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# The territory and implications of urban violence for the work process of community health agents in a primary healthcare unit


O território e as implicações da violência urbana no processo de trabalho dos agentes comunitários de saúde em uma unidade básica

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## Abstract

In the context of Primary Health Care, urban violence is characterized as a challenge that has direct impact on the health sector due to the geographical localization of health equipment in vulnerable areas and strong interaction of the workers with situations that endanger them, implicit or explicit to their safety. In this study we discuss the implications of this phenomenon for the work and the development of the bonds established between the Community Health Agents and the population within a territory. We used a qualitative methodology and theoretical approach of the social representations, aiming at increasing the understanding of how health policies are implemented on the daily routine in the light of interactions, conflicts and decisions that permeate the contacts with the public in the provision of the service. As a result, we emphasize that community violence and its representations interfere in the development of healthcare promotion and prevention strategies and in the development of bonds, making negotiation channels more restricted. It is fundamental to strengthen the work process of the health team through collective discussion and networking in the prevention and minimizing individual risks about their workers and with a possibility of accomplishing a straight work with the assumptions of integrality of care and reduction of inequalities.

**Keywords:** Primary Health Care; Urban Violence; Community Health Workers; Territory; Bonds.

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## Resumo

No contexto da atenção primária à saúde, a violência urbana é um desafio que tem impactado diretamente o setor por conta da localização geográfica dos equipamentos de saúde em áreas de vulnerabilidade e da maior interação dos trabalhadores com situações que colocam em perigo, implícita ou explicitamente, sua segurança. O artigo discute as implicações desse fenômeno no trabalho e na construção dos vínculos estabelecidos entre os agentes comunitários de saúde (ACS) com a população em um território. Foi utilizada a metodologia qualitativa e o referencial teórico das representações sociais para compreender como a execução das políticas de saúde se concretiza no cotidiano à luz das interações, dos conflitos e das decisões que permeiam os contatos com o público na produção do serviço. Como resultado, destacamos que a violência e as representações em torno desta interferem na produção de estratégias de promoção e prevenção e na produção dos vínculos, tornando os canais de negociações mais restritos. É fundamental que o processo de trabalho das equipes de saúde esteja fortalecido com discussões e articulação em rede na minimização dos riscos individuais sobre seus trabalhadores e como possibilidade de efetivação dos pressupostos da integralidade do cuidado e redução das iniquidades.

**Palavras-chave:** Atenção Primária à Saúde; Violência Urbana; Agentes Comunitários de Saúde; Território; Vínculos.

## Introduction

The Family Health Strategy (*Estratégia Saúde da Família* - ESF) has been adopted as the new model of reorganization of health care since 2006, seeking to strengthen the primary health care (APS) through the expansion of the population's access to health and, at the same time, to impact quality of life indicators, monitoring and surveillance of the existing aggravations (Scherer; Pires; Soratto, 2014). It is the gateway to the Brazilian National Health System to millions of Brazilians - especially in areas more socioeconomically vulnerable -, based on the assumptions of an integral and fair promotion of health care, recognizing the importance of the territory in the wide understanding of health and disease processes (Junges; Barbiani, 2013).

Healthcare working processes and actions recommended by the Brazilian Primary Health Care Policy (*Política Nacional de Atenção Básica* - Brasil, 2004, 2012) should be aligned, therefore, with strategies focused on territorialization, according to which there must be greater proximity between healthcare teams and the population, which may better qualify the different demands, ordering them by level of complexity and actively seeking them, not expecting them to reach the services, but going to them. This implies a misplacement regarding the way to conceive and implement a public policy traditionally thought of as an intervention made "from top to bottom," i.e., limited to the hospital field, focused on the figure of the doctor and on the disease.

Therefore, the current model of health care is characterized as a complex challenge to healthcare teams, since responses are required from them concerning demands that have been progressively incorporated as part of the scope of activity in the sector, including, among others, social inequalities, gender violence, violence against children and adolescents, and drug abuse (Minayo, 2006). Hence, the work of community health agents (ACS) is of paramount importance, involving actions, such as domiciliary visitations and activities of healthcare promotion and prevention, intervening in the microspace understood in its different dimensions, which comprehend factors such as income, work,

culture, interpersonal relationships, housing conditions of the population, education, and health aggravations (Junges; Barbiani, 2013).

