Intervention research as research-support: the case of POP RUA

A pesquisa-intervenção como pesquisa-apoio: o caso do POP RUA

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Abstract

This article discusses the production of knowledge in the field of public health, developing the idea of research-support as a modulation of participatory intervention research in the field of health. Participatory intervention research was used and perfected by Enativos Research Group of Universidade Federal Fluminense, in the scope of Gaining Autonomy & Medication Management (GAM) in the field of mental health. In these experiments, the production of autonomy and the increase of participation in health practices were in question. The issues of the field have ended up modifying their own research practices. This research used the same methodological approach of the intervention researches at GAM, in the interface between basic care and mental health, in a service of Street Outreach Clinic team (Consultório na Rua); in Rio de Janeiro, called POP RUA. This article is a mixture of report and essay which analyzes the transformation of intervention research into research-support with POP RUA, proposing support as a method to produce knowledge in qualitative research, in the scope of intervention research. Such transformation is possible because health production processes understood as inseparable from processes of knowledge production and care production are supported.

Keywords: Intervention Research; Research-Support; Qualitative Methodology; Street Outreach Clinic team (Consultório na Rua).

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Resumo

Este artigo discute a produção de conhecimento no campo da saúde pública, desenvolvendo a ideia de pesquisa-apoio como uma modulação da pesquisa-intervenção participativa no campo da saúde. A pesquisa-intervenção participativa foi usada e aperfeiçoada pelo Grupo de Pesquisa Enativos, da Universidade Federal Fluminense, envolvendo a Gestão Autônoma da Medicação (GAM) no campo saúde mental. Nestas experiências os problemas do campo modularam as práticas de pesquisa, cujo sentido era produzir de autonomia e aumentar o grau de participação nas práticas de saúde. Esta pesquisa utilizou-se da mesma abordagem metodológica das pesquisas-intervenções na GAM, na interface entre atenção básica e saúde mental, em uma equipe de consultório na Rua do Rio de Janeiro, chamada POP RUA. Este artigo é um misto de relato e ensaio que analisa a transformação da pesquisa-intervenção em pesquisa-apoio com o POP RUA, propondo o apoio como método para produzir conhecimento nas pesquisas qualitativas, no escopo das pesquisas-intervenção. Tal transformação é possível pois são apoiados os processos de produção de saúde entendidos como inseparáveis de processos de produção de conhecimento e produção de cuidado.

Palavras-chave: Pesquisa-Intervenção; Pesquisa-Apoio; Metodologia Qualitativa; Consultório na Rua.

Introduction

Since Enativos: Production of Knowledge and Care (*Enativos: Produção de Conhecimento e Cuidado*), a research group of Universidade Federal Fluminense, started researching and proposing interventions in the health field, it did so through the methodology of participatory intervention research, with the theme of Gaining Autonomy & Medication Management (GAM) in the area of mental health. However, in 2013, the group started a new research front, now in the field of primary health care. In 2012, the Ministry of Health established the Street Outreach Clinic (Consultório na Rua) teams,[1] a primary health care service that articulated, more directly, mental health practices and primary care. The group members then understood that in these new services there was an issue that they considered important: the care of the experience and the experience of caring. A research process has begun with the first team of the Street Outreach Clinic (Consultório na Rua) in the municipality of Rio de Janeiro, called POP RUA, which worked in the health programmatic area 1.0, in the downtown area. It was created in 2010 as both a Family Health Team[2] and a Street Clinic of Mental Health team,[3] which gave it unprecedented characteristics, serving as reference for the formulation of the Street Outreach Clinic Team (Consultório na Rua).

POP RUA was a service that gathered and articulated the logic of primary care (PC), mental health (MH) care and harm reduction (HR) care.

1 The Street Outreach Clinic team (Consultório na Rua) is a service provided for in GM/MS Ordinance No. 2488/2011 (Brazil, 2011b), which established the National Primary Health Care Policy (PNAB) – understood as a Health Care Network priority. In turn, GM / MS Ordinance No. 122/2011 (Brazil, 2011a) defines the guidelines for the Street Outreach Clinic team (Consultório na Rua)' organization and operation. They are part of the Psychosocial Care Network primary care component and develop primary care actions, according to PNAB fundamentals and guidelines. The teams should be multiprofessional, aiming at increasing their capacity for effective intervention in different issues and health needs of homeless population. The work should be carried out on-site, in an itinerant manner, through actions shared and integrated with other health care points, according to the user's needs. Among the activities performed, there are the active search for and the care of users of alcohol and other drugs.

