

The territory in research, the territory of research: the leading role of territory in participative research-intervention*

Território na pesquisa, território da pesquisa: protagonismo do território na pesquisa-intervenção participativa (abstract: p. 14)

Territorio en la investigación, territorio de la investigación: protagonismos del territorio en la investigación-intervención participativa (resumen: p. 14)

Iacã Machado Macerata^(a)

<imacerata@id.uff.br> 

Christian Sade^(b)

<christiansadevas@yahoo.com.br> 

Júlia Florêncio Carvalho Ramos^(c)

<julia.ramos@estacio.br> 

* This article is a result of research financed through a scholarship from the Coordination for the Improvement of Higher Education Personnel (Capes).
^(a,b) Departamento de Psicologia, Instituto de Humanidades e Saúde, Universidade Federal Fluminense. Rua Recife, lotes 1-7, Jardim Bela Vista. Rio das Ostras, RJ, Brasil. 28895-532.
^(c) Departamento de Psicologia, Universidade Estácio de Sá. Macaé, RJ, Brasil.

The article discusses the notion of territory in the practices of health care and research based on the experience of participative research-intervention about the work of a Street Medicine team. The practice of care analyzed is characterized by a specific mode of relationship with the users' life territories. To understand this relationship, it was necessary to broaden the discussion, reflecting the Primary Health Care in the Brazilian National Health System (SUS) and the meaning of embracing the leading role of the territory in this scenario. The methodological approach adopted implied building a research device in which the territory was the protagonist of the investigative process, leading to a reflection of the participation of the territory in participative research-intervention. At the end of this process, an approximation between caring and researching was analyzed, expanding the possibilities of understanding the role of the territory in both practices.

Keywords: Territory. Street medicine. Participatory research-intervention. Primary health care.



Introduction

Research methodologies can be differentiated according to the type of relationship they conceive between subject and object of research¹. Such relationships determine different procedures in an investigation, including the treatment given to the territory. Traditional approaches to research treat territory as often equated with its spatial-temporal location, inhabited by subjects and objects that differ from it. This text develops the proposition that besides a dimension limited to its historical and geographical location, the territory delimits a field in which a complex network of actors and elements share experiences. This situated experience, in a certain space-time and built through an inextricable network of actors and elements is what we will call territory.

This discussion emerged as a result of the development of a participatory research-intervention experience² (approved by the Research Ethics Committee of the School of Medicine, Universidade Federal Fluminense/Plataforma Brasil, process CAAE: 09987112.0.0000.5243) together with a team of homeless street clinic, also known as POP RUA, which will be the object of analysis during this article.

The Homeless street clinic is an itinerant health service, part of the network of Primary Health Care (PHC) in the Brazilian National Health System (SUS). This service is directed to homeless people, and is composed of multiprofessional teams that aim to guarantee the comprehensiveness of care for this population. A team that operates in the city center of Rio de Janeiro carried out the POP RUA survey. One of its results was the formulation of a technical document³ regarding the practice of service care, co-authored by researchers and workers.

The care practice developed by the POP RUA workers requires the constitution of a specific relationship with the users' life territories. In order to understand this relationship, it was necessary to broaden the discussion, reflecting on the production of health in the PHC within the SUS and what it means to embrace the leading role of the territory in this scenario. Following this discussion, the participation of the territory in participatory research-intervention was debated. Taking the clinical practice of the POP RUA as an object of study generated effects for the proposed methodology, making it necessary to understand the leading role of the territory in the investigative process and not only in the care practices at SUS. Thus, it was necessary to understand how the territory participates in research practices and how it can have its leading role acknowledged. At the end of this journey, it was analyzed an approximation between caring and research, expanding the possibilities of understanding the role of the territory in both.

Territorial orientation in SUS: the POP RUA and the leading role of the territory

Brazilian health and psychiatric reforms were contemporary movements, which included those linked to the struggle for political openness and re-democratization of the country. Despite their distinctive actors and histories, the reform movements in Brazil have common roots and strengthened each other. The wider confrontation with the centrality and verticality of the power of the movements for re-democratization was translated in the field of health into questioning the centrality of biomedical power/knowledge and the hospital-centric healing model. Such questions were connected



and fed from the discussions that took place in the international context, linked to the resignification of the specific concept of health, no longer defined as absence of diseases, where the importance of social and mental dimensions, besides the biological one, was also affirmed⁴.

