**ORIGINAL ARTICLES**

# Exploring pandemic territories: cartography of a street clinic during the covid-19 pandemic

## Entre territórios pandêmicos: cartografia de um Consultório na Rua durante a pandemia de covid-19

## Entre territorios pandémicos: cartografía de un Consultorio en la Calle durante la pandemia de covid-19

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## ABSTRACT

The objective of this article was to conduct a cartographic study of a street clinic during the Covid-19 pandemic. The cartography was based on an experiential approach in a street clinic located in a major city in southern Brazil, between August 2021 and January 2022. It became evident that the flows and operation of the service acknowledged the alternative territories inhabited by the homeless population, often overlooked by other parts of Brazil's Unified Health System. Both historically established barriers and those emerging from the pandemic were encountered. It was observed that the homeless population does not conform to rationalized urban plans, displaying unique patterns of engagement with the urban territory. Recognizing the significance of the service, coupled with a comprehensive understanding of the unique living conditions of homeless individuals, proved indispensable for the provision of effective care.

**Keywords:** Homeless persons; Street clinic; Unified Health System; Territory; Cartography.

## RESUMO

O objetivo do presente artigo foi realizar uma cartografia de um Consultório na Rua, durante o período da pandemia de covid-19. A cartografia foi produzida por uma vivência no consultório de um município de grande porte no sul do Brasil, de agosto de 2021 a janeiro de 2022. Foi perceptível que a locomoção e o funcionamento do serviço reconhecem outros territórios das Pessoas em Situação de Rua, muitas vezes não percebidos por outros pontos do Sistema Único de Saúde. Foram encontradas tanto as barreiras já estabelecidas historicamente quanto as emergentes da pandemia. Foi vivenciado que a esta população não utiliza o território do modo que a cidade racionalizada planeja, sendo, portanto, singular. O reconhecimento do serviço, aliado à compreensão de como as Pessoas em Situação de Rua vivem no território urbano, em cada realidade, mostrou-se essencial para a produção de cuidado.

**Palavras-chave:** Pessoas em Situação de Rua; Consultório na Rua; Sistema Único de Saúde; Território; Cartografia.

## RESUMEN

El objetivo de este artículo fue realizar una cartografía de un Consultorio en la Calle durante el período de la pandemia del covid-19. La cartografía fue producida por una experiencia en un Consultorio en la Calle en una gran ciudad del sur de Brasil, de agosto de 2021 a enero de 2022. Se pudo observar que la locomoción y operación del servicio reconocen otros territorios habitados por personas en situación de calle, a menudo no percibidos por otros puntos del Sistema Único de Salud. Se encontraron barreras, tanto históricamente establecidas como emergentes debido a la pandemia. Se constató que la población en situación de calle no utiliza el territorio de la forma planificada por la ciudad racionalizada. El reconocimiento del servicio, junto con la comprensión de cómo viven las personas en situación de calle en el territorio urbano en cada realidad, se mostró fundamental para la producción del cuidado.

**Palabras clave:** Personas en situación de calle; Consultorio en la Calle; Sistema Único de Salud; Territorio; Cartografía.

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## INTRODUCTION

In 2019, it was estimated that 221,869 people were homeless in Brazil, representing around 0.1% of the country's population (Natalino, 2020). However, these figures do not consider the effects of the Covid-19 pandemic, the economic recession and the rise in prices that followed, generating an increase in this population in subsequent years (CNJ, 2022).

When considering public policies for people in this situation, social vulnerability is a crucial factor, especially in the health field, given the daily difficulties faced by homeless people in accessing health services, whether in the public system or in the private sector. These difficulties were accentuated during the pandemic period (SMDH, 2021).

Street clinics are one of the services that the Unified Health System (SUS) can choose to adopt to ensure the expansion of access to healthcare among the homeless population. These street clinics are categorized within "Primary Care teams for specific populations" and regulated by Ordinance 2,488 of 2011, which established the National Primary Care Policy (PNAB), and by Ordinances 122 (2011) and 123 (2012) of the Ministry of Health (Brazil, 2011a, 2011b, 2012). The service, which is part of the Primary Care network, seeks, through the mobile work of multi-professional teams, to develop shared actions between points of the Health Care Network (RAS), using, when necessary, the facilities of the Basic Health Units (UBS) in the territory (Brazil, 2021).

