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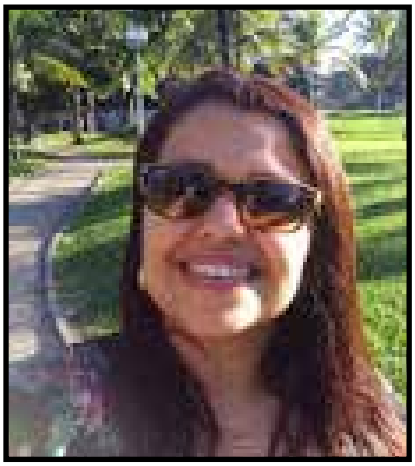

Habitus in caring for the street population: an ethnographic study

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ABSTRACT

Objective: To analyze the constituent elements of health professionals' habitus belonging to two teams of Street Clinic, located in the west of city of Rio de Janeiro. **Method:** An ethnographic study, with interviews, questionnaires and ethnographic observation. Data was analyzed according to the concept of habitus proposed by Pierre Bourdieu. **Result:** Some elements specifically related to these professionals were similar in both teams, such as professional trajectory, perception of their care practices and linkage with vulnerable populations. **Discussion:** It can be said that these professionals have antecedents that make them defend this space of care and become important for the development of their practices, as a cultivated habitus. **Conclusion**: The personal and professional trajectory of all the professionals who participated in the study, added to the posture and the perception about their practices were decisive in the construction of singular care practices performed with the street population.

Keywords: street people; vulnerability; cultural anthropology

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INTRODUCTION

To realize care for the street population (SP), first of all it is necessary to know the person who lives in the street, both personally and socially: the causes of living in the street, the survival strategies, and the formats of socialized and constructed bonds. New forms of care should also be considered, surpassing the traditional model, not focusing specifically on the disease, but on the subject, or rather, on the group of subjects (street population). This implies modifying and broadening some aspects such as listening, therapeutic process, reconstructing the work proposed in manuals, all considered "normative". Thus, the current proposal is to discuss the singularization of the care practices performed today by the Street Clinic Teams (*Equipes de Consultório na Rua*, eCnaR). To understand how these care practices are built and what elements are linked to these practices, we need to comprehend and understand how professionals build this care habitus with this population. We assume that this habitus is built from the subject's trajectory, both professional and personal, allied to their own perception.

The concept used by the United Nations (UN) for "street population" is related to street or "shelterless" people living in the street due to natural tragedies, war or unemployment; or "homeless", such as those who do not fit as shelterless[1]. A decree establishing the National Policy for the Street Population states that a street person is part of a heterogeneous population group that has means of survival in productive activities in common, developed in the street, with broken or frail family ties, without reference to a regular housing[2].

When the Ministry of Health presents the proposal to instrumentalize the primary care health professionals to work with street population, it presents the possibility of expanding and building new forms of action[3], demonstrating that there is no way to "standardize" these practices. Forms of care are created during the work processes and practices of the professionals who work directly with the homeless population, considering the health needs of these subjects and the CnaR teams. The Street Clinic (*Consultório na Rua*, CnaR) consolidates itself after a movement to fight for greater access to health for homeless population through specialized teams and Primary Care services. Work approach is to offer health care to people in their place, considering their living conditions and citizenship[4].

To analyze the eCnaR's conceptions of care, according to the homeless people's health needs, it is clear that interactions between the health professionals and the people living on the street permeate cultural and social influences. It is intended to discuss these conceptions of care from the category of Pierre Bourdieu's habitus[5,6].

For Pierre Bourdieu, the notion of habitus notion[5,6] is related to the social structures, inserted in certain social and historical conditions, "shape" the bodies of individuals by introjecting them values, meanings and behaviors which, from there, build their social world. Thus, the professionals who work with the street population incorporate specific elements that are "built" through their experiences and the development of practices with this population. These elements are part of this "habitus" of the eCnaR professional.

To understand which elements are inserted in the professionals, we chose the following as objective: to analyze the constituent elements of the habitus of health professionals belonging to two eCnaRs.