ACS are workers who are “on the front line of the services” all the time, interpreting and adjusting public policies considering the contact with the public through their tasks (Lipsky, 1980). They serve as the mediation and management regarding what can be done in certain situations with the available resources and according to which is provided for in the guidelines they follow (Scherer; Pires; Soratto, 2014). This work is, therefore, based on practical knowledge that combine values, evaluations, beliefs, and decisions mobilized in everyday contingencies in order to circumvent the problems within different contexts.

Although they are discussed in different epidemiological and qualitative studies on the ESF, the underlying challenges that this guideline implies to the consolidation of a new model, few researchers have focused on the repercussions of urban violence, especially in large urban centers, on the work process of the teams, and on the dimensions of health care that comprise relationships between workers and users (Almeida, 2015; Lancman et al., 2009; Lima, 2017).

The term “urban violence” can be understood as a social phenomenon generically designated as a set of expressions that affect the feeling of continuity of daily routines and personal safety (Machado, 2011) of people with or without kin bonds outside their home environment (Kruger et al., 2002). Developed by a network of social relationships, representations, and systems (Feltran, 2008; Machado, 2011) within the context of health care, violence has been a growing problem within the sector itself, being related, in part, to the geographical location of health equipment in areas of vulnerability and risk, where several tensions and conflicts are common and endanger, implicitly or explicitly, the safety, social well-being, and the health of populations and workers.

Taking this into consideration, with this article we seek to situate the discussion on the implications of urban violence for the conformation of the ACS's work in a primary healthcare unit in São Paulo, considering its social representations. We highlight

in our analysis three key elements that emerged as a shared reality: obstacles and constraints on access to the territory, boundaries in the professional practice, and relational/therapeutic bonds established with users within this context. Moreover, we aim to contribute to an incipient debate on public health and on public policy studies (Lotta, 2012), broadening the analysis of how the implementation of healthcare policies takes place on daily life, in the light of interactions, values, and conflicts that permeate the contacts between professionals and the public in the provision of the service in the territory.

## Theoretical and methodological path

We adopted a qualitative approach through the analysis of social representations of the ACS. Social representations were initially addressed by Moscovici (2003), responsible for creating and systematizing a theoretical construct about this mode of knowledge, which emerged from the common sense that permeates everyday life in order to produce communication and understanding of the world (Caldeira, 2000; Machado, 2011; Moscovici, 2003; Porto, 2010). This knowledge results from the apprehension of reality by subjects based on their social, material, and symbolic contexts, but they are able to acquire autonomy, moving from their home bases in order to be related to other specific repertoires of representations. Social representations can also be prepared in different ways and expressed in narratives, jokes, shared conversations and images, among other social dynamics that operate to arrange, organize, classify, and give meaning to the everyday life (Caldeira, 2000; Moscovici, 2003; Porto, 2010).

Caldeira (2000), when studying the social representations of the population of São Paulo concerning urban violence, highlighted that, in their core, such did not only sought to organize and give meaning to the experience of disorganization and rupture caused in the trajectories impacted by a violent crime: the representations produced by specific groups, at the same time, strengthened and broadened the feelings of danger, developing, therefore, reaction and protection strategies, such as spatial segregation, avoidance and prejudice

rules, able to shape the social interactions and the way of experiencing the public space. According to Porto (2010), we can understand urban and social violence both in their objective manifestations, through data, behaviors, and social practices, and in their subjective dimensions, considering meanings that subjects assign to events.

In this article, we consider that this objective reality, shared by the ACS, regarding activities in a territory marked by different situations of violence, can be accessed and explained from their representations – some of which are created based on their common experiences as residents and workers and by other wider channels, such as mass communication (Caldeira, 2000) –, influencing its provisions and practices in the workplace and in the bonds that are established with the users. In other words, it is not only the “fact per se,” the violence in the territory, that interests us, but also how the components of this reality are designed, improved, and realigned from the point of view of the ACS, producing evaluations and justifications in decision-making within the professional practice. This approach of the theory of social representations (TRS), used in the course of the investigation, assisted us as a “guide” in the deepening of the issues brought about by our interlocutors.

