REVISTA BRASILEIRA DE MEDICINA DE FAMÍLIA E COMUNIDADE

www.rbmfc.org.br
ISSN 2179-7994

Research Article

The Hour of the Star That Never Comes: Macabéa as a cartography of care for women made invisible in the Family Health Strategy

A Hora da Estrela que não vem: Macabéa como cartografia do cuidado às mulheres invisibilizadas na Estratégia Saúde da Família

La Hora de la Estrella que no llega: Macabéa como cartografía del cuidado a las mujeres invisibilizadas en la Estrategia de Salud de la Familia

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Abstract

Introduction: Macabéa, the protagonist of *The Hour of the Star*, portrays the invisibility of women in public health. Like Clarice Lispector's character, many women remain silenced in their suffering, neglected by ineffective state policies, and exposed to multiple forms of violence: symbolic, institutional, and structural. **Objective:** This study aimed to reflect, through the figure of Macabéa, on the care provided to invisible women and their expressions of suffering within the Family Health Strategy. **Methods:** This is a theoretical-documentary study. Based on care cartography, person-centered medicine, and expanded clinic, narrative blocks were built using field diaries, team meetings, and home visits, forming affective and ethical territories that emerge from daily clinical practice. **Results:** The narratives reveal seemingly banal complaints — such as vague pains, insomnia, and "accumulated fatigue" — that conceal stories of structural violence, care overload, and historical silencing. Although public policies have expanded the scope of women's health over the years, many of these experiences remain at the margins of traditional clinical care. Listening, in these cases, cannot be limited to symptoms; it demands presence, patience, and willingness to recognize what has yet to be named. **Conclusions:** The essay proposes a clinic that embraces absences, waits without haste, and trains physicians capable of sustaining complexity without reducing it to a diagnosis. It suggests that even when the "hour of the star" never comes, care is reinvented through radical listening and the gesture of staying.

Keywords: Primary health care; Women's health; Family practice.

How to cite: Vasconcelos LT, Fernandes DMAP, Alencar RGO. A Hora da Estrela que não vem: Macabéa como cartografia do cuidado às mulheres invisibilizadas na Estratégia Saúde da Família. Rev Bras Med Fam Comunidade. 2026;21(48):4962. https://doi.org/10.5712/rbmfc21(48)4962

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Funding:
no external funding.
Ethical approval:
not applicable.
Informed consent form:
not applicable.
Provenance:
not commissioned.
Peer review:
external.
Received: 08/15/2025.
Approved: 12/10/2025.
Associate Editor:
Bruno Pereira Stelet.

Resumo

Introdução: Macabéa, protagonista de *A Hora da Estrela*, é um retrato sobre a invisibilidade das mulheres na saúde pública. Tal como a personagem de Clarice Lispector, muitas mulheres seguem silenciadas em seus sofrimentos, negligenciadas por políticas estatais ineficazes e expostas a múltiplas formas de violência: simbólica, institucional e estrutural. **Objetivo:** Refletir, a partir da figura de Macabéa, sobre o cuidado às mulheres invisibilizadas e suas expressões de sofrimento na Estratégia Saúde da Família (ESF). **Métodos:** Trata-se de um estudo teórico documental. A partir da cartografia do cuidado, da Medicina Centrada na Pessoa (MCCP) e da clínica ampliada, foram construídos blocos narrativos baseados em diários de campo, reuniões de equipe e visitas domiciliares, compondo territórios afetivos e éticos que emergem da prática clínica cotidiana. **Resultados:** Os relatos revelam queixas aparentemente banais, como dores vagas, insônia e “cansaço acumulado”, que ocultam histórias de violência estrutural, sobrecarga de cuidado e silenciamentos históricos. Ainda que políticas públicas tenham ampliado o escopo da saúde da mulher ao longo dos anos, muitas dessas experiências continuam à margem da clínica tradicional. A escuta, nesses casos, não pode se limitar à queixa; exige presença, paciência e disposição para reconhecer o que ainda não tem nome. **Conclusões:** O ensaio propõe uma clínica que acolhe ausências, espera sem pressa e forma médicos capazes de sustentar a complexidade sem reduzi-la a um diagnóstico. Ao final, sugere que, mesmo quando a “hora da estrela” não chega, o cuidado se reinventa na escuta radical e no gesto de permanecer.