The creation of the street clinic (Consultório na Rua) resulted in new initiatives for the homeless population that had not been previously available, and which became singularly necessary during the pandemic (Fiocruz, 2020). This article publishes the partial results of a study that focused on a street clinic in the municipality of Londrina, in the north of the state of Paraná, a municipality with more than 500,000 inhabitants (IBGE, 2022). In the municipality, there is a shortage of housing, as reported by the municipality's housing authority, with approximately 12,540 people living in irregular housing (Londrina, 2021, 2022; Nascimento, 2016). While on the one hand the municipality presents itself as a hub of urbanization with commerce and industry, on the other it is facing a housing deficit, reflected in the public policies exercised in the city. Cheaper land is earmarked for housing projects, while urban real estate developments strengthen speculation. (Pagani; Alves; Cordeiro, 2015).

When we look at the homeless people living in the municipality, we are faced with the difficulty of obtaining official data to guide such discussions, since nationally the homeless are not included in the census. We therefore rely on data produced by state or municipal entities or the Unified Social Assistance System (SUAS), for example CadÚnico, which does not allow for comparisons and monitoring over time (Natalino, 2020). Although there may be discrepancies between estimates made a survey of homeless people in the municipality, carried out through a partnership between universities, the Public Prosecutor's Office, and the Homeless People's Movement, showed that there were at least 822 homeless people in Londrina in 2018.

In 2021, there were 725 registered homeless people on the CadÚnico database, resulting in a rate of 124.81 homeless people/100,000 inhabitants, a level close to that of national metropolises such as Recife and Goiânia (CECAD, 2022; Lanza; Rocha; Miani, 2019).

Due to its location in an inland region, Londrina has seen its urbanization intensify because of a demetropolization process typical of Brazil. Thus, the homeless end up moving between the municipalities belonging to the region, continuing to flow and move, often in search of income and housing (Lanza; Rocha; Miani, 2019; Maricato, 2011). Far from massifying the homeless and distancing them from their individualities, these representations show the territory through which the street clinics relations with the homeless take place and, thus, characterize the dimension of the space covered by the street clinic team.

Given this scenario, the aim of this study was to map a street clinic in Londrina during the covid-19 pandemic.

## THE ENCOUNTER AS A METHOD: THE CARTOGRAPHIC PROCESS

This research is the product of a doctoral thesis, and is part of a larger project, "Analysis of new social movements and health production on the outskirts of the metropolitan region of Londrina (PR)", produced following a cartographic proposal. The fieldwork for this research was carried out between August 2021 and January 2022. The activities of a street clinic in Londrina were monitored by the main author of this article, who has a degree in nursing, philosophy and was studying for a doctorate in public health up until the time the research was carried out. Since the researcher is on the autistic spectrum, his experience was based on this territoriality.

This is a qualitative exploratory study with a cartographic approach. The cartography proposed here is based on Gilles Deleuze and Félix Guattari's theoretical approach. It is considered a "geophilosophy", since the construction of science proposed by the authors takes place on the same terrain as the production of reality, traversing intensive elements, flows that cut through and produce an organizational level, in other words, the affections we experience. This process takes place through encounters, experienced on a non-representative level, in which flows of desires are produced. Therefore, considering an immanent, productive, and evolving level, cartography aims to create a map of this intensive production of reality, based on charting the lines and desirous flows that permeate the researcher (Costa; Amorim, 2019; Deleuze, 2013).

Due to this characteristic of cartographic research, there is no *a priori* established hypothesis for the development of the study. There is an insertion into the proposed territory, in which, while the process is being experienced, an analysis is made of the production of reality that affects the researcher, and, from there, a map is created of this existential territory that is produced by the encounters (Cardoso; Romagnoli, 2019).

The primacy of this research approach lies in the level of experience, so that this level itself takes place as an intervention, in the inseparability of researcher, object, subject and knowledge. This inseparability is formed between vertical and horizontal relations of modes of social organization, which are crossed by a transversality of cartography aiming to map the flows that cross this environment (Passos; Barros, 2015).

All cartography is intervention research, and to carry it out, it is important to understand that it will take place in a process entangled with power relations. Conflict and resistance will emerge from the encounter (Lima; Merhy, 2016). Considering that these encounters will take place in a specific space, this intervention occurs at the same time as the researcher's experience, who must therefore be open to this investigation, recognizing their involvement and their place so that their insertion is based on a research ethos, where the problematic field in which the research takes place is open to redesigns, deviations, and reconfigurations (Passos; Barros, 2015).