2 Typification of primary health care service, which is a care model reorientation strategy, operationalized through multiprofessional teams in basic health centers. They are responsible for tracking a defined number of people (2,400 to 4,000), located within a defined geographical area. They work with health promotion, prevention, and recovery, rehabilitation of diseases and more frequent aggravation conditions and health maintenance of this community.

3 Team aimed at expanding reception and articulating the network for access to socially vulnerable drug users. The Street Clinic started in Salvador in the late 1990s, is itinerant and composed of mental health and primary care professionals and at least one social care professional, performing on the streets routine of psychosocial/educational activities and interventions with drug users. These teams have supplies for treatment of common clinical situations, as well as condoms, booklets and instructional material, bandage materials and commonly used medications.

There was identification, in the composition of this service (Macerata, 2013), a hybridism necessary to cope with the complexity of street health demands, involving biological, psychological and social needs. In the composition between PC, MH and HR, there is a territorial practice in common, a care that is provided by inhabiting the user's territory of life. Care in POP RUA was built and transformed by the territory. This territorial relationship was necessary to build an integral look at health, which sought to blur the boundaries between mental, body and social dimensions, and make the territory a space of care, a place that promoted the users' autonomy in their treatment and the involvement of various actors in the care. The connection between practices of PC, MH and HR in POP RUA was to make the care an effect of the network of relationships that are built in the territory rather than a specialized technical procedure (Macerata, 2015).

The participatory intervention research that Enativos built with POP RUA was a process of institutional support. In this article, the transition of participatory intervention research to what is called research-support will be addressed. Research and support were dimensions of the same intervention: research on the care carried out by the team, at the same time and through institutional support for POP RUA, which took care of the work process. Two operations in a single practice: knowledge production and care production. How did this transition from participatory intervention research to research-support occur? What is support in this experience? How does this public health management technology impact participatory intervention methodologies? This article unfolds the coadunation between support and research, developing the notions of intervention and participation, based on the cartographic track "to cartograph is inhabiting an existential territory" (Alvarez; Passos, 2009), and contributing to the expansion of the meaning of institutional support as a tool, from the meaning of territory that POP RUA presents us.

Support, participatory intervention research and cartographic perspective

Intervention research means a participatory qualitative research method. Based on a Brazilian inflection of institutionalism, intervention research defines its action plan between the production of knowledge and the transformation of reality, seeking to access processes – not only of subjects and objects, but processes of subjectivation and objectification (Rossi; Passos, 2014). It builds intervention devices that affirm the political meaning that all research carries (Rodrigues; Souza, 1987), in which the moment of intervention is the moment of theoretical production and, above all, of producing the object and the subject of knowledge (Rossi; Steps, 2014).

The methodological approach of participatory intervention research contributes to placing the researcher and the researched side by side. POP RUA's care practice is no longer an object and starts interfering with the research. The worker is no longer just the subject of the research but also its producer. Recognizing activity where only passivity is traditionally identified is to produce a change in the field. The object is in the position of subject, and a subject has perspective and agency, speaks, thinks, creates, demands; it is recalcitrant. The group's challenge, in the POP RUA research-support, was to make the object participate, gain prominence in the process, moving from the passivity of those who are investigated to a position of knowledge producer. Thus, researchers-academics were not in the field to collect data about a defined object, but to cultivate and produce information with the researchers-workers (Sade; Ferraz; Rocha, 2013). The research was conducted by a change of attitude both of the researcher and of the researched, which is defined as experience access and sharing (Kastrup; Passos, 2016). Repositioning of the worker was an effect of the interventional character of the intervention research (Passos; Barros, 2009). One does not know to later transform, but one transforms in order to know. Turning the worker into a researcher is correlated to the transformation of the researcher into a worker: the researcher starts supporting the worker's work.

