The production of the common as a care strategy for complex users: a cartography with homeless women

Ariane Goim Rios (https://orcid.org/0000-0002-3328-8747) [1]
Clarissa Terenzi Seixas (https://orcid.org/0000-0002-8182-7776) [2]
Kathleen Tereza da Cruz (https://orcid.org/0000-0002-9847-3281) [3]
Helvo Slomp Junior (https://orcid.org/0000-0001-5346-0965) [3]
Emerson Elias Merhy (https://orcid.org/0000-0001-7560-6240) [3]
Silvia Maria Santiago (https://orcid.org/0000-0003-0587-2935) [1]

[1] Programa de Pós-Graduação em Saúde Coletiva, Faculdade de Ciências Médicas, Universidade Estadual de Campinas. R. Tessália Vieira de Camargo 126, Cidade Universitária, 13083-887. Campinas SP Brasil. arianegoimrios@yahoo.com.br
[2] Faculdade de Enfermagem, Universidade do Estado do Rio de Janeiro. Rio de Janeiro RJ Brasil.
[3] Faculdade de Medicina, Universidade Federal do Rio de Janeiro. Rio de Janeiro RJ Brasil.

Abstract *This paper discusses the low power of traditional care offers for so-called complex users in the health sector. It aims to show, from the narratives of two guiding-users, that professionals, services, and policies disregard the multiple singularities involved in the care and attempt to overlap their knowledge in asymmetrical relationships. They are often put at stake in their ability to generate interesting and more life-producing offers. In this sense, this work built on two qualitative, cartographic studies that aimed to reflect, based on two guiding-users, promoting considerations on how contact with the field/territory and the meeting with these two women (guiding-users) deterritorialized concepts and affected researchers and research. The results indicate that cartography allows the production of the common, understood as a way of operating health work. Here, one seeks to consider each subject's unique individual power as a fundamental issue for the production of care. The disease leaves the scenario as a guide, vulnerability as fragility or impotence, to make way for the "defense of a life worth living" as a guide. Possible lives that users generate, whether or not they are in the streets and a vulnerable condition.*

Key words *Cartography, Common, People living in the streets, Complex cases, Qualitative research*

Introduction

Living in the streets in Brazil has been associated with drug addiction, vagrancy, failure, and risky nature of urban centers, insecurity, theft, robbery, street dirt, and disorder. A disqualifying and stigmatizing image of these living beings was built from this societal imaginary, which negatively echoes in people's daily practices and public policies in general. The absence of quantitative and qualitative systematic knowledge about the lives of those living in the streets, along with the culture of welfare, invisibility, intolerance, prejudice against the different and state disinterest, kept the scope of "reactive" government actions to address immediate issues such as shelter, food, and clothing[1].

In this sense, working from the perspective of ensuring social rights is still a challenge for governments and their care networks. If social assistance is a right that should aim at the future separation of the assisted, the prevailing *modus operandi* is still that of the *social disposal of a population that is addressed as surplus. These programs are marked by the institutionalized practices that aim to remove these people from the streets, providing few possibilities for restructuring their lives*[2].

Living in the streets and being a woman heightens socially shared stigmas: it is gender mainstreaming reinforcing other exclusions. It means facing socially produced formulations from an overview of people living in the streets, and what would be "the best" for them.

Providing care for these women who live what Public Health technically labels "vulnerability situation" is often an arduous task in health. They say it is "complex"; that is, because its object is users require care technologies that are not always customary in the routines of health professionals, who do not adapt to the more expected behaviors that tend to standardize care offerings. Such cases are often frustrating for health professionals and teams who often report a sense of failure when conducting their actions in adverse scenarios. Sometimes, they lead to abandonment or taking purely prescriptive measures, reducing the probability of establishing bonds[3] because *the meeting of street-living drug users and health professionals is deterritorializing for both*.[4] (p. 58).