For the research in question, the area of concern was established based on the researcher's experiences and previous studies, as well as the discussions held in the research group, "Observatório microvetorial de políticas públicas e educação em saúde UEL/Londrina" (Microvector observatory of public policies and health education UEL/Londrina, own translation*).* In these discussions, the issues related to the street clinic were intertwined with the concerns raised by other minority groups and their relationship with health services. These had already been mapped by the group and included people living in urban occupations on the outskirts of cities and people with disabilities.

These research group discussions took place in a space where the collective processing of other fieldwork operated in a group dynamic of collecting affections and production of a shift in the reverberations of this

process in the group, so that the field and the experiences were also called into question (Cruz *et al.*, 2016; Passos; Barros, 2015).

As a result of these processes, new questions and suggestions were raised in the space between the researcher's experience and processes in the group. Consequently, there remained a desire to continue the investigation and to build new maps with the health service for the homeless population. Contact was thus revived for a new experience in the field.

This way of doing research requires ways of organizing and recording experiences and affections, so that the products of this period are not lost over time and are processed to gain a voice through being written down. Considering the premise that "the method is the encounter, the rest are tools" (Lima; Merhy, 2016 p. 19, own translation), it is necessary to use tools that make sense and are coherent with the territory where the affections are lived. To produce knowledge from these experiences, the researcher uses a real toolbox (Moebus; Merhy; Silva, 2016). The selection of tools used in this study considers that the researcher is affected by their experiences and affects and acts on their surroundings, so that they are "subjected" to the field of research, *in mundo* (Abrahão *et al.*, 2013).

As the first instrument in this toolbox, we used an approach that begins with a "user-citizen-guide" device, with Michel Foucault's understanding of the device as a heterogeneous network that can encompass discourses, architectures, laws, protocols, among other elements that relate to what is said and what is not said (Bertussi *et al.*, 2016).

The "user-citizen-guide" focuses on care processes and the production of life, so that the researcher involved is not seen as an observer, but as part of the very production of knowledge with the user, recognizing multiplicities and decentralized entities during the process (Feuerwerker; Bertussi; Merhy, 2016; Merhy *et al.*, 2016a). Using the assumptions already established in "user-guide" and the imposed materiality of the territory being monitored as well as its characteristics, it was coherent to use the term "worker-guide", since the researcher, during his experience, followed the paths marked out by the workers of the service in question. The researcher followed the team's activities in full, from the beginning of the shift to the end. Itinerant activities, meetings, campaigns, and other actions that might arise during the period were monitored.

The "cartographic diary", an element of the researcher's toolbox, was used because it is a way of recording experiences that not only contains notes referring to the field where they were objectively inserted, but which, in an attempt to introduce the analysis of the subjective production of affections, also includes the impressions, feelings and reactions experienced throughout the period in the field (Slomp Junior *et al.*, 2020).

Stemming from this experience in the territory with the street clinic guide workers, the mapping process includes the experience as well as writing and the processing of these affections, so that the very process of writing the maps is a cartographic production. Two vectors of analysis were then drawn up from the map created by the researcher. The first focused on the relationship between the street clinic and the city during the covid-19 pandemic, and the second on the relationship between the homeless population and their ways of living. Both vectors are interdependent and appear intertwined in the analyses.

## A STREET CLINIC FOR COVID-19 ON THE STREET

In the construction of the cartography, the territory of the city used by the street clinic emerges as a vector for discussion. As the researcher monitored the guide workers, a sense began to emerge of how they recognized and experienced the territoriality of the city, and how the city contrasted with the territoriality that the homeless population produces in it. To further the discussion on the production of territory by the street clinic team, it is necessary to explain how the service is set up in the municipality and its stated purpose.

The team the researcher was part of was registered as Modality II and had nursing professionals from the upper and middle levels, psychologists, social workers, and a social educator, all of whom were women. However, the team also included medical professionals from the municipality's Family and Community Medicine Residency program, who spent one weekly session with the street clinic, i.e. there was a medical professional there for two sessions a week. It is worth mentioning that, during the research period, some professionals were hired and relocated, so that the team, which until then had only been providing assistance in the morning, started to do so in the afternoon as well. Unlike the traditional Family Health Strategy (ESF), which deals with a territory delimited by a population number established by the National Primary Care Policy (PNAB), the operating territory of the street clinic in question is the urban space as a whole. At the beginning of the experience, the street clinic was housed in a headquarters in a central area of the municipality, with its own space for meetings and rooms for materials, documents, and medical records. However, during the research, the service was transferred to a Basic Health Unit in the west of the municipality, with a more limited structure, due to the Basic Health Unit's exclusive role during the pandemic as a vaccination facility for covid-19.

