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"My child gave me my life back": cartography of the "Rede Cegonha"

Maria Raquel Rodrigues Carvalho[a]
Maria Salete Bessa Jorge[b]
Túlio Batista Franco[c]

[a,b] Programa de Pós-Graduação em Saúde Coletiva, Núcleo de Pesquisa e Inovação em Saúde Coletiva, Centro de Ciências da Saúde, Universidade Estadual do Ceará. Avenida Dr. Silas Munguba, 1700, Campos do Itaperi. Fortaleza, CE, Brasil. 60740-000. mkel.rc@gmail.com; aria.salete.jorge@gmail.com
[c] Departamento de Planejamento em Saúde, Instituto de Saúde Coletiva, Universidade Federal Fluminense. Niterói, RJ, Brasil. tuliofranco@id.uff.br

The present study analyzed the protagonist role of health workers in healthcare systems in a capital city of Northeastern Brazil, through the coordinated work of the Rede Cegonha ("Stork Network"), Psychosocial Care Networks, and Redes Vivas ("Living Networks"). This was a qualitative and cartographic study about the experience of a pregnant woman who used drugs, and the participation of health workers in the studied territory, who were involved in her care process. Data collection and analysis was carried out using workshops, in-depth interviews, field diary, observation, and flow charts. The results showed the frailty of formal networks in providing comprehensive care to its users and the power of living networks as efficient spaces of care. The study presents a new perspective for thinking networks, and their access points and work flow.
Keywords: Health care. Pregnancy. Drug users. Crack.

Introduction

The purpose of this paper is to discuss the Stork Network (SN) and the Psychosocial Care Network (PCN) focusing on providing care for the drug abuser. We analyze the functioning of networks in their broad sense, that is, encompassing formal, protocol and the "live networks", and recognizing that they are also constructed by the action of health professionals and users.

For data production and analysis, the mapping method was chosen because the purpose was to analyze the networks' functioning based on socio-affective issues that are implicated in this scenario. Mapping allows us to give visibility to the affects in a continuous movement of production of the social environment and the production of oneself and the other, in the entanglement of relations that permeate the users' world and their intersection with the world.

For this study, it was selected a pregnant woman - referred to herein as a "guiding user" – as our data source on care production in the context of the networks surveyed. She was selected according to the health team's criteria, under the recommendation that the research subject would represent a complex "extreme case", in the sense that she challenged the care team itself regarding their limits of knowledge and practice. The user "guided" the study through her life story, revealing her experience at a special moment of her life: her pregnancy.

By first tackling this issue, it is noted that the Brazilian Ministry of Health (MH) proposes the construction of the Health Care Networks (HCN) for organizing the users' flows and accesses to the Brazilian Unified Health System (UHS). The HCN must be organized on the needs of coping with vulnerabilities, illnesses or diseases that affect people or populations. In 2011, the following thematic networks were prioritized: The Stork Network (SN); the Urgency and Emergency Care Network (UECN); the Psychosocial Care Network (PCN); and the Healthcare Network for the Disabled (HND). In this way, there was a complete network transversality by the themes: qualification and education; information; and health regulation, promotion and surveillance[1].

The SN was established under the Decree 1459/11 for ensuring improved access, coverage and quality of prenatal care, childbirth and puerperal care and child care in order to reduce maternal and child mortality, since mortality rates were high, mainly in Northern and Northeastern Brazil[2]. On the other hand, within the UHS, the PCN aims at providing assistance to people suffering or with mental disorder as well as with special needs arising from the use and abuse of crack, alcohol and other drugs[3]. Such networks form the corpus of formal networks that comprise the object of this study.

The SN represents the possibilities of paths followed by the pregnant woman who searches for health care services at UHS. Nevertheless, it is understood that a SN user is not just a pregnant woman, but rather an individual with all the singularities and specificities of a person in her full existence. Therefore, she can be attended not only by a network, but by a multiplicity of networks that provide care for this target audience. Thus, to be able to provide effective care for the population, the Brazilian care networks need to ensure the connection and flow of users regarding all services required for their care.