Thus, this paper aims to discuss the production of an ethical-political common between professionals and women who were the guiding-users[5] of the two studies we addressed. From the findings of these works, we discuss the possibility of adopting the production of this "common" as a way of operating health work. The balanced perspective was the meeting between different ones, in which one seeks to consider the singular potency of each individual as a fundamental matter for the production of care. The common is a reservoir of singularities in continuous variation, an inorganic matter, an organless body, an unlimited capacity of the most diverse individuations[6]. Building a common that allows mutual affectation, creating bonds, and formulating strategies for living and supporting each life's power[6] is a daunting challenge. This consideration of the common presupposes the joint construction of solutions to users' problems to make sense for everyone. The very concept of what is an issue shared and rebuilt in a relationship of trust and bonding was the point.

Methods

This is a composition between the results of two qualitative, cartographic studies in the process of production of collective knowledge from the experience with others in the world of care[9]. The research settings were two large cities in the Southeast and South regions of Brazil. Both investigations were carried out by two distinct research groups that share a common theoretical field and underlie the National Network of Observatories on Health Policies and Care/CNPq. The details about the criteria for choosing the municipalities surveyed and the constitution of Poliana and Rosa as guiding-users are specified in the respective research materials mentioned above.

Based on the works of Deleuze, Guattari, and Rolnik[10-12], we understand cartography as a knowledge-producing process. That is not given a priori, but takes place in encounters with other bodies – with or without organs[13] and affections, recognizing everyone as intensive knowledge producers. In this sense, cartography streamlines the researcher's asymmetrical place in the relationship with the other in the world of research, overturning specific (established) worlds and establishing others.

The guiding-user tool[14] was adopted to produce such cartographies, which allowed taking the lives of Rosa and Poliana, guiding-users of these studies. They are analyzers of the services' hardships, the teamwork process, health care networks, and how public policies work in practice. More than a methodological choice, the user's

construction as a guide is an ethical-aesthetic belief that shifts the other from the position of an object to that of co-producer of knowledge. The selection of two guiding-users from different states in the country occurred *a posteriori* after identifying two "similar" existential territories (women + living in the streets + complexity from the viewpoint of health). Some similarities in the characteristics of cities chosen were observed, but, above all, since they were two cartographies employing the same tool for their production (guiding-user).

From the viewpoint operationalizing the research, both teams started from the benchmarks described above to position themselves in the field, but with different entrances. The researcher who accompanied Rosa was part of an intersectoral network of services that already monitored her, facilitating building the bond with the guiding-user. The team that followed-up Poliana consisted of two types of researchers: a group with a monthly presence in the field, another consisting of the team of caregiving workers, and Poliana herself.

Cartographic field diaries of the cartographies of the singular worlds of Rosa and Poliana were produced in each of the two surveys. More than recording descriptions of the observable, cartographic field diariesare a collective-singular record in a composition seeking to give language (expression) to the affections produced in the meeting with the other as an intercessor, discussing the very production of the lenses. The narrative fragments of these diaries are called "scenes" and are presented and analyzed in this reflection.

The study that refers to guiding-user Poliana was conducted from January 2014 to December 2016, and was approved by the Research Ethics Committee. The study that refers to guiding-user Rosa was conducted from February 2015 to January 2017, and was approved by the Research Ethics Committee.

Scenes produced from cartographic processes with guiding-users Rosa and Poliana

The scenes presented are narrative fragments of the cartographic field diaries of both studies. The criterion for choosing those that would be brought here was based on their power to streamline certain institutions and act as analyzers of specific processes in health care production. All names are fictitious. However, it is essential to clarify that this was a narrative strategy adopted in the original studies validated by the participants.

Poliana, scene 1: the street, prostitution, drugs

Poliana is a 27-year-old woman described to us by the Primary Health Care(PHC) unit team as a user of psychoactive substances, especially crack and alcohol, consuming more than one liter of the distillate daily. She has two children – a boy of about 10 years old sent for adoption, and a younger girl who lives with her paternal grandmother – from her former partner. Her partner died from AIDS about three years earlier. Poliana lives in a dark, unventilated basement under a sister's house, with a visually impaired mother, half-brother Beto, and a ferocious dog that does not allow the entry of any stranger.