The change of base, as the professionals referred to it, was a continual occurrence. The street clinic was used to recurring physical changes. The clinic has already been located, for example, next to the kitchen of a Basic Health Unit, or inside a Basic Health Unit with allocated rooms, always with very limited space and poorly adapted to the needs and complexity of such a service.

When the researcher was introduced to the experience during the pandemic the base was in a central area, in a former private clinic that had been bought by the municipality. The team felt that this was the place where the service could take root and program actions. However, shortly after the start of the experience, the team was informed that they would be relocating their base and would once again be located within the physical space of a Basic Health Unit.

This change of location surprised the researcher, since the new environment seemed to be a place where the service, even though it was still adapting, would have the potential for new modes of organization and action. The announcement of the change disheartened the team, as expressed in speeches that highlighted how this was a recurring theme in the street clinic's history, a situation that ended up coming back to haunt the members, as if they were always on the verge of a change, an eternal return.

This characteristic of the street clinic is like that of many homeless people, this state of imminent change, something that was often stated by the team itself to the researcher. This condition of being uprooted from the territory, formulated by Arnold (2004), stems from an agency of bodies that prevents subjects creating existential territories with the locals, as they often end up making their experience an eternal present, not knowing if they will be in that space the next day. In this way, like the users themselves, the street clinic uses the street to produce its way of operating and functioning.

For the street clinic team, the feeling produced also came from agencies that do not allow the service to identify itself with a base, in a space that has a certain permanence with long-term action planning Unlike other health services, especially the Basic Health Unit's themselves - which operate in a delimited territory where people in the surrounding area sign up (catchment area) - the relationships established by the street clinic team cannot be thought of and organized in the same way.

On the other hand, this way of working led to countless encounters in which the service ended up using other places as a base for actions or procedures with users, such as various links with the Basic Health Units, social assistance sectors and other facilities. Within this way of working there is typically a need to move around the city, which, combined with the move, means the street clinic team usually take to the streets at the start of the shift and only return towards the end, having been on the move constantly. Travelling around the municipality was intense and had to take place between urgent demands and others that had

been previously scheduled. As the team had two budget cars to use, they split into two groups, organizing themselves according to their needs. The use of the vehicles allowed the teams to move around a large part of the urban territory, through areas where the team already knew there were homeless people, in groups or on their own. However, as professionals were needed for vaccinations against Covid-19, a vehicle ended up being used for this purpose.

The needs that the street clinic sought to meet during this period were no different from those before the pandemic. However, the team's fatigue during the process was noticeable, something already shown in other studies that demonstrate health professionals' exhaustion during the pandemic period (Magalhães *et al.*, 2022). The street clinic team works on the move. This, coupled with the need to wear Personal Protective Equipment (PPE) a uniform consisting of scrubs and driving an uncomfortable car, made the work shifts exhausting. This was particularly true as there were high temperatures in the municipality, even in the morning, and the constant need for PPE and precautionary measures even made it difficult to stay hydrated. These working conditions are in line with what Teixeira *et al.* (2020) cite, stating that, in addition to presenting new problems to be faced, the pandemic has exacerbated situations that were already chronic in relation to the working conditions of health professionals.

## TERRITORIES OF THE STREET CLINIC

When it comes to moving around the city, it's important to understand that the city, or the layout that delimits the municipality, is not exactly the only territory of the street clinic.

The days were usually busy, as the team started early in the morning and had a schedule with several places to visit. They often had to travel to various parts of the city, and not infrequently the team came across emergency situations that led to changes in their route. This ranged from someone informing them of a person who had been injured and needed care, to family members calling to inform them of a situation that had become a matter of priority.

Street clinic teams are open to unexpected encounters and will therefore frequently have to make journeys that are not shown on official maps of the municipality's urban space. It was necessary to understand how the user got around, how they lived, what they liked to do or who they hung out with, to then decide on the best search route according to their needs.