The relevance the user gave to the network that could in fact provide care, comfort and resources to reduce her suffering is crucial to both understanding the functioning and identifying the potential devices and weaknesses present in the process. If, on the one hand, the care networks that were planned by the protocols with predefined flow are important for the care management, on the other hand they are insufficient, since they work with specific cases of the clinic area, without forecasting of the intense intersection among them.

Another aspect worth mentioning is that the health professionals themselves produce their care networks. This happens because it is common their attempt to connect their networks of professional contacts - in both emergency units and in other health services, sometimes even in other health units – in order to ensure the creation of an unexpected emergency "care line" for providing care to an immediate need[4]. Here we can notice a clear demonstration of developing new networks by the own health professionals team as it uses a self-management of the productive process that is provided in their living work. This space is run by the own health professional; therefore, he/she, in the molecularity of his/her everyday work relations, can work in that network according to his/her interests, possibilities and sense attributed to the act of caring.

Both the formal networks - those designed and organized by management norms - and the Live Networks - those that do not follow any rules and that are established by the micro-political environment of the work process - operate at the same time in the dynamics of care management. The latter can have different and varied formats, since they are built to meet specific needs that take place in a particular space and time. However, it is worth mentioning that equally to being built, acquiring strength and characteristics of individual care, the Live Networks, while meeting their objective of guaranteeing access, resources and care to the user, can also be undone in a natural way. Hence, they are networks that may have an ephemeral fluidity, malleability, flexibility and existence, or that may get new shapes within the health services.

Based on the botanical rhizome concept, Deleuze and Guattari[5] present an important reference for the discussion on care networks. They use this reference to relate it to open systems of connections that move in the social milieu through assemblages, that is, producing new relational formations on which is gradually built the *socius*, that is, the social environment where each one is inserted.

In this perspective, an important element for reference is that the network production is social, where the *socius* is constituted of relations between people, health professionals, among themselves and with the users. Consequently, it is a socio-affective construction, disclosing that it is constituted as a fold, where the environment influences people's affective body, operating in it as a device and, at the same time, acting intensely in the production of the world, constituting it, at the same time, as a permanent social production and an affective space. The fold is illustrated by the Moebus ring, where there is no separation of "inside" and "outside", but a single arrangement in its dynamic and intense functioning, working through the power of the bodies that constitute and meet themselves in the care setting[6].

By this means, life and care take place without the existence of a structured axis on which they are organized and produced in a structured way, but which happen from multiple connections and flows built in processes that create contact lines among social agents who are the source of producing reality[4].

It is necessary the presence of the following characteristics so that the health network is characterized as rhizomatic, which operates in the micropolitics of the health work process and that has

the live work in act as an element centered in this productive activity: operate on connections and continuous flows - any network point can be connected to another; have heterogeneity - capacity for coexistence, compromise, conflict management and high self-assessment ability; operate with the multiplicity guideline - principle associated with the non-exclusion general idea, where each can make connections in multiple directions and with many other subjects who also integrate the core of this flow; detect ruptures and non-ruptures - when the network is broken, it can quickly be recovered at another place, rebuilding itself; and present the principles of mapping, where the connections produce maps through the flows in which transit the actions of the singular subjects who act in that network[4].

These characteristics belong to the everyday activities of the health professionals who build their own networks, since they continually cope with the unusual and the unpredictable, which consequently instigates them to a creative work whose main resource is the will or desire, acting as a driving force that sets them in motion. This picture can be associated with the full range of technological resources that supports care provision and contributes to the management of challenging situations. Hence, by observing this context, one can realize that everything happens through the protagonism of the health professionals and users, without whom those networks would not exist. It is in this perspective that the Live Networks (LN) are labeled, here understood as ongoing hypertext networks, that is, networks that sometimes are circumstantial, assembled and disassembled, sometimes more stable but functioning, above all, as digital network logic, which can emerge at any point, without having to obey a logical ordering of the analog networks, in the same way as a hypertext[7].