For data collection, we used a script with semi-structured questions, open and flexible, complemented, in the course of the interaction with respondents, with other questions (Manzini, 2004). Silva and Ferreira (2012), through a literature review, stress that the main elements found in scripts of interviews, aligned with the TRS, contained questions that followed a type of order and structure, starting from more particular and concrete questions to those including reflections and more general judgments of the studied phenomenon. In our script, we added more descriptive questions: general information about the interviewee, professional career, the daily work in the territory, types and situations of violence deemed more frequent, and questions that invited the ACS to reflect and express their views – which comprised definitions of what they identified as violence and, especially, urban violence; what were the implications that such events had on the planning and development of the work

and on the relationship with the users; whether they had felt threatened, directly or indirectly; and what were the decisions made due to the events.

Data collection was carried out between February and July 2014, and the selection criteria adopted for the interviews was the inclusion of workers working for at least of two years in the territory. We interviewed 13 ACS, being 12 women and 1 man. The greater participation of women is associated with the fact that the chosen Primary Healthcare Unit (UBS), at that time, had three male ACS, one only inserted in the inclusion criteria of the study. In addition, we did not establish a predetermined number of respondents, and we sought to make use of the representation of the subjects regarding the quality of the information obtained and the degree of homogeneity of the group. (Fontanella; Ricas; Turato, 2008). The representation in TRS points out that “there is representation only if it is followed by correspondence in the practices carried out by a decent amount of people within a group” (Wachelke; Camargo, 2007, p. 381), reflecting, therefore, certain dimensions of the social context in which people are inserted and, at the same time, demonstrating how the subjects connect with certain structural aspects in order to recreate this dimension from its singular trajectories.

We analyzed the material based on content analysis (Bardin, 1994) – a strategy commonly employed in research that uses the theoretical approach of social representations, including the field of health (Silva; Camargo; Padilha, 2011) – following three steps in the methodological path: exhaustive reading of the obtained material and resuming the questions of the initial step of the formulation of assumptions; separation of themes that emerged into categories/themes; and aggregation of data, seeking to create inferences and interpretations about the studied phenomenon (Minayo, 2007).

The study obtained the permission of the Ethics Committee for Analysis of Research Projects of the Faculty of Medicine – University of São Paulo and the Ethics Research Committee of the Municipal Department of Healthcare (CEP-SMS), which analyzed and issued Opinions no. 190, of May 19, 2013, and no. 40, of December 16, 2013 respectively.

All the respondents signed an informed consent form and they were guaranteed the right to anonymity, in such a way that all of the names mentioned here are fictional.

## The territory and access constraints

There are many factors that influence the performance of healthcare teams. One of them, although considered strategic from the point of view of the effectiveness of the actions, has not been much discussed in analyses: the centrality of the territory and its connection with the healthcare unit, the teams, and the added population. In this regard, we highlighted in the research the difficulties ACS have in accessing it, with impositions and restrictions that daily permeate the work. The most common implications within this context are related to the notion of urban violence, with the presence of groups, factions, and people involved in illegal activities, especially drug trafficking, and the arbitrary presence of the police.

One of the oldest ACS of the UBS highlights the initial obstacles in the implementation of the ESF and the fear of the public concerning this proposal for greater proximity of workers, and it is necessary to conduct a “negotiation,” in such a way healthcare teams can indeed enter the community:

*It was the beginning of ESF here, you know, in the implementation, so we went out on the streets to register families, many were afraid, they did not give us their documents, they were giving false names, wrong date of birth, they were afraid, they've never seen that. At first, due to intense drug trafficking, we were not allowed to enter the community, they thought we were spies, that we were going there to spy on them and to report them, they didn't understand what was the job of the ESF. We were forced to held meetings inside the community with the heads, you know, to introduce ourselves, show our badges, call the management, the managing council to go into the community and say that we were there to help them with health issues, doing our job for healthcare prevention and promotion, we didn't want to interfere in drug points or anything, we weren't there to report anyone, we were there to*

*help. [...] Because all families who were registered would have access to UBS, to medical appointments, to have free pass in the UBS, UBS was available to them for whatever they needed. We were threatened, some men there said that as soon as we got into the slum they would blow up our heads, our neck. (ACS 1, has been working for 14 years)*

The speech calls attention to an intrinsic feature of the work of the teams, especially ACS, which comprises the logic of mediation, that is, the establishment of bridges and the transition between the different daily spheres of regulation. Within the aforementioned context, this intercession task demanded an effort of informal articulation of actors directly involved with this policy, such as the ACS, members of the managing council, and the board of UBS, in order to inform and convince the population of the legitimacy of the service that was being implemented. Essential practical arrangements were negotiated, without which the safety of health teams and the planned activities could not be ensured.