One scene that affected the researcher took place during a call at the entrance to a wooded area in the urban region of the city. While we were talking to the residents, we became aware of a service user who had diabetes and was a crack user. We needed to find them to follow up on the assistance already provided by the street clinic team. The team set about thinking about how to find them, and the psychologist began the exercise of constructing an image, for me, of the service user's own travel map, using points of reference from their life. Phrases were constructed to indicate the places the woman used to pass through, including the forest we were in. She used to walk near a public building in the morning, and if we didn't find her there, we could look for her in the area where another service user used to stay, as they both used to hang out together. The worker chose to wait there because, according to the map she had constructed, it was possible that the user would pass by before we had completed the service we were providing at the time. To the surprise of the researcher, who wasn't expecting such an outcome, the user was seen walking down the street a few moments later.

There is something exceptional about the contingency within this story. A recurring feature of the street clinic team was the recognition of the possible territories that the team knew and sought to understand. Some places function as shelters and more fixed points for some homeless people, while for others, the same places only function as a waypoint on their daily commute.

One concept that can explain how we came to understand the notion of territory, together with the street clinic team, is one of many offered by Milton Santos (2005). In the text The Return of the Territory, he presents territory as something constructed and determined from a social reality and which escapes the notion of region. He offers a new perception of space, which functions differently, describing it as horizontalities and verticalities, with horizontalities being the domains of contiguity, territorial proximity, and verticalities being the points distant from each other, linked by forms and social processes. These vertical and horizontal territories occur at the level of the city's organization and are produced according to their use. According to Santos (2005, p. 255, own translation): "[...] it is the use of the territory, and not the territory itself, that makes it the object of social analysis". Consequently, we must understand that staying in each territory depends on our condition and is necessarily linked to individual or collective existence.

Territories, in this multiplicity, can take on overlapping functions even though they are in the same space (Santos; Souza; Silveira, 1994) – they can be made up of contiguous/horizontal places and places in networks/vertical places. However, it is also the networks that make up the banal space, which the author reclaims as an element of territory in a broad reading of geographical space, in which territory is one of the categories of social analysis that encompasses human beings and their productions (institutions, organizations, etc.) (Santos, 2005). Thus, banal space can be made up of the same references to places, the same points of reference, but with totally different or even antagonistic simultaneous functions.

This radical idea, conveyed by Milton Santos' (2005) concept of banal space, became noticeable during the experience, when the same point in a territory could function as a shelter, a meeting point, a place for drug use, a resting place, among others. As the territory became known to the street clinic team, its functions became clearer, since it could subsequently be used to carry out activities, in accordance with care processes. This vision of the multifaceted territory enabled the street clinic to operate in a way that was closer to the reality of its users, while at the same time understanding the way of life practiced there. It often made it possible for care to produce connections with other points in the territory, through the functions that were now known and evident there, connections that were sometimes formed through daily work with people living on the street.

These functions, which can be articulated by territories, form a network in which vertical points connect according to social processes with distant points in space - horizontal territories are established by their proximity (Paula; Gomes; Toniolo, 2021; Santos, 2005). The street clinic uses the horizontal urban territory to move to the necessary vertical points. An example of this way of operating was seen in the connections made at the Specialized Reference Centre for the Homeless Population (Centro POP). They connected with points where groups of homeless people lived, which in turn connected with a shelter in another part of the city, and so on. We were witnessing the formation of vertical points in a horizontal space within the city through which the street clinic was moving. It was difficult for those who weren't involved in the process to be aware of them.

If, on the one hand, there are spaces that converge with the understanding of the territory-network and which are established by connections that are already regulated and scrutinized within an urban space – rationalized by street sections, blocks and squares, for example – on the other hand, there are also spaces that flow through another regime of existence, which converges with the understanding presented here of banal space, in which encounter is imperative and which forms true living networks (Merhy *et al.*, 2016b). It is these living networks that will dictate how flows are constructed and dissolved in the dispute with the rationality of metrics, walls, and organizations, competing meanings in the face of lived affections, be they of joy or sadness (Merhy *et al.*, 2016b).

By visiting environments that escape the structured logic of the health system, the street clinic gets closer to living networks. These meetings take place in squats, viaducts, woods, vacant lots, abandoned buildings

and even in places that, at first glance, don't seem to be related to street clinics' work, such as houses and condominiums. Recognizing the heterogeneity of the homeless is not related to prevailing stereotypes in society, but rather to the places that need to be navigated to provide care for these people. The intrinsic immanence of living networks thus emerges at the organizational level through a territoriality recognized by the street clinic.

