Essay

Imagining the work of community health workers: notes for a discussion on territory, health and care

Imaginando o trabalho do agente comunitário de saúde: notas para uma discussão sobre território, saúde e cuidado

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Abstract

The purpose of this essay is to present reflections on the territory-health-care triad, starting from the practice of community health agents as a context that allows us to visualize the complexity of this relationship. It is a theoretical-reflexive essay produced through the integration of knowledge from social anthropology and health sciences. In this sense, we highlight three reflective sessions whose notes propose: firstly, discussing territory and territorialization in the context of the technical-bureaucratic practices of the Unified Health System (SUS); secondly, discussing the relationship between care and medicalization, seeking to critically analyze the health-illness-care process in correlation with the territory; and finally, discussing the potential of community health agents in managing sociocultural meanings and representations in the care provided by primary health units. We emphasize that even the use of sociocultural concepts of territory requires recognition of the inherently dynamic nature of territorialization practices, and that care, equally, should be understood as a way of producing and signifying relationships in the world that are not exclusively related to health.

Keywords: Community Health Workers; Sociocultural Territory; Health, Primary Health Care.

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Resumo

O objetivo deste ensaio é apresentar reflexões sobre a tríade território-saúde-cuidado partindo da prática do/a agente comunitário de saúde, como contexto que permite visualizar a complexidade da relação. Trata-se de um ensaio teórico-reflexivo produzido a partir da integração de saberes envolvendo a antropologia social e as ciências da saúde. Nesse sentido, destacamos três sessões reflexivas cujas notas propõem: em um primeiro momento, discutir sobre território e territorialização no contexto das práticas técnico-burocráticas do SUS; em seguida, discutir sobre a relação entre cuidado e medicalização, buscando pensar criticamente o processo saúde-enfermidade-atenção em correlação com o território; e, por fim, sobre o potencial do/a agente comunitário de saúde quanto ao manejo de significados e representações socioculturais na atenção prestada pelas unidades básicas de saúde. Apontamos que, mesmo a utilização de conceitos socioculturais de território demanda o reconhecimento da natureza intrinsecamente dinâmica das práticas de territorialização e que, o cuidado, igualmente, deve ser compreendido como forma de produzir e significar relações no mundo não exclusivamente relacionadas com saúde.

Palavras-chave: Agentes Comunitários de Saúde; Território Sociocultural; Saúde; Atenção Primária à Saúde.

Introduction

This essay emerges from different academic and professional activity contexts of its authors. It is a collaborative construction that assumes "territory" and "care" as important markers in the activities developed by community health workers (ACS). In this sense, imagining the ACS work process has taken on a notable place in the Study and Research Group on Nursing, Body, and Health (GEPECS) and at broader levels within the Postgraduate Programs in Health Sciences (PROCISA) and the Postgraduate Program in Social Anthropology (PPGANTS), both linked to the Federal University of Roraima.

Thus, as essayists, we present the hallmark of the meeting of different perspectives and the recognition of Nursing and Anthropology integration as a crucial step to addressing the diversity and complexity of events involving PHC care practices. Selecting the ACS as a nexus in this debate is our perspective of the binomial "territory" and "care" in their theoretical and epistemological nuances.

As is well known, the Unified Health System (SUS) is based on a broader concept of territory than one that identifies it only as a spatial or geographic form. Recognizing that behaviors and sociocultural-epidemiological profiles develop differently in different contexts is a relevant gain for the practice of a health system concerned with universality, equity, and comprehensiveness, as it allows health to be situated within a broader framework of references. In other words, the discussion about territory allows for recognizing that practices related to health and, thus, health programs and policies, whatever they may be, will have different expressions under their distinct contexts.

However, the very concept of territory can lead to pitfalls in implementing the SUS doctrinal principles. The importance of operationalizing PHC by defining territories of coverage has already been widely debated in the specialized literature. From the outset, we highlight the pendular nature of this operationalization, sometimes between a concept of territory as a bureaucratic-topographical entity and sometimes as a process (Gondim et al., 2008).