The notion of support is proposed by Campos (2005) as an intervention method that focuses on the power and knowledge relations present in the institutions, aiming at a critical group that can produce analyzes on these relationships and

make joint commitments. The supporter's task is to track the groups and assist them in setting up co-management processes to transform work processes. Support is an institutional function and intervention methodology (Oliveira, 2011). It activates collective spaces that promote interaction and joint construction between the subjects, recognizing and handling, with the affections involved, the power relations and the multiplicity of knowledge for the construction of common goals, agreements and contracts that promote the capacity of groups' critical analysis. From the perspective of the National Humanization Policy of management and attention of Healh Care (PNH) (Brazil, 2009), the co-management aimed by support is developed through the triple-inclusion method, that is, inclusion of: different subjects that participate in the production processes of a given institution; social analyzers that result from the first inclusion and indicate the critical points of the institution; and the group, as a relational and affective dimension in a given collective experience. The supporter creates laterality (a plan where the actors and factors are side by side, without losing sight of the difference between them, neither horizontal nor vertical), and also stands beside the group supported, thus allowing increased degree of transversality (Guattari, 2004), exchange, and mutual transformation among the subjects involved in the process. In this sense, support helps establish new health practices from the tension between the instituted and that which institutes (Lourau, 1993). Support operates in the borderline between clinic and politics, highlighting the inseparability between the models of care and models of management, in which these domains mutually interfere.

From the institutional analysis, it is understood that the participation of the different subjects involved in a research process is an ethical-methodological guideline for activating institutional transformation processes and for openness to institutive processes, through the production of collective analyzes of implication (Lourau, 1993).[4] The laterality and the creation of a collective space of composition enable increased degree of communication openness within and between groups (Guattari, 2004), in guidelines for co-management and autonomy of the researched groups. Thus, support and participatory intervention research are seen and operated by a cartographic perspective, which disseminate ethical and political positions, and refer to the way human beings position themselves in the face of the production of reality, aiming to access, track and map the relationship plan and the processes involved in the naturalization of what is taken as natural, in the institutionalization of what was instituted and in the subjectivation of the subjects. The matter of interest to cartography is the production process. Regarding the methodological clues of cartography,[5] three are highlighted: all research produces reality, so all research is, in one form or another, intervention (Passos; Barros, 2009); cartography enables the access to the common plan, the plan of relationships, which implies attention and appreciation of the participation of different actors in a given field of research (Kastrup; Passos, 2016); all cartography is done by inhabiting in the existential territories investigated (Alvarez; Passos, 2009), a certain approximation and immersion in such territories.

The POP RUA research was constituted as an intervention by highlighting and interfering with the relationships between professionals, practices and devices involved in caring. This was done through a process of living in the territory in its multiple natures: (1) the geographic territory of downtown Rio de Janeiro; (2) the sanitary territory under the responsibility of the team; (3) and the existential territory that was defined by the processes of subjectification of workers, users and other agents.

The notion of territory is intrinsic of POP RUA's practice. In Enativo's research, it was noted that in that place there was a territory clinic (Macerata, 2015), which was a reception and invention operation,

4 The concept of implication is worked by René Lourau (1993) as a set or node of relationships that a given actor has and by which is possessed, when in relation to a particular field, institution or social space. Implication, in this sense, differs from engagement. The implications of subjects disseminate their perspective in a given relational space, influencing this space while being influenced by it.

5 Refer to Passos, Kastrup and Escócia (2009), and Passos, Kastrup and Tedesco (2014). On the cartographic perspective, refer to Macerata (2015).

through modes of relationship in the three dimensions of the territory. Care that operates in a territorial way: **for**, **in**, **with**, **across**, **of** the territory, and that makes care more a network of relationships to be activated or promoted rather than a technical procedure of one actor over the other. The territory also takes care, not just the health professional does it. Investigating this team's work implied a research practice that resembled the support practice. Support allowed passing through the three dimensions of the territory in the field investigated, that is, geographic, sanitary and existential dimensions. It identified the geographical territory with the health care territory; included in the care space the existential dimension of the workers involved in the process, enabling their subjective displacements through the ethos of support: tracking, producing laterality and transversality. The issue was to research care practices that took place through processes of territorialization. Researching and intervening meant understanding the intervention research process as a process of territorialization.[6]

