ORIGINAL ARTICLES

Listening, affection, and amorousness: ethnography on the construction of care on the street

Escuta, afeto e amorosidade: etnografia sobre a construção de um cuidado na rua

Escucha, afecto y amorosidad: etnografía sobre la construcción del cuidado en la calle

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ABSTRACT

The objective was to identify elements of the care practices of two Consultório na Rua (Street Clinics) teams, in the city of Rio de Janeiro, Brazil. This study is based on the idea that health practices must be built from a *habitus*, as defended by Pierre Bourdieu. This anthropological research used ethnography as a method for capturing data; its analysis followed the proposal of domain analysis. The narrative permeated care spaces with qualified listening and user embracement with the identification of affection and amorousness as constituent elements of care for the homeless population. It is concluded that care is built on the street based on "horizontality", i. e., in putting oneself in the other's place, in being together, and with user embracement and practicing listening with affection and amorousness.

Keywords: Homeless people; Healthcare professional; Primary Health Care; Ethnography; Public health.

RESUMO

O objetivo foi identificar elementos das práticas de cuidado de duas equipes de Consultório na Rua, localizadas no município do Rio de Janeiro, Brasil. Parte-se da ideia de que práticas de saúde devem ser construídas a partir de um *habitus*, defendido por Pierre Bourdieu. Esta pesquisa de cunho antropológico utilizou a etnografia como método para a apreensão dos dados e a sua análise seguiu a proposta da análise de

domínio. A narrativa permeou espaços de cuidado com escuta qualificada e acolhimento, com identificação de afeto e amorosidade como elementos constituintes do cuidado à população de rua. Conclui-se que o cuidado se constrói na rua, na "horizontalidade", ao se colocar no lugar do outro, no estar junto, com acolhimento, escuta, afeto e amorosidade.

Palavras-chave: Pessoa em situação de rua; Profissional de saúde; Atenção Primária à Saúde; Etnografia; Saúde pública.

RESUMEN

El objetivo fue identificar elementos de las prácticas de cuidado de dos equipos de Consultório na Rua, ubicados en la ciudad de Río de Janeiro, Brasil. Se parte de la idea de que las prácticas de salud deben construirse a partir de un *habitus*, defendida por Pierre Bourdieu. Esta investigación antropológica utilizó la etnografía como método de captura de datos y su análisis siguió la propuesta del análisis de dominio. La narrativa permeó los espacios de atención con escucha y recepción cualificadas, con identificación del afecto y la amorosidad como elementos constitutivos de la atención a la población en situación de calle. Se concluye que el cuidado se construye en la calle, en la "horizontalidad", en ponerse en el lugar del otro, en el estar juntos, en la acogida, la escucha, el afecto y la amorosidad.

Palabras clave: Persona en situación de calle; Profesional de la salud; Atención Primaria de Salud; Etnografía; Salud pública.

INTRODUCTION

The construction of care for homeless people is permeated by obstacles linked to access to public policies, access to health services, and specific aspects related to health professionals who work in Consultórios na Rua (CnaR – Street Clinics). Engstrom and Teixeira (2016) highlight that these professionals must cultivate in their health practices the ethical and political commitments to defend life and display empathy and solidarity – which are all clinical and relational skills necessary to work with vulnerable populations.

The teams of Consultório na Rua (eCnaR) are made up of different professionals following the foundations and guidelines of the National Primary Care Policy (PNAB) - to work *in loco* addressing the health needs of populations living in the streets. Activities can be carried out in an itinerant manner, developing shared actions integrated with Basic Health Units (UBS) – as pointed out by the Ministry of Health (MS) (Brazil, 2012), which are part of the health services performed by the Primary Care Health (APS). Having teams linked to APS, such as the eCnaR, represents a significant advance toward the construction of humanized care by considering this population as subjects with rights and duties, consequently favoring the citizenship of this group. These practices stress and promote changes in the organization of services, which are, in most cases, set in rigid and inflexible ways with the requirement of documents, clothing, and hygiene (Engstrom; Teixeira, 2016).

Given the ethical, human, and technical aspects that must constitute the care practices of the eCnaR, this study investigated how these professionals build their health practices with people who live on the streets. Working with vulnerable populations also permeates a political, social, integral, and equitable purpose in its actions. But a question immediately arises: how to produce assertive actions that bring gains for these citizens who have the street as their home territory? To do this, the starting point is the premise that their health practices must be anchored in specific clinical and human competencies that are built from a structuring *habitus* that reflects their practices and relationships.