These episodes of denied access to the territory do not, however, seem to be a constant for healthcare teams these days anymore, although they still sporadically occur. Apparently, the progressive change in the mentality of the population corresponds to an increasingly relation of the service to the acceptance and legitimacy of the work that is carried out in the territory, and it is important, hence, the figure representing the ACS as workers and residents in the dissolution of any barriers to access and contact. Moreover, this change was followed, as we will see later, by certain rules for living together that have been incorporated to the work and the routine of the teams, making accessibility to the territory subject to the regulation of some limits more common:

*There have been cases like, I think, of how their material was arriving, the guy here at the station asked: “do you have anything important to do there? If you don't, don't go in there, in that day.” He talked to my nurse and to the director at the time, we were also going to visit his wife, who has just given birth, and he brought [us] here to give the*

*guidelines because we weren't suppose to get in, we were just getting ready to go to there, that's when he got here [...]. When you have a scheduled referral, if you have an appointment that has been scheduled, transferred, and rescheduled, I look from the far end [of the street], there's always someone there, so they know I want to get in, then one of them comes to me, asks me what's going on and then I have to explain: "look, the appointment of whoever was rescheduled in here and I need to deliver [it]," because it's not fair that someone misses an appointment, "no, that's ok, go on," and they keep an eye on me, I just go specifically to that house and get out right away. (ACS 2, has been working for 9 years)*

Frequently, access restrictions that still permeate this work are also associated with rumors and information that circulate to the ACS that the police can enter the territory, stressing the possibility of clashes and shootings. Workers fear being an indiscriminate target of these actions or being mistaken for "thieves disguised as ACS" by security agents, who sometimes wear plain clothes, without identification.

The police raids looking for people involved in illegal activities generate a feeling of discomfort and embarrassment for the ACS when attempting to access and establish contact with users. The atmosphere of instability that these actions bring to the territory ends up, moreover, influencing them as for the suspension of domiciliary visitations and in the no circulation in certain streets and alleys. When taking this precaution, they are trying to avoid, at the same time, being mistaken and described by the population by the term "tattletale" - that is, people who like to "snitch" -, an always latent tension in this work since the beginning of the implementation of UBS.

## Limits on the professional practice

From the presented questions, we highlight as relevant the notion of territory developed by workers in the design of their strategies and approaches. This assumption refers to a comprehensive perspective that considers the dynamics, relationships, and meanings produced concerning the experiences

lived by the subjects within this context. Moreover, it is in such space that, partly, the contents of ACS values and standards of their social practices and conducts are processed.

On a daily basis, the work of the ACS is adjusted and interpreted in the contact with each user and family, but we can identify in these approaches certain regularities, such as boundaries and challenges imposed on the performance of their activities, although they are not usually verbalized, perceived, or even discussed collectively among workers. Hence, it was very common to emerge on the interviews implicit or explicit constraints concerning the performance of the teams in working with certain topics, especially of promotion and prevention of drug abuse in families and in the community.

In individual approaches during domiciliary visitations, ACS mentioned that this happens only when there are "gaps" in the relationship with the users, that is, when there is a spontaneous demand. The rationale used to support this practice is related to an internal guidance of the service as for ethical and privacy boundaries in the relationship that must be respected, to the extent that the will of users and their families to express themselves and request aid must prevail.

However, even though the aforementioned criterion is a component of the evaluation in the approach, other factors are interacting and modulating professional decisions such as the feeling of insecurity in working with the subject and the practical experience that warns the ACS about potential problems and misunderstandings with the population:

*It's very tricky. How am I supposed to address it? Only if a patient comes to me or the family... I can only address this theme because it's different if I warn you of a sexually transmitted disease instead of telling you about some drug. I can only approach this subject if you give me some space. If I go to the family and I say "look, my son, my husband," that's different, there I have the freedom to give some guidance, but if I don't, then I don't. Because as far as I'm concerned, my job here is not drug prevention, you know? My job here addresses [drugs], sure, it*

*comprises health, but it's not directly connected.*  
(ACS 3, has been working for 7 years)