The LN do not exist by themselves, as they are built by the users in their relationships with the health professionals, among themselves, with their relatives, with religion, with the world and all their devices, thus generating comfort and giving support in their care. Nothing is preformatted in the LN, which have as protagonists their production characters. It is worth highlighting that the LN are not opposite to the formal networks; they coexist and, at times, when the formal networks do not work, the LN take place. Sometimes, they also act as complementary, whereas in other times the formal networks do not even exist, giving rise to the performance of the LN. In short, the LN emerge to add support to care.

Method

This a qualitative research study that applies the concept mapping as a data analysis tool. For geographers, mapping is conceptually represented by a drawing that accompanies and is designed at the same time as the landscape transformation movements occur, unlike the map, which is static, the representation of a static whole. Not only in geography can be found cartographies. Psychosocial landscapes are also mappable. They are the accompanying and making processes, at the same time that there are certain world deconstructions (their loss of meaning) in contrast to another world compositions[8].

Mapping is justified for being a type of knowledge production, primarily due to be recognized in the context of an aesthetic of knowledge. The knowledge acquired by affects is pondered as

valid by some authors[9,10]. The effects of affects on the body-knowledge make it suitable for some actions in the world, changing it into a highly powerful tool to work on life. In this perspective, it emerges the "intuitive science"[10], presenting an association between the knowledge born in contemporaneity and hegemonically acknowledged as "scientific" and the knowledge that is produced based on the effects of affects on the individual. The "intuitive science" reveals a new aesthetic of knowledge which also requires new tools for its construction[9]. As it can be noticed, there is no intention to de-characterize knowledge accepted as "scientific", but to recognize its insufficiency and thus add to it new components that can express its extraordinary complexity, referring to the same complexity that inhabits the human world.

As reported by Moura and Hernandez[11], maps can be thought of as connectable and modifiable objects, opened by different methods, that lend themselves to poetic interpretations, incorporating cultural values and political beliefs by shaping and reshaping the space. Deleuze and Guatarri[3]: […] the map is open and connectable in all of its dimensions; it is detachable, reversible, susceptible to constant modification. It can be torn, reversed, adapted to any kind of mounting, reworked by an individual, group, or social formation (p. 22).

With that, there is the first clue to the mapping method: mapping is following a process and not representing an object[12]. According to Rolnik[8]: […] to provide a language to demanding affects, it is basically expected of him that he would be immersed in the intensities of his time, and aware of the languages he encounters, he devours those which seem to him possible elements for the composition of those cartographies that deem themselves necessary (p. 23).

This paper addresses the experience of a guiding user, a pregnant crack addicted woman, and of all the characters involved in her care process. The research was conducted in a capital city in Northeastern Brazil, whose health organization is divided into seven health districts. The guiding user lived in the district the City Center and the research was guided by the Stork Network devices that were offered to her in that district.

Several means or tools were used in the data production that would allow us having a broad and deep knowledge of the pregnant crack addicted woman and all the network connections and flows in which she was inserted or produced. For understanding the affects and their production in the social environment, it was necessary to have a stronger contact with that user in her territory as well as with the other protagonists of her relationship. In such a way, a monitoring of that user was established over a period of time. Moreover, several data sources were employed to obtain the narratives that could show a more comprehensive picture of her daily life. A field diary was used for the factual record of all experiences lived in the research field.

Taking part in workshops where health professionals talked about their impressions on the Health Care Networks operation and analyzed the case of the pregnant crack addicted woman was the first strategic tool applied in this study. The workshops were held from November 2014 to November 2015 and in each month it occurred in a different service, making a total of twelve workshops. Health professionals and managers took part in those workshops, reaching the total number of ninety-two

participants. The discussions of health professionals in service and towards the user helped to demonstrate the close connection between work and care, with implications in the use of specific tools for caring, protocols, staff, structured knowledge and work technologies. This first approach provided a general idea of the issue live work, particularly as a driving force for care, which is its main device.

A narrative interviewing technique with open-ended questions was conducted with the pregnant crack addicted woman and with the people she interacted with. In the interviews, the most remarkable aspects of her life and her existence in the world were addressed not as a drug user but as a person in its entirety that goes far beyond the relationship with drugs and the health services. With this approach, there was a more comprehensive picture of the subjectivation processes produced by her life track and the experiences it provides. The effect of the affects granted by her daily experience with the world of life as well as her production ability in the world through the modification of her own affective body were objects of analysis. This ongoing, close and singular contact with the interviewee has revealed the mechanics of self-production and world production, simultaneously as a process found in the production of care and in the networks.