Observing that complex relationships occur at sociocultural, political, economic, and health levels within a given territory and that the territory does not exist expressly but emerges as a product of human action does not necessarily account for the complex movements by social stakeholders. More than seeking a model that can account for all socio-epidemiological events, we should consider the human extrapolation regarding technical-bureaucratic practices and, therefore, vis-à-vis the territories imagined within official documents, especially when we are invited to think about ACS leadership.

Whether in mapping to study the ACS work in PHC or designing field research involving anthropologists and nurses, extrapolating the space of territories described by public health institutions has become crucial. The practices of individuals often bring them into contact with different bodies, making them visit health spaces differently. From this perspective, the idea of the individual as a subject of reason, centered, endowed with a fixed identity, gave way to a more open and unstable subject form in postmodernity, demanding that public institutions also begin to address these complex movements (Hall, 2006).

In these preliminary reflective lines, we imagine the power of ACS actions and highlight the need for their valorization within the SUS territorialization practices. We recognize that the ACS are crucial social stakeholders in bringing the population closer to the Family Health Strategy (ESF) because they belong to the territory. As we understand it, the ACS figure is understood as a social stakeholder with more significant established links and the ability to identify the necessary demands of the population within the territories circumscribed to the PHC Units (UBS) (Brazil, 2018a).

More than that, if considered within this broader problem of the different territorialization processes, the ACS may be crucial in mobilizing (in)formal care devices in the territory and the health networks themselves towards practices more attentive to how subjects move around places and, perhaps for SUS advancement if the importance of this closer dialogue with the population is understood.

The first section spurs discussions about territory and territorialization, reviving its polysemy and the need to be imagined within its correlations with the overflow of bureaucratic practices defining the territory. In the second section, we focus on the relationship between care and medicalization, seeking to think critically about the health/illness/care process in correlation with the territory. In the last section, we aim to gather discussions that present the ACS potential to contribute to using sociocultural meanings and representations in the care provided by health services.

The sections are entitled "Reflective Notes" because we understand that we are delving into complex terrain by problematizing the correlation between health, territory, and care, mainly because we suggest that such vectors are not as delimited or isolated in social situations as one might imagine. Thus, more than sections where one can find finished concepts, each station gathers theoretical-reflective insights to gradually present the ACS practice in the relationship established with the territory-health-care triad.

First reflective note: territorialization and territorial impermanence

Reflecting on territory closely related to the ACS practices is a complex task. Many representations are available in the different approaches to this simple word, from the more stable ones, such as in the political and institutional approaches to borders and the nation, to the more open ones, such as those debated, for example, within what is called the philosophy of difference (Deleuze; Guattari, 2011; Deleuze; Guattari, 2010).

Considering the use of the notion of territory, especially for health, also represents a complex undertaking, given the large number of debates already produced in this regard and due to the significant implications that its use holds for (re) organizing SUS health processes. At the center of this managerial and political context, it is necessary to consider how the ACS represent the territory where they dwell and develop health actions with the community.

In other words, even if the idea of territory is strained to produce operational assumptions more attentive to sociocultural content in the context of technical health documents, its other representations will persist, as all policy is also practiced in actual situations. Therefore, we should remember that the delimited terms and concepts in the texts of the PHC journals, manuals, laws, and projects do not unequivocally determine the interpretations and circulation these contents will have among their subjects and spaces of destination and action. In this sense, SUS territorialization coexists with the multiple representations beyond that defined in the programs advocated by the Ministry of Health.

In this sense, the predominant conceptualization of territory is sometimes still one that rests on a designated, physical, immutable, lasting space restricted to a geographic area, clearly defining habits, languages , and social behaviors in which the ACS has a specific role with families. The reflective challenge is overcoming this rigid territory representation. To do so, we should look at the ACS in their entirety, recognize the psychosocial dimensions that emerge in their interrelation with the dynamic socio-physical-cultural environment, and (re)cognize the development of their community actions (Bezerra; Feitosa, 2018).

