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Between Streets and Networks: Care Practices and Resistance in Contexts of Social Vulnerability

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Abstract

This article examines care practices and forms of resistance that emerge in socially vulnerable contexts, particularly within urban peripheries and informal settlements where structural exclusion shapes health needs and access to services. Drawing on literature and empirical evidence, the essay highlights how informal care networks, community health strategies, and grassroots collectives create alternative pathways of support beyond formal health systems. These practices are understood not only as survival mechanisms but also as expressions of collective agency that challenge institutional neglect and health inequities. The analysis foregrounds the role of social ties, solidarity networks, and community-based interventions in mitigating the impacts of poverty, violence, and structural discrimination. The article concludes that recognition and strengthening of these "street to network" practices are essential for equitable and culturally resonant public health strategies, requiring policies that move beyond biomedical models toward integrated, participatory, and context-responsive care.

Keywords: community care, social vulnerability, informal networks, health equity, resistance.

Introduction

Amid persistent social inequalities, health and care cannot be fully understood through the lens of formal health systems alone. In contexts marked by extreme vulnerability – such as informal urban settlements, peripheral neighborhoods, and economically marginalized territories – formal health services are often inaccessible, overstretched, or mistrusted. In response, community-

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based practices, informal networks of support, and grassroots movements play a critical role in sustaining health and well-being.

These practices reflect the lived realities of populations that navigate social exclusion, economic precarity, and systemic violence. In many cases, they emerge not as complements to official services but as primary sources of care, rooted in reciprocity, solidarity, and collective resilience. Examining these practices sheds light on how health emerges from the interstices of social life, shaped by networks of mutual aid and shared resistance.

Community networks often address gaps left by formal systems, such as basic social support, psychosocial care, chronic disease management, and health education. They mobilize personal and collective resources, utilizing knowledge grounded in lived experience. These practices are deeply relational, drawing on family ties, neighborhood bonds, and collective identities that empower individuals and communities to navigate structural barriers.

By exploring how care practices and forms of resistance manifest between streets and networks, this article seeks to illuminate pathways toward more inclusive and equitable public health strategies. It emphasizes that acknowledging informal care systems and resistance practices expands our understanding of health beyond institutional boundaries and opens space for transformative approaches rooted in community agency.

Methodology

This paper is a theoretical and interpretive essay grounded in recent literature from public health, social epidemiology, medical anthropology, and sociology. It synthesizes empirical studies, community health research, and theoretical contributions that address care practices in socially vulnerable settings. No primary data collection was conducted; instead, the approach integrates findings from peer-reviewed articles and reports published between 2022 and 2025, identifying patterns in informal care networks, community resilience, and resistance practices.

The analysis focuses on mechanisms through which care is enacted in everyday life, including mutual aid networks, local solidarity strategies, and community-based health initiatives. Emphasis is placed on understanding how these practices both respond to systemic gaps and contest inequitable power structures that limit access to formal health services.

References are presented in APA format at the end of the article and support the conceptual framework developed through this critical synthesis.

Discussion

1. Social Vulnerability and Informal Care Practices

Social vulnerability refers to the susceptibility of populations to harm due to exposure to structural forces – such as poverty, discrimination, violence, and marginalization – that limit access to resources, opportunities, and services. In such contexts, informal care practices often emerge as fundamental strategies for survival and well-being.

In many informal urban settlements, residents rely on extended family networks, faith-based groups, and neighborhood associations to provide care that would otherwise be unavailable. These networks often deliver immediate support for basic needs, including food provision, childcare, elder support, and emotional care. Their embeddedness in daily life gives them a relational strength that formal services frequently lack.

Informal care also plays a vital role in health navigation. Navigating complex and often unwelcoming health systems can be daunting, particularly for those facing linguistic, cultural, or socioeconomic barriers. Communities develop localized knowledge and practices for interpreting symptoms, accessing services, and advocating for care. These practices are shaped by shared experiences and collective memory, reflecting a form of social learning that enhances community capacity.

Importantly, informal care is not merely substitutive but proactive. Examples include community health promoters, peer support for chronic disease management, and mutual aid during crises such as pandemics or economic downturns. These actions represent a continuum of care that responds dynamically to needs, fostering resilience in the face of adversity.

2. Networks of Resistance and Collective Agency

Informal care practices are closely tied to resistance against structural exclusion. Social networks function not only as systems of mutual aid but also as sites of collective agency that challenge marginalization and articulate alternative visions of health and well-being.

One form of collective resistance can be observed in community health movements that organize to demand better services, equitable policies, and accountability from public authorities. These movements often emerge in response to systemic neglect and exclusion, leveraging collective voice to push for policy change.

Other forms of resistance are enacted through everyday practices that subvert dominant norms. For example, cultural practices that affirm dignity and identity in the face of stigmatization can reinforce a sense of belonging and psychological well-being. Grassroots campaigns that promote culturally resonant health education – such as indigenous or Afro-descendant health narratives – contest standardized biomedical frameworks that may exclude or marginalize local knowledges.

Networks also produce resilience in the face of violence and insecurity. In contexts where violence undermines trust in institutions, community solidarity networks function as protective systems, offering psychosocial support and tangible aid. Such networks often collaborate with non-governmental organizations and public health agents to co-create localized responses that are contextually relevant.

Thus, care and resistance are deeply intertwined: networks provide care while simultaneously enacting forms of resistance that affirm human rights, dignity, and collective empowerment.

3. Implications for Public Health: Recognizing Networks and Supporting Agency

The recognition of informal care practices and networks of resistance has profound implications for public health theory and policy. First, it challenges the assumption that formal health systems are the sole or primary sites of care. By acknowledging the legitimacy and efficacy of community-based practices, public health can expand its scope to include non-institutional forms of care that communities have historically developed.

Second, policies that engage with community networks must emphasize partnership rather than paternalism. Health

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interventions co-designed with communities are more likely to be culturally appropriate, equitable, and sustainable. An asset-based approach recognizes community strengths rather than framing vulnerability as deficit alone.

Third, supporting networked care requires investment in health-promoting infrastructures beyond clinical services—such as community centers, peer support programs, and social protection mechanisms. These interventions can complement formal systems by enhancing access, trust, and continuity of care.

Finally, public health strategies must integrate solidarity and resistance as central components of health equity. Supporting community agency contributes to collective resilience and fosters environments where health justice can flourish.

Conclusion

Between streets and networks lies a rich tapestry of care practices that are vital to understanding health in contexts of social vulnerability. These practices – rooted in community connections, solidarity, and collective resistance – demonstrate that health is not produced solely within formal health systems but also through everyday social relations.

By recognizing and strengthening informal care networks, public health can become more responsive to the lived realities of marginalized populations. This requires policies that move beyond biomedical models toward inclusive frameworks that honor community agency, cultural relevance, and participatory engagement.

Addressing health inequities thus demands an expansive view of care—one that acknowledges the invisible yet powerful networks that sustain health and resist structural exclusion.

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