The principles and guidelines of the SUS instituted in the 1988 Constitution are the direct legacy of these reform movements. The principles of comprehensiveness and participation in the SUS induce the system to promote actions built in the midst of relationships of production of health and life, both of subjects and collectives, and no longer planned according to exclusive biomedical criteria. Producing health started to involve listening and including the experience of those you care for, taking it as the protagonist of your own care process, as expressed in the proposal of the expanded clinic⁵.

Following this direction, Mental Health (MH) and Primary Health Care (PHC) policies are formulated, each proposing in its own way those care actions oriented to the accomplishment of such principles. Among the central common tenets to both policies, we can highlight the confrontation with the hegemony of hospital forms of care - represented by the general hospital and the sanatorium - and the guarantee of rights and citizenship as fundamental actions of care. In this sense are the stakes put on the Harm Reduction (HR) paradigm, which questions hospitalization and abstinence as *a priori* treatment strategies, therefore shifting the substance's drug problem to the way related to, by the subjects in their context⁶. There is a displacement of the place where the treatment and the production of knowledge regarding the user - be it the insane, the junkie, or the patient - passing from the doctor and the hospital to the territory⁷. MH activities do this through the investment in psychosocial attention, seeking the treatment of the user in his community, including the participation of family members and other networks of relationships. Still in the scope of MH, HR proposes actions in the place where drug users live, including users and former users as team members. The PHC teams are located and operate close to the users' living spaces, also incorporating community residents to the care teams (Community Health Agent - CHA), redirecting their actions towards the territory.

An indication of this redirection, common to both PHC and MH policies are the home visits. As explicit in the name, the visits consist of team workers going to the users' place of residence. This device is considered key for the development of health promotion and prevention actions, since it can reinforce the links between the team and users, enabling health practices in tune with the space where users' lives unfold. The term domicile in the expression home visit provoke some misunderstanding, since a person's home is not always a domicile, as in the case of the street population, which ends up not receiving attention from many services because, among other factors, it is not domiciled. The fundamental aspect of the visit is the presence in the place where a person's life unfolds, including his/her home, but also the surroundings, his/her community. This departure from the service to the community has the function of inducing a certain functioning aiming to operate through bonds, the relationship based on trust and mutual exchange, in a way that the practices of care are in tune with the situational experience of professionals and users, producing their interventions from the experiences lived in a shared manner².

Therefore, an operational similarity is observed between the logics of care that permeate PHC, MH and HR: a certain way of seeing and acting in the territories that express the bets that were made in the formulation of SUS itself. The practices conveyed by these paradigms have as methodological directions to inhabit and follow the user's life territories, and to produce health in and through the user's life territory, using the territory as a source of resources for health production. The work in and through the territory has the sense of accessing the users' ways of life in order to build new possibilities of care.

It is by the agency between PHC, MH and HR that the POP RUA was implemented⁸ in downtown Rio de Janeiro in 2010. The territorial logic of the services of PHC, MH and HR, although giving relevance and sustaining their practices in the territory, discursively affirmed a fair need for a leading role of the user - a first movement against the authoritarianism of the biomedical model, expressed in the centrality of the doctor and the hospital. We identify in the care practice of POP RUA, the emergence of another protagonist, which does not exclude that of the user, albeit re-signifying it: the leading role of the territory.

The ways of life on the street are extremely diverse and even incomprehensible to the most common ways of life in a society. A service that seeks to build care for people who live on the streets must be open to this otherness, to these unfamiliar ways of existing. In the experience of POP RUA, it was not possible to provide care by pure reference to health values and concepts strictly linked to the knowledge instituted in the academic fields. There is a diversity of ways of being and caring that take place in/by the street. It was essential to POP RUA to build care in articulation with the ways of functioning of the street. In this sense, the territorial orientation already taken by PHC, MH and HR policies is radicalized in this service, because the care carried out based on the agency between health practices and ways of life on the street, was based on cohabitation and sharing of a territory.

The sharing of territory was not only due to the fact that teams and users shared the street space. Taking care of a person or group living on the street requires access to the practices and relationships that characterize homelessness in broader dimensions - political, cultural, social dynamics - but also situated - in that space, at that moment, for that person. It is in the territory that these singular and collective dynamics materialize and are engendered. What is learned in the practice of this service is that the territory is not confused with the geographic location, it is a process of production located in the midst of which subjects and spaces are constituted.

