also observed whether there was any association or combination with medications and whether they were used to combat HIV infection, tuberculosis, or psychiatric comorbidities. They also reviewed whether there were barriers and difficulties to preventive practices. Given this information, and with the goal of acting more efficiently and kindly, the ARDs, taking into account the knowledge, behaviors, and processes in the region, planned to develop action strategies, from general guidelines to the availability of supplies.

Before the CR teams went into the field, they discussed strategies for accessing the area (pre-field); and after field activities, the team made an assessment of the difficulties encountered (post-field) to improve intervention planning. A technical meeting was held weekly to discuss administrative and clinical issues, case management, and the drug use policy scenario. The following resources were used: MS manuals, brochures on HR and HIV/AIDS, scientific articles, and current news on the issues. Thus, in structuring the activities, pre- and post-field issues were addressed, which at the same time functioned as a training process.

In order to qualify this training process, a clinical-institutional supervision was established for the team, which served as a space for sharing experiences, reflecting on practice, and examining problematic situations of the ARDs and arts educators. During the supervision, interpersonal relationships and difficulties experienced in the group were also worked on. Reflection on the work process and self-assessment promoted positive changes and led to commitment and responsibility in the ARD's work with drug users and in cooperation with other teams.

Lack of support and difficulties in networking were common themes in clinical-institutional supervision and characterized the major challenge in territorial work, in addition to the interpersonal conflicts that sometimes arose due to the presence of former CapsAD users in the technical team of the CR. The new view of the user and the team's own biases and limitations were widely discussed. The work of supervision focused on the relationship 'person who uses drugs and professional', the process of encounter between them and the other technicians in the team, that is, on people and their subjectivities. Thus, through moments of trust and hope, relationships of bonding and acceptance emerged[20].

Among the impacts observed through the work of the CR teams is a significant increase in referrals to the social assistance and health network, including CapsAD themselves and the sensitization of professionals from the SUAS and SUS networks to the care of drug users, especially from the Social Assistance Reference Centers, the NASF and ESF teams, and the specialized services for HIV/AIDS and other STIs. Also worth mentioning is the collaboration with community leaders and participatory budgeting, which promotes intersectoral collaboration.

Thus, the work of the CR favored the qualification of the network of services for the care and support of people who use drugs and their families, the promotion of the line of care for people who use crack with universities and clinical physicians and psychiatrists of the SUS network, the formation of a working group to discuss service and consensus on approaches to support users of crack, identifying the possibilities of support of SUS devices.

The actions were tailored and focused on the needs of the people and were carried out in the place where they were. According to Merhy[20], working in a user-centered care

model requires a commitment to more collective management of work processes in health care teams. This includes a multidisciplinary and interdisciplinary team that aims to promote health, assess behavior change related to substance use and safe sexual practices, benefits achieved, and reduction of risk and harm in the lives of people assisted.

> In this sense, the technological resources it has are practically inexhaustible, since it focuses on live work, which, as a light technology, generates a constant commitment to the task of 'welcoming', 'making responsible', 'solving', 'autonomizing'[20(5)].

Strengths and lessons learned from the Recife Street Outreach

The Health Department was transformed with the election of new municipal management and was affected by disinvestment at the federal and state levels, including aspects of funding, care design, and discontinuity of interventions[21]. Political and ideological factors hindered changes in models of care for people who use drugs and people living with HIV/AIDS in the city of Recife.

It's well known that the formulation and implementation of care interventions for people who use drugs and people living with HIV/AIDS imply disputes, contradictions, meanings and profound interests in decision-making and in the production of discourses, between knowledge and interventions from conservative or progressive ideologies[7,22].

In relation to alcohol and other drugs and considering them as a historical and contextualized fact, Marques and Couto[23] found in a study in the city of São Paulo that discontinuities and ruptures in municipal programs developed during periods of management change brought important changes that intervened in the city's social welfare and health systems and, consequently, in the implementation of public networks and services:

> [...] reflected in the vicissitudes and changes in policy proposals, management and organizational structures and cultures, models of attention and care, and popular participation in decision-making processes[23(155)].

Regarding HIV/AIDS policies[7], the above authors also point out that the symbolic and practical connections are the target of contestations in gender, sexuality, human rights, political activism, and funding; and as such, they are directly affected by the dimensions of the health crisis. In the words of these authors:

> [...] various events and initiatives - in the social and governmental spheres, inside and outside the SUS - have focused fiercely on key aspects of the fight against HIV/AIDS, expanding the possibilities of stigma, prejudice, fear and violence, jeopardizing the continuity of globally recognized interventions and reducing the possibilities of adequate responses to the current profile of the epidemic in Brazil[7(4602)].

While the establishment of the CR in Recife demonstrates the effective work of the ARDs in the SUS - and represents the strengthening of the HR approach to the care of people who use alcohol and other drugs and people living with HIV/AIDS - at the same time, it also shows the difficulty of accommodating service teams with homeless people, which cause some discontinuity in the proposal. It's worth noting that during the pandemic there was also a decrease in the number of people served by the CR.