According to Barth (1998), the approach to cultural variation as a result of territorial discontinuity, that is, that cultures vary with the degree of distance between them, always marked by well-defined borders, produced the argument that each human aggregate necessarily constitutes a culture, occupies a territory, and demarcates fixed borders unproblematically, among other essentialisms. Conceiving social groups as aggregates of self-contained meaning poses many problems, for example, in the studies of sociocultural situations in which one perceives, among other things, the permanence of cultural borders, even in circumstances in which geographical or political borders perhaps no longer exist.

The problems that the notion of territory brings to light for social analysis are diverse, especially when we look at controversies and critical events in contemporary life. How can we explain, for example, the clarity with which subjects define their social, political, and cultural affiliations, even when they cease to be part of the geographic territory to which they once belonged, as in the modern world's human mobility situations? How else can one explain the coexistence of such distinct cultural manifestations, even internally, within a single political territory? Therefore, the idea that a territory gathers a homogeneous set of cultural manifestations is problematic and deserves attention when the ACS figure is questioned.

These compositions open spaces for dialogue with the ACS activity in the territory, especially when they are affected in their daily work by the lack of access to families represented by the limited home visits (HV) in closed houses, substandard infrastructure conditions in the territory, difficult community mobilization with health services, and popular participation in the SUS. At the same time, one must recognize within their practices the expression of love, friendship, bonds with families, and usefulness in monitoring the people's healthcare in the territory (Bezerra; Feitosa, 2018).

Specifically in health, adopting the work by Milton Santos (1998) to problematize the idea of territory has become well known. His concepts contain how people use the territory, not the territory itself as if it were an entity dissociated from social agents. It follows that adopting territory as a valuable concept for health also involves assuming territorial dynamics since, as the author suggests, new designs and representations of the inhabited space will always occur in a territory, involving its functionality, occupation, possible human actions, and the subjects that integrate it, among other issues.

Evoking personal memories about ACS use of the territory paves the way for unfinished reflections that consider its spaces and devices as integrating elements in the care dynamics. In this sense, we should consider that for the ACS, streams, squares, community gardens, herbal medicine houses, flower shops, schools, dance teaching centers, churches, spiritualist centers, houses of prayers, and healers form a dynamism in the territory useful for producing healthcare.

Aligned with the empirical findings conducted in the Amazon context, we noticed the importance of other social stakeholders in the territorial spaces who provide care in the daily encounters and ACS statements. They are often closer and more accessible to people and better accepted than biomedical care, which has a formal and rational way of thinking about health know-how. Traditional ways of maintaining life are unique and part of the daily lives of the people dwelling in the territory. Also, while "wandering" through the territories with the ACS, we noticed that the so-called traditional healing practices take different forms, such as "cleansing", massage, teas, "medicinal bottles", prayers, bringing relief to "bad spells" and comfort to people (Feichas; Schweickardt; Lima, 2019).

These spaces, devices, and social stakeholders are responsible for producing a territorial dynamism captured and used by the ACS when they meet with people and families to screen health needs. The authors infer these meanings about the territory's existential dynamics from experiences in workshops for producing talking maps with the ACS in the UBS and from real experiments in the territories during extension activities in PHC in the extreme north of Brazil, Roraima, Boa Vista.

Continuing our reflections, another important discussion about territory concerns its political expression for the space of a country, contradicting the idea of a hierarchy between space and territory and that territory is an apolitical category. The territory does not exist without territorialization, appropriation, and referentiality with space (Santos; Silveira, 2009). Therefore, reducing the territory to the concept of space is reckless for health, as it leads to understanding the territory as a mere resource for administrative management or the physical management of health spaces. Thus, it is necessary to expand the use of territory by delimiting units and hierarchies of action and its theoretical potential to improve the understanding of the health processes experienced therein (Monken; Barcellos, 2005).