This paper is derived from a doctoral dissertation of the Academic Program in Health Care Sciences, Fluminense Federal University.

METHOD

This is an ethnographic study of an anthropological nature, developed in two eCnaRs, located in the west of the city of Rio de Janeiro. The ethnographic study facilitated the understanding of the professionals' practices and the attainment of elements linked to care, through the researcher's immersion and observation in the field. Ethnographic doing presupposes a description of each individual's interpretation of events, facts, phenomena, all permeated by culture. In the ethnographic description what is interpreted is the flow of social discourse and the interpretation involved[7].

The research was conducted through participant observation, individual interviews and a self-administered questionnaire about the interactions of the health professionals with street people. The whole data collection process took place during six months in each team, with insertions of the researchers in the workspaces of the professionals, which constituted closed spaces such as clinics and Health Units and in open spaces, such as the streets, among the years 2018 to 2019. All the professionals of both eCnaRs were observed in their practices both within the Health Units, as in the streets.

The self-administered questionnaire contained specific information about the professional's profile and elements about the research subject's trajectory and perception. These data were grouped into two tables (Tables 1 and 2) so that they could be analyzed together with the interview and observation data.

The ethnographic observation focused on accompanying the professionals and noting in a field diary how professionals acted and built their care practices. The questionnaire was given to each professional as soon as the research was presented and the terms of free and informed consent.

The interviews were conducted in different spaces according to the availability of each professional and could take place on the street or in the Health Unit. All the professionals agreed to participate in the interviews. The interview questions were based on the professional's profile, consisting of elements based on the educational, family and professional trajectory and the perception of each subject about their health care trajectory.

The participants were 22 professionals from both CnaR teams. All the participants were professionals who act as "support" for the eCnaR and those who worked in the eCnaR, coming from various health categories: doctor, nurse, psychologist, dentist, social worker, nursing technician, street worker. The inclusion criterion was to be a professional who would work with care for the street person, and who had been part of the eCnaR for over a year. The exclusion criterion was the professionals who were on leave during the research period.

The data generated in the field research were

analyzed and discussed through categories that emerged from the concept of *habitus,* proposed by Pierre Bourdieu.

For Bourdieu, the real individual agent within the field is analyzed; in their formation, trajectory and positioning, constituting individual traits of the characteristics of individuals[8]. For research, this means working on aspects such as biography, trajectory (personal and professional) and local practice in relation to the practice logic of the fields in which they occur[9].

This article presents a part of the analyzed data more related to the elements of the professional profile. To present these data and analysis, two tables were constructed with information from the self-administered questionnaire, and the data related to the interviews and ethnographic observations were presented through two categories: "Professional experience with vulnerable populations" and "Perception about care practices for the street population".

The study was approved by the Ethics Committee on Research with Human Beings of the Antonio Pedro University Hospital, UFF, and the Municipal Health Secretariat of Rio de Janeiro, No. 2,308,442. The participants' anonymity was guaranteed through the use of the letter "E", followed by the interview number, with sequential numbers from E1 to E10 for the Programmatic Area 5.3 team and sequence numbers from ER1 to ER12 for the Programmatic Area 5.1 team, both from the city of Rio de Janeiro.

RESULT AND ANALYSIS

In order to present the elements related to care among the research participants who work in both CnaRs and thus seek to understand who these subjects are, a table was constructed with some variables specifically related to the professionals, such as the professional career and the their work perception. For analysis and presentation, two tables were constructed for each street clinic team. Chart 1 will be presented first, with data for the CnaR team from Programmatic Area 5.3 and then Chart 2, with data referring to Programmatic Area 5.1.

Referring to the eCnaR, the professionals were doctor, nurse, psychologist, social worker, social agent and another two health agents. In this team there are two "supporters" who were also part of the research. Chart 1 shows that all the professionals are between 30 and 49 years old. Regarding chronological working time in the Basic Health Care space, the vast majority has been working for over 10 years. Regarding work in the CnaR team, most have been working for over 4 years.