*We give guidance, right, but even so we don't have much because we are afraid of going deeper because of [the] dealers, the parents who adopt them [teenagers]. Whatever I can do to help, obviously I'll do it, but very wisely, because you can't go too far, each one has their life and I have my life here in this neighborhood for 40 years, so I can't. [There is] Insecurity in getting in, talking, I just don't go that far, I just don't, you know? I don't cross the line. For example, there's this boy smoking marijuana I have to speak to, 'cause if I don't I feel bad, I say "Gee, what's my job, after all. What am I doing here?".*  
(ACS 4, has been working for 11 years)

The speeches indicate important challenges that are faced in the work process on health in APS and in the consolidation of this policy, such as the incorporation of the broadened notion of social aspects of health and disease - including the use of drugs and community violence -, difficulties in broadening actions directed to the concepts of health promotion and prevention, and, furthermore, the impacts that these different demands produce on the subjective and objective dimensions of workers and their jobs.

So far, the ACS have mentioned that they have never received threats linked to the prevention work, but their assessments, representations, and experiences in the territory demonstrate a sense of vulnerability that is translated into the adoption of measures aimed at, first, theirs and their family's safety. The porosity of the relationship that goes beyond the line of health care is a recurring concern that ends up raising, in some workers, questions linked to the ethical dimension of the limits of their work, when they interact, work, and live very close to their public.

The organization of the work of the teams does not seem structured enough to support the implementation of the actions of ACS and meet the community demands related to consumption and abuse of drugs, although this would be a central problem, according to the workers. This is an issue that has been negatively affecting the physical and

emotional health of families - including ACS families - and the entire territory where the consumption is more focused on socialization spaces for the youth such as the surroundings and within the region of public schools.

According to the interviews, interventions carried out by ACS are specific and spontaneous, often conducted in educational groups that deal with various matters within the internal space of UBS. In addition, partnerships among sectors with public schools are often directed to actions concerning oral health, immunization schedules, and the environment, but with limitations on other assumptions recommended by the Health at School Policy [*Política Saúde na Escola*] (Barbieri; Noma, 2013; Brasil, 2007), i.e., the integral health care and expansion of the rights of children and youth through actions focused on raising awareness about drug abuse and promoting a culture of peace. This problem is pronounced, according to the ACS, also due to the insecurity that affects education professionals, who already have recommended, in some approaches carried out at the schools, not to focus on the theme:

*We did a job once on cigarettes, then the principal herself told us not to focus too much on the drug issue, right, because you know you have retaliation. You want to get there and expose it, but at the same time you're afraid of speaking, of being barred.* (ACS 5, has been working for 14 years)

Very often, other situations have emerged in the research within the territory of activities that are not directly linked to the conflict and to the representations of urban violence, but which influence the work and configuration of the links established between the ACS and the population during the community approaches and domiciliary visitations. These are reports involving experienced constraints that go beyond the circumstances related to the "world of crime," not being restricted only to users of the services who are inserted in this dynamic.

Thus, it is noteworthy that the defensive attitude assumed by ACS also involves discussion of genre. At UBS, most teams are composed of women, and



this condition, associated with the type of work they perform, is an aspect that must be considered in the understanding of how the practices and interactions concerning health are affected by this dimension.

We highlight the “pickup lines”/harassments that all ACS reported having already suffered from users during visitations, with speeches, obscene gestures, and invitations to intimate contacts. In these circumstances, the majority takes as a strategy to avoid entering the houses of single men or those who are not accompanied by their wives, making a quick approach outside of the houses with the usual questions in order to achieve the goal established of monthly visitations. The following visits are carried out, but the ACS seek to go accompanied by another worker, thus avoiding the possibility of spreading malicious rumors in the territory. In addition, workers reported swearing aimed at them - especially when workers are circulating in the territory during some scheduled activity - such as offenses based on gender stereotypes and reinforcing the idea that the job of the ACS is, for instance, just “to stroll” and “to gossip about others’ lives,” or that they are “sluts.” Such derogatory behaviors end up generating limit situations of tension with users such as arguments, gossips, and fights.

In domestic approaches, problems still present different nuances. If the users are, for example, linked to activities, such as drug trafficking and robbery, or if they abusively consume alcoholic beverages and other drugs, have an aggressive history, or even if they usually reject and swear at the workers during visitations, the ACS seek to do the job as soon as possible - preferably accompanied and not entering the residence - in order to protect themselves against certain information that they consider it may compromise their personal safety or against direct threats to their body integrity and morale.