In SUS territorialization practices, the territory is emphasized for its possibility of representing sociopolitical issues, where the interaction between the population and health services can be verified. Such practices are considered active processes employed by the SUS toward constantly recognizing "people's living conditions and health situation in a covered area" (Gondim et al., 2008, p. 12).

Therefore, territorialization is central to implementing SUS policies and conforming to ACS activities within PHC. However, we indicate that they may also function as reinforcers of territory as a concept under which a population occupies specific places, with some sociocultural and epidemiological profiles obscuring the dynamic dimension of territoriality and territorialization processes.

According to Merhy et al. (2019, p. 74), territory mobilization configures, together with other categories, a set of values and forces that can manage subjectivities in the health system. If attached to an idea of "assigned territory", social groups also come to be known as "physical" places, which can be known without the effective participation of others. This way of visualizing the territory captures and manages subjectivities, conditioning them to respond only to what the system can observe. As we will see later, the closer action of subjects can reveal movement modalities between multiple life representations, which may or may not be described in the health system's labels regarding its assigned population.

Besides territorialization as a way of recognizing health conditions, we, therefore, grasp that it would also be necessary to invest in understanding territorialization processes as dynamic and affective forms through which people occupy spaces, not only in the geographical sense but in the sense of belonging and the relationships they build with the different elements underpinning their subjectivities.

In this logic, important ACS attributes to be highlighted in a theoretical and reflective note on the territory concern the bond, reception, respect, and feeling responsible for the families. Thus, the sound encounter with the other, here extended to spaces and devices, appears as a great enhancer of the professional action and the connection with the territory, which can promote a favorable implication with the work and the territory (Bezerra; Feitosa, 2018); that is, adopt a conception

of territorialization less associated with its physical and spatial dimension and more with the overflows resulting from "inhabiting a place". Recognizing that territories are under permanent construction if their approaches proceed through the crystallized characteristics typical for the health system to operate is not enough.

Although territorialization operates as a way of moving health practices, putting pressure on the most rigid territory forms, what also stands out are the ambiguities and challenges inherent to this way of organizing the ACS work process around care production, which paves the way for us to enter the second note that interweaves reflections on the territory-care-life triad.

Second reflective note: territory, care, and life medicalization

The issues mentioned above may become more evident when we consider the dimension of healthcare and the defense of life. If, on the one hand, territorialization is an important strategy to strengthen the contact between the ACS and the population, on the other hand, it also seeks to maximize the resources used by health services, increasing the number of people reached by their practices. The territory, equally, although it seeks to express a sociopolitical dimension of human relations in a given space, also appears in the SUS as a representation of the complex network of territorial units and divisions, expressing different managerial and hierarchical plans and the different responsibilities distributed throughout the primary health network (Gondim et al., 2008).

In many of the guiding documents for health practices, when studying territory and territorialization in the SUS, the terms are based on the ideas of "mapping" and "delimitation", "definition of coverage areas", and "identification of profiles". At all times, territorialization activities are guided by the unequivocal definition of a space where health teams can act, and light is shed on the ACS performance here. Such activities contribute to expanding the supply of health services and ensuring SUS equity, comprehensiveness, and universality. At the same time, however, we draw attention to the implicit care conception that lies therein and how it can also contribute to social life medicalization.

This occurs because, in their territorial work, the ACS often focus on disease control in their relationships with people and are placed in situations of vulnerability and social risk, which can trigger a condition of ethical-political distress and make them passive and indifferent to the needs and subjectivities circulating in their community's reality (Bezerra; Feitosa, 2018).

The idea of care that prevails in territorialization practices understands subjects as immediate correlations of their territories. Even amid recognizing the distinctions of social territories and their procedural nature, some of these contexts are often reified around categories such as "urban", "rural", "liquid", "vulnerable", "poor", "insecure", or others, which hypostatize these places as homogeneous and replicable spaces of relationships. This results in less ACS attention to how different representations circulate and how subjectivities are multiply constituted regarding the territories people occupy.

