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INTERTWINING PATHS AND CARE: HEALTH CARTOGRAPHY FROM THE PERSPECTIVE OF THE USERS OF THE CLINIC ON THE STREET

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ABSTRACT

The Street Clinic represents a vital element in the provision of health care to the Homeless Population, a group traditionally marginalized in access to health services. Objective: The

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purpose of this study is to explore and elucidate how users of the Street Office perceive the health care they receive, identifying and mapping the existential territories that influence the interaction of users with health services and how this affects the formation of their subjectivities. Method: A cartographic research approach was used to generate data, which were collected through the participant observation of the researcher during the activities of the Street Office and through semi-structured interviews with the users of this service. Data validation was conducted with the support of members of the Laboratory of Interdisciplinary Qualitative Studies and Research in Health (LabQuali). Results: The findings indicate that the Street Office implements adaptable lines of care and establishes itself as a health reference point for users, contributing to the promotion of emancipatory actions and the strengthening of individuals' autonomy. Conclusion: The study reveals the importance of flexible and humanized approaches in the provision of health care, and highlights the value of practices that favor the emancipation and accountability of users in the management of their own health. The research highlights the Street Clinic as an innovative model of care that effectively responds to the needs of a population often made invisible in public health policies.

Keywords: Street Clinic. Homeless People. Health.

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INTRODUCTION

Homelessness is a critical social issue that affects millions of people around the world. The homeless population is diverse, including individuals of all ages, genders, and ethnicities. According to available statistics, the homeless population in the world presents a wide range of situations, from people living without any type of shelter to those living in precarious housing.

The data point to a complex reality, with countries such as Pakistan and Nigeria presenting alarming numbers, with 8 million and 4.5 million people living on the streets, respectively (Fazel; Geddes; Kushel, 2014; Liu; Hwang, 2021). In the United States, it is estimated that more than half a million people are living on the streets per night. In Brazil, the homeless population has increased significantly, with estimates indicating a growth of 38% between 2019 and 2022, reaching 281,000 people (*World Population Review*, 2024).

In this condition there is a predominance of adult men, but the number of families, women and young people living on the streets has increased. Data from different regions show variations, but consistently indicate that ethnic minorities are overrepresented among homeless people. Homelessness affects thousands of people globally, with estimates varying widely due to difficulty in counting and varying definitions of homelessness (Gutwinski *et al*, 2021; Stone; Dowling; Cameron, 2019; Topolovec-Vranic *et al*, 2012).

The causes of homelessness are multifaceted, including economic factors such as: unemployment and lack of affordable housing; social factors, family breakdowns, and insufficient support systems; and health issues, including mental health and substance dependence. The intersection of these factors creates a cycle that is difficult to break, where a lack of resources leads to the street, and life on the street exacerbates existing problems (Omerov *et al*, 2020). Internationally, the definition of homelessness encompasses a wide range of housing conditions, including sleeping in the open, being in inadequate shelter, and lack of secure tenure. Homeless people are characterized by extreme poverty, broken or weakened family ties, lack of conventional housing and the use of public spaces and degraded areas for housing and subsistence, either temporarily or permanently (Brasil, 2009).

Health care models to meet the needs of homeless people vary, with some countries implementing targeted services such as street medicine programmes, while others rely on overall health systems that may not meet the unique needs of homeless individuals (Lemões, 2019). Reducing the homeless population globally is part of human rights work

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and is a focus for the United Nations (UN) 2030 Agenda for Sustainable Development. Actions include eradicating poverty, ensuring healthy lives, and promoting well-being, thereby reducing inequality within and between countries (Liu, Hwang, 2021; *World Population Review*, 2024).

Brazil, in line with the guidelines of the 2030 Agenda, has adopted measures to address this issue, reflecting a commitment to human rights and the reduction of inequalities. In this context, the Street Office (CnR) strategy stands out as an initiative aligned with global efforts, aiming to provide accessible and qualified health care to vulnerable populations, within the Psychosocial Care Network (RAPS). The Street Clinic (CnR) is an integral part of the National Primary Care Policy, focusing on "Primary Care for specific populations" within the Psychosocial Care Network (RAPS), established by Ordinance No. 3,088 of 2011 (Brasil, 2011). This network articulates several points of attention to mental health, substance abuse, and other demands, promoting qualified and accessible care for vulnerable populations.

The CnR team is characterized by its multiprofessional nature, its responsibilities are the discussion, construction and maintenance of singular therapeutic projects (STP), direct care in the place where people live and regular visits to strategic points for the active search of users. Health interventions include the distribution of supplies and vaccines, general or specialized medical consultations, dental care, prenatal care, laboratory and imaging tests, feasibility of surgeries, as well as therapeutic workshops, guidance and follow-up in personal hygiene care, and interaction with Primary Care and other services (Brasil 2009; Brazil, 2011).