During the experience, it became clear that the empirical knowledge of street clinic workers about this network of vertical connections throughout the territory constituted a way of working that characterized the service itself. Despite being itinerant, the work process is not limited to moving around circumscribed or neighboring regions, but rather to seeking connections between places and territories that are relevant to care and expanding access to users, stressing the living networks that can emerge.

By establishing connections and networks, the street clinic provides a service that can give visibility to these people and guarantee them access to other services. The clinic recognizes and reaches the places where people live, while other services or even their neighbors don't know them at all. There is also the affirmation of access to services in which the barriers are caused by the homeless person's own body, generating signs that limit and hinder their access to the Basic Health Unit and other points in the care network. These experiences corroborate studies that have shown difficulties among this group both in approaching the services of the Unified Health System (SUS) and accessing these services (Oliveira *et al.*, 2021; Valle; Farah, 2020).

It was in this networking and connection building that the street clinic demonstrated its potency. For example, on the many occasions when they were unable to transport the user in the street clinic's car – as this is not permitted in the municipality – the professional would contact the ambulance service (SAMU). After that, the professional would accompany the user to the Emergency Care Unit (UPA), since the members of the street clinic were often the only professionals the homeless person trusted - they were the people they knew and who could offer information during the ambulance service care.

This way of creating networks, activating them, and moving between them in the territory ends up creating a unified health service. This is achieved by getting close to the homeless person, by recognizing and getting involved in the territories connected by vertical points, which may be seen as trivial by other health professionals and services, but which, on the contrary, support and enable this construction. The street clinic professionals know the woods, trap houses , viaducts, squats and, above all, the people who live in these places by their names, nicknames, and conditions. In this way, a bond is created with these people that is not limited to the health service environment, but to the very reality in which they live. The street clinic team thus acts as a potential producer of care, guaranteeing access to health care networks within the Unified Health System.

## THE HOMELESS PERSON BETWEEN THE SMOOTH AND THE STRIATED

The street clinic operates in a territory that can be viewed through its horizontal and vertical aspects in terms of the organizational level of the city itself and which, at the same time, seeks to implement its actions through living networks, where meeting users is its imperative. During the experience, the tension between these possible ways of working was noticeable, which generated many discussions and debates within the team itself. This is because, if on the one hand there is a construction of horizontal and vertical territories that are established in the urban environment experienced, on the other hand there is a construction that precedes the very production of these places.

In these territorializations and deterritorializations, there is a process of becoming that is therefore constant and immanent to the very relationships of the person living in the social machine. According to Deleuze and Guattari (2012), it can be understood that there is a level of organization that seeks to striate this territory, consisting of the contained flows and organization of the city, in which there is the correct

place to walk, live, take the bus, drive, etc. In other words, there is a surface divided into ranges and sections. There is also the striation of time, in which things happen at certain times of the day, for example, the increase in traffic, peak hours, the opening and closing of shops. All of this demonstrates that the city space is striated par excellence; it needs a rigid layout to function, instituted by the state apparatus.

If there exists a space that has been developed in the pursuit of the striation of this surface, there is, in the same interplay, a space of a different nature, smooth, unlimited in all directions, centered, in a continuous variation. It is in this space that the events take place, in other words, the meetings that produce a living network, in which the formations have less relevance than the perception of the forces of the event. There is thus a dispute that never ends because smooth space can always become striated, and vice versa. However, the ways of living in these spaces often produce an attempt to subjugate one to the detriment of the other. The city can be seen as an attempt to subjugate smooth space (Deleuze; Guattari, 2012).

The city is considered to be a space that is not self-contained, but a place where there is a continuous movement of individual and collective disputes. Under the rule of capital, the contemporary city seeks a way of living that aims for the accumulation of capital itself, creating and destroying territories in the urban meshes themselves, so that striation is its basic condition. By organizing and scrutinizing life, validating certain modes and subjugating others, the city produces subjectivities. If it produces subjectivities, it is because in these disputes there is the potential for recognizing and valuing singularities – a subjective city (Guattari, 2012).

When I met some of the users that the street clinic assisted during this period, I could see the tense relationship between the smooth and the striated, as they were not guided by the city's strict layout. These tensions arose when the researcher encountered city environments that were not designed to operate in certain ways – for example, the collection of tests and the application of dressings in a public square where several homeless people lived, and which had been renovated after the pandemic. The installation of a surveillance system turned the square into a hostile environment for those people – the smooth environment became striated.