Hence, data was obtained from the information coming from the workshops carried out by health professionals and which led us to choose the case on the guiding user, that is, the pregnant crack addicted woman. To analyze it, in-depth interviews were conducted with the guiding user and the other subjects involved in her care process. Furthermore, there were applied participant observation and field diary throughout the research. Thus, the analysis of the care flows, their connections, notably the protagonism of the guiding user in setting the networks closes the care production analysis cycle in the Stork Network and the Psychosocial Care Network. The synthesis of the analysis is found in the perception of: i) providing care to the user; ii) her affective body production regarding the social environment; iii) networks production for self-care, which matches the formal networks and “the Live Networks”, the product of her action towards self-care.

The research acknowledges that health professionals and users also produce knowledge, or better said, they have a previous knowledge on their reality, on the health problem they are dealing with and on the ongoing care processes as well. These aspects concerning life and care are shown to the researcher through the interviewees’ narratives. When reported, the narratives have the content, tone and texture of the narrator, that is, they become original when retransmitted, therefore producing data. Health professionals and users produce the research also because they disclose the knowledge they produced. Thence, they are active co-participants and protagonists, rather than being just merely objects on which an alleged knowledge is ahead of them to be interpreted. The researcher stands beside the research subject so that they can jointly produce knowledge[9].

Briefly stated, mapping becomes a process in which the cartographer has no assumptions, no script to be followed, no closed method, therefore differing from the conventional production form. S/He conducts herself/himself in the open field, the uncommon, the unexpected, at random for delving into the guiding user’s life experience. By doing so, processes emerge towards the researcher's path, together with the guiding user. On the other hand, some limitations also come out along the study, such as

the impossibility to generalize the expected results, since each user is unique and her/his life story becomes exclusive in her/his experiences in the networks.

For showing the results, the authors have chosen to report this research in the third person, given their collective construction. This paper comes from a multicenter project involving several Brazilian states. It was developed by the Federal University of Rio de Janeiro, submitted and approved by an ethics committee in human research, under the protocol 560.597.

Results and discussion

The choice

It takes place towards the implication of the researchers within the research itself. According to Lourau, as quoted by Romagnoli (2014)[13], "the implication denounces that what the institution triggers in us is always the reflection of a collective production of values, interests, expectations, desires, and beliefs that are juxtaposed in this relationship". The researchers from other states were taken to previously unknown territories, under new encounters, subjected to a displacement of the domestic and familiar "comfort zone". This leads the researcher to have tools to handle the research that go beyond the usual knowledge. They are related to issues like: How to enter a territory where you do not know anyone? How to access communities? How to connect to the guiding users? With those issues, the process has got uneasier, given the natural tensions of some creative ability, the perception of scenarios and the building of support networks.

The first visit to the *locus* of the research was conducted for knowing the territory and for finding out about people's connection to the study. At that moment, in order to present the research proposal, a workshop was held with professionals acting in Primary Health Care.

At the subsequent meetings, the health professionals were collaborative. Furthermore, a Community Health Agent (CHA) reported several cases under care in her Health Unit. The researchers have chosen the following problematic to conduct this study:

> A drug user looked for the Health Unit at end of her pregnancy. The first test result was positive for syphilis. She was then sent to the maternity hospital but didn't show up. The baby was born. A home visit was made while she was at home; however, no examination was performed on the newborn baby. The mother of the pregnant woman informed us that she was using drugs and so she was instructed to return to the Maternal Infant Health Program to perform the exams.

That guiding user was chosen for presenting herself with a difficult-to-manage care situation and generated discomfort in the health team, since she was a pregnant woman who used drugs, described as "not very collaborative" and seen as a case of tension among the health professionals of the care network. In this way, there was a search for the CHA responsible for that territory, so that more information about that specific guiding user could be gathered. It should be underlined that the data collected referring to the description and discussion about her life story had their anonymity assured, in the same way as in relation to the other participants of this study, which explains why all the names mentioned in this work are fictitious.