POP RUA research process

Demands-order-demand

The field of this research was built at the end of 2012. From Enativo's interest in researching POP RUA's care practice, it contacted the team manager, presenting a proposal that involved researching this care practice and, in parallel, fostering the strengthening of this practice. At this time, the objective of the research was to understand how workers accessed the subjective experience of living on the street, as it occurs for the service user. Initially, the research project was set up in partnership with the National Humanization Policy (PNH) in the Brazilian National Health System of the Ministry of Health, and had a clear division between the objective of the intervention (made in partnership with the PNH) and the objective of knowledge production. This division constituted what is called, to some extent, Axis A – the technical part of support – and Axis B – the academic part of the research. This interest in intervention and partnership with PNH was due to the fact that one of the authors was the first manager of POP RUA and, at that time, was a consultant for PNH and also performed Doctoral research.

The first conversation with POP RUA manager aimed to raise work topics in the Axis A intervention, considered important by the team, as until then research, that is, Axis B, was a side effect. Posteriorly, the group would talk to the whole team to address these needs. These two conversations were part of a process of constructing an institutional intervention order (Lourau, 1993), in which one (or more) component of an institution orders something from an intervention team, based on a selection of demands from the institution. In the case of this research, the service manager selected some issues that Enativos could work together with the POP RUA team. During the conversation with the manager and the whole team, the partnership with PNH ended, leading Enativos to set up a research arrangement with three field researchers: a Doctoral student, a Master's student and a scientific initiation student.

The proposal was presented at a general meeting with all professionals after talking to the manager: a research on the construction of a therapeutic project and the care strategies in the territory. However, the team rejected the proposal, justifying that much research had already been done there, and the knowledge produced was never the knowledge of the team researched.

However, the rejection was not related to the content of the order placed by the manager. At first, one of the reasons for the rejection referred to the "role" of the former manager and researcher in the research process: would the role of researcher be diminished by the role of first manager? Would the

6 For Deleuze and Guattari (1997), the territory is not mere geographical demarcation. It cannot be taken as given and pre-existing reality. It is the procedural and qualitative dimension of space, formed by "territorializing expressions" and "territorialized functions." Territorializing then involves, at first, giving way to a situated expressiveness, which is what composes a territory, constituting it as a place to live in, as a very place, a very world. Only later, in an already territorialized reality, the functions of a given territory will emerge, where its formalization or "institution" occurs. The territory is an expressive signature embodied in conducts, but cannot be explained by them. It is an ethos.

role of first manager over the role of researcher diminish the team's autonomy and relevance regarding the definition and design of their own work? Although the rejection, which during the process becomes a questioning, was centered on the figure of the first manager, it was the gateway to a broader issue that covered the theme of the team's autonomy and relevance in defining and designing their work and what is related, for health research, to a way of research that could be poorly participatory. It was possible to understand the rejection as a demand for greater participation and importance of the team, as a requirement for creation of the laterality in the process of knowledge production. At the general meeting, the research had to negotiate and open a space for workers' participation in the design of the research itself. Performing research would involve not only intervene but undergo intervention. It was necessary to create a research territory within the team territory, necessarily co-inhabited and co-managed by researchers and workers. The team demanded legitimacy as a subject of the knowledge production experience. The recognition and legitimation of these subjects was a point of convergence between the team's request, the support work and the methodological approach of participatory intervention research.

A second demand, now collective, was made: the research would help the workers be authors, producers of knowledge of their own practice. It was necessary to state what had been created by the team so far. Field experience dismantled the initial research design and the division between axes A and B became a false issue, since research would be both research and support.