Beto is about 10 years older than Poliana. He is a small, skinny man, and has been living with his mother and Poliana for some years. He is a bus collector and often misses work to accompany Poliana, diagnosed with AIDS and Tuberculosis, on tests or appointments. *He's her emergency room. He's already putting his life aside to take care of her, but sometimes she swears at him, and he gets upset*, says the older sister, the only one we were able to talk to on that visit. *But it's that thing: when she wants to go out looking for what she is not supposed to look for, he goes out himself, seeks around, and ends up buying it for her*.

Poliana rarely opens up with the team, and the bond seems fragile. The connection seems to be between the more affable half-brother Beto and nurse Suelen, to whom he says that Poliana prostitutes herself to get the money to buy alcohol and crack, which bothers him a lot. The bond with the research team is also not straightforward: in some of the first approaches, Poliana refused to receive us and even screamed, from inside her house: *I'm not a guinea pig!*. What were Poliana's previous experiences with health professionals that would justify this statement and her withdrawn behavior?

Poliana, scene 2: anguish, administrative barriers, and moral conflicts

These conversations with the nurse show that Beto and Poliana's relationship has several complications that indicate the presence of an incestuous relationship, which greatly affected most of the unit's health workers. They asked themselves, for example: *How far does the human being go?*. In turn, the research team also inquired: what connection could there be between that supposed re-

lationship and prostitution, drug use, the preference, choice, inevitability of living in the streets? Are we operating as moral researchers in judging other people's choices for their lives? How could the harm reduction rationale contribute in this case? Many new reflections about the brother and the family context emerge: *one invaluable lesson learned was reconsidering right and wrong concepts*, nurse Suelen says one day.

Poliana, scene 3: the disappearance that intensified the presence

Poliana disappeared! – is what we discovered when we contacted the nurse, at a distance, a few days before returning to the field. *She's in the streets, and he [Beto] doesn't even want to talk about her!* – there was a general feeling of giving up and failure.

At the health unit, in conversation with the nurse and the manager, the event began to take shape: Beto had said that in the previous weeks Poliana had been spending more time in the streets than at home, consuming much alcohol and crack, returning when she got worse, with fever and cough. He had tried to admit her to treat pneumonia with a pleural effusion, but she refused to do so, and, in a heated debate, Poliana declined and criticized him. She said: *I don't want anything from you; you are useless ... you are nothing but another dog in my life!* Beto felt offended, not wanting to take care of her anymore. The research team searched for Poliana in regions she used to visit, visited the Social Assistance unit in the region, and Poliana's aunt, unsuccessfully.

Poliana's absence – her escape – produced a reverberation, bewilderment, and raised a question: *What now?* Poliana generates questions about the teams' work process, forcing us to change our way of doing things/being a health professional and researcher, requires another viewpoint, and produces fundamental interferences in the researchers.

Here, the absence finally raises other questions for the research team: why are we saying that she "ran away"? Was she "busted"? While being "looked after" by her brother, why does Poliana seem unable to live in that house? What other life or home was she looking for? What life was she rejecting? Was this a typical or not so typical situation of gender-based violence? What "interventions" could be and were still required from the care network?

Many affections and discomfort are produced in that encounter, in our female bodies, reverberating the violence suffered by so many Polianas in us.

Poliana, scene 4: another Poliana appears

A few weeks later, Poliana returns to the health service looking good, more physically and emotionallyvigorous. For the first time, we achieveda direct access to her, without Beto's presence. Beto now disappears and must be "removed from the streets" by Poliana because of alcohol abuse. Poliana shows the unprecedented desire to submit to HIV treatment: *I want to get well!*.

We went out with the user to support her in obtaining the copies of her documents. In this journey, we discovered that her brother had confiscated her original papers under the pretense – internalized by Poliana – that she would be unable to keep them safe, and leaving home alone, including doing tests or looking for jobs, asshe would be lost without him. That is when violence becomes more palpable to us, a feeling of insecurity, and the emotional dependence that Beto had long produced in Poliana.

At the time, among our many shared concerns were the feeling that streets, drugs, and prostitution might be, for Poliana, a way of operating some "self-harm reduction". This is when we needed to deconstruct the health professional in us who, in the production of health care, views the streets as a non-place and illicit drugs and prostitution as insecurity, as non-possibilities for producing life.