In addition, there were also tensions in admitting people who used drugs but didn't express a desire to stop using. This problem presented a major challenge to mental health teams: HR. For the teams that worked directly with HIV/AIDS, this was already a very common situation. It's clear that the change in

care logic in the care of people who use alcohol and other drugs and people living with HIV/AIDS requires constant evaluation of services and intervention strategies. Therefore, the actions of the CR can be seen as:

- an innovative clinic that reaches out very well to people who use alcohol and other drugs and live on the streets with HIV/AIDS;
- a cross-sector strategy to reduce risk and harm, expand access, and improve people's quality of life;
- a guide that aims to break the logic of abstinence as a single approach to understand the uniqueness of each person.

Thus, we believe that the CR in Recife has proven to be an effective strategy from the beginning for access and comprehensive care for people who use alcohol and other drugs and live with HIV/AIDS, aimed at achieving three main objectives, as Merhy[20] outlines in his discussion of the care and intervention model: 1) the ongoing creation of welcoming spaces, accountability, and bonding with people who use drugs; 2) the construction of a clinic that also creates spaces for relationships and interventions that are shared and where there is a play between needs and different technologies of action; and finally, 3) the presence of spaces for talking and listening exchanges, as well as for complicity and accountability.

One of the principles of CR is to respect the knowledge and processes already present and established in the community in order to create action strategies, guidance, and availability of supplies. Another important aspect was the regular presence of the team in the same place and at the same time in order to be able to create a bond between the users and the professionals. For this purpose, the teams of CR had to map and survey the focal areas so that the systematic trip to the same area could be established. Also, the decision to work at night and during the day to intervene in the area is worth highlighting, since the use scenes in Recife are migratory and even 'seasonal', that is, there are no '*cracolândias*' as in São Paulo and Rio de Janeiro[24]. In this way, the interventions had to privilege the way the use scenes occurred in the area and try to take into account the needs and differences.

Another important lesson learned concerns the need to provide a minimum level of security for teams as they enter the field. By not using the police apparatus, it was always important to conduct a thorough observation of the area by having the teams go through the operational scenarios at different times and days of the week to study the vulnerability aspects in these contexts. It was only after this mapping that the selection of sites for the approach was made.

Final considerations

Despite the challenges, it's necessary to know and acknowledge that this area is dynamic and historically determined. In order to consolidate a model of care based on human rights, the authorities and society in general must invest in ongoing training, studies, and epidemiological research that show the results obtained in different contexts.

The educational approach of the CR and the promotion of prevention activities help to strengthen HR practice in the SUS as a public health strategy and reduce vulnerability to STI/AIDS associated with the use of alcohol, crack and other drugs. The exchange of experiences allowed reflection on how the Recife City Hall has developed intervention strategies for the care of people in street dynamics, based on HR, and the need to resist with a project that changes the lives of people who use drugs and live with HIV/AIDS.

Acknowledgements

The authors would like to thank the people who use drugs, who live with HIV, who live on

the streets, and harm reducers who inspire us in the daily struggle for a just public policy that considers the nature of drug use as something human that will never end, and that they're human beings who have a right to care and attention.

Collaborators

Medeiros PFP (0000-0003-1679-5330)* contributed to the design, planning, data interpretation, writing, revision and approval of the final version of the manuscript. Rameh-de-Albuquerque RC (0000-0002-5273-1476)* contributed to the design of the study, data analysis, review, writing and final approval of the manuscript. Almeida RBF (0000-0002-3330-6992)* contributed to the design, planning, data interpretation, writing, revision and approval of the final version of the manuscript. Campos-Boolitreau ARL (0000-0002-9598-2443)* contributed to the design of the study and review, writing and final approval of the manuscript. Valois-Santos NT (0000-0002-5290-092X)* contributed to the writing, revision and approval of the final version of the manuscript. Marques ALM (0000-0002-9314-0904)* contributed to the writing, revision, and approval of the final version of the manuscript. ■