In this premise, the *habitus* of eCnaR, the object of this present reflection, is based on the *habitus* category defended by Pierre Bourdieu (1983, 1996). Bourdieu advocates that social structures, inserted in certain social and historical conditions, "shape" the bodies of individuals, introjecting values, meanings, and conducts into them, building their social world and practices. The *habitus* is influenced by the environment and institutional processes and practices that tend to reproduce certain regularities due to the schemes created by the varied influences (Bourdieu, 1983).

The conceptions of care of these professionals regarding the health needs of homeless people are influenced by cultural and social mediations, as proposed by Bourdieu (1983, 1996), by bringing essential elements that architect the care practices of eCnaR. Taking this as a basis, the question of this study was: what elements linked to the *habitus* of eCnaR professionals are accessed to carry out their care practices?

The objective of this study was to identify, through narratives, elements of the care practices of two eCnaR located in the city of Rio de Janeiro, Brazil.

METHOD

This anthropological research used ethnography as a method for capturing data. Uriarte (2012) teaches us that fieldwork must be carried out through immersion to guarantee an ethnographic practice, not just a methodology or a research practice, but living the theory itself. Geertz (2008) also states that narratives seek to describe each individual's interpretation, bringing to the scene things, events, facts, and phenomena, all permeated by culture. Thus, the choice for ethnography was due to the study's questioning to understand the elements linked to the *habitus* in the professionals' practices. It was necessary to immerse themselves in direct observation of the study participants with the street natives.

This research is anchored in the theoretical-methodological approach of Pierre Bourdieu (2015), which proposes the *habitus* category that is constructed through affinities between the subjects' behaviors, their structures, and their conditioning factors. They thus constitute dispositions incorporated by social subjects throughout their socialization process, integrating past experiences, perceptions, assessments, and actions taken.

This ethnography was carried out with professionals from two eCnaR located in the West Zone of the city of Rio de Janeiro. A group of 17 participants from various categories in the health sector was thus formed: doctors, nurses, psychologists, dentists, social workers, nursing technicians, oral hygiene technicians, occupational therapists, and street agents. The fieldwork was conducted over nine months in each of the teams, totaling more than a year and a half in the research field between 2017 and 2019. One of the teams conducted visits twice a week and the other team conducted visits every day. Each visit could last up to six hours.

The researcher's reflexivity process throughout the fieldwork was fundamental for understanding the data set, as usually happens in other ethnographic studies (Minayo; Guerriero, 2014).

The study was carried out through direct ethnographic observation, interviews, and the application of a questionnaire on the interactions of health professionals with the homeless population. The materials used in the ethnographic research were: a field diary used to monitor teams both in the Basic Health Units (UBS) and during street activities; a semi-structured interview script created by the researchers and applied at established moments with the professionals; and a semi-structured questionnaire, which was given to the professionals at the beginning of the study.

To preserve the identities of participants, and in compliance with ethical precepts, the interview transcriptions adopted the following dynamic: each interviewee received an E code for interviewees from one of the teams, and an ER code for interviewees from the other team, followed by the number corresponding to the interviewee's order. Thus, the personal identification of each professional was preserved, and they were represented by E1 to E9 and ER1 to ER8, respectively. However, because this article is one of the products derived from a doctoral thesis, it only presents part of the analyzed data and it does not present the content of all interviews.

The data analysis followed the proposal of the ethnographic domain analysis (Spradley, 1980), which seeks, through field notes, to identify cultural patterns that constitute categories of meaning. These domains, which constitute the categories of cultural meanings, were discussed based on the concept of *habitus*, hence meeting the study's objective.

This study was approved by the Human Research Ethics Committee following Resolution no. 466/2013 of the National Health Council under opinion no. 2,308,442.

RESULTS AND DISCUSSION

Initial scenes: spaces of care on the street with qualified listening and reception

The ethnographic narrative permeated two UBS scenarios located in two neighborhoods in the West Zone: Santa Cruz and Realengo, both in the city of Rio de Janeiro. The Santa Cruz health unit, located in an area of great social vulnerability, is classified as a Mixed Health Unit (UMS) with Primary and Secondary Care services. The Realengo health unit, which constitutes a Family Clinic, is classified as a Primary Care service according to the municipality. Both units are located close to the train line that crosses the city, an area where homeless people live.