In this context, we can understand the definition of territories as discursive formations, not entirely dissimilar to other practices in the biomedical field, in the sense that they seek to establish, with a specific "set of rules and regularities, determined in time and space, the conditions for exercising the enunciative function" (Foucault, 2017, p. 144). It is also clear that the technical paradigm concentrates on the ACS, a dominant hospital-centric vision disaggregated from the care provided to humans and their relationship with the territory. This situation gives rise, from the care viewpoint to challenges for the care practices they perform, namely, standardized territories, lack of knowledge of the movements of community life and the micro-area of activity of team peers; the lack of articulation with other social policies such as social assistance, education, security, and the informal networks of the territory such as religious institutions and non-governmental organizations (Faria; Paiva, 2020).

In this understanding, when a given territory is defined under the heading of "urban", "rural", or "vulnerable", there is a set of behaviors, discourses,

and practices that one seeks to circumscribe, name, and legitimize. The health service learns to expect and see this profile in the assigned population, and the population, in turn, is approached and served under the sign, ultimately, of rurality, urbanity, and vulnerability. The care practices that emerge from this, therefore, accompany this circumscription. The discursive ACS practices also engender a policy of recognition, which excludes that it cannot name and circumscribe.

Here, we pause to ask: Would it then be the role of the SUS to address all the particularities and specificities of the population? Perhaps it is not a matter of separating the population into majority or minority tendencies at all times, defining a territory by the most regular and apparent tendencies. However, rather than taking diversity as a starting point in the production of strategies for territorialization and care, taking it from the beginning as a nexus for understanding living ways and care modes.

The challenge is always to understand that the social, human, political, environmental, and geographic resources distributed throughout the territory include everything that can come to integrate the unique and singular perspectives of the subjects; however, also that the subjects inhabit a variety of territories in contemporary life, with which they construct meanings and reframe their actions and that deserve attention by the ACS in territorial experiences.

Another issue in this debate relates to the (mis) encounters between medical/health anthropology and epidemiology. We observed previously how the health discourse is always based on sociopolitical conceptions. In particular, the meeting of medical anthropology and epidemiology agrees with the dynamic nature of the health-illness-care process (Menéndez, 1998). Despite the several converging points, we should consider some important dissonances, mainly regarding medicalized behaviors and social representations.

In continuation, Menéndez (1998, p. 74) exemplifies this situation when discussing the category of "lifestyle". Although epidemiology and medical anthropology take ownership of the idea of living conditions as significant for understanding health and disease processes, the two use this conceptual framework differently. For one – anthropology –, lifestyle would appear as a holistic concept; for the other – epidemiology –, lifestyle would appear as "risk behaviors".

For anthropology, "lifestyle" would correspond to a search for understanding the different levels through which diseases are articulated (individual, collective, subjective, and political), seeking to see in subjects-groups-communities expressions of broader social processes. For epidemiology, on the other hand, "lifestyle" is emptied of this comprehensive trait, preferring to adopt intervention at the level of the individual and in the biological causation of the disease, taking the sociopolitical aspect only as an accessory in the description, without any explicit correlation with the disease.

Still anchored in Menéndez (1998, p. 75), we take the habit of smoking as an example. It cannot be separated from the "global conditions in which subjects produce their lives" because "the global context is at stake through lifestyle". In a British epidemiological study, the author adds that male smokers from lower classes have a higher risk of dying than men from higher classes. In this case, class belonging would be the habit's conditioning factor. In the case of the British, as it is not so different from other places in the world, including Brazil, male interaction in bars is a form of social belonging. This habit's persistence is well-organized, with meanings that can be explored regarding class and belonging. Such habits "express the way of being in the world, cultural identity, and social differentiation."