For the geographer Augustin Berque⁹:

To pretend that territories are, in fact, a neutral space, and that our ties with them are only subjective projections, is an interpretation that excludes the primary reality of any territoriality. (p. 15)

The understanding of a subject who exists outside her/his environment would constitute an abstraction, which progressively reduces the environment to an objective and manipulable environment. Such abstraction promotes a mutilation of human existence, since it is based on the notion of an absolute individual subject, detached from his environment. Similar



operation is promoted with the notion of object, also an absolute abstracted from its environment. For Berque, territoriality is a dynamic relationship between objectivity - space and bodies - and subjectivity - the existential and experiential relationships of those living in a given environment. Of which the author calls *mediania*: the dynamic junction of the two “halves” that form the human being, his individual body and his medial body, the means shared with other beings and that is, therefore, common to them.

Each one, in his/her own way, establishes ties with certain places and the relationships of territoriality go beyond the individual, integrating him/her into a world, where the inner world of each person is in continuity, not only with that of other people, but with the environment. Following Berque, persons are implicitly the territory, which, in turn, supposes the people. In a correlated way, the ethnologist Von Uexküll¹⁰ states that every lived space is subjective, and to such extent, each living person would own a version of the world, what he calls *Umwelt*, or world of one’s own: world of action and world of perception, which form an integral whole. Each being has and is held in his own world, belongs to a world different from the others, which contains objects and perceptions that have meaning only within a specific life. Thus, also for Von Uexküll, no space is independent of the subject, thus existing neither subjects in themselves or objects in themselves. Articulating these propositions, we understand territory at the same time as a common space between beings, shared, but shared in singular parts - and a singular common.

In the same sense Guattari¹¹ defines territory as an existential domain that is produced through the collective and impersonal agency of heterogeneous components, constituting complex forms-states: a subject, a group, a community. But these bodies will always be in adjacency, or in relation to, delimiting and exchanging with an alterity that is also subjective, also in movement. This makes these complex forms-states to be temporary stabilized. With this definition, subjectivity gains a different sense from a merely symbolic internal instance of the subject. It is not that space influences the subjectivity of a subject: space itself contains a subjective dimension, by containing in itself enunciations, affections, and pre-personal intensities. The subjectivity takes place in a temporalized space, the space in pulsation, temporal rhythm, alive, as a tangle of paths that are composed by the components of the media, in a network of actors¹². The territory is a situated relational experience, a world for a subject.

Although geographically a certain street in which a person lives and in which a health worker works may be considered to be the same, from the point of view of the experience of each one of them, such street may be absolutely different, to such an extent that it cannot be said to be the same street. In fact, the street only remains the same in a perspective in which a previously instituted world is conceived, of which the street is a part, regardless of the experience one has of it. From another point of view, it can be considered that the street depends on those who relate to it, in the same way that they are produced in the encounter with the street: the so-called street dweller effectively becomes so, in the process of settling in it; health workers constitute themselves as care agents when this care is implemented, never before.

The care action carried out by POP RUA involved the construction of a shared space of experience, in order to pay attention to strategies that take place in the street and build others in agency with these. Accessing the experience of a territory meant being affected



by its production process and transforming jointly with it. In order for care to effectively take place, it was necessary to produce a new territory, to be inhabited by users and health workers, in which the joint construction of care took place.

The care that was verified in POP RUA, in addition to be focused on the subject and not on the disease⁵, was built through the territory, embracing the subjects and accessing the production processes of their existential territory. The clinic does not belong to the territory; it is a clinic of territory². The preposition “*of*” holds multiple “prepositive” meanings for the relationship between the clinic and the territory: in, with, in, between, to, per, facing, from. In the clinical action of POP RUA, the territory itself takes care: care agents that are part of the territory are activated, passing through people (merchants, guests, residents, institutional and non-institutional agents), diverse institutions, pets and even architectural elements and objects.