Professional care practices for the homeless population take place both in the UBS and on the streets within an assigned territory. In one of the teams, during weekly meetings, the discussions focused on the need to redefine territory, user's demands, and round planning, which was a practice of direct care on the street. The work process was, in this way, also redefined through the demands presented seeking dynamism and resolution.

There was a specific nomenclature to define the work carried out on the streets. In Santa Cruz, the team uses the word "ronda" (round). In Realengo, the team uses the term "abordagem" (approach), both expressing visits carried out on the street. These nomenclatures were given and formulated by the teams themselves, and both terms meant health practices carried out on the street. However, there was a difference between work processes: in one of the teams, the visits took place twice a week; in the other, these visits could occur every day. This was due to the availability of a vehicle to carry out care practices on the street.

Direct observations of consultations took place in private rooms, creating an environment of privacy. The experience in both teams was permeated by a scenario of listening, affection, and acceptance with great interaction between the teams and participants. According to reports, most of the demands were linked to human immunodeficiency virus (HIV) testing, tuberculosis treatment, and the search for personal identification documents.

Another space in which one of the teams developed care practices was in a shelter for homeless people in the same territory as the unit. This space is considered a Municipal Social Reinsertion Unit, created in 2010 as a specialized social facility for adults in vulnerable situations to meet the demands of people who are on the streets. The health demands of the population of this shelter were met and monitored by the eCnaR (Paula *et al.*, 2018). Concerning the infrastructure for carrying out the practices, both teams had small rooms to promote consultations and care – they served as an office and a place for coordination. A meeting room was also provided at the health unit for both teams for collective activities such as training and case discussions among other activities. In ethnographic observations, during team meetings and/or gatherings, both groups had the presence of a supporter – a city hall professional whose objective was to support the teams and promote the health actions carried out by both.

Street practices were constructed according to the identified problem and the homeless person. All actions were problematized and agreed upon longitudinally. Therefore, an essential element that appeared in the speech of one of the health agents was 'listening'. As much as there is anxiety for something to happen, in this care, it is essential to listen to others and be with them. The condition of those on the street requires healthcare professionals to listen very sensitively:

I think that's it: listen... see what need they have... sometimes it's not just ours, sometimes... because we get anxious... our anxiety is: we have to take them off the street, he needs a lot of things, but we have to put our feet on the ground and look at each other and say: "What do you want, right?" I think that's it, we are very automatic in the clinic. But it's different on the street. And we have to adapt to it, that's why I say: it's very light, it's not so closed, right? When you are inside a clinic. That's why I say: that's it, that's the job, we can do a lot with them. Keep your anxiety at bay because the homeless population sometimes walks one meter and two meters backward, but we always have to be with them. That's it, being with them all the time. (ER1).

These moments were of great relevance to the research, as they provided elements of the individual and collective *habitus* of professionals. A certain uniformity was noticed between the perceptions and statements of the professionals, even with different professional training and previous experiences. Ethical and human commitments, sensitivity, listening, affection, and lovingness were present at all times, and

the collective purpose was the construction of unique and resolute care. They always said that there was no distinction in care, that professionals did not see them as they really were, that they were seen only for the condition they were in:

I think what was best about our strategies was this issue of care, of us looking at each other without just looking at the drug user, right? Because it is the large public that we have been working with nowadays. If we didn't look at this from the beginning [...], I think this would be a very big barrier. That's what I told you, we started to see each other, not just the condition they were in, right? (ER3).

It was found that health activities, that is, care practices aimed at these people, are permeated by the street, constructed and reconstructed on the street. It's as the professionals themselves say – "The street is already given". Even though the teams brought together professionals from different education and backgrounds, they were all very similar in the way they constructed their health practices, demonstrating the existence of a professional *habitus*:

With the homeless population, it's different because the street is already given to them... So, you have to work now with a health proposal taking care of the subject, no matter how much you see, have a holistic view of the space where he is, how careful he may be on the street [...] you will have a qualified listening, and then, depending on the qualified listening, you will work with harm reduction. And harm reduction is not just for alcohol and drugs, it is for other issues such issues of sex, and food, when there is food. So, this proposal differs a little, but it is under the same flagship. (ER5)

The CnaR was configured as a service that analyzes health practices, as it works based on street demands. For Vargas and Macerata (2018) the entire management of the work process is carried out by demands built in the relationship between the dynamics of the teams and the territory. This form of care management demonstrates the process of building the specific *habitus* of these professionals, confirmed by the statements about "qualified listening" and the issue that "the street is already given". These facts demonstrated that to work with the homeless population it is necessary to understand the details of this territory.