Some team members had previously produced 16 statements on POP RUA's care practice. From this, the proposal was formulated: the research would support the development and systematization of guidelines, methodologies and devices of care in POP RUA, having as its final product a technical document (Equipe POP RUA 2012/2013; Grupo de Pesquisa Enativos, 2014). Then, the research objective was replaced: from access to user's experience to access to worker's experience. The way of designing the research was connected to the way POP RUA's care operates: shifting the emphasis on the researcher or caregiver to the territory, space of subjects' relationship and life. The territory is paramount for the practices and the logic of care of PC, in which POP RUA is included. The basic is the territory, not as mere geographical delimitation, but as a plan of the concrete experience of the subjects and groups (Macerata, 2015). It is with this basic element that the PC work occurs, but also the MH and HR work. Homeless users inhabit the city's territory in unique existential conditions, which requires working with the street as an existential territory.

Research-support devices

There was creation of a device for knowledge production, systematization and evaluation of POP RUA's practice, called Workers Intervention Group (GIT), in which discussions about the practice occurred and had three functions: to research, intervene/support, and record the product of this process. It brought together three academic researchers-academics from Universidade Federal Fluminense and some 10 POP RUA workers. GIT was periodically transformed into a Narrative Group (GN), in which researchers-workers were introduced to what had been systematized by researchers-academics from the discussions at GIT. GN validated and modified this material, a process inspected by Enativos, which brought together the three researchers-academics and the other components of the research group.

GIT meetings occurred biweekly from April 2013 to March 2014. Among the workers, five community health agents, two doctors, two nurses, two social workers, four psychologists, a technical manager and a family health resident doctor participated more directly in the research.[7] The device was open to professionals who wished to participate, and the commitment to attendance was the inclusion criterion.

Each GIT meeting began with a triggering statement from the discussion, drawn from the team's earlier statements about their work.

7 More than eight meetings.

It was the starting point for the discussion development. Each statement was inserted in one or more themes systematized by the researchers-academics: (1) POP RUA Clinic: (1.1) the clinic and the subjective dimension of care; (1.2) the clinical and subjective experience of drug use; (1.3) clinic management. (2) Territory: (2.1) cartography of the existential territory of those who inhabit the streets; (2.2) territory of health production in the three dimensions of care: care, prevention and promotion; (2.3) territory and intersectorality. (3) Knowledge production: (3.1) knowledge formulation and systematization; (3.2) practice analysis and learning.[8] At GIT, the researchers-academics performed three roles: (1) **handling**, which consisted in facilitating and co-managing the group discussion, with questions and speech distribution; (2) **annotation** of what was said and visible, which consisted of taking note of what was related to the guidelines, methodologies and devices; (3) **observation** of what was outside the regime of visibility and enunciation of the device, that is, record of what did not directly refer to the team's care practice, for example, movements, political issues that appeared in the group, that is, all surrounding the care practice. GIT's purpose was to formulate guidelines, methodologies and devices for POP RUA's work. However, other important elements of care that were not directly within its scope had to be observed. These three functions, at first predefined among the three researchers, have been distributed over time, and they are no longer specific to anyone. The handling was distributed, even shared with the workers, according as grouping intensified. After the meetings, the material recorded was transformed into their **memories**, which were the expression of the recorded content of the discussion, as well as the group's movements observed. Each memory text was reviewed by each of the field researchers so that it was as collective as possible.

A GN meeting was held approximately every six GIT meetings. This devolution was made as something called **narrative**, which already used guidelines, methodologies and devices as discussion systematization. GNs had the function of validating what the research systematized and analyzed. At each GN meeting, the group was asked to make the effort to evaluate how to enunciate, organize and express the care practice. At the end, another memory of the meeting was constructed, which recorded the workers' interventions in narratives and meanings constructed and perceived collectively. Narratives were also discussed and validated in the supervision space, where the process was evaluated and decision-making made with the team.

GIT and GN were two-way intervention spaces: they produced knowledge and transformed the work done by workers, but also research practices and investigation knowledge. They were spaces that enabled workers becoming researchers and researchers becoming workers, since researchers participated in the work process systematization and the workers in the knowledge production process. Mutual intervention between research and health work.