An example of this diversity of elements is the situation in which the team, lacking a place to stay for three users diagnosed with tuberculosis, made a temporary ward next to the service, using the marquises, the blankets that the people on the street keep in the drains. On another occasion, it was identified the need to take care of the user’s dog when he needed to be hospitalized and had no one to take care of the animal. The hospitalization would not be subjectively possible for the user if he had to abandon his dog. In other case, it was noted the participation of a journal seller in the administration of psychiatric medication for a user. Although the health network is very precarious, it showed a remarkable capacity to activate resources - even if scarce, but necessary - present in its own territory.

The clinic is in the territory and is modified by it, and can involve sewers, dogs and journal sellers, for example. It also modifies the territory, turning the sidewalk into an infirmary, the dog into a family member and the newsboy into a caregiver. On the one hand, the leading role of the territory is activated, because it is the environment through which life develops, the concrete materiality of life conditions. On the other hand, the clinic’s action potential is amplified, because it is in the territory that the complexity of a life presents itself. Care gains another connotation: it is not only the procedure of a specialist; it is a network of support and treatment that is activated, involving the most diverse actors. The role of the health specialists is transformed: it is up to them to use their knowledge in order to cultivate a present potential of care to a greater or lesser degree in the territories. In this sense, those who intervene are not outside the territory: they become another element of it. The proposition of territory as a relational space, and, therefore, space for the genesis of subjects, groups, communities and team work, imposes the understanding of care and health in broader terms, including the idiosyncrasies given in each situation.



Research practices and territory

Traditionally, the production of knowledge adopts a representative perspective that supposes independence and separation between subject and object of research¹. In this mode of seeing and practicing research, the territory of life of the researched field can be apprehended in two distinct ways. The first is that of experimental research, for which the setting in which the research takes place (the laboratory) must be purified so that the variables that compose it are submitted to rigorous control. The control of variables allows the establishment of a causal relationship between the aspects that determine the phenomenon studied. For this type of research, it is necessary to exclude the multiplicity of variables and components that the territory offers. Within this same perspective - which we call representative - there are also the so-called field researches, whose pretension is to understand certain phenomena as they happen in a certain environment. In this case, it is observed the need for another type of control, different from that which is made of the variables in laboratory conditions: control of the research device, so that it does not interfere in the phenomenon studied and allows its apprehension.

What is observed as common between laboratory and field approaches that are described, is the fact that both are based on a separation between subject and object of knowledge, where to know is to unveil a given reality, to represent it. Subject and object exist as such, prior to the relationship that is established between them.

The cartographic perspective places its bets on the inseparability between subject and object, in their coemergence¹³. It does not separate subject and/or object from the relationship that constitutes them and it does not conceive a space as being independent from the subject who experiences it. From a cartographic perspective, research implies necessarily inhabiting an existential territory¹⁴. In the field of research, a space is not an objective piece of data that can be totally controlled by the researcher, nor can the practice of research be controlled so as not to produce interference in the space where it operates.

The relational space constituted in the encounter between research and field, we call the territory of the research. To consider a territory of the research is to approach the singular and at the same time, shared and situated experience of the subjects involved in the process of an intervention-research¹⁵. It is a relational plan where the process of production of knowledge and production of subjectivity will take place. If the relationship is the medium that constitutes the terms involved in a relationship of production of knowledge - subjects and objects - the territory of the research for participative research-intervention is the place where the processes of subjectivations and objectifications that occur in the research take place. Such processes only take place in a localized manner, in a specific space-time domain.

The POP RUA research has built a territory in the middle of the one of the team. In the same way that care involved attending and cohabiting the territory of the street, the way the methodology of the research was built could not dispense the work of listening to the team and cohabiting in its territory. The care exercised by POP RUA was not only guided by the protocols and procedures already known, to the detriment of the know-how that circulates in the streets. In a similar way the research was not the field to apply a project. The knowledge generated in the research relied on the leading



role of its participants and, more intensely, on the leading role of the relationship space between research and the field. It was in the encounter between research and field, that the research design was agreed upon.

The arrival at POP RUA involved entering its territory in the city of Rio de Janeiro: strolling frequently Praça XV, Largo da Carioca, Lapa, Rua da Relação, Praça da Cruz Vermelha. All the gestures and intensities present there: hurried steps, business, exchanges, prophecies of the end of times, observers, police repression, masses of people, improvised beds, informal commerce. Making this journey created an environment for the researchers, showing the complexity of the landscape in which the care was taking place: the dynamics that involved that territory, how the actors positioned themselves in the street, which spaces were more propitious for people in street situations, what kind of work they did.