Palavras-chave: Atenção primária à saúde; Saúde da mulher; Medicina de família e comunidade.

Resumen

Introducción: Macabéa, protagonista de *La hora de la estrella*, representa la invisibilidad de las mujeres en la salud pública. Al igual que el personaje de Clarice Lispector, muchas mujeres siguen silenciadas en su sufrimiento, desatendidas por políticas estatales ineficaces y expuestas a múltiples formas de violencia: simbólica, institucional y estructural. **Objetivo:** Reflexionar, a partir de la figura de Macabéa, sobre el cuidado de las mujeres invisibilizadas y sus expresiones de sufrimiento en la Estrategia de Salud de la Familia. **Métodos:** Se trata de un estudio teórico-documental. A partir de la cartografía del cuidado, la Medicina Centrada en la Persona y la clínica ampliada, se construyeron bloques narrativos basados en diarios de campo, reuniones de equipo y visitas domiciliarias, conformando territorios afectivos y éticos que emergen de la práctica clínica cotidiana. **Resultados:** Los relatos revelan quejas aparentemente banales — como dolores vagos, insomnio y “cansancio acumulado” — que ocultan historias de violencia estructural, sobrecarga de cuidados y silenciamientos históricos. Aunque las políticas públicas hayan ampliado el alcance de la salud de la mujer a lo largo de los años, muchas de estas experiencias siguen al margen de la clínica tradicional. La escucha, en estos casos, no puede limitarse al síntoma; exige presencia, paciencia y disposición para reconocer lo que aún no tiene nombre. **Conclusiones:** El ensayo propone una clínica que acoja ausencias, espere sin prisa y forme médicos capaces de sostener la complejidad sin reducirla a un diagnóstico. Sugiere que, incluso cuando no llega “la hora de la estrella”, el cuidado se reinventa en la escucha radical y en el gesto de permanecer.

Palabras clave: Atención primaria de salud; Salud de la mujer; Medicina familiar y comunitaria.

INTRODUCTION

Throughout history, women have been called upon to survive: facing state neglect, compulsory motherhood, the burden of caregiving, and domestic violence. In primary health care (PHC) settings, this survival often manifests in exhausted bodies, normal test results, and evasive diagnoses. The complaint, almost always trivialized, reveals a biologically alive but subjectively silenced existence.[1]

This condition of survival that transcends the physical body and enters the territory of subjectivity also finds an echo in literature, a space where women are frequently portrayed in a state of silent resistance.

Clarice Lispector, Ukrainian by birth and a resident of Recife by necessity, transformed her experience of poverty in northeastern Brazil into sensitivity and a human gaze—attributes necessary for those working in PHC.[2,3] In her work, Clarice portrays with delicacy and strength the silent resistance of women in the face of invisibility and lack of belonging.

Her last character, Macabéa, the protagonist of *The Hour of the Star*, embodies this character that remains in the world without fulfillment. A woman from the Northeast of Brazil, impoverished, lonely, and alienated from her own desires, she represents what clinical practice often ignores: life that resists. Macabéa “didn’t know she existed,” and perhaps that is why she lived so little.[4] Her apathy and pale existence indicate alienation, the effect of multiple structural violences that reduced her to almost nothing.[5]

Just as in fiction, in Brazilian reality, female invisibility has also become a field of historical confrontation. The Comprehensive Women's Health Care Program (PAISM), from 1983, broke with the vision centered on reproduction, proposing comprehensive and humanized care.[6] Later, Viva Mulher strengthened the screening for cervical and breast cancer, and the Stork Network, from 2011, expanded attention to the pregnancy-puerperal cycle, focusing on humanized childbirth. Despite the advances, gaps persist in the care of women who, although they have survived, continue to suffer from symptoms and pains that escape clinical logic.[7]

This mismatch intensifies when medicine, instead of listening to suffering, transforms the uniqueness of the female experience into pathology. Vieira[8] describes the medicalization of the feminine as a form of control, naturalizing the idea of the woman's body under constant surveillance. Menstruation, pregnancy, and menopause have come to be treated as clinical events that can be corrected, silencing subjective experience in the name of biomedical normativity.