Rosa, scene 1: live harm reduction in action (meeting with the Street Clinic)

We found Rosa through the Street Clinic (CnaRua), in a territory gathering drug users, in a suburban neighborhood of a municipality close to a large capital in the Southeast. On the way, the case is summarized as follows: *Woman, 40 years old, crack, alcohol and other drugs user since she was 18, with intense street experience. Mother of nine children, and pregnant with the tenth. None of the children were with her. She broke up with the family. No current partner and no prenatal care monitoring.*

When we arrived, Rosa, from a distance, warned us that she had been waiting for the CnaRua team the previous day without using drugs, but *today I can't, I already used some*. We approached her and said: *No problem, it doesn't matter that you used them, Rosa, you can be seen there, even if you used it. It is better than not going*, said the CnaRua professional. We continued talking, and Rosa told us a little about her life sto-

ry, as the mother of her children, a woman, drug user, and a street-living person. She was moved when talking about her children and spoke more about them than about drugs. She said she wanted to be with the child she now carried in her womb.

She refused to go to the maternity hospital for prenatal care tests, or the Psychosocial Care Center for Alcohol and Other Drugs (CAPS-Ad). She apologized and said he couldn't do it, attesting: *When I use it, I get into a craving mood later*. To which the CnaRua professional replied: *Use it and then let's go*. We knew that without prenatal care and prior organization of life, it would be practically impossible for Rosa to stay with her son, due to the inevitable intervention of the Judiciary in the maternity ward, as noted in previous cases. Therefore, we asked ourselves: what desires were at stake or disputed? How can we promote access to health and ensure the exercise of motherhood in the face of verbalized desire? However, above all, how to motivate self-care, so that it could unfold in the eventual care of the child?

Rosa, scene 2: operating care between the streets and the hospital

In medical care performed at the reference maternity ward, it was assessed that Rosa had a severe obstetric risk, and the indication was for hospitalization until the time of delivery. It would be seven weeks ahead if this happened on the scheduled date. Seven weeks of hospitalization for a woman whose territory/home has been the streets in the last few years!

In a visit, we found Rosa half-naked in the room, only with the hospital gown open, right after the intervention of a group of more than ten nursing students to perform an examination. Rosa was irritated by this situation. She claimed she felt like a "guinea pig" and complained about her body's exposure. She was uncomfortable with her hospitalization and the recent diagnosis of gestational diabetes, which implied in a restrictive diet. We discussed some strategies to manage this discomfort. She told me about her desire to have her baby, but that she did not know what it would be like from then on and said, with regret: *while my baby is in my belly, I carry him. Afterward, I don't know what will happen*.

Subsequently, an intersectoral meeting was held between Mental Health, Social Assistance, and Maternity Hospital to discuss this case, and the themes brought up at this meeting are emblematic.

The frequent difficulty of hospitals in receiving cases such as Rosa's (which is justified by what they called *lack of knowledge for psychiatric cases*) prevailed. The inadequate hospital structure (*but the windows here are made of glass!*) and the risk of keeping *a psychiatric patient* in a maternity hospital, referring to the risk of self- and hetero-aggression by Hospital staff and patients. Finally, a request is made by Management: *we have to make sure that she is not a danger to the team. Can you mention this in writing?*.

Certainty? In writing? Danger? How can we manage the stigmas around these "complicated cases" to not impact the very care the user would receive? How can we break with such fragmented institutional practices (clinical/obstetric vs. mental health demands)?

Rosa, scene 3: about the times and the prophecies that come true

In the process that ensued the birth of Rosa's son, which culminated in providing shelter to her baby, the network followed its intersectoral meetings to monitor the case. Rosa was placed in full hospitality mode at the CAPS-Ad (Psycho-Social Care Centre for Alcohol and Drugs). This health center had practically become her home lately, because her stay there also facilitated daily visits to her son, due to the geographical proximity of the services. In a meeting with the reception service, we discussed the conditions for the baby's "removal" (housing, work, abstinence, among others). We considered that this reconstruction could be gradual, and, above all, the exercise of motherhood could also generate life power to effect such changes.