This study aims to explore the perception of users of the Street Office about the care received, mapping the existential territories that influence the relationship of users with health and the impacts on the production of subjectivities. The analysis integrates the interactions between health workers and users, based on Brazilian theories about the health work process, power relations and the cartography of care lines.

METHODOLOGY

The study in question investigates the interconnection between territory, place, mapping, borders and subjectivity, adopting the cartographic method as a qualitative approach. Inspired by the theoretical concepts of territory and nomadism of Deleuze and Guattari (2012), that is, a concept "territory" is like a subjective and symbolic construction,

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marked by the delimitation of spaces that acquire specific meanings. Within this context, the cartographic methodology emerges as a crucial instrument to probe and understand the dynamics and interactions experienced by the CnR team and its users, becoming a key element of the research (Passos; Kastrup; Escóssia, 2009).

During the period from November 2019 to January 2021, the researcher, immersed in the daily life of the CnR team, conducted nine in-depth discursive interviews until she reached data saturation. This prolonged commitment to the field was fundamental for a deep immersion and understanding of the daily dynamics of the CnR team, and the discursive interviews carried out adopt a format that favors flexibility and openness, allowing the interviewees to guide the conversation as much as the researcher (Tedesco; Sade; Caliman, 2013). The interviews addressed both lived and pre-reflected experiences, favoring the emergence of representational planes of force (Campos, 2013).

The research was also enriched by the maintenance of a field diary, referred to as a "street notebook", in which the researcher documented a variety of observations, feelings and reflections during contact with the CnR team (Pozzana, 2014).

One interview, in particular, was highlighted as a catalyst in the production of data, as it comprehensively addresses the research themes and serves as a reference point for the identification of thematic categories arising from the users' narratives and the researcher's experiences. The analysis and validation of the data were carried out in collaboration with a group of researchers from the Laboratory of Interdisciplinary Qualitative Studies and Research in Health (LabQuali), through shared readings, enriching the understanding and interpretation of the results.

Eligibility criteria were established for participation in the study, including a minimum age of 18 years, follow-up by the CnR for at least one year, and voluntary consent to participate in the research. This study obtained ethical approval, ensuring compliance with ethical guidelines in research with human subjects.

RESULTS AND DISCUSSION

The subjects mediated by this study are those who make the public space a place of permanence and circulation. Homeless people promote a collision between vulnerability and health care, which not only bothers but also imposes challenges. To map this reality, this work proposes a path that weaves together the subjectivities of workers and users of the CnR service, having as a crossover a body-research (Tedesco; Sade; Caliman, 2013).

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Each cross-section delimits a thematic category, which arises from the analysis and decanting of the data.

FIRST CROSSING: "I WAS GETTING ALONE"

The experience of loneliness and helplessness is, as Freud (1969) already denounced, universal and primary; From this, there is no escape. Here, it is not a matter of naturalizing an experience of suffering, but of thinking about it from the crossings and discourses that may or may not give rise to the helplessness of those who live on the street (Passos; Kastrup; Escóssia, 2009).

In the circulation through the space/street, it was possible to hear subjects marked by helplessness and abandonment, whose names of suffering have deep intimacy with the lack of existential recognition in a family or affective nucleus, as revealed in the following statements:

> My life was very difficult, my sister left Montes Claros and my father was an alcoholic and I stayed more my father knows, sometimes I had nothing to eat... [..]my father took it and went to live in the construction where he worked here in Montes Claros and I took it and was left alone. (E3)
>
> My life like this. I was born, my mother abandoned me. I was raised in a shelter and halfway house. (E4)

This non-recognition seems to promote tensions that relocate existential subjective positions. Starting from what Deleuze & Guattari (2012) call the "principle of multiplicity", where reality should be considered as a product of various, heterogeneous, contradictory, rhizomatic and agential determinations and in which "an assemblage is precisely this growth of dimensions in a multiplicity that necessarily changes its nature as it increases its connections" (Pozzana, 2014, p.16), It must be assumed that the experience of "being alone" is not closed in on itself from a relationship between cause and effect, but is a product and produces discourses, lines, affectations and historicity.