In cases in which signs of domestic violence are identified, the ACS continue to exercise their discretion, although recognizing that this approach is not only of their responsibility, but of the entire healthcare team. In practice, however, their representations on the issue indicate that the existing technical resources at their disposal are insufficient to support, in a professional and

safe manner, the actions. Criteria that define a health intervention of a family meddling are not always very well understood by users and by ACS themselves, who showed such concern in many speeches. This allows questioning the effectiveness and scope of the activities, since to know how far you can go with an intervention can be translated into a very arbitrary professional conduct, which is individual and based on common sense, without the required theoretical and technical support of formal assignments for the job.

An ACS working in the healthcare unit for nine years said that she did not use to pass on to her team how difficult it was to work on the visits with some families in the territory. Only two years ago, when she did an improvement course on domestic violence, she learned that, by following certain professional conducts and reporting on some of these issues, there would be no danger of her name being directly linked to the notification of cases. The fear, however, is still constant nowadays, both for this ACS and for the others, who admit they cannot deepen their work in certain contexts, feeling that their interventions, when not well supported, can worsen the family situation:

*It does hinders [the job], because sometimes people want to take certain attitudes and we can't because of this community violence. The family doesn't accept certain things, they accept my visit, I give my guidelines, I do the prevention job, but it's something that I go there for, [it is] the same thing when I go in and when I go out, there's no improvements. This man is extremely ignorant and bad and I'm afraid of him hurting his children or his own wife if I want to go deeper. If I go deeper he may even do something [with me] because I live in the same community, in the same street, so, I mean, if we take certain attitudes who is the first person he's going to think of that did something? It's me. (ACS 2, has been working for 9 years)*

The individualized attitude of the ACS as for not passing on to the teams all her impressions about the observed family and community issues is a trait that marked all the speeches. The filter and the selection of information that was not passed on

show certain degree of ignorance and uncertainty in relation to practical developments that a report or a notice is capable of producing. Moreover, implicitly, a weight equivalent to a complaint was attributed to the notification. The fear of suffering retaliation and the confusion of the terms - which, in practice, may assume interchangeable meanings - are not restricted to the work of these ACS, being highlighted in other research the impact of this uncertainty on other professional categories, reflecting on the underreporting of cases of domestic and child violence (Kind et al., 2013; Silva, 2012).

As it is known, ACS are not responsible for notifying violence cases and other existing aggravations in the territory, but they can often identify, before other team members, the points of greatest vulnerability where the families live and higher concentration of sale and use of drugs and alcoholic beverages. In our research, we mention certain episodes in which ACS refused to fill in information and pass them on to the former UBS manager, claiming to be in danger, since the population knows that they are the only ones who have this kind of detailed information in the areas with such actions.

It is worth highlighting that the exercise of professional discretion, whether of the ACS or of members who work within the scope of APS, can have consequences in health information records, contributing to the invisibility of issues relevant to the local planning and monitoring (Kind et al., 2013; Silva, 2012; Velloso; Araújo; Alves, 2013). In our study, although we cannot numerically dimension this phenomenon in the studied UBS, it was mentioned that nurses also feel affected by the local reality, refusing to notify certain cases of domestic violence for fearing retaliations from the users.

In the field of evaluation of public policies, there is a gap in the discussions on this stage of implementation of the strategies, in which the actors involved in the construction of the daily work use their discretion in different contexts that influence the conformation of the job and the provided health care (Lipsky, 1980; Lotta, 2012).

Within the ESF scope, the professional's autonomy is encouraged - which, supported by the guidelines, establishes healthcare lines with

users from the establishment of bonds, and these techniques are also adapted due to the existing resources of the context. This "immaterial" basis of the work combines, therefore, values, subjectivities, and plasticity (Ayres, 2004; Merhy, 2002). What we emphasize, however, is that not always there is alignment between practices and representations of workers who are working at the core of the service with guidelines of the proposed policies. As Lotta (2012, p. 223) points out, in the implementation process there are several actors operating at different levels - federal, state, municipal -, in "a chain of decisions and interactions that generate specific contexts, which, for their turn, produce both differentiated practices and forms of interaction between implementers and users that determine the access to policies."