The co-authorship of the knowledge produced is relevant, both in the field of public health practices and in relation to the production of health knowledge, what can be called field of Collective Health (Saúde Coletiva). Betting on the laterality and transversality between technical and academic perspectives is realized in the way of assembling the research device, in the way of conducting it and in the final product of the research. It is unusual for research subjects to leave the anonymity guaranteed by a confidentiality agreement, what Vinciane Despret (2011) calls "nameless effect" that erases the singularity, the expressive force of a subject. Although care professionals are the actors in direct contact with users' existential territories – the focus of public policy -, they often play a role as executors rather than as health policy makers. Marking the co-authorship of workers in the production of knowledge allows emphasizing the objective of outlining strategies that meet the singularities of each territory.

Thus, in the field research process, the following steps occurred: contractual construction of the research device; GIT discussion; construction of

8 Categories of analysis constructed by researchers-academics in the research supervision space, based on thematic content analysis (Minayo, 2013) of the 16 statements constructed by the POP RUA team about their practice.

memories of meetings; narrative construction; devolution and validation of the narratives in GN; systematization of the technical document, process evaluation, and research closing.

Research-support process

It was necessary to inhabit the space of the team and to produce another space in the midst of its territory. Enativos inhabited POP RUA's territory and made POP RUA inhabit Enativos's territory, which produced interference in these two territories. Enativos influenced the field and the field influenced Enativos.

The discussion gained consistency at the first GIT meeting. Many people spoke, giving examples of concrete situations related to the theme proposed: *in my area, the approach on the street is this way, with so-and-so, for example, was like this* (ACS 1). It was necessary to be aware of who wanted to talk and didn't talk. The work experience gained expression in the speeches. The psychologist says: *this is going to be very interesting; I think it is very interesting to hear what people think of something we do without much talking* (Psychologist 1).[9]

Meetings occurred in a circle, whose center was a space for the composition of the research territory, where a process of speech and silence was composed and inscribed. The group begins with silence, which gives space for the trigger statement. It is the first position. When the statement is made, it introduces an element that begins to compose the scenario. This first position is very open: a number of imaginable and unimaginable paths can be followed from the statement. The trigger statement only gives rise to themes, questions, situations, and possible approaches. Then, a second silence period occurs to repair the initial position that the statement presents. How to stand before it? Which way to go?

The work at GIT was to take a position in the face of the statement in its initial formulation, previously made by the team. Not in relation to this previous moment, but in relation to what it implied in the present experience of the team's practice. What does this statement, which has a history, propose to present experience? It might take a while for the group to find a second position that related to the first position of the statement. This could happen in the first speech, or, in order to find this second position, it was necessary to discuss more, so that the group could position itself, introduce an element that would bring the initial statement closer to the present experience. It was only the second position that gave meaning to the first. When the group introduced a third position, a composition emerged: a relationship with the first relationship established between the first and second positions. It was a relationship with a relationship that began, the stabilization of a sequential unity and which the group began to compose, producing new meanings that had a minimum of stability to express something. Thus the common was composed.

For example, the statement is triggered: "to consider the street a clinical betting tool." It set position 1. The group could discuss the theme in a broader way by asking what meant to transform the street into a clinical betting tool; or take a fraction of it: the clinical betting. An experience related to street care was presented: *the user was in advanced state of tuberculosis, but did not accept to be hospitalized, so we developed the following strategies* (Nurse 1). This was position 2. From these two positions, a third was introduced: *the patient can be attended living on the street, but and when the patient is very weak? Should the patient be hospitalized?* (Nurse 2). The discussion could consider hospitalization. All of these possibilities led to position 3: the constitution of a relationship with another relationship. GIT's focus was to reach position 3 (stabilization of a sequential unit) so that one could compose something without falling into a sequence that drifts infinitely and creates nothing.