Table 2 presents the elements of the professionals of the eCnaR of Programmatic Area 5.1. Similarities are evident, but also specific attributes that are contained in them. Most are between 30 and 49 years old. About their professional career, most also have experience in the area of Basic Care, working in the street clinic team for over a year. But overall, the mean is 3 years.

Professional experience with vulnerable populations

In both teams, subjects have professional trajectories with vulnerable populations, which in a way favors the professional' profile to perform care practices with homeless population.

Chart 1: Elements linked to the habitus of eCnaR subjects - Programmatic Area 5.3 of the municipality of Rio de Janeiro, 2019:

Identification/ Age	Profession/ Occupation	Working Time with SP	Connections with vulnerable populations	Professional Career	Link with practice
E1 68 years old	Doctor	4 years	Actions in the Prison System	Psychiatry Professor and Criminal System Physician	Patient Care
E2 31 years old	Psychologist	3 years	Undergraduate and Graduate actions	Since training, met demands of SP	Satisfaction for the work developed
E3 35 years old	Nurse	4 years	Actions in the FHP	FHP with vulnerable populations	Link with reality transference
E4 33 years old	ACS	1 year	Actions as CHA on traditional teams	CHA of traditional team	Patience
E5 54 years old	ACS	4 years	Actions as CHA	CHA of traditional team	___
E6 45 years old	Social worker	4 years	Actions as CHA	CHA of traditional team	Making a difference
E7 45 years old	Nursing assistant	4 years	Actions as a nurse at BHC	Basic Care Professor and Nurse	Facilitating access
E8 40 years old	Dentist assistant	4 years	Actions in the Amazon with indigenous population	Dentist in the FHS and with the riverside population in the Amazon	Helping people in vulnerable level

Source: Developed and adapted by the author, from the *habitus* extraction chart featured in Cheryl Hardy's Social Space chapter[10].

Regarding the connections with working with vulnerable populations, the subjects show approximation to practices with different types of population in vulnerable situations. In this way, these subjects bring to the Street Clinic scenario previously built forms of working with vulnerable groups, which give them possible differentiated forms of care:

> Actually, with the CnaR I've been working for 4 and a half years, but I already have experience in FHS on SP. In all, I work for 9 years. (E7)

> [...] Even working in community and having vulnerable people, we saw that the vulnerability of those in the street is very different. (E3 R)

> [...] in this Unit, three years and a little more, which is the time of the team's existence and in São Paulo, I worked in the CAPS AD which does

Chart 2: Elements linked to the habitus of the eCnaR subjects – Programmatic Area 5.1 of the municipality of Rio de Janeiro, 2019

Identification/ Age	Profession/ Occupation	Working Time with SP	Connections with vulnerable populations	Professional Career	Greater link to practice
E1 R 31 years old	Nursing assistant	3 years	Actions as a nurse and manager in BHC	In the FHS, as a nurse and Unit manager since 2011	Case management and strategy implementation
E2 R 44 years old	Psychologist Assistant	15 years	Actions developed since graduation	Acts as a psychologist in BHC and as an assistant	Giving visibility and rescue to the citizenship
E3 R 38 years old	Social worker	3 years	As CHA	In BHC (15 years)	Guaranteeing access and social recovery
E4 R 42 years old	Social worker	5 years	As CHA and in the development of integrative practices	At the FHS (11 years), with development of community therapy and integrative practices	Integral care to SP
E5 R 47 years old	Social worker	2 years	CnaR only	Did not working in health, acted as sales promoter	Working with people
E6 R 24 years old	Occupational Therapist, Intern	1 year	As a therapist in mental health	Worked in Psychiatry (1 year), then in the CAPs and NASF (1 year), now in the CnaR	Favoring access and building care possibilities
E7 R 37 years old	Oral health technician	3 years	As an oral health technician	In the FHS (6 years) as an oral health technician	Reception and bond
E8 R 38 years old	Occupational Therapist	2 years	Developing social work since the age of 18, later with adolescents in the street	In BHC (4 years), working with adolescents who abuse psychoactive substance	Bond