However, the lengthy and unpromising process led Rosa to disbelief in achieving a favorable outcome. After being fully admitted to a CAPS and later staying at a shelter for people living in the streets, she returned to her territory of use, namely, the streets.

A central issue that emerged from his cartography was the difficulty of producing a common ground between Rosa and the entire network involved in the case. Many voices spoke for or even within Rosa, deciding about her life. With a few exceptions, people were almost hoping to witness her inability. No one believed she would resort to her inner strengths and expand them. Moreover, a question haunted us: why was it so hard to work from the perspective of shared care between mother and baby? Why do we promote separation in the name of protection?

Discussion

Complex cases and professional inquiries

The so-called "complex cases" underlie the different health services, and are thus named because they *mobilize, in various ways, the different workers and services involved in the network around their care*[3] (p.220). In the research presented here, the public health services teams named this complexity when they felt powerless in the face of what they thought was an inadequacy between perceived problems of users and the current offers. They narrated their feeling of inability to relate to users whose life proposals were foreign to them and whose world perspectives were so different from their own, which hindered management. They understood that several types of violence and exclusion marked lives. For this reason, they required intersectoral actions, which justified the involvement of various institutions in the health network, social assistance, security, education, community, NGOs, Justice, among others. They thought they had made a substantial investment and, even so, they had hardly achieved any resolution[3] (p. 220). We analyze users Poliana and Rosa as "complex cases" from this framework.

The scenes confirm the challenges of care work and evidence the multiple existences of these two users: women who design their life journeys, building powers in territories we call "streets", which is "home" to them.

There are so many similarities between the stories of Polianas and Rosas. How do health professionals see the lives of these women? How do we address the lens of insecurity and shortage: living in the streets (homelessness), poverty (lack of money), blackness (negative value of race), low schooling (lack of education), and the coerced feminine? These lives tend to be classified from arbitrary societal parameters that usually label these users as lacking the ability to govern themselves, aggravating their significant social disadvantage. Thus, living in the streets, drug use, and pregnancy in such situations, are inappropriate, irresponsible, and insane choices. They often reverberate to society as impotence, inability to view them through another aspect: that of other and unknown power. Rosas and Polianas do not "fit in" these framings.

Furthermore, much of what we consume and underpins us are subjectivities expressed to understand and live life[15]. These compositions also underlie health and social workers in general, who tend to reject other ways of organizing life, often unbearable or just about tolerable for professionals. They produce their practices in a prescriptive (the correct way to live life) and classificatory way (life that deserves to be lived or not)[16]. The difference is operated as asymmetry, hindering understanding the different ways of living as a power[17].

As professionals, we can also ask ourselves what the "good outcome" of these narrative passages would be. How can we see the power in the lives of these women? However, the scenes evidence that the concept of "proper life" seems to necessarily involve abstinence, home, work, consumption of goods. We have a long way here to navigate towards this continent of diversity, the other, and these other worlds.

The movements of complex users: "agreements and disagreements with professionals"

The allows us to seize the movement of guiding-users who unsettle the professionals, because they are themselves living self-networks and are continually inventing ways out for their lives. When in the streets, places marked by specific and plural codes – solidarity, sharing, disputes, and disagreements – often unfamiliar to workers, they question the institutional knowledge and practices in the services. They aim to address their "unusual" existences and build a universal care proposal, that is, shared between workers and users.

How can we understand, for example, the situation of Poliana, who "ran away" from home whenever she got better? The visibility of Poliana's active movement to run away from something (an unbearable life?), gave way to other viewpoints (18). What did Poliana think or feel about all of this? What happened in that house, which was unbearable? What kind of relationships were established between them? What did Poliana's movement teach us about her? Perhaps, as seen in later conversations, the best life or care is not always within domestic quarters, the family, or institutions.

However, one day, we were surprised to find Poliana very well, sure of herself, making plans, unlike the Poliana, on the edge of existence, we had known earlier on. Good disorganization then puts the team in another mode of listening, which can resonate powers to exist, multiple possibilities of existential reconnection. Poliana taught us that some power always underlies ex-

istence and makes us think that it can never be ruled out as long as one lives.