The research involved the creation of a device called the Workers' Intervention Group (GIT). This group took place at the POP RUA headquarters in intervals that varied between weekly and biweekly, with meetings of two hours for two years. Due to fact that it was present in headquarters, GIT established itself as a specific territory in the middle of the POP RUA territory.

The direction to produce with the team knowledge about their practice was to understand that cartography is in itself to access the experience¹⁵. We understood that this access to the experience would be made possible, as a priority, by living in an existential territory. The perspective of the population is that the territory is not a finished object about which to speak and which may be manipulated, but a means with which one is implicated in the construction and which has the effect of self-construction. To inhabit the territory means to be present, turning our attention to the emergence of another territory that is formed when inhabiting, to the differentiations that are produced in the field and in research. The existential territory in this dwelling becomes a territory of shared experimentation among the various actor-subjects as well as other elements present.

Every experience is always rooted in a territory. Therefore when we refer to the territory of the POP RUA we refer to the situated experience, in the time and space of those workers, in agency with the most diverse elements that compose their work space: institutional, social, health field processes, the reality of the streets of downtown Rio de Janeiro, the dynamics of social exclusion, etc. When we refer to the territory of the research, we refer to the territory that emerges between research and field.

Both the methodology and the object of the research itself were constituted in the encounter between research and POP RUA. The research, which began at the end of 2012, initially had the problem of the access to the street experience by the worker. In the initial conversations for the agreement of the research with the collective of the team, there was a refusal to this proposal that, as we later understood, did not refer directly to the proposal itself, but to the research in general. According to the workers, previously carried out surveys in that service collected the information and presented no counterpart for the team. For them, the researchers took ownership of what the team had created and listed as their findings. After some years of intense invention of care practices for the street population, the team manifested



its desire to be the author of the knowledge about its practice. The team itself had already initiated this process: the workers had produced statements guiding their practice. However, they had not been able to follow up on the endeavor due to various difficulties. In the space of the initial research agreement, the collective that gathered workers and researchers understood that the team's demand for the research was that it should be able to support them in formulating and enunciating the directions, method, and concrete arrangements for their care practice. This demand from the workers was considered legitimate and favorable to the realization of the research itself, contributing so that the participants could become worker-researchers alongside the researchers-academics. Participatory research-intervention gained institutional support⁵ becoming research-support¹⁶. It constitutes a space of production of knowledge of the team about its care practice, as well as the research on care in POP RUA. The institutional support in the health field was assumed as an intervention methodology that does not propose the establishment of a hierarchical relationship between those who intervene and those who receive the intervention, but a lateral relationship between different institutional positions: the focus of the supporters is not their conceptions, their knowledge, but the existential territory of the team supported¹⁷. A research-support proposes that the research intervention be positioned from the problems and questions posed by the territory of the research, and not by problems and questions prior to, and outside of the field researched.

In the first two field trips, the GIT meeting did not take place. In the first week the manager and the psychologist couldn't participate and the other workers present didn't agree to start without their presence. On that occasion, we stayed by the Praça da Cruz Vermelha surroundings, waiting for the arrival of one of the two professionals. The following week, one user was threatening to kill the psychologist and the whole team was mobilized by the problem. That day we remained in the unit until the situation was resolved. We lived in that moment a situation that marked the daily life of POP RUA: the precariousness of working conditions, the pain with which one deals, the institutional violence.

In those meetings when the GIT was not held, we started to inhabit the POP RUA, observing the users' drawings on the walls, the installations made by the team, pictures, phrases, war cries. Inhabiting the territory first required understanding it from how it presented itself, but also feeling it and participating in what was happening in that space-time. From the point of view of the researchers-academics, it was necessary to undo all previously constituted knowledge about the POP RUA and learn how to savor the geography of the new territory that was made there. To inhabit was not an initial stage to begin the research, on the contrary, it involved seeing, listening, and knowing, in the course of all the research. It also consisted in being seen, in showing our presence: to remain with the team in moments of tension and to keep on the GIT event going, even when there were few people or unfavorable conditions.