This distance between symptom and meaning is discussed by Narrative Medicine, which seeks to reconnect clinical practice to human stories. For Vankova,[9] narrating and listening are ethical gestures that reintroduce singularity into illness. Grossman and Cardoso[10] highlight reflective writing as a means of elaborating on lived experience and maintaining continuous care. Thus, narrating also becomes a form of care.

In this way, this article aims to cross Macabéa with the ordinary women who "appear" in the Family Health Strategy (ESF) and complaints that present themselves as medical problems, but which, in essence, reveal themselves to be expressions of social and structural violence that are still little recognized by the clinic. As Lispector[4] states, there are times when it is no longer a matter of writing with art, but of recognizing that "there is the right to scream, so scream."

METHODS

Paths travelled and meanings constructed

This qualitative essay adopts the cartography of care as its foundation, articulated with person-centered medicine (PCM) and expanded clinical practice, with the aim of reflecting on the modes of illness and care of women rendered invisible in the daily routine of the Family Health Strategy (ESF).

Cartography of care: foundations and principles

Cartography, as outlined by Deleuze and Guattari[11] in A Thousand Plateaus: Capitalism and Schizophrenia, does not seek to represent reality, but to accompany it in its movement, mapping forces, affects, and processes of subjectivation in constant transformation. From this perspective, mapping is following the process, not fixing a final product.

We are also inspired by the contributions of Brazilian authors such as Oliveira e Sampaio[12], who broaden the concept of cartography as an ethical-aesthetic-political device in the field of health. According to these authors, the cartography of care is based on the principle of implication: the researcher does not place himself outside the field, but becomes part of it, also being affected by the relationships that accompany it. Research is thus constituted as a process of co-affectation, in which knowing is also caring, listening, and transforming oneself together with the other.

Field diaries as scientific material

The field diaries, produced immediately after the consultations and home visits, were used as a device for recording and elaborating on the encounters. The aim was not to transcribe speech or describe events in a factual way, but to produce sensitive narratives that captured the movements of care.

Following Passos and Benvides[13] and Passos et al.[14], these records were treated as materials for the production of meaning, not as empirical data in the positivist sense. They were analyzed reflectively in meetings with the health team, in a collective movement of interpretation and reconstruction of meanings. From this analysis emerged clinical micronarratives, which reveal the interplay between pain, silencing, and resistance present in the daily care of women. In the end, it was possible to construct affective and analytical maps that give new meaning to the experiences..

Justification for approach

The choice of care cartography proved particularly suitable for the object of this study: the modes of illness and care of invisible women, as it allows us to embrace the complexity, uniqueness, and subjective dimension of these experiences. Unlike descriptive and statistical methods, cartography makes it possible to give visibility to the invisible, following subtle processes that escape the traditional logics of measurement, but which are essential to understanding care in its human and relational dimension. When articulated with PCM,[15] cartographic listening broadened the clinical field, breaking with the hegemony of biomedical anamnesis and recognizing women as subjects of knowledge. The expanded clinic[16,17] offered the ethical horizon of understanding care as the production of bonding and meaning — shifting the focus from closed diagnosis to inventive encounter.

Ethics and narrative construction

Because of ethical commitment, the narrative blocks presented are not based on direct or identifiable statements from users, but on themes emerging from clinical experience, worked on as affective territories and lines of meaning. Inspired by the writing of *The Hour of the Star*, by Clarice Lispector, the narrative fragments compose clinical, ethical, subjective, and teaching layers, expressing what was lived, reflected upon, and transformed in the daily practice of health care.

RESULTS AND DISCUSSION

As for the future, she can figure it out herself

This essay offers neither answers nor diagnoses. It is, above all, the exercise of the right to scream. A scream that crosses the consulting room, the classroom, and the unit's corridors, finding an echo in Macabéa and in so many others who, like her, don't know how to scream or have forgotten how. As Clarice Lispector[4] wrote: *"The everyday annihilates me [...]. I see that I write before and beyond myself. I am not responsible for what I write now."* So, what do we do? We scream. So that there is astonishment, disrupting the text of the books — our clinical books teach us everything and give us nothing to help us in the journey —; so that there is discomfort in those who need to be disturbed in order to change; and so that those who care also hear themselves. The narrative blocks that follow have been organized from some alternative titles of the book. Because, like Macabéa, many women we attend to have no name in the system, no place in the protocol, but they exist. And they expect us to see them.