The choice of the term 'flowers' to name each character of the guiding user's life story has emerged due to this study primarily being a reference to the Stork Network, which refers to maternal-infant care, where pregnancy often refers to the image of a woman blooming to become a mother.

The guiding user in (de)construction

> Cactus Flower (hereinafter called Flower) is a 27-year-old woman in her first pregnancy. A crack user, she used drugs the night before delivery. She spent all her pregnancy on the streets, with no contact with her family. Lady Lily only found out that her daughter was pregnant when Flower was five months pregnant. Flower even made a prenatal visit in her pregnancy. At the time, the nurse who had attended her sent her to a maternity specialized in high-risk pregnancy care, sited in the Health District of that territory. Nevertheless, the nurse had no time to pick up Flower's pregnancy test results since she went into labor as soon as she was admitted to hospital.

A moment with Lady Lily

> My story is so like that! I think it can even lead to a life story book. These people who are drug users, you know, this drug business is like a plague (Lady Lily).

At that first moment, Lady Lily's fragility was perceived regarding the meaning of drug use in her life, given her suffering while watching her daughter on the streets and by trying to help her. After her granddaughter's birth, Lady Lily came back home and faced new obstacles: her husband and Flower's father, who was an alcoholic, had a relapse and returned to drinking due to his daughter's return to the house. Moreover, a nephew of Lady Lily, who is a next-door neighbor, consumed crack in front of her house.

When we requested to make an interview with Lady Lily, she reported recent episodes of domestic violence between her husband and her nephew and required that the interview would be conducted at another place. She did not touch the matter of her husband's alcoholism when asked about her family.

Flower consumed drugs throughout her pregnancy. She reported that she did not want the baby and that she would give her baby up. Lady Lily said that when Flower was 18 years old she had asked her to leave the house to work. With her mother's help, the girl got a job as a nanny and was fired two years later. After that, Lady Lily rented a small room for her daughter to live in. Lady Lily did not want to believe, but it was at that moment that Flower had her first contact with drugs.

In those visits to Flower, Lady Lily noticed her daughter's pregnancy and tried several times to take her to prenatal visit. Flower went to an appointment and, after being admitted to the hospital, ended up having a normal delivery at the municipal Maternity of reference. The night before, she had used drugs.

Lady Lily said that Flower arrived at her house in the morning of the day of her granddaughter's birth asking for help to go to the hospital, but then she realized she was already in labor. Flower reported that when she arrived at the hospital she received a very well welcoming, adding that her daughter was born "without any problem". Nevertheless, they had to remain in the hospital for ten days because both of them were infected with syphilis. After leaving the hospital, she returned to live with Lady Lily and her family. She did not want the child initially, but then she changed her mind. According to her report:

> [...] she had never made an appointment and she didn't want one because she didn't want that baby. She even stated in the conversation that she would keep taking drugs and that she neither wanted to make appointments nor keep her baby. The mother now feels happy because after the baby was born she found her beautiful, because the baby is beautiful. She changed her mind. She didn't want to give her child up anymore and her mother is controlling it until now [...] (Lady Rose).

Flower reported that after her baby, named Little Flower, was born, she had no health problem. She always refers to her baby as "healthy", as someone who "didn't have any problem because of the drugs" she had taken. Notwithstanding, we could notice in our meetings that Little Flower was a very restless and easy-crying baby. Flower stopped using drugs, including crack or any legal drugs like alcohol and cigarettes.

In this context, we could notice the importance of the family. Even when experiencing intense suffering, the family does not give up, does not refuse giving care to the family member when s/he is captured by drugs. Other studies show the relevance of family within the context of crack use. Reis

and Moreira[14] reveal that it is neither an easy nor simple task the family coexistence with a family member who is a crack user, leading the family to feeling overloaded. Yet, it is possible that the family does not abandon their crack addicted family member and wishes her/his life keeps going in the best possible way, to better and less harmful ways. Hence, fraternal love is shaped as something that is far beyond any family conflict.