E9 R 43 years old	Nurse	1 year	As a nurse in the FHS	In the FHS (2 years) as a nurse, in communities with many cases of pregnancy and tuberculosis	Power of action in cases and agreement in networks
E10 R 49 years old	Family Doctor	9 years	As a doctor in the FHS in Rio and SP	Medical residency in Gynecology and Obstetrics (2002-2004), working since 2004 in the FHS (Manguinhos/ FIOCRUZ FHP)	Users and services human relations, adaptation of protocols to local reality
E11 R 56 years old	Nursing technician	3 years	Previous experience as CHA	In the FHS, as CHA for 12 years	Helping the other
E12 R 39 years old	Social worker	3 years	As CHA	In the FHS as CHA 12 for years	Team work

Source: Elaborated and adapted by the author from the *habitus* extraction chart presented in Cheryl Hardy's Social Space chapter[10].

> care... there was a clinic in the street too, but I was a doctor in the CAPS AD. So, I did the care of the street population. [...] I think that's what combined with this work, right? To be able to work with who is most vulnerable, right? And it's not a simple vulnerable, it's a complex one. (E10 R)

But there are also professionals who reported even working now at the Street Clinic, the contact with this population came from previous performances, as shown by the following speeches:

> No, I never acted, I mean, in jail has. I worked in the penal system, as a psychiatrist. (E1)

> Yes, I worked in CAPSAD, I already had contact with SP, now I was working professionally at the beginning of 2014, when I worked at the General Hospital, Orthopedics, emergency, not especially the person who was living in the street, but we received a lot of patients who were living in the street during hospitalization. (E2)

> Yes, because of the church, outside the clinic, I also practice, I used to do social work before, always in the street working with them, for already 15, 20 years. (E6)

The professional profile connects as an indispensable attribute for street work. It does not appear at the beginning of a care practice, as many point out. IT was being introjected, incorporated into the subject-professional, representing the sum of his personal and professional trajectory plus his perceptions and values.

> [...] I already had a profile for this service even without knowing which profile it was. Yeah... so when I went to work... the profile of that population is very precarious; it was very vulnerable. So... since when I joined Family Health, that change was already... it's... natural (E10R)

> [...] having a profile to work with this population, because if you don't have it, you can't either, right? Because you see a bit of everything, you have to put a lot of things aside when you enter the clinic on the street... religious part... thing that... things you believe in... a lot of things you have to put aside, for you to be in the clinic in the street. I think you have to have profile, profile and articulation (E11R).

The speeches bring the importance of having a unique profile to work with street people, and that the presence of this vulnerable other in professional life makes them rethink and revisit not only their work practices, but make them review everyday life practices:

> [...] to put myself in the other's shoes right, what I want for myself I don't want for the other, so it's something that still shocks me a lot because I have very little time with SP. [...] What bothers me is the look of people with naturalness to those people who are lying on mattresses in the streets is something that really bothers to see how that goes unnoticed to others, I don't want this for me. I want that this always bother me so I can bring this to our daily lives here at work, so that's it. (E8)

> [...] to allow change, this transformation, because nowhere is the same as the other, I am a person that I am always allowing myself to transform, hopefully that will make me a better person right. (E8)

> [...] not only homeless people, I put myself a lot in the place of the other. Sometimes we see, I'm talking generally, we have to treat the person as an equal [...] we need the money to keep up, but if you don't have the profile to work, to do that, the gift of taking care of the other, of arriving, of making the change, of shaving, because it is not only about the medication, [...] I think this action is very important, taking care of the other. (E2)

Perception about care practices for the street population

The different perceptions regarding the care developed for the street population, connect and can be summarized in three strong categories: bond, welcoming and resoluteness. The professionals point out the following in their speeches: *"Conducting cases and implementing strategies", "giving visibility and rescue to the citizenship", "ensuring access and social recovery", "favoring access and building care possibilities", "power of action in cases and network agreement", "adaptation of protocols to local reality"* and *"helping others"*.