Still in A Thousand Plateaus, Deleuze & Guattari (2012) clarify that lines of flight are those that allow an outflow of affects, movement, circulation, which escapes institutionalization, while the lines of segmentarity comprise everything that tries to stratify, segment, crystallize and prevent movement, not by chance presenting itself so prominently in institutions, ideologies and people. The eruption of a rhizome occurs precisely at the intersection between lines of segmentarity and lines of flight, producing deterritorializations and new connections:

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> When I went to the street, it was when I was about nine... Nine to ten years... That's when domestic violence happened to me on my father's side... that I don't even like to remember... And then I went to the street. (E6)
>
> Then they said: "Do you want to travel with us?" I want to, I just don't want to stay inside that house there, because I'm not obliged to prostitute or have sex with my stepfather. Then I took it and started traveling. (E2)

A survey conducted by the Brazilian Ministry of Health (Brasil, 2012) reveals that the main reasons why people start to live and live on the street are: alcoholism and/or drug problems; unemployment and disagreements with father/mother/siblings. The experience of "being alone" reveals another face of the challenges of health policies: there are positions and discourses that disregard individual suffering as a collective responsibility, making the human experience of existing an enterprise. Thus, subjects become mini-enterprises that self-regulate and, by their own merit, achieve some kind of success or failure (Safatle; Junior; Dunker, 2021).

Professionals who provide care through the eCR report, for example, moments when they are harassed by individuals who witness the care provided to Homeless People (PSR), being questioned about the legitimacy of providing service to that population. Similar situations were experienced in the office on Rua Manguinhos in Rio de Janeiro (Araújo, 2019). It is, according to Foucault (2016), about "making live and letting die".

There seems to be a relationship between lack and power, which evidences certain resistances, resilience and denial of processes of subjection (Rodrigues; Oak; Yasui, 2019). Not infrequently, the logic of production, when associated with a definition of health, outlines commitments not only with the scientific field, but also with the production of life, the discourses put into operation various issues, including power relations (Conceição, 2018).

Therefore, it should be considered that a clinic is composed of several dimensions of functioning: spatial, dramatic, sound, linguistic, investments and modes of existentialization. It is necessary to open up the possibilities towards its plurality and multiplicities, instead of leading it back to any unity (Pelbart, 1993).

SECOND INTERSECTION: "YOU WALK DOWN THE STREET AND YOU BECOME INVISIBLE"

The street is the sign of what civilization represents, the eruption of the flow of people, things and affections. The polis, from an Aristotelian perspective (Aristotle, 1982),

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makes man a city being, a citizen, belonging to an ultimate community that not only defines him, but also transforms him. If man is, par excellence, a political being, he is also a walking being, who circulates and circulates, who moves at the whim of countless variables, whose gerund of thinking produces power of movement.

In this second intersection, two verbs are conjugated: "to walk" and "to stay". The first speaks of the coming and going of those who are on the street and the peripatetic territory that is being constituted; the second speaks of the intersubjective positions that emerge from the affectations and captures of those who live on the street (Andrade, 2019). Discourses are capture hooks, they structure hierarchies and ways of existing. Foucault (1998) says that power "is prolonged, penetrates institutions, is embodied in techniques and equips itself with instruments of material, eventually violent, intervention" (p. 182). His investigation reveals the constitution of the tactics of domination, the forms of subjection, the material operators and the strategic forms used by local systems to convert the multiplicity of wills and existential forms into a uniform and normalized mass.

According to Varanda and Adorno (2004), the social representation of the Homeless Person in Brazil is historically framed in the domain of institutional apparatuses linked to their assistance. In addition, the subjects themselves are absorbed by such representations, fitting into the social spectrum that goes from the condemnation of the "vagabond", the inopportune threat of the "delinquent", to the resigned victimization of the "beggar". These are incorporated positions that consolidate the disqualification, incapacitation and precariousness of the existence of these subjects, in addition to sustaining a regime of social discard:

> I found myself in a situation where no one gives a hand, no one helps you, no one ... you can't find anyone even to spit on you at this time boy ... to talk like this ... The guy saw me and spat on me. (E1)
>
> We are frowned upon, you know? We are frowned upon, we, I don't know, you know, society rejects people, you know? (E3)

It is possible to identify situations of "noise" in encounters on the street. When listened to, the noise can reveal the presence of instituting processes: multiple lines of flight imperceptible or asphyxiated by the institutional model. In this case, the noise of invisibility (Franco; Merhy, 2012).

By allowing us to question the ways in which living work is captured by the instituted, the lines of flight broaden the horizons to a "deterritorialization", determining

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other possible acts of care and serving as a foundation for the transformation of health actions into the daily act of work itself. According to Merhy *et al* (2011), "life resists and in this resistance it systematically opens lines of flight, for which we need to invent ways to support and make them visible" (p.100). Life resists when affections that escape institutional logic emerge from encounters:

> When we're in this world on drugs on the street, we're very humiliated. People throw our self-esteem into the mud. So, that's why many of these homeless people can't get out of it, because not everyone sees it the same way they see it (CnR). Not everyone comes to us like they come with affection, attention. (E4)

It becomes an important problem when one considers Deleuze's (1992) readings about the "society of control", revealing a new form of power, no longer exercised in direct action to bodies and to the confined spaces of institutions, but in a new regime of domination, which is focused on the prevention and control of risks, in open mechanisms, modularized and incorporated into the great social mesh, making individuals prisoners in the open field. During the cartography, existential territories demarcated by the relationship with drugs and micropowers were revealed, which branch out through the city's capillaries:

> You just go to these places, it seems like it's automatic, it feels like your GPS... your GPS, which guides you where you are going... so that he only points ... only for tragedies, only for the mouths, only for the bars, only for these places like this... it seems that it is automatic... all in the same direction (E1)

> Bean. Where there were drugs (laughs). São José, the city in weight, everywhere you can think of, I was running. I started recycling and I walked everywhere. He walked the whole city and scrap iron... [...] he looked for the drug, came, smoked and returned to Feijão. (E4)

In this trajectory crystallized by the search for drugs, it was possible to witness that the approach of the team of the office on the street (eCR) causes ruptures and makes holes in a path sedimented by discourses and positions of power, betting on the peripatetic clinic, on *on-site interventions* and on the enterprise of making affections circulate through other ways and places (Lancetti, 2014). The eCR, when it listens, summons, welcomes, reprimands and holds accountable, not only fulfilling a bureaucratic function, but also involving its users in its own existence.

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THIRD INTERSECTION: "THE OFFICE ON THE STREET COMES FIRST"

According to Merhy (1999), in the face of major macrostructural reforms in the institutional or organizational control of health policies, the true paradigmatic change in care is closer to a policy woven into the daily life of health services and the relationships and representations conceived between workers and users.

It is in this space that Merhy *et al*. (2011), based on the conceptual elaboration of "micropolitics of live work in action", considers the territory to be the place where the consummation of health care takes place. Health, as a product, is generated at the moment of its execution, that is, in the interaction between the worker and the user (Feuerwerker, 2014).

Living work, thought precisely as that which happens "in act", is verified in the intentional and free action of the worker to operate the objects for the production of goods. It differs, in this way, from "dead labor", described as the production that is accomplished, once incorporated into the instruments of work and no longer enjoys the purpose of creation (Merhy *et al*, 2011; Feuerwerker, 2014).

Among the barriers for homeless people to have access to health, social and racial prejudice and discrimination related to hygiene conditions stand out, increasing the vulnerability of this group (Hallais; Alves; Barros, 2015). To take care of unique needs, the importance of practices based on harm reduction, networking and the establishment of bonds is reaffirmed. In this sense, when talking about their relationship with health and with institutions related to care, users highlight the role of the Street Office:

> I look here (CnR) too, then they go and a referral and I go to Alfeu de Quadros or there in the ... close to the "DR", but this is always where I come from. (E3)
>
> I look for you, the street clinics, for me to take my injection and sometimes ask for medicine. (E6)
>
> It's because they, at least they, help us... If we need something they help us... And in the PSF no... (E7)

Care involves the construction of bonds, through qualified listening through welcoming, breaking with prescriptive and punctual approaches, serving as an instrument for accountability for one's own existence, which favors the relationship between professionals and users (Ferreira *et al*, 2019). It is possible to verify this perspective in the following statement:

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> I would like every city to have a Street Office, right? I would like it very much, because for me it was very useful, so I think that this work of yours, very useful, in many points of view, right? (E2)

The space of interaction between professionals and users configures their territorial scope, formed jointly by the various actors on the scene, responsible for change and mutually affected by the collective, living and existential territory that surrounds them. This space is also a background of complex variables and tensions, as well as a field of the unknown and of non-knowledge, in which subjects are incessantly summoned to the invention of new life arrangements (Merhy *et al*, 2011; Feuerwerker, 2014).

The affluence of various connections, typical of living work, constitutes the drawing of an open map, a "cartography" within the work scenario. As illustrated by Deleuze and Guattari (2012), the cartography of health production develops as an agency of polymorphous lines of connection in different intensities, networks of multiple inputs and outputs, plastic, moving, connectable at any point in the plot, in open, a-centered and non-definitive flows and, above all, timeless, and the bond is an important factor in this process. A study carried out by Ferreira et al. (2019) with users of the CnR of Maceió, in 2016, revealed that listening and relationship were highlighted by users as primordial elements in access to health, which is in line with the findings of this study.

CONCLUSION

Faced with the question of how homeless people understand health care, it was possible to apprehend that concrete and effective care begins its movement in everyday life, in the micropolitics of health production, in the living act of work and in the direct and routine contact between worker and user. In this way, the Street Clinic brings with it the potential to invent innovative health production modes, precisely because it is located in a borderline, heterogeneous and unstable scenario, in which noise and lines of flight predominate. What escapes and breaks the instituted can become the fruitful source of new lines of care.

The study sought to investigate the perception of CnR users regarding health care, such investigation could be expanded from the interview of the professionals who work in the service, which is a limitation of this study. In this sense, further investigations are needed that include other actors in the care network.

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