If *habitus* constitutes a system of dispositions – of ways of perceiving and feeling, of doing and thinking – this leads us to act in a certain way in a circumstance (Bourdieu, 1996). This doing and thinking about what "the street is like" and how to build a "street practice" is part of the *habitus* of these CnaR professionals.

In both eCnaR, it was possible to carry out a series of actions such as welcoming users on demand, mental health assessment, registration of street residents, active search, health promotion, and disease prevention activities – through guidance and lectures, mapping the territory, and mainly facilitating access to other services with equity. The activities were built with the team, by the team, and with users based on this listening. The way the activities were constructed caught our attention:

Sometimes they have nothing, nothing in terms of health, but you talk to them [and they] leave there happy, they thank you. I think this is really cool, the listening, the listening that we have to do with the patient, you stay there for 15 minutes, 20 minutes with them, you see that they are happy that you are there listening. (E4)

Embracement was a strategy for inserting the user into the SUS because many who arrived did not have a registration. In these cases, the agent filled out a form with personal data, and even without documentation the person gained access to the health system. This action strategy was also a facilitator on the streets,

especially when the teams encountered people who needed health care and did not seek it because they did not have a document – sometimes they even tried to obtain the documentation but were unable to do so. The eCnaR presented itself as a facilitator of access to care.

The dispositions that are part of the construction of *habitus* are plastic and flexible, acquired through the internalization of social structures, internalized through unconscious bodily and mental routines, allowing us to act without thinking (Bourdieu, 1996). Thus, this unique action of the professional with the homeless population can be explained. The professional's attitude of commitment, sensitivity, listening, and affection shapes practices that are embodied as *habitus*.

Scenes of care: affection and lovingness as constituent elements of care on the street

There was a large group of eight homeless people, all in front of a bank. The professionals knew all of them, except one, who was covered. There was a sparkle in people's eyes when they met the teams. Other residents approached a team, they wanted to talk, talk about other people who disappeared and didn't know where they had gone.

The team started by talking to one of them. Two professionals sat on the same mattress as this homeless man and began to ask him some questions. He was lying down, with a sad face and teary eyes, and was very thin; he was a soft-spoken black man around 30 years old. Of them all, he was the cleanest and most organized. They spoke to him respectfully, staying at the same eye height to make eye contact, seeing, feeling, and hearing what he had to say. They noticed the suffering of others and were very sensitive to their demands. Affection was present in this care.

The resident who was covered, lying on a mattress on the floor next to the group, seemed to be sleeping. But, that afternoon was hot, a warm late winter day with a small breeze, which somehow alleviated the heat a little. The team asked who he was and they quickly replied that he was young and that he looked sick. The person talking about him was another homeless woman, very articulate and talkative, who sold sweets in front of the bank. She said she was married, but stated that she didn't have sex because she didn't like doing it on the street. So, she did not accept the condom offered by the health professionals. There was a great bond between her and the team. She knew the group very well and in a way took care of them. She said that she tried to take the "new resident" to a unit for care but he didn't want to go. When the team contacted him, they realized that he had a fever and needed to be treated in a health unit. Soon they began to organize themselves to take him to the nearest unit. The approach ends with the team taking this new resident to the unit. The articulation occurred via one of the professionals' cell phones.

Care was built on "horizontality", sitting together on the same mattress, looking into each other's eyes, and getting close to understanding what they were saying – these were moments of love. That day, at least two people arrived and approached the team and congratulated them on their work. The affection was perceived not only by the researcher but also by the people who circulated in the center of the neighborhood.

During the development of their practices during street visits, affection and love were clear in both teams, which appeared in the details: in the moments of looking into the eyes, in the attitude of sitting next to the person on the street, in the interest in knowing why they weren't taking their medication, why they didn't want to go to the shelter, knowing how they were, and knowing why they were on the street, all without pre-judgment. These scenes were constant.

Lovingness is one of the principles of health practices guided by the theoretical-methodological perspective of Popular Education (PE). According to Cruz, Carvalho, and Araújo (2018), lovingness is one of the principles of the National Policy for Popular Education in Health in the Unified Health System (PNEP-SUS); there are still few systematizations of experiences and theoretical insights into this principle, its paths, obstacles, and expressions in practice. Lovingness is brought to health as the constitution of critical,

committed, and humanizing actions in health work, contributing to professional practice, particularly for those imposed by a technicality perspective. From this perspective, the concept of lovingness was brought to the health practices experienced during the study. The technical work of health practices became more humanized with love.