The handling facilitated reaching this third position, a collective creation, whose material was the concrete experience in both directions: what each worker had of lived experience, and the way he/she felt, experienced every situation present in GIT: *what was it like and what is it like to decide to build a bed for serious tuberculosis patient on the sidewalk next to the service?* (Researcher-academic 1). Handling led

9 Phrases in italics indicate statements transcribed as made by workers.

the group to find this third position: *but how is that, can you give an example? So the problem posed is...? Does this imply which relationship with the user, with the management?* (Researcher-academic 1). The handling aimed to stabilize a minimal unit of discussion that was interesting, that is, when a speech or debate was better able to mobilize, when people spoke more intensely, or when there was silence. Or even when there was disagreement between points of view that seemed important for care. The handling traced what was being composed in the scenario, its course and meaning. It could be done with silence, laugh, a look, or listening carefully to a speech. It was at the service of the group's experience, and not simply at the service of a topic of interest to researchers-academics. Enativos' point of view should be soluble so that it could mingle with the collective movements at GIT. It does not mean that Enativos made neutral interventions. It strengthened some meanings and sought to weaken others from how it saw and felt the GIT experience. Certainly, at times the researchers-academics were wrong in being deaf to the meaning of the composition. Therefore, the handling also occurred and primarily with themselves. Managing following the clues of the cartography method required learning ways of paying attention to themselves and to the relationships in the group.

Enativos' members sought to connect with what they felt and understood to be important to maintain the GIT experience. This means that GIT was not a space owned by the POP RUA team: GIT was built as a space of composition between researchers-workers and researchers-academics. Managing was aimed at stimulating access to the experience of caring, and at formulating this experience. GIT was the opportunity to make knowledge from practice. Cultivation and harvest.

Questions like "why?", "what does that make you think?" and which reinforce the tendency to form a "meta-discourse" on experience were avoided. Questions like "how?" and "so what?" were sought, which have a greater degree of indetermination and invite to wander more broadly through experience. The questions should not encourage pre-established answers, but the movement and collectivization of the questions investigated and the creation of new meanings and ideas by producing differentiations, drawing new lines of conversation, and promoting new mediations.

The common sought in GIT was not the same as producing consensus. It was to make the discussion be shared by the workers in singular parts. That is, to make each one feel part of the discussion, even if there are disagreements and dissent. Approaching the experience of care and then formulating guidelines did not require thinking about the ideal, or hiding failures at work, but thinking about successes and failures. The key to sustaining the common even in the dissent was not to seek immediate resolution of a particular impasse, but to sustain it, leave it open, and monitor it.

Effects of research-support

The last stage of the research was process evaluation and closure. A collective dimension emerged from this research-support territory: the research territory inhabited by workers-researchers and researchers-workers. The collective exercise of saying, discussing and designing care was also a space of care for those who cared. It created collective assemblage of enunciation[10] and promoted transformations in workers.

In some GIT meetings, the statements that directly related to the practice of care were not discussed, but the complicated situations that the team lived with management (mass exit of the mental health team, delayed salaries and transportation vouchers, exchange of management). Most of the meetings discussed more than POP RUA: the violence

10 Assemblage is the articulation between heterogeneous elements, from which something is created and something is modified in the terms involved. The expression becomes a semiotic system in it, a regime of signs, and its content, a pragmatic system of actions and passions (Deleuze; Guattari, 1997). Every statement is always an expression of assemblage, in its dimensions of content and expression, and it is always collective: always made from the articulation of a diversity of materials and immaterial elements, subjects and objects, semiotic, technical regimes, etc. This is evident in the POP RUA research-support, that is, the statement is very evidently produced in a group, a collective experience that allows the articulation of a diversity of factors: experiential, technical, personal history, professional places, etc.

of the health network with workers and users; the pain of seeing users dying of disease or murdered; the extermination events.

> *The only space we can count on is this street, with these actors who are there* [...] *when we ask for help from the established power... including the secretariat itself... nobody proposed to take the patient and put him in the car... the partnership turns out to be the stranger, the newsstand guy. We need a space to talk about it, we need it.* (ACS 2)

Participatory intervention research, crossed by a cartographic perspective, can only include politics and affections.[11] The inclusion of analyzers, disagreements and conflicts created conditions for the group to constitute itself as a territory of expression and formulation of issues of all kinds, since the very problem of taking care of the existential territory of the street is an issue of several orders of complexity. Building meanings for the experience lived, accessing the experience, enunciating, discussing, reformulating, were at the same time practices of knowledge production and care of and at work, which had the effect of taking care of the worker.