It’s my fault or A discreet exit through the back door

There are times when the consultation ends and a weight hangs in the air. Not because of something said, but because of everything that escaped us. A hazy feeling that the patient left as she arrived: full of questions. These are consultations where the protocol was followed: blood pressure taken, prescription printed, treatment explained, but where the silence weighed more than the dialogue.

As soon as I leave the room, I sometimes think: it’s our fault. Because we need to know if something was there, hinting, but we are unable to touch it. Perhaps because we lack time — or courage. Is it the system’s fault? Because no listening can withstand ten minutes and a full queue. Deep down, it’s not just that. The blame is diffuse. It permeates training, the way we haven’t learned to listen, the idea that clinical practice needs to arrive at a name — and that, without a diagnosis, there is no care.

Clarice Lispector, by Rodrigo S. M., expresses a similar sentiment when observing Macabéa living in silence: “As for the girl, she lives in an impersonal limbo, without achieving the worst or the best. She only lives, inhaling and exhaling, inhaling and exhaling. [...] But why am I feeling guilty? And trying to relieve myself of the weight of having done nothing concrete for the girl’s benefit?”[4]

These are women who live on a thin thread of survival, between a vague complaint and a normal examination, between a request for attention and a rejection of themselves, the same weight: that of not having done enough. Or only what was possible — and what is possible, sometimes, is little.

There are also the anti-Macabéas. They don’t remain silent, they scream; they don’t suggest, they demand. They challenge with their presence and anger, refusing the minimum. They ask for exams, reports, listening, and for that reason they are seen as exaggerated, suspicious. We have learned to identify suffering as something contained, polite, “reasonable,” and those that overflow are viewed with suspicion — or with weariness. We forget that this waltz of exaggeration is often the way pain has found to appear — after years of inert silence.

PCM reminds us that care is not about us, the caregiving agents, nor about how much the consultation wears us down. It is about what it means to her. Her, our patient; our reason, our centrality. It is about recognizing that the cry is also a diagnosis, that intensity is also language, and that true listening is not done only with technique, but with presence.

Between method and flesh, there is an abyss. The method says to welcome; the flesh, at times, stiffens. The method says to ask more; the flesh wants to finish quickly. The method says that there is value in what is not said; the flesh is afraid to listen too much. And it is in this struggle — between ideal care and a tired body — that we continue, day after day, trying not to run away from the scream or the silence.

Deep down, a question remains that does not fade: do we prefer the trained Macabéas? And guilt, in the end, is a sign. A sign that there is something more in the field. That care is not neutral. That there are flaws that are not technical errors, but an absence of relationship. Guilt, here, does not paralyze. It pushes, makes you think. It raises the question: how many Macabéas passed by me and I didn’t see them? How many anti-Macabéas did I delegitimize?

She didn’t know it existed or Whistling in the dark wind

A pattern of nameless patients begins to emerge. Women who arrive without urgency, but frequently. They complain of back pain, heartburn, dizziness upon standing. Some speak of “accumulated fatigue,” others of “blood pressure rising when they get nervous.” When we ask what they imagine it could be, they respond: “I think it’s all in my head” — and sometimes they don’t even say that. They say “nothing.”

These complaints are repeated with variations, as if following a choreography of the invisible. The woman who treats candidiasis every month. The one who has had tension headaches for years. The one who says the problem is insomnia, but has never slept properly since her husband died. None of these stories seemed “important” in the medical record. But they all carried the same subject matter: a life too small for the pain they felt.

However, in the cartography that is made in everyday life, these symptoms were not diagnoses — they were warnings. Each complaint is a password to a territory of silences, of subtle violence, of old erasures. Gynecology does not seem to listen to them. Psychology is distant. General practice is overburdened. In health services, they circulate without anyone taking responsibility for listening to the whole woman. Family medicine itself, with its fundamental pillars of PHC, seems not to translate training into full practical application, making it very clear that what is necessary to provide care has not yet been achieved.