The concept of affection comes from discussions about welcoming in the health area. Scholze, Duarte Junior, and Silva (2009) say that affection is brought to permeate the professional's empathy through self-knowledge and the ability to identify verbal and non-verbal demands, explicit or contradictory, of the other's suffering. Affection is present in empathy, qualified listening, and identifying the suffering of others. The rounds were not configured as practices of withdrawal but as practices of welcoming, listening, and being together.

As homeless people begin to occupy public and private places, sleeping on the sidewalks of shops and banks and in urban centers, this scene becomes naturalized and at the same time begins to go unnoticed. Who stops and reflects on those people lying down in the middle of the day on a Wednesday in a very busy place? Who asks if they need anything?

During the ethnographic incursion, it was noticed that, when the team arrived at a place of this type, passers-by who regularly pass by that place and by those people, stopped to watch the scene. The professionals were immediately identified by the white coats they wore, and the calm way in which they approached people was also noticed. This was noticed among the teams everywhere they worked on the streets. People around them stopped to see what the professionals were doing there, with an air of surprise and curiosity. In the professionals' statements, the issue of the invisibility of homeless people, who were made visible when the CnaR was active, became clear:

I don't know if it's their need, they're on the street [...] because they're a little invisible... they think they're invisible... when we got to them, they said: "Wow, that never happened here in this area. We thought that [...] people didn't care about us, right?" (ER4)

The "social invisibilization" of the homeless population was also another concept that appeared in this ethnography, being a constant in several studies on the homeless population. The invisibility adopted here permeates what Delfin, Almeida, and Imbrizi (2017) argue, stating that there is a play of shadow and light in which subjects/groups become invisible, as other elements are made visible.

For the care to be effective, a relationship must be built based on the other's needs. In a way one of the most present needs of people on the street is to be seen. To be seen, one needs to feel like a citizen, and for that one needs to have a document. Thus, this demand, the request for documents, proved to be relevant. Not having an identification document is being invisible, it is as not having an identity as a person.

Having a document means working with the emancipation of the subject, making him visible, as a citizen. In this way, we also guarantee resolution, which occurs in this relationship of bond and trust between the subject and the professional:

I think the delivery of the SUS card is a very interesting point because they are in the middle of the street, they don't have a document, they have nothing. (E4)

The active search to be there, always being present, trying in some way, in every possible way, right?, to give that positive result to the demand that we encounter, the active search I think is one of the most important, despite the precariousness that we have to do this search. (E6)

This type of care was observed on several occasions. Both in the life and death of the person on the street - having a document means feeling important. In an observation in the waiting room of the Santa Cruz team's offices, the dialogue between a cleaning professional and the health agent expressed this relevance. They were talking about a homeless man they knew who died at the UPA. They were sorry that he was buried as an indigent and that they had not been able to contact his family.

This issue was always an aspect that permeated the conversations. When monitoring the teams, there was always a request for documents and discussions surrounding the search for a family member. The professionals said that many did not remember his real name and that others did not want to give their names due to legal problems. Reports about the family's search permeated the conversations with the teams, impacting the professionals who, in a way, acted as "investigators" of the families:

What caught my attention the most in terms of patient care or listening? Because, like, I get a little touched, sometimes, when you stop to listen to a homeless person and they report that they have a family, that was impactful for me, because you keep thinking, like, how does a person who does have a family ends up in a situation like this? [...] And it's very gratifying for me too, it makes me very happy when you find someone on the streets and manage to put them back into their family. So, it's a little different, right? from one job to another. (E5)

Having a document is necessary even in the event of death when receiving a benefit. This was explained to people on the streets who had not had documents for years; many wanted to change this situation, they wanted to have a document, to have a benefit because for them, not having a document means being invisible to society.

For Hallais and Barros (2015), Kertesz *et al.* (2014), and O'Connell *et al.* (2010), the challenge of care involves breaking the "invisibility" of the homeless population so that real conditions are provided for these people to participate in society, reflecting, for example, on the various processes that are inherent to their movement of being on the street. Care does not only come from listening to the other but from making the other a citizen and the protagonist of his/her life. This occurs mainly in the participation of the homeless person in the care provided by the professional. The subject is inserted into their own health process, which makes it possible to bring them into the articulation and formulation of their own care.