A comparable situation can be found in Brazil. According to the National Health Survey (IBGE, 2019), the percentage of tobacco smokers aged 18 or over who earn up to 2 minimum wages is approximately 83% of the sample. Around 32% of these, equivalent to the highest percentage among the other wage brackets, earn between half and one minimum wage. Only 8% earn between three and more than five minimum wages. In their broader meaning, these data may suggest that class

division, even though salary is not the only element to be considered in this context, is an important determining factor in the smoking tobacco habit in Brazil.

What occurs in the wake of these data, however, is the total disregard for the care strategies of the population involved in terms of the meanings attributed, for example, in this case, to smoking. We should consider that every social group uses prevention and care criteria when faced with the illnesses that affect them, which implies that some cultural representations and practices are associated with the health-illness-care process in social groups. Although it recognizes such representations, epidemiology tends to place them in the place of risk, imagining "the population's representations and practices as factors that adversely affect their health; they perceive them as knowledge that needs to be modified" (Menéndez, 1998 p. 75).

Considering the representations of care practices produced by the ACS beyond the place of "obstacle" to the health system is, therefore, essential to produce life care forms that effectively dialogue with the plurality that emerges from the territories. According to Merhy et al. (2019, p. 75), echoing this same issue, the ways of living in the territories produce distress and poor adaptation to environmental and economic situations, but they also produce "powers and unique ways of relating that need to be recognized and worked on in their singularity. A singularity that 'collective actions', mostly education and guidance, cannot consider".

A quick understanding of the term territorialization can, therefore, lead to limitations in health services, primarily if their performance is based on preconceived definitions (Monken; Gondim, 2008). Furthermore, this restriction may reflect the limitations of the ACS regarding the different practices present in the territory, hampering the expanded pulsatile praxis in a place where it is challenging to understand.

If services are restricted in a given area, accepting the available care diversity will not be possible. With these thoughts in mind, we have incorporated a third note on the ACS work process withing PHC, set out below.

Third reflective note: Imagining the community health work, PHC, and care

In this third reflective pillar, we are interested in delving deeper into the dialogues about the ACS, their role regarding the ideas of territory and care that we discussed in the two previous notes, and their crucial role in PHC functioning. Therefore, a first note should be made about the place of ACS in healthcare networks, starting with the PHC functioning, which is often considered the preferred gateway for contact with users and the place for dialogue in care networks (Amaral et al., 2021).

Let us say then that PHC can be interpreted, however, in different ways: as a program restricted to services, as the care level responsible for the first contact with the population, or even as a comprehensive service, taken as a context for the production of public health actions and clinical services for the entire population (Giovanella; Mendonça, 2012).

In its broadest sense, PHC has essential attributes in its composition: longitudinality, comprehensiveness, and coordination. As a result of the experience accumulated by a group of stakeholders historically involved with Brazilian public health, elements are identified in the National Primary Care Policy (PNAB) itself that reflect the construction of a PHC oriented to the needs of families and communities based on the provision of services and actions necessary for their territories (Brazil, 2017).

The PHC units (UBS) are located in the primary healthcare system and are the leading service in the healthcare network. Strategies are needed to address the population needs whether through the ESF or the provision of Primary Care teams (eAB) to provide care in the UBS unit. The ESF reorganizes the primary healthcare work process to resolve the individual and collective health situation in the territory's specificities and dynamics (Brazil, 2017).

In this context, the ACS plays a key role in developing activities to promote health, prevent diseases and illnesses in the territory, and provide health education through periodic home visits (HV). This space stimulates people's participation and

identifies users who can strengthen integration with the UBS health team (Brazil, 2017). Also, the ACS are responsible for mapping territory, which helps the team to monitor families and reinforces the need for their activity in close contact with the population (Lima et al., 2021; Brazil, 2018b).

The HV is the ACS' central activity. It occurs at least once a month per the needs of families in the territory covered (Giovanella et al., 2021). In the HV, the ACS identifies health problems and situations of vulnerability. Because they are in direct contact with the daily lives of families in the territories, they can detect several situations and play a fundamental role in users' access to PHC services (Lima et al., 2021).