In this perspective, it reemerges the strength of the Live Networks and Flower's protagonism in this construction process, building new paths to overcome drug addiction. Flower did not resort to any mental health care. Furthermore, at no time did she have support from health care for issues concerning both her abstinence and her baby's, as Little Flower was exposed to crack, though indirectly, in the intrauterine period.

A moment with Flower

> On our first encounter with Flower – a meeting of unfamiliarity at first –, she was sitting down in one side of the room with her daughter on her lap and holding her in a surprising way. Unequivocally, the dimension of protection that was established in the bond between them was sensitive. On the other side, there were the researchers, sensitive to the moment, but, at the same time, concerned for facing Flower and her daughter. Actually, the multiplicity of feelings stemmed from confronting the new, the strange, the unexpected, and the imponderable that would emerge there as a relationship.

The interaction with Flower was shy in the beginning. She gave us short answers, which intuitively seemed to reflect her fear of speaking. She seemed very far away and, now and again, was harsh, giving us monosyllabic answers and not allowing us to draw into her story. Nevertheless, at the end of our first meeting, as we were leaving the room, she started to talk and invited us to go to her house in order to look at the name of the doctor who had treated her at the hospital, adding that she was "very well treated there, although…".

Flower had first thought that she would be mistreated, or even not welcomed, by the health care service for being a crack user. Thus, she was surprised by the health professional's attitude because he provided her with good care service.

Regarding the previous meaning of drug use in her life, she reported:

> I liked it. I didn't care. People talked, and I didn't care at all. I used it until I lost myself.

In relation to the current meaning of drug use in her life, she stated:

> Destruction, no friends, no family. I don't think I'll use it anymore. It was destruction. It destroys the person. If the person doesn't have any control (over its use), she blows it, do you understand? She wants to leave the house and never see anyone else again.

Referring to the meaning of her daughter to her, she emphasized:

> My daughter gave my life back, do you understand? I didn't live before (her birth), and she was born without any problem.

Flower's speech is very significant, and it unveils that her daughter's birth acts as an event, with high interference in her subjectivity field. In the production of affects, there is a movement in which their effects are incorporated, that is, they become part of your affective body. According to Deleuze[15], based on Spinoza's philosophy, these effects, called "affections", are the result of the affects to which the body is exposed and modified from this encounter. These changes, which are ongoing, operate a subjectivation process in which there is an intense process of subjective production, and from this Flower modulates her relationship with the world.

According to Deleuze[16], drug use is related to two structuring questions. The first, which takes the nucleus of desire, interferes in the "perception system", or better said, in the perceptual processing, taking as reference the internal and external perceptions, that is, the affective field in its relationship with the *socius*, where in the intercessor space (established "between" two bodies) the user is produced together with the world around her/him. The second question refers to deviation, and the first image that emerges is the "lines of flight" as a possibility to re-signify the reality in which you live and, consequently, you only obey yourself. Here the socio-affective field builds possibilities, understanding the "lines of flight" as a production process of the self-perception and of the world, operating in the field of perceptions, "percepts" and "affects".

It is discussed within these parameters the different forms of relationship between user and drug, being paramount to demystify this issue in the same way as Xavier[17], who states regarding crack use: "around 20% to 25% become addicted, while the others remain in the pattern of recreational use." It is concluded from this assertion that the great majority of drug users are not addicted to the drug but maintain the heart of the desire that is bound to the several sources of pleasure and happiness coming from the world around them, operating a world perception in expectations they themselves control. In this movement, the users operate their deviations, their "lines of flight" of the reality with which their affective body do not compose and give a new meaning to the world to be part of it. It is a complex, sensitive movement, where the affective body operates in high intensity and means the user's control over the drug. The opposite occurs when the heart of this desire is structured as the only source of pleasure onto which people throw themselves, being consumed in a movement from which there is no chance of

"deviation", since in this case it takes place a capture of their desire, reducing their ability to act in the world.

It is noticed that the baby's birth enabled an encounter of such power and affection, which supplied the mother's affective body, restoring her source of happiness, empowering her to act in the world, giving her a greater vital force. In this way, there was a replacement of the field that had been previously focused on crack and now has shifted the center to her relationship with her baby, thus opening up possibilities for rebuilding the lost bounds. So, she recovers the missing link with the world of life, the way of existence and the possibility of her affective body expression.