References

1. Souza BMB, Vasconcelos CC, Tenório DM, et al. A Política de AIDS no Brasil: uma abordagem histórica AIDS Policy in Brazil: a historical approach. J Manag Prim Heal Care. 2010; 1(1):23-6.
2. Santos VB, Miranda M. Programas de redução de danos no Brasil: uma revisão de literatura. Rev Psicol Divers e Saúde. 2016; 5(1):106-18.
3. Mesquita F. Aids e drogas injetáveis. In: Lancetti A, organizador. Saúde e Loucura 3. São Paulo: Hucitec; 1991. p. 46-53.
4. Brasil. Ministério da Saúde. A Política do Ministério da Saúde para atenção integral a usuários de álcool e outras drogas. Brasília, DF: Ministério da Saúde; 2003.
5. Passos EH, Souza TP. Redução de danos e saúde pública: construções alternativas à política global de "guerra às drogas". Psicol Soc. 2011; 23(1):154-62.
6. Rameh-de-Albuquerque RC. Da pessoa que recai à pessoa que se levanta: a recursividade dos que usam crack. [tese]. São Paulo: Universidade Federal de São Paulo; 2017.
7. Agostini R, Rocha F, Melo E, et al. The Brazilian response to the HIV/AIDS epidemic amidst the crisis. Ciênc. saúde coletiva 2019; 24(12):4599-604.
8. Antunes da Costa PH, Mendes KT. Contribuição à Crítica da Economia Política da Contrarreforma Psiquiátrica Brasileira. Argumentum. 2020; 12(2):44-59.

*Orcid (Open Researcher and Contributor ID).

9. Instituto Brasileiro de Geografia e Estatísticas. Cidades e Estados. Cidades e Estados do Brasil: Consulta de área, população e dados básicos dos municípios. Rio de Janeiro: IBGE; 2022.

10. Instituto Brasileiro de Geografia e Estatística. Síntese de Indicadores Sociais - Uma análise das condições de vida da população brasileira. Rio de Janeiro: IBGE; 2020.

11. Bastos FI, Bertoni N, organizadores. Pesquisa Nacional sobre o uso de crack: quem são os usuários de crack e/ou similares do Brasil? Quantos são nas capitais brasileiras? Rio de Janeiro; Fiocruz; 2017.

12. Santos NTV, Almeida RBF, Brito AM. Vulnerabilidade de usuários de crack ao HIV e outras doenças transmissíveis: estudo sociocomportamental e de prevalência no estado de Pernambuco. Recife: Fiocruz; 2016.

13. Brasil. Ministério da Saúde. Portaria nº 1.190, de 4 de junho de 2009. Plano Emergencial de Ampliação do Acesso ao Tratamento e Prevenção em Álcool e outras Drogas no Sistema Único de Saúde – SUS. Diário Oficial da União. 4 Jun 2009.

14. Brasil. Decreto nº 7.179, de 20 de maio de 2010. Plano Federal de Enfrentamento ao Crack e Outras Drogas. Diário Oficial da União. 20 Maio 2010.

15. Recife. Decreto nº 22.643 de 14 de fevereiro de 2007. Prefeitura do Recife. Institui o Programa Mais Vida, no âmbito da Secretaria de Saúde. Diário Oficial. 15 Fev 2007.

16. Nery Filho A, Leite ARV, Monteiro LF. Guia do projeto consultório de rua. Brasília, DF: SENAD; Salvador: CETAD; 2011.

17. Recife. Prefeitura do Recife. Lei Municipal nº 17.400 de 28 de dezembro de 2007. Cria cargos efetivos no âmbito da administração direta do município. Diário Oficial. 28 Dez 2007.

18. Londero MFP, Ceccim RB, Bilibio LFS. Consultório de/na rua: Desafio para um cuidado em verso na saúde. Interface Commun Heal Educ. 2014; 18(49):25160.

19. Brasil. Portaria nº 122, de 25 de janeiro de 2011. Define as diretrizes de organização e funcionamento das Equipes de Consultório na Rua. Diário Oficial da União. 1 Fev 2012.

20. Merhy E. Em busca da qualidade dos serviços de saúde: os serviços de porta aberta para a saúde e o modelo tecno-assistencial em defesa da vida. In: Cecílio LCO, organizador. Inventando a mudança na saúde. São Paulo: Hucitec; 1994. p. 117-60.

21. Uchôa R, Medeiros PFP, Pergentino PRLM. Programa Mais Vida – Redução de danos no consumo de álcool, fumo e outras drogas: avaliação da implantação no município de Recife no período de 2009-2012. In: Castro Neto AG, organizador. Ensino, pesquisa e extensão na área das drogas: indissociabilidade na produção e na socialização do conhecimento. Recife: UFPE; 2018. p. 113-30.

22. Ronzani TM, Costa PHA. Desafios para a prevenção e tratamento em álcool e outras drogas: quais evidências procuramos? In: Associação Brasileira Multidisciplinar de Estudos sobre Drogas. Drogas e políticas públicas: educação, saúde coletiva e direitos humanos. Salvador: UFBA: 2015. p. 155-64.

23. Marques ALM, Couto MT. Políticas públicas de cuidado dirigidas a pessoas que usam drogas no município de São Paulo/SP: uma análise desde a perspectiva da interseccionalidade. Cad Bras Saúde Ment. 2021; 13(37):138-160.

24. Bastos FI. Crack in Brazil: A public health emergency. Cad. Saúde Pública. 2012; 28(6):1016-1017.

Received on 04/29/2022
Approved on 09/26/2022
Conflict of interests: non-existent
Financial support: non-existent