The presence of eCnaR made the person on the street better known inside and outside the UBS:

[...] and we started to take these residents and insert them into the clinics [...] they became better known within the clinics, people started to serve them better [...] When you say: "Ah, I'm homeless", but when it's from the Consultório na Rua, then people treat them differently. They always tell us that. I found this very interesting, the care they receive now at the clinic... Sometimes, they arrived shouting: "No, I'm from the Consultório na Rua"; "I am a client of Consultório na Rua"; "I'm a patient", then they see it differently. People inside the clinic said: "Oh, there's one of your patients here who needs to be checked". If you can't answer, we take care of it, and then, the next day, we go there and ask if everything is okay to see if we managed to solve the problem. (ER4)

Transforming the invisible into visible, guaranteeing access to health services and care, and helping to guarantee documents that identify them as citizens are factors linked to love in the health area. If lovingness is linked to critical, committed, and humanized action, as pointed out by Scholze *et al.* (2009), the practices built with people living on the streets were full of this constituent, which was lovingness.

Thus, as reported by Ferreira, Rozendo, and Melo (2016), CnaR acts as a social support with affection and perspectives for change, bringing improvements in health and living conditions through bonds and dialogue with the homeless population. These details explain and make explicit the professional *habitus*. It is not common for a professional to sit next to a patient, much less on the same mattress that is on the street. Looking into the eyes can be a specific and essential characteristic for caring for those who live on the street.

As much as we understand that all healthcare professionals must look into the eyes of the person being cared for, we know that not all healthcare practices work this way. This characteristic was internalized in these professionals. They constitute, as Bourdieu (1996) says, learning products of a process that is no longer conscious and that expresses itself naturally. It is the *hexis*, which constitutes the construction of *habitus*, presenting itself as a posture in these professionals. Remembering that the *hexis* was built from an *ethos*, which was composed of the practical values of these professionals.

The acquired social structures, which interfere in the practice are constituted by the *ethos*, *hexis*, and *eidos*. The *ethos* comes unconsciously from constructed values that govern everyday life as if they knew the rules of the game. The *hexis* comes from principles internalized by the body such as acquired bodily expressions; and the *eidos* is related to a specific way of thinking, as an intellectual apprehension of experienced reality (Bourdieu, 2001).

In this study, it was noticed that the *habitus* was introjected, marked by love, affection, and listening, that is, they were processes built on the street and with the street. Throughout this *habitus* construction, the street was present and necessary. When professionals say that "being on the street" was fundamental to "being with them", the street is soon perceived as the guiding axis for the construction of this *habitus*, or better, as a space for shaping the *habitus*.

It is believed that this research can contribute to the care of homeless people with the inclusion of effective and affirmative actions in health practices based on listening, love, and affection. The study can encourage the creation of more resolute proposals for public policies in the area of collective health for homeless people. The development of new research on the topic is recommended, as care practices for the homeless population are implemented.

FINAL CONSIDERATIONS

Given the results of this study, it was considered that the *habitus* of eCnaR professionals was shaped by doing the work, its relationships, and established norms in a movement of construction and reconstruction of care practices, and in a dynamic of performing healthcare permeated by the street and on the street.

The eCnaR professionals who needed to know the dynamics of the street to plan their actions also needed to know the people who were on the street, recognizing their relationships, identities, and sufferings to plan their practices. In this way, knowing this 'other' and the dynamics of the street allowed the professionals to establish, maintain, and legitimize care for the homeless population.

The practices constructed by these professionals were not carried out randomly – their construction permeated the logic of classification of the construction of the *habitus* of care for the homeless population. The incorporation of the previous trajectories of these professionals, combined with each person's perception and reading of the world – with different forms of understanding and respect for the "invisible" on the streets – made this care singular, becoming unique in the daily care for people living on the streets. This care came permeated by listening, expressed by the affection and love of each professional, from how they see and perceive themselves in the world, in their relationships with others, and in the construction of their care practices. This professional's *habitus* was built through the moment and how, in the collective and with the collective, the profession of care was constructed creatively and resolutely.

Care is built on the street in "horizontality," in eye to eye, in putting oneself in the other's shoes, in being together. The current challenge is to build care networks, because, in the absence of eCnaR, care needs to happen. Care must exist beyond the eCnaR with more love and affection so that these practices can be implemented for every homeless person.

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