Therefore, it is as if these women are not allowed to fully exist, not even in the most relevant spaces for care. They come asking for “a sleeping pill,” “an injection to relieve pain,” and we often respond “yes,” with anxiolytics, more analgesics, and referrals to nowhere. Over time, we began to question this practice and learned to recognize in them the same material as Macabéa: a kind of existence that claims nothing because it does not believe it can. It was not hysteria or somatization — but a long history of non-recognition, a kind of suffering without a label, that escapes the manuals.

The fear of asking, even when filled with the need to do so, ends up being the most silent of sufferings. The fear of exposing themselves and hearing “no” to their face, like Macabéa: *“Was she foolish enough to ask? And to receive a ‘no’ to her face? Perhaps the empty question was only so that one day someone wouldn’t say that she hadn’t even asked. For lack of an answer, she seemed to have answered herself: it is like this because it is like this.”*[4] These women, when they come to us, seem to carry a silent doubt: would it be foolish to ask what I feel? Just as in Lispector’s work, the lack of an answer becomes an answer in itself: “it is like this because it is like this.”

The exeresis of the legitimacy of their own complaints can also be understood as a way of “not suffering” as they walk on the fragile bridge that crosses the abyss separating them from care: the denial of their own bodies so as not to perceive the gap in support; the impossibility of a full experience of health. These women do not know they exist — perhaps we, as professionals, do not know either.

She doesn’t know how to scream

She arrives on time. She brings old exams, her Unified Health System (SUS) card, and her up-to-date vaccination card. When she enters, she smiles. She says everything is fine. The main complaint is always minor: a little pain in the knee, discomfort in the stomach, an itch that appears from time to time. There are no signs of urgency, nor explicit requests. The consultation is clean, quick, and calm. And yet, something lingers in the air.

This woman — who does not complain, does not demand, and is not late — is often considered a “good patient,” but the absence of complaints is not synonymous with well-being. Over time, we realize that one of the most difficult silences to hear resides there: that of the woman who learned, from a very young age, that she should not take up too much space, but does not complain because she never learned that she could; because she has been ignored or blamed so many times that her body has learned to be silent along with her. Sometimes, this silence is praised: “she is strong,” “she does not cause trouble”; others, it is underestimated: “there’s nothing wrong with it,” “it’s all in your head.” In both cases, listening fails.

And therein lies the enigma of those who, like Macabéa, live by the motto: *“since I am, the only way is to be.”*[4] They do not seek answers, because they have already learned that there is no way to ask without receiving in return the empty echo of indifference, so they exist through an inert acceptance of what is imposed. Their suffering is a mirror of this “way of being,” without words—a being that passes, does not live, because it does not yet know what it truly means to be.

In PCM, we learn that suffering does not need to be validated by an examination to be real. The expanded clinic teaches us that care does not begin with conduct, but with the bond,[18] and in this bond, the unspoken weighs more than any report. These women, who do not complain, are sometimes the ones who most need to be seen. They carry the weight of homes that never rest, of loves that control, of jobs that exploit, and the body molds itself to the surroundings, hardening — until it ceases to feel. The cartography of care allows us to perceive this subtle design: the absence of complaint as an expression of an anesthetized life.[14]

Starfield[2] already pointed out that care in PHC requires the ability to understand the patient within their social and cultural context, as a way to ensure equity and effectiveness. As Morais et al.,[5] suggest, feminine in Lispector’s writing reveals a subjectivity marked by silences, interruptions, and unease that escape linearity — marks that also traverse the narratives of women who arrive at the consultation without knowing exactly what they are looking for, but carry, like Macabéa, a request for recognition.

Vankova,[9] when addressing the concept of narrative medicine as a potentiator of care, states that there is a need for prolonged *attention* to nuances, *representation* to rework what has been heard, and *affiliation* for recognition between doctor and patient. Therefore, it is necessary to relearn how to listen to the silence and to ask without intruding; to notice gestures, glances, and timing, because some pains don’t surface — they accumulate in layers — and sometimes all these women need is for someone to finally acknowledge them.

A feeling of loss

These situations are not always noticed immediately. Sometimes, it is only when the unit empties, the noises cease, the chair where the patient sat becomes cold, and the crumpled prescription paper is already in the trash. That is when her traces reach me, and I wait for some kind of answer — but what arrives is a dense silence, mixed with a certain grief and anger. Anger at the world that made her arrive in that state. Anger at the structure that limits us. Anger at myself for having brushed past her pain like someone driving over a pothole and thinking, «I’ll deal with that later»—except her road is full of potholes, and I kept going.