The sentence "my daughter gave my life back" sounds like the great expression that the roles are reversed here. In other words, it sounds as if the daughter were the mother's caregiver. Nevertheless, how can a newborn be the caregiver? Well, care in this case operates by the power of its affects, by the relationship intensity, by the affects moving in the "field of consistency", defined by Spinoza[10] as a field that is established in the interactivity "between" bodies and this space, which is neither in the mother's pole nor in the child's, but notably in the space of encounter where everything happens. It takes place there the remarkable exchange of affects with powerful effects on both mother's and daughter's bodies, that is, the "affections" that imprint deep marks on the affective body, molding them into others. These are changes that are produced into the subjectivation plan and that are the onset of the mother's modification, who in turn starts to act in the world, but also in another way, since she already perceives it modified. In this case, we observe "the Clinic of the Affects"[18] as a conceptual unit to disclose a care relationship which is based on the encounter.

The Flower Network is a connection of the formal and living networks that she has produced. No contradiction is perceived between them, but complementarity. Nonetheless, it can be also noticed in some moments the predominance of one against the other, given it can be observed, in this case, the nonexistence of the Psychosocial Care Network and the fragility of care for users of mental health services.

It is acknowledged that the care network that was built around the user and her health problem has its own protagonism and the one coming from the people who were part of this network, such as the health professionals and the user's mother herself. This network established working arrangements with the user and produced events that made possible an outcome that could be opened to new possibilities. Thus, it emerged a new perspective towards the mother's and child's existence from a care that had the encounter as its central aspect.

Final remarks

This study converges to reflections concerning the construction of formal networks, such as the Stork Network (SN) and the Psychosocial Care Network (PCN), and the Live Network (LN), built together with the person's life story and her potentialities; therefore, not distorting or reducing the

meaning of any of the care networks, but understanding them as complementary possibilities for a single aim: the care.

It is also important to point out that the effort undertaken by the health professionals show their ability for providing care. They find this opportunity in the "Creative Work"[19], which is the environment where the health professionals are able to detach themselves from the subjugation of prejudices, moral and religious values, among others, placing themselves straightforwardly to attend the user with the goal of providing her/him care. Lacking any retroactive force towards the encounter, the health professionals find themselves free and ready to act, having as reference the self-encounter. In this scenario it is invested its full power, opening itself up to the feasible protagonism of users and health professionals, empowered in their affective body by the effect of the positive affects that flow in the relationship.

It is evident that care is not only composed of affection. Therefore, the tools inscribed in the technologies of knowledge and in the machinery are therefore required. In the end, one has to cope with the affective body as well as with the anatomic-clinical body integrating the same organism. Thus, it is important that devices such as lifelong education are created so that they can offer a perspective of qualifying new health professionals who can recognize the existence and operative capacity of the affective body.

It is noteworthy to recognize that the research shows the evidence that the health professionals and users play a strong role in the construction of care networks and, in this sense, they make evident that they produce care. Hence, they are not merely objects that can undergo interventions, but that aim at finding solutions using the available resources. Their commitment to the support network they built, the care they have sought to provide and the competence to make these connections demonstrate that care is offered through a network composed of a diverse range of formal and informal, protocolary and intuitive, social and affective arrangements, and it is exactly in this entanglement that care is produced, seen as a territory of uncertainty and, concomitantly, of spectacular creation and achievement power.

Finally, it is highlighted the need to offer connected, rhizomatic health services, which should not be provided in a fragmented way, given that the subjects in this scenario are complex and unique, therefore demanding a comprehensive care.

Collaborators

All the authors have actively participated to produce this paper. Maria Raquel Rodrigues Carvalho conducted the drafting, literature review, field data collection, interviews transcription, data analysis and discussion, conclusion and text layout according to the publication norms of the journal. Maria Salete Bessa Jorge participated in the literature

review, data analysis and discussion, and in the manuscript revision and approval of the final revised version. Túlio Batista Franco contributed to the literature review, data analysis and discussion, and conclusion of this paper.

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