In remote territories, HVs by the ACS becomes the people's only contact with health services. Their reality places them amid different demands that permeate family and social issues, sometimes invisible to the health service. ACS work through HVs is a moment of strengthening bonds in relationships and valuing health among families (Giovanella et al., 2021; Lima et al., 2021).

This ACS presence overview shows us the centrality of this stakeholder in performing the PHC activities and the high degree of responsibility placed on their tasks. They are widely recognized as a link between services, health teams, families, users, and territories.

The ACS role is very special as it can effectively mobilize broader healthcare concepts and, simultaneously, more concrete daily aspects about how people experience healthcare and care. The fact that ACS duties continue to be strained toward providing health networks with increasingly accurate information about the territory, including provoking discussions about the need for their professionalization and the incorporation of new duties (Brazil, 2006; Brazil, 2020; Méllo et al., 2021), seems to overshadow, however, a central point, which has been on the agenda of Brazilian health policies since its inception: the system's difficulty in effectively dialoguing with users.

What is central to the ACS work, motivating repeated reflections on their role, activities, and professionalization? More than their work, the ACS figure highlights and puts on the agenda the importance of a place for dialogue with SUS users.

The emphasis on this ACS unifying role also expresses an urgency for new ways of considering and including users in the health system. It is precisely a system designed to think about health broadly. As we mentioned, it would be a place to make the user dimension impact how care is thought about in the context of UBS and social control environments.

Furthermore, we believe the ACS role should focus less on what they can "collect" about the assigned population and more on understanding the territory and territorialization of subjects so that the UBS can continue it. The health education and reception activities through HVs thus represent the care model implemented and can even produce lasting bonds between users and health units.

However, the ACS should be seen as a crucial network component committed to care continuity and planning care in a way integrated with the territorial reality. On the other hand, however, services struggle to recognize that subjective dimensions are also part of people's health production strategies. It is a mistake to imagine that health is the exclusive domain of the State or the health system. This inability to engage in dialogue and recognize the territory as a field with multiple life forms processed is reflected in the difficulty of implementing existing territorial knowledge in the health units' practices (Merhy et al., 2019).

Again, talking about the PHC universe and returning to imagine the ACS work as a nexus within a set of relationships, we should also underscore the care conceptions that emerge from the use of what is captured in territorialization practices. Especially in the ESF, Merhy et al. (2019, p.75) state that data are used to blame care practices and health conceptions that emerge from subjects, making territorialization utterly contrary to its initial proposal of functioning as a methodology of mediation and knowledge of system users.

Reflecting on care is necessary to create a place for effective listening and dialogue and to enhance territorialization practices. The findings of an ethnographic study on child care can shed light on

an important detail in this regard. During a field visit, a researcher observes a grandmother and her granddaughter getting ready for school.

Among the dilemmas of this moment of preparing children to leave home is the situation of, as the authors say, "dominating the granddaughter's nature": The grandmother recognizes her granddaughter as very upright, a result of her father's and grandfather's personality, and says that the girl does not accept being cared for in the right way, or having her hair done because going to school with her hair loose would express a destructive nature. She reinforces, saying: "We no longer have anything, so we cannot be pigs" (Bustamante; Mccallum, 2014, p. 686).

The report highlights the close correlation between personal projects for constructing the person and care notions. What is offered to the granddaughter aligns with what the grandmother imagines as the notion of person, mediated by issues of class and power relations (Bustamante; Mccallum, 2014). Therefore, every circumstance in which care occurs includes implicit conceptions and values of constructing the person, which the subjects implement in their relationships. Care, therefore, is not exclusive to the universe of health but also a way of producing and reframing relationships in the world.

Recognizing this nature of care is central to producing a bond with health system users. The encounter between ACS and subjects will not be mediated exclusively by the discourse of the disease or data collection but will meet what Menéndez (2009) calls self-care practices, that is, strategies subjects employ to address their illnesses.