In Rosa's case, her home or home reference was not the CAPS-Ad or the Social Assistance shelter, but the streets, an inhospitable place for some, but a safety-promoting and receptive environment in those distressing living and waiting moments. Several partners and partnerships were established, several moments of approximation were found, but not the entire care chain worked to ensure that the mother-child dyad be set and protected until it established itself autonomously. Even so, the good experiences lived by Rosa allowed a certain persistence in the claim of the custody of her son, albeit with a very slim chance of success. Demand for those who represent what is right and decide about abstinence, home, work, consumption of goods still prevails.

The different relationships established were evident in the various meetings narrated with Rosa, in the meetings with the CnaRua (street clinic) team, the maternity hospital, and the institutional care team. There, we sought cartography intervention as a tool for the production of the common, but sometimes disagreements were observed between the service network and Rosa's world. These movements ended up unfolding in Rosa's removal from the network and, consequently, from her son.

Disease as a guide x power and production of the common

Also, we could identify in the scenes that, in health practices, disease is often used as a guide. Such posture creates a filter in which affections or interferences produced in our body or the other body are held as something secondary and even undesirable. They are biases against the range of objective information we are impelled to seek or quantify, and interventions we are coerced to do. It is no coincidence that both Poliana and Rosa scream at some stage in their relationships with health services, *We are not guinea pigs!*. Thus, they express the discomfort with practices that consider their bodies as objects, trivializing their lives and voices, not recognizing them as valid interlocutors[19], and with whom it is necessary to build a common plan.

Therefore, the production of care is burdened by several types of barriers and limitations. These are difficulties in overcoming the disease model as a guide, which "shapes" us[18] to silence our affections and those we provide care to. Addressing relationships with users exclusively dealing with

the disease implies establishing a low-power, asymmetrical relationship. Thus, one is the holder of knowledge/power, and his/her knowledge and conceptions about ways of caring serve to disqualify and invalidate those of the other. It is about the relationship between the healthy, who has privileged information and knows how to live correctly, and the weak, sick, and devitalized, who knows nothing. It is an unequal reservoir of powers, in which all possibilities are not explained. However, this relationship removes the professional from the meeting/exchange with the other and the possibility of building, in this encounter, a common place with the user, which brings the powers of each one to the fore.

Here, blurring the boundaries between researchers and health professionals, we can reflect on the moments when we do not know what we are facing, what constantly challenges us, brings us enormous discomfort, and makes us lose the safe foundations of technical statements and the life we introject as the most adequate. Another noteworthy aspect is the silenced voices of these users in the relationship with the agents operating the policies, given that what they think, feel and plan for their lives has no space, since they are, a priori, disqualified as valid interlocutors.

However, life's power is disseminated everywhere, even in the non-standard ways of living, such as those of Rosa and Poliana. This power of life in every corner makes us wonder: What new networks of life are out there? What are the odds of seeing the emergence of a common place that aggregates these powers dispersed in different scenarios, such as those covered by our study?

After all, what is this common place, if not a meeting point for the singularities of users, health teams, researchers, in constant change? It is not a common place that overlaps the singular, but that allows multiplicity and variation to flourish in a relationship, strengthening them instead of overruling them in favor of pseudo-homogeneity. As can be seen, in this meaning, the "common" has nothing to do with unity, measure, and sovereignty in the classic sense of the word, but with an understanding that the composition between different enriches practice[16]. It is about establishing other space-time meanings for new associative and cooperative ways, in which desires in composition can emerge and give way to new worlds.

However, how can we create escape routes from authoritarian practices and produce an ethical-political common to care for these women? In dialogue with various authors, Peter Pál Pel-

bart speaks to us of a concept of common that considers the singular potency of each individual, with his quantum potency and, thus, the power to affect and be affected. A common not only as a "combination of individualities", but a productive space par excellence, *a virtual background, pre-individual social vitality, pure non-totalizable heterogeneity, which has nothing to do with unity*[6] (p. 4).

The question that surfaces here is whether this meeting of health teams and users can be established in affectivity for this productive space. It is about how one being can receive another in his world, but respecting the relationships and individual worlds, and this "receiving the other" meaning foreignness, sharing new ways of life and existence.