The problem situations constructed in GIT were an expression of the multivectoriality of situations on the street. Many present vectors, many intensities: joy, pain, violence, tension, attention, sexual desire, wonderment, joy. The workers dealt with this multivectoriality, and enunciating the care handling in the GIT space meant that a similar handling should occur in the research-support territory: to articulate the present vectors and construct meanings. In the process evaluation, the care effect of the research-support was validated:

> *It was very important that in the moments we did not discuss guidelines* [...] *you allowed us to express our dissatisfaction, what we were experiencing... we were allowed to do it.* (ACS 2)

> *This GIT space, for me, went beyond discussing the guidelines. It was a space where I could perceive us as a team, and how important it is... With this research work, there is a document that supports what I'm talking about... it's something that was built beyond us.* (Nurse 2)

The researcher's own implication, as a former manager, was not deterrent – as he would not be neutral enough – nor was it neglected – as if he was not part of the process. Having analyzed this implication served to transform it into research work material, as a reading and issue building key: team's importance in the production of knowledge of their work; importance of the research territory in the research process.

During the research period, there was variation in the presence of team members in the research device. However, the group's process continued so that its functioning and productive effects were maintained. Interruptions in continuity of participation did not become interruptions in the process. The process certainly occurred because there were always a minimum number of team members, although they were not always exactly the same. However, there was a presence in GIT that was not confused with the sum of the people. There was "one below and beyond the subjects" that was the index of the construction of an existential territory of the research itself: *in a time of major changes, this was maintained, and it was important; this space allowed us to find a common point* (Doctor 1).

The research-support

The research-support produced knowledge and care of and with the team's work practice. When intervention research takes place in health work processes, the team's existential territory is what is supported. Support, as proposed in previous work (Macerata; Soares; Ramos, 2014), always involves care of existential territories, because it does not only target individual subjects, representations and provisional forms of a given field of intervention. It primarily aims at work processes that are also subjectivation processes that constitute the subjects: researchers, workers, users.

11 Affection here differs from being affectionate, kind, as occurs in common sense. It has the Spinosan sense of movement of attraction and repulsion that a given body undergoes and that affects the relationship with other bodies. Affection is the very matter of relationship.

If support initially appeared as a parallel process to research, it was soon realized that it became a mode of intervention research in the health field that qualified the intervention dimension of research: a commitment to the institution and, more specifically, to the institutive dimension health institutions. A method of care of the conditions of health work production.

The idea of support as an expert's action weakens with this experience. Special themes can be worked on, but the specificity demanded should come from the relationship with the collective supported, which materializes as a territory, that is, as a situated collective experience. Research-support never starts with a project that will be the same. The way it is designed is done in the process of supporting, always from a composition with the territory where it intervenes.

In the relationship between research and field, it is created, through a composition with the existential territory researched, another territory that becomes a plan of co-emergence of researcher and researched, subject and object. This is the meaning of participation that is highlighted in research-support: to constitute a territory of relationship in which researchers and workers, who start having transversal perspectives and practices. Composition is not sum or symmetry between two elements. Composition is relationship with relationship, which shifts the protagonism of the subjects (in this case, researchers or workers) and transfers such protagonism to the common experience in a space of relationship.

Support as a way of producing health is also a way of producing knowledge. In the health field, intervention research is research-support: because it supports health production processes, taking care of the existential territories where the involved actors live. In the POP RUA research, support has been transformed into a research operating mode. This mode updates the interventional and participatory meaning of research in the health field.

Contaminated by the field, where care was the care of existential territories, the research produced knowledge supporting the existential POP RUA's territory. Thus, support is not only a management tool, but a tool for the production of knowledge and care of health groups. Work processes are supported, but the health work process, whether in management or care, is a care process. In cartography, there is the guideline of not representing reality, but of accessing the experience of reality researched by those who live it. In research-support, it is necessary to inhabit and take care of existential territories. Inhabiting the territory, and consequently co-producing the territory, is the effective way of accessing the experience of the subjects involved, since all access to the experience of the other occurs through one's own experience. There is no experience independent of one's own ways of accessing it.

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Authors' contribution

Macerata conceived and designed the study. Macerata, Soares and Oliveira conducted the research, analysis and interpretation of data, write the article and performed the critical review. All authors approved the article final version.

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