To maintain this relationship, the ACS should understand the context in which they intend to produce their health actions and be open to this perception of social relations mediated by the construction of bonds. In other words, it is impossible to think that the population will accept what is proposed under the "more correct" or "scientific" concept since it is subjectively about bodies traversed by multivariate social relations, singular lives, and their care and assistance strategies.

When communication between the ACS and users is mainly focused on the disease, perceptions of care become biased and only capture what the system can initially observe without being open to the diversity and creative ways in which people engage in health. Regarding access or adherence to health services, this difficulty in dialogue greatly harms health services.

Based on the above, we see a stopping point that ACS leadership in PHC is vital for building healthy practices in the territory, especially by enabling access to UBS policies and services. Their capacity exceeds their technical duties in surveillance to broaden their view of the actual and potential needs of families in the territory. However, it is necessary to reimagine their work without romanticizing and heroism, redistributing responsibility for producing a SUS more attentive to living conditions to all levels of this same system and not just to the ACS (Pedebos; Rocha; Tomasi, 2018).

A stopping point: (in)conclusions imagined to intensify investigations

With the certainty that there are many questions about the "territory-health-care" triad, we made a brief stop in constructing dialogued notes between Social Anthropology and Health. We bear in mind that interdisciplinary integration, that is, that which runs through the meeting of Anthropology and Nursing, has become a powerful route to imagine and reimagine the ACS work, especially when, in their nature, the notes evoke authorial memories in the production of speaking maps, provide thoughts, investigative clues, reflections, examples, questions and hypotheses that escape what is usually found in PHC technical manuals and documents.

The search for foundations to imagine healthcare led by the ACS, together with families, social groups, and communities, expands the idea of territory as a place where health services operate in a physically limited geographic area to intertwine in the existence of humans, spaces and social devices that carry with them ways of conceiving the health-disease process, maintain cultural pluralism and

have vibrant affective flows of belonging in the places where they are assisted.

Therefore, this pause is also unfinished because we were fed by dimensions that emerge as relevant in (re)imagining the ACS performance in an interdisciplinary way, considering the correlation between care and territorialization. The idea of constructed territorialization builds on the notion that thinking about territory is not just about collecting information but seeking to understand the different forms of belonging as valid to the UBS care model and the multiple care forms as part of the health and care practices of the population within the SUS.

In this way, the SUS is a nexus of the territorialization processes to which health policies refer, in that what it mobilizes through units, networks, and practice-guiding documents also contributes to defining social reality. Concepts and discursive forms such as those found within the health system's many acronyms (ESF, APS, ACS, UBS, among others) establish and reframe the social (Foucault, 2014).

These bodies obtain information about the territory and become part of the territorialization processes, regarding which the subjects begin to construct their needs and subjectivities. Given their responsibility for these contexts, the very implementation of units and the construction of their different areas of influence contribute to how subjects begin to interact with the surrounding space.

(In)conclusively, we believe that as essayists, this manuscript paves the way for critical and reflective analyses of the ACS know-how considering their performance within the territories. We believe that this conceptual zone of inseparability of health-care-territory is a priority for health managers, professionals, and counselors. In this direction, this essay will help advance discussions on care and management and propose emerging investigative perspectives considering the discursive formations of the term territory.

Thus, we hope we have shown nuances regarding using a sociopolitical approach to territory. If, on the one hand, sociopolitical-cultural-economic mediation is recognized in the construction of SUS territorialization practices, at the same time, images of territory that hypostatize relations of permanence, regularity, and homogeneity crystallize, which can overly hinder establishing links and the reception of subjects served by the SUS.

We aimed to reiterate that, within sociopolitical approaches to territory are intrinsic traps that can lead to even new life medicalization processes and, contrary to what would be sought, a reduced dialogue with the health system's users. Therefore, the challenge of territorialization persists, although we do not disagree that this is a revolutionary strategy and an important methodology for ensuring that diversity is well received in the public health system.

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