The research was supportive, because besides co-producing data for his research activity, it also had the task of creating conditions for the recruitment of a collective of workers capable of thinking and enunciating their practice, making the passage from know-how to a make-know. This means that what the team knew how to do was not given, nor how to know, nor how to have a ready-made one. The process



made conditions both for knowledge to be produced and for the practice itself to be recreated in the midst of the exercise of expressing it. To express the practical experience was to access the experience of caring in its collective dimension, the common experience of caring. This common was lived and meaningful in different ways, but maintained as a base the same plan. Not infrequently there were affections of surprise, agreement and strangeness in relation to the perspective of a coworker about a certain subject. The differences were recognized, but also considered legitimate, valid. The collective and singular experience was validated, through the device of access to it. The work of the research was to create the conditions for the group gathered there to access and share each other's experience, collectively building and sustaining the territory of the research. Such conditions were created by the invitation to participate and by listening, that is, by the co-management¹⁸ of the discussion.

However, the support did not only have an effect on the team's work. The territory of research also interfered in academic research: its researchers, its methodology and its products. This territory formed by workers and researchers allowed the constant questioning and displacement of institutional and historical vectors that tend to crystallize power relations between those who research and those who are researched. The territory of research allowed the support to be a mutual process, destabilizing the colonizing logic in which the academic world would be the protagonist, having the power to produce knowledge and support.

Understanding research as building and being simultaneously constructed in a territory of relations with the field enables another connotation to the notion of object. It is no longer a reified object, a data to be known. It is an object-event¹⁹ that co-emerges in the agency process between research and researched practice. In the act of saying and systematizing statements about care in POP RUA we were at the same time participating in the process of care and creating a sense of care within the team.

What was discussed at GIT about care was not a single voice enunciation; the content of the technical document was not enunciated consensually. There were often opposing and even conflicting positions in the discussion of a specific topic. The key to the production of a common territory of research was to make dissenting positions coexist, avoiding to reconcile them or to solve them in some way. It was not sought an immediate resolution of a certain impasse, but to support it, to leave it open. This posture of co-management⁵, created the conditions for the group to constitute itself as a territory for formulating problems of all kinds: health, city, existential.

The construction of this territory made the research and the care of the team interplay with each other through the methodological arrangements that were created. The space of collective production was (re) defining subjective positions, from the research space itself. The management of discussions, the construction of the memory of discussions, the way of guiding the content of memory in texts was always defined in collective spaces. The designs and functions, pre-defined by the researchers-academics were transformed throughout the process and served only as a starting point for a first stage. The territory of the research was sustained by a meta-stability, a continuous updating, which was not based on coherence, but on the consistency of being within,



open and attentive to the process. Far from being a way of disorienting, such attitude was a commitment of the research to the process of research in the field, a commitment to the territory of the research that was being formed.

Territory in participatory research-intervention

We call the encounter between research and the field in participatory research-intervention as the territory of the research, because we understand that this is the space of genesis of the produced knowledge, space marked by a creation without creative entity. The produced knowledge is not exclusively of authorship of the researchers, not even exactly of authorship of the participants of the research. It emerges in the relationship, in the cohabitation. From this territory of shared experience, the subjects involved also emerge and re-actualize themselves; they are modified after exiting from the experience.

The way of conceiving the territory in a research on health care promoted approaches between research and care, bringing new meanings to 'participation' in research-intervention. In the care of POP RUA, the territory could not be treated as mere spatial delimitation. The senses of care present in POP RUA implied taking the territory as matter, means and end, making it the protagonist of care himself. For this team, caring also consisted in learning to perceive how the territory cared. The research on POP RUA adopted a similar perspective: the way of researching cultivated a space for relationships in which workers and researchers could make decisions, exchange, learn and create together.

Throughout this text, we aim to describe how the territory can have its leading role exercised and valued during the course of a research. Such leading role is intrinsically linked to the sense of participation that we want to affirm: a participation that invites co-management and co-authorship of research, which makes researched subjects participate and intervene in the genesis of knowledge, and researchers participate and intervene in health practices. It is understood that territory is the relational domain and the situated and concrete experience in which subjects and objects coemerge²⁰ and that it participates by modifying the subjects involved in the research and the objects of investigation. We can affirm that in participatory research-intervention the territory is a fundamental part of the process of knowledge production.