The waiting then becomes a clinical act. Not as inertia, but as openness and presence, because there are pains that cannot be resolved with immediate action. There are violences that require patience to be seen, and there are silences that need time to become speech. Waiting, in this sense, is sustaining listening when it still has no sound.

In this scenario, teaching also transforms. Students learn not only by observing behaviors, but by noticing how we handle doubt. How we do not reduce complexity to a code from the International Classification of Diseases (ICD) and how, sometimes, we leave the answer suspended — because only time (and listening) can reveal it. Waiting has become part of the job. I hope it returns. I hope that, one day, it will say what it has never said. I hope that listening will be more attentive, more open, more complete. Meanwhile, teaching and learning continue.

The hour of the star (that never came)

I await the star. I hope that one day one of them will say, “Now I feel alive,” as if the care, at last, had worked. I hope the protocol works, that the team finds the right word, that the woman smiles with relief at the end of the consultation. The star moment, however, does not come. And perhaps it never will. What does come, however, is something else: the recognition that care is not a destination, but a field in motion; that there are days when all we can offer is company—and that is already a lot; that keeping a woman alive, listening to her absences and respecting her silences, is already a form of radical care in a world that has silenced her forever. In addition, practices have changed. We began to notice when the body speaks without words. We created informal conversation circles, organized the schedule for slower reception, and talked about the Macabéas of the territory. For example, a resident proposed a self-care project for family caregivers, and a community health agent began noting in her notebook the “issues that don’t make it onto the form.” Listening expanded — and with it, the clinical practice.

The cartography of care teaches us that it’s not about solving problems, but about being together; about producing deviations, cracks in daily life, micro-transformations. MCCP gives us language to name what we intuit: that the person comes before the problem; and the expanded clinical practice sustains the gesture of not knowing—not as a failure, but as a method. Narrative medicine, in turn, humanizes the therapeutic relationship and shapes the clinician as an ethical subject. By writing about the encounter, the professional re-inscribes themselves in it, re-listens to the other and to themselves, elaborating meanings that support care without reducing its complexity.[18]

Perhaps the star will never come because, for some women, it was extinguished too soon. What we can do is keep the light shining brightly enough for her to see herself. And, who knows, perhaps wish together for another time — the time of listening, of recognition, of dignity, of wholeness. This is a clinical practice made of small gestures and long waits. A clinical practice that is like how Clarice Lispector wrote Macabéa: full of interruptions, doubts, and silence, but which also has a stubborn faith, certain that even if the star doesn’t shine, light can be born from the encounter.

FINAL CONSIDERATONS

As for the future: what if Macabéa were alive today?

Between the publication of The Hour of the Star in 1977 and the year 2025, an entire country rewrote its history of health: the SUS (Unified Health System) was born, and policies promoting women’s health were consolidated. Even so, Macabéa did not die. If she lived today, perhaps she would live in an urban periphery, take two buses to get to the Basic Health Unit (UBS), and say, “Everything’s fine, I just wanted to renew my blood pressure medication.” Perhaps she would have become a mother before knowing what she wanted from life; perhaps she would have survived violence, a nameless depression. Perhaps she would never have heard the word “acceptance” — or perhaps she would have, but would not know what to do with it.

Macabéa, in 2025, would be the portrait of the woman who resists in the interval between the politics that saves and the care that is delayed. She would be the present body of an updated negligence: more subtle, more diffuse, but still real. A stereotype forged over centuries — that of the woman who doesn’t really get sick because she has always been trained to swallow the world. What can we, family doctors, do? We can, first of all, see what remains on the margins. There are consultations that require less haste and more presence.

We can use the stethoscope, but also our gaze, our listening, our poetry. We can remember every day that, between diagnosis and care, there is a whole world. The star may never come, and Macabéa never had the courage to have hope, but it is up to us to build change, because in our daily routine of care that we can still build care that recognizes, validates, and accompanies.[19]

CONFLICT OF INTERESTS

Nothing to declare.

AUTHORS’ CONTRIBUTIONS

LTV: Conceptualization, Writing – review & editing. DMAPF: Conceptualization, Writing – review & editing, Methodology. RGOA: Conceptualization, Writing – review & editing.

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