The perception that the research subjects have of the place they occupy to promote health to the homeless population and the understanding that it is important for this care to happen, is present in the speeches

and was also observed in ethnographic incursions. Their own perception of their work makes them stand also as essential figures for the homeless population care. There is their own identification with the work they develop, as perceived in some lines:

> [...] I think this has a lot to do with identifying the work, right, so, I always identified myself from there the first stage with indigenous health, I always identified a lot with the primary care, [...] the person has to have a profile, otherwise he doesn't stay. Or if it stays, it gets hard. But it was by identifying the work, this look, that it has what's different in my life, so it's different. I think you have to really want to make a difference to be able to do quality work, so I think that's right. (E8)

> [...] we have to sit next to them and participate, we feel so good when we arrive, because nobody looks at a person who lives in the street, if we observe it, sit in a place and keep watching, between a person sitting there and a person passing by, he does not look, it is as if he/she were a paper there, and it is not that, if we go to take the story of that individual, we begin to see who he/she is, we see that he/she studied, has study, has profession, he/she is there now, why is he/she there? [...] (E2)

And, they also highlight, for the importance of the relational process between the professional and the user:

> [...] I think it's... the management of relationships. Yeah... I think all this professional's work is based on that. It is the management of how you relate. Either with the user or with the network [...] (E10R)

> [...] My job is to explain risk, advantage, why you need it, why you don't need it, why it's important... trying to give meaning to something he/she may not know. This is more important than prescribing something. So if I can do that, I make room for the therapy to happen after the meeting. (E10R)

> With the street population is already different because the street is already given to them... so you have to work now with a health proposal taking care of the subject, however you see... have a holistic view of space where he/she is [...] (E12R)

DISCUSSION

From the data presented, it is clear that the experience and previous work with a vulnerable population, regardless of the time that occurred, favors the creation of a unique profile to work with the homeless population. Many practitioners were already developing practices for similar groups before joining the CnaR teams, which became essential for building this *habitus* of each of them.

Various experiences narrated about previous practices with people in vulnerable situations, whether acting in the Family Health Strategy, even in social "works" demonstrate the "willingness" or engagement of the professionals to work with this population group. Such experiences help to understand the familiarity of working with vulnerable populations and

the specific context of their practices, even if they had not previously worked with street population.

The constituent elements of today's professional profile are directly connected, for all respondents, to their family background, values and experiences before they became today's professionals. This set contributed to the current work with street population, A profile that has been shaped and that many do not even realize. This is the habitus! And that becomes present when developing care practices with this population.

The personal and professional trajectory of all the agents who participated in the study, added to the posture and the perception about their practices were crucial in the construction of singular care practices performed with the homeless population. The professionals report the need to have a specific profile to work with the homeless population and the very importance of this work for the construction of bonds and articulations for care practices to occur.

For Bourdieu, understanding the practice requires relating the "regularities" of the social fields to the practical logic of the actors. This practical logic source is the *habitus*[11].

The habitus focuses on our way of acting, being, feeling and thinking[6]. It captures how we carry our story within us and brings it into the circumstances of life, how we make our choices. This set of choices depends on our current context and our past journey.

Thus, this care becomes more familiar, composing the subjective structures of the subjects, and may determine some specific care practices for the street population, in addition to feeling satisfied with their own performance.

CONCLUSION

Bond favors work, constituting an important element to constitute the profile for working with the street population. Care time for the street population also favors the formation of this profile, as well as their experience in Basic Care and in the eCnaR.

The previous experience with vulnerable populations made the practices performed, which constitute the habitus of this professional, favored differentiated and resolute forms of care. This professional's way of acting is introjected, with the sum of his professional and personal career, with his perceptions and values.

This article limitation is that the study was conducted in only two eCnaRs, not including more participants for the research. Because its method is ethnographic, immersion in the research setting takes time, and cannot, at this time, being part of a doctoral study, because of time, encompass other participants from other eCnaRs.

In this study, it is recommended that the selections of professionals who work with the street population, to favor the bond with this population and to favor singular practices to this public follow some elements presented, such as time of practice in Basic Care and with vulnerable population and others elements that are part of the profile of this professional.

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