It is the territory, as a situated experience and relational plane, the element that may establish a plane of laterality and transversality²¹ between researchers and participants. It constitutes a heterogeneous common, sheltering the singularities, that can enlarge the possibilities of emergence of new meanings, new knowledge, new subjective positioning. The research, through the inclusion and in agency with the territory of the field, creates a territory of research, which is not private property of any subject, but space of common experience that shelters in laterality, both researchers and researched.

The attitude of the researcher is, on the one hand, an attitude of presence and porosity to the territory of the field, while on the other hand, an attitude of engagement and co-responsibility with it, giving up the perspective of absolute control over the research process. The establishment of a dialogic experience²², where



researchers can talk to the field, and listen to its “voice”, would define the participative character of the research. In this way, researchers and participants modify each other from the relational space that is built.

There is a bet on the territory that bridges the ways of producing knowledge in participatory research-intervention and the practices of caring for the POP RUA. On the one hand, it was observed that the way of producing care operated by the health team has contaminated the way of producing knowledge. On the other hand, the way of doing research has also contaminated the ways of caring. The very enunciation of the guidelines, methodologies and devices of care of the POP RUA has promoted transformations in practice, as it has been reported to us: “last week’s discussion made me rethink the possibilities of this case”, or “I changed my posture with the user X, following what I thought the function of the CHA could be”. Not only was research done regarding how care is carried out by a certain team; it was also a device that promoted care among workers and researchers was also effectively produced. Knowledge and care co-engineered in this participatory research-intervention: care generated knowledge, just as the production of knowledge promoted care effects.

The inclusion and the creation of conditions for the leading role of the territory proved to be strategies to face both the biomedical and hospital-centric centripetal forces in the field of care, as well as the sterility of the separation between subject and object, in the field of knowledge production. Research and care have affirmed themselves as participatory practices, of inclusion of the experience of the other and additionally, of building and sharing a common experience that is situated between those who care and those who are cared for, those who research and those who are researched. In participatory research-intervention, the researcher participates in the territory of the field being investigated at the same time as the territory participates in the research. The participation is a co-participation with mutual interference.

Authors’ contributions

Iacá Macerata: conception, design of the work; participation in the discussion of the results; writing of the manuscript and critical revision of the content. Christian Sade: participation in the discussion of the results; critical revision of the content. Júlia Florêncio Carvalho Ramos: participation in the design of the work, discussion of the results; writing of the manuscript and critical revision of the content; All authors participated in the approval of the final version of the manuscript.

Copyright

This article is distributed under the terms of the Creative Commons Attribution 4.0 International License, BY type(<https://creativecommons.org/licenses/by/4.0/deed.en>).