The power of cartography

A recurrent issue is that of the limited alternatives built in a co-participative way with the users, through health or social assistance services, a weakness reverberating in the lack of team power and the fragile bonds established. Cartographic listening gives visibility to the dissonance of these offers with the reality, demands, and desires of users and the lack of tools that help change the course of cases in which a negative outcome is already expected.

However, what is expected of success or failure in the teams does not account for the multiple facets of life outside health services and others. Incorporating the design of multiple lives into the approach and care projects of different subjects is technology, knowledge, and practice to be incorporated by social policy professionals.

Taking cartography as a strategy to experience the operators of the approach, intercessors of the relationship, the disease gives in to its "guiding function" to the life experienced in its different ways of producing and inventing the different aspects of existence. It is not to a particular life idealized by a sector that sets out as exclusively technical, whether health-related, social or even legal, but does it for a possible and even desired life by the subjects who engender it, whether they are in the streets or not, or in a situation of significant social vulnerability or not. What public policies could then make other invitations? What new existential germinal connections would be possible to produce more life? Another significant issue for cartography is time: we work on time dimensions negotiated between technical time, research time, and guiding-users' lives. However, we seek "common time" lapses in which the most significant actions can occur: the time of events. From the time-space discussion, we bring about what common time and space is, building a territory for these interlocutors to meet: with Poliana and Rosa, the permanent investigative effort was building these common plans or time-spaces. Perhaps an even more challenging endeavor in a different methodological approach than the one used.

Moreover, cartography as a builder of common, shared plans finds resonance, for example, in the harm reduction proposal. It is not the technical team's absence of a desire for intervention, but the construction with users of what is feasible to continue living life in each space-time, through another setting of accountability[20]. Finally, it shows us a way of searching for and seeing the other symmetrically, building a shared knowledge that can germinate in more significant actions than those we have produced, especially for substance users living in the streets.

Final considerations

In the crossing reported here, we face the challenges of establishing a concept of common that effectively supports the expanded powers in shared singularities. Such singularities are only possible by allowing the affections promoted by these meetings, overcoming a pseudo-common that is satisfied with "living with differences". However, the latter is not that frequent in the searched networks.

The professional issues and implications in the field when working with complex cases call for team deterritorialization. The issue that surfaces is investing so that this team-user meeting carries a high degree of affection for this productive space. It could be seen forming a new, more extended, expanded relationship, a power that belongs to all and each individual, and is placed for health teams. It is no longer about reterritorializing one in the same. Instead, it is an expanded space-time, producing more life, for oneself and the other: a biopotent becoming. In the methodological aspect of working with complex cases, we observed that it is essential to expand a prescriptive view of abstinence, home, work, consumption of goods. In this sense, we understand that cartography provides a more forceful intervention that seeks to build "common space-times". That is part of this ethical commitment to affirm an intervention promoting self-care as a practice of freedom and that, when increasingly

producing more life, make practices governing the lives of others an exercise of unquestionable sovereignty meaningless.

In conclusion, the production of the common as the production of intensive coexistence space-times seemed possible to us through a cartographic approach. It allowed accessing reality plans that are not obvious, and sometimes incomprehensible a priori. Besides paving the way for interferences and interventions that affect all subjects involved, and the very process of knowledge production.

By aligning two selected independent research in two cities, the effort produced a shift from a specific over-coded, pre-conceived, uniform, and static vision about these women. It started from the hypothesis that failure to approach often derives from the inadequate offers of public policies aimed at women living in the streets, considering the various technological care dimensions. In practice, these women have been reduced to a complicated, challenging issue, and what is inscribed, subjectified in us, social professionals, concerning the adequate ways of living. We are left with the belief of a common that presupposes an expanded individual, existential, and internal territory embracing a different understanding of the ways of the world, producing more life in meetings, giving way, listening, and dialoguing with new possibilities.

Collaborations

AG Rios, CT Seixas, KT Cruz, H Slomp Junior and SM Santiago contributed in an equivalent way to the realization of the studies, participating in the stages of project elaboration, field research, analysis and interpretation of data and writing of the article. EE Merhy participated in the phases of project elaboration, research coordination, data analysis and interpretation, and article writing.

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