Other scenes make these "smoothenings" clearer. For example, at a certain moment the team needed to find a user, but any frame of reference pointing to her possible whereabouts was not in the striated and rationalized city. For the street clinic team, looking for the person in streets, avenues, buildings or even squares would not be a viable option. We had to get tangled in paths, wade through streams, urban forests and abandoned structures. The striated territory made no sense for the street clinic's work, except in terms of understanding its tension with the smooth space.

The urban environment functioned as a desert to be slid through, with oases to be created or destroyed as they moved. While the street clinic and other public services make their journeys by car, moving between the horizontal and vertical points of the organizational level of the territory, the users seemed to move in an intensive way, often guided by their feelings. In this case, the street doesn't become a necessary path, the forest doesn't become an obstacle to get around, but rather points where they establish themselves as they glide through a specific territory. The existential territory is built up as they navigate the tension between the smooth and the striated environments, deriving from their intensities.

Often, in conversations within the street clinic itself or with other services, the notion would emerge that a particular homeless person was always in a place between the vertical points already mapped and known by the service. However, when trying to visit these users, they were often found on a "schizophrenic walk", as Deleuze and Guattari put it in The Anti-Oedipus (2011). They were walking according to their intensities, in which the physical and temporal spaces striated by the city made no sense. They strolled through streets, alleys, wastelands, streams, and rivers, without a very specific destination, but rather as if they were gliding through places.

This way of living the urban territory exercised by homeless people differs from the mode of organization to which the contemporary city is subjected, promoting tension between the services involved and health work. Merhy (2005), thinking especially about health work, brings up the concept of soft, soft-hard, and hard technologies, referring, respectively, to the technologies that encompass the relationships between subjects that take place in meetings, those that encompass organized and structured knowledge and those technologies that lie in material resources. This way of understanding these health technologies exposes the constant relational potential between ways of producing care.

However, depending on how these technologies are related, the production of care that takes place in the act – known as living labor – can be subjugated by hard technologies, resulting in an imperative of dead labor. In other words, work that is not aimed at any product, but which seeks to regulate with rigidity in the face of protocols, equipment, and regulations. This limits the worker's own freedom and creativity, which is inherent to living labor in the act (Franco; Merhy, 2012).

Modern north-centered Western society tends to establish a rationality within the city, in which everything conspires and functions according to an expected way of living, of getting around, constrained by the state apparatus. When some of the homeless people do not act in accordance with urban rationality, the equipment and services designed for the general population are not prepared to give access, as they do not provide the soft, soft-hard, or hard technologies that enable such care (Merhy, 2005).

The homeless population's difficulty in accessing these services has already been demonstrated by other studies (Cervieri *et al.*, 2019; Lira *et al.*, 2019; Neves-Silva; Martins; Heller, 2018). Here, it is seen not only because of the way services are organized, but also because of a difficulty in recognizing that those who are homeless often end up using the urban territory in a way for which the rational way of constructing services and public policies is not prepared.

This way of inhabiting the cities, which deviates from modern striated territorial conventions, is usually enforced by the state apparatus through repressive public security policies, which is unlikely to guarantee access to health care for this population. Therefore, homeless people, who previously faced challenges in terms of access and visibility in the health system, have found themselves vulnerable to the new situation during the Covid-19 pandemic (Nunes *et al.*, 2021). In this context, the street clinic functioned as one of the services that managed to reach these people, while other services seemed to inhabit distant, not to say non-existent, territories for the homeless population.

## BY WAY OF CONCLUSION: BEYOND THE PANDEMIC

In view of the cartography presented, while accompanying the street clinic guide workers in the construction of maps, the street clinic team's potential to move through territories that are unusual for other services in the Unified Health System network in the municipality became apparent. The street clinic's actions often encountered barriers in the face of changes in work processes resulting from the covid-19 pandemic, but they also encountered barriers that had already been established historically, reflected in the difficulty homeless people faced in accessing other Unified Health System services.

It was also possible to see that many homeless people may not travel around and use the city in a streamlined and rationalized way. These living people are often not guided by such an organization, but rather by intensities, which evade any prior organization. This way of living in the city, being singular and unique, brings to light the need to get closer to and work with services and equipment that promote the integration of homeless people with the various points of the care network, with the aim of producing care.

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