References

1. Silva AE, Passos EH, Fernandes CVA, Guia FR, Lima FR, Carvalho JF, et al. Estratégias de pesquisa no estudo da cognição: o caso das falsas lembranças. *Psicol Soc.* 2010; 22(1):84-94.
2. Macerata I. Traços de uma clínica de território: Intervenção clínico-política na Atenção Básica com a rua [tese]. Niterói: Universidade Federal Fluminense; 2015.
3. Passos E, Equipe Pop Rua 2012/2013, Grupo de Pesquisa “Enativos: conhecimento e cuidado”. Diretrizes, metodologias e dispositivos do Pop Rua [Internet]. Rio de Janeiro: Universidade Federal Fluminense; 2014 [citado 10 Abr 2020]. Disponível em: <http://redehumanizaus.net/acervo/diretrizes-metodologias-e-dispositivos-do-cuidado-no-pop-rua/>
4. Paim JS, Almeida Filho N. Saúde coletiva: uma “nova saúde pública” ou campo aberto a novos paradigmas? *Rev Saude Publica.* 1998; 32(4):299-316.
5. Campos GW. Um método para análise e co-gestão de coletivos: a constituição do sujeito, a produção de valor de uso e a democracia em instituições: o método da roda. 2a ed. São Paulo: Hucitec; 2005.
6. Lancetti A. Clínica peripatética. São Paulo: Hucitec; 2008.
7. Furtado R, Passos E. Espaço e loucura: uma análise dos espaços de cuidado na reforma psiquiátrica. In: Furtado R, Passos E. Saúde mental coletiva: clínicas e vulnerabilidades. São Paulo: Schoba; 2012. p. 409-30.
8. Macerata I. Experiência POP RUA: implementação do saúde em movimento nas ruas. *Rev Polis Psique.* 2013; 3(2):207-19.
9. Berque A. Território e pessoa, a identidade humana. *Rev Cienc Soc PUC-Rio.* 2010; 6(1):11-23.
10. Uexküll J. Dos animais e dos homens. Lisboa: Livros do Brasil; 1982.
11. Guattari F. Caosmose. Rio de Janeiro: Ed. 34; 1992.
12. Latour B. How to talk about the body. *Body Soc.* 2004; 10(2-3):205-29.
13. Passos E, Kastrup V, Escóssia L. Pistas do método cartográfico. Porto Alegre: Sulina; 2009.
14. Alvarez J, Passos E. Cartografar é habitar um território existencial. In: Passos E, Kastrup V, Escóssia L, organizadores. Pistas do método cartográfico. Porto Alegre: Sulina; 2009.
15. Kastrup V, Passos E. Cartografar é traçar um plano comum. *Fractal Rev Psicol.* 2013; 25(2):263-80.
16. Macerata I, Soares JGN, Oliveira AM. A pesquisa-intervenção como pesquisa-apoio: o caso do POP RUA. *Saude Soc.* 2019; 28(4):37-48.
17. Macerata I, Soares JGN, Ramos JFC. Apoio como cuidado de territórios existenciais: Atenção Básica e a rua. *Interface (Botucatu).* 2014; 18 Suppl 1:919-30.
18. Passos E, Carvalho SV, Maggi PMA. Experiência de autonomia compartilhada na saúde mental: o “manejo cogestivo” na gestão autônoma da medicação. *Pesqui Prat Psicossociais.* 2012; 7(2):269-78.
19. Fonseca TMG, Costa LA. As durações do devir: como construir objetos problema com a cartografia. *Fractal Rev Psicol.* 2013; 25(2):281-99.
20. Varela F. O reencantamento do concreto. *Cad Subj.* 2003; 1(1):71-86.
21. Guattari F. *Psicanálise e transversalidade.* Aparecida: Idéias e Letras; 2004.
22. Metcalfe A, Game A. ‘In the beginning is relation’: Martin Buber’s alternative to binary oppositions. *Sophia.* 2012; 51:351-63.



O artigo discute a noção de território nas práticas de cuidado e de pesquisa em saúde com base na experiência de pesquisa-intervenção participativa sobre o trabalho de uma equipe de Consultório na Rua. A prática de cuidado analisada caracteriza-se por um modo de relação específico com os territórios de vida dos usuários. Para isso, analisa-se a produção de saúde na Atenção Básica no Sistema Único de Saúde (SUS) e o que significa acolher o protagonismo do território nesse cenário. A abordagem metodológica adotada, por sua vez, implicou a construção de um dispositivo no qual o território foi protagonista do processo investigativo, levando a uma reflexão sobre a participação do território na pesquisa-intervenção participativa. Ao final desse percurso, analisou-se uma aproximação entre cuidar e pesquisar, ampliando as possibilidades de compreender o papel do território em ambas as práticas.

Palavras-chave: Território. Consultório na rua. Pesquisa-intervenção participativa. Atenção básica.

El artículo discute la noción de territorio en las prácticas de cuidado y de investigación en salud a partir de la experiencia de la investigación-intervención participativa sobre el trabajo de un equipo de Consultorio en la Calle. La práctica de cuidado analizada se caracteriza por un modelo de relación específica con los territorios de vida de los usuarios. Para ello se analiza la producción de salud en la Atención Básica en el Sistema Brasileño de Salud (SUS) y lo que significa acoger el protagonismo del territorio en ese escenario. El abordaje metodológico adoptado, a su vez, implicó en la construcción de un dispositivo en el cual el territorio fue protagonista del proceso investigativo, llevando a una reflexión sobre la participación del territorio en la investigación-intervención participativa. Al final de ese recorrido se analizó una aproximación entre cuidar e investigar, ampliando las posibilidades de comprender el papel del territorio en ambas prácticas.

Palabras clave: Territorio. Consultorio en la calle. Investigación-intervención participativa. Atención básica.

Translator: Félix Héctor Rigoli

Submitted on 10/18/19.
Approved on 08/31/20.