Within the local micro politics, we emphasize in the analysis two factors that contribute to this process of differentiated practices. The first issue comprises a set of tensions, conflicts, feelings of insecurity, and violence cases in the territory that produce specificities on the individual and collective work, deepening local inequalities related to health promotion and prevention and, therefore, for the mobilization of the population to access to other rights. The second aspect concerns the organization of the service considering this reality. If the work of the teams is not based on education and continuing training of workers, on protocols and approaches committed to the promotion of rights and the culture of peace (UnB, 2014), in addition to discussions through forums and collaborative networks, the decisions of ACS when performing their duties will be vague, based on common sense, and limited to their effectiveness. Furthermore, if there is no communicative space for recognizing the suffering and developing strategies of resilience in adverse scenarios, these elements will contribute to the reproduction of other patterns of violence that the ACS are exposed to beyond the urban violence such as occupational and gender ones.

## Establishing bonds in the territory

When addressing the use of relational technologies, the literature highlights the density

of relationships as a component of innovation and qualification of health care, valuing the bonds in the resignification of relationships and practices, assumptions of a new ethical dimension, and work technique (Ayres, 2004; Carvalho, 2004; Teixeira, 2005).

Establishing relational and therapeutic bonds within health care is, therefore, a dynamic process that is subject to the incorporation of different meanings (Campos, 1994), and which assumes flexible features with developments not fully determined, both in relationships and within the contexts in which they are circumscribed (Almeida, 2015). In our research, the interactions established between legal and formal borders of healthcare practices, and informal and, often, illegal borders existing in the territory are also a particularity that redefines the assigned meanings and the quality of relationships in the promotion of health.

Hence, it seems relevant to us to emphasize strategies that workers consider when carrying out their duties such as occasions when access to the territory is denied or restricted. What is at stake in the ACS attempts to negotiate these situations is not only putting health care into practice, but also the creation of a narrative able to “legitimize” their presence and the whole team’s in the territory and on the lives of the attended people, informing them and convincing them of the importance of the service through the production of “consensus” – though these are always provisional. Such aspect marks a shift in the analysis of the implementation of public policies, traditionally focused, almost exclusively, only on the power of formal and intentional decisions of institutional actors, disregarding the dynamics of power and the pressures that are exerted “from the bottom,” through the protagonism of non-state actors in this process (Marques, 2013).

The progressive acceptance and adherence of the population to services is established by multiples belongings of ACS in the territory, and their official registration as UBS workers is not the only condition able to dissolve barriers of relationships and access. Overall, the credibility of ACS is conquered because they are still residents who have known and lived for years with the reality of the place, connected to this space by a network consisting of family

members, friends, neighbors, and acquaintances. These different insertions emerge on the speeches of older ACS as criteria enabling the access to part of the population, generally refractory and difficult to approach, inserted in illicit drug trafficking circuits and/or drug use:

*As long as I'm at that little spot, which is a small place, they seek not to use the drugs they were using [...]. I see they have much respect for my job [...]. It's more about STDs, they ask me, there have doubts, they have complaints and I guide them to look for help in the unit, if they have symptomatic cases of suspected TB, even if they don't live in the region, some people live there in Vale Alto, I request the examination of Koch's bacillus for them and tell them they can undergo treatment in any healthcare unit. So much so that one guy had tuberculosis and he treated here in the unit, he's from another region, but he treated it here. (ACS 2, has been working for 9 years)*

In addition, the relational and communicational skills of ACS, potentiated by these bonds, are credentials that give greater safety to move in different micro areas and differ older workers from those who do not live in the same place – healthcare technicians, doctors, and nurses – or those who are working for a short time in the profession:

*I think it's because I live in the neighborhood for a long time and I know a lot of people, so I'm sure that they won't hurt me because I'm not harming them in any way. The older “scoundrelism” then, has a certain consideration for the ACS and for me too. They, the younger ACS, are already little afraid because they are people who were not born in here, who live here but who had no connection with the community. Since I've been living here for 40 years I have connections everywhere, I've done all the job my friends do nowadays, everywhere they have been to I've been there too. (ACS 4, has been working for 11 years)*

Transitivity between the borders allows even the circulation of information about what is happening or is about to happen in the territory. Then, rumors

and warnings that arrive directly in the UBS or during the work of the ACS on the streets, that they cannot access the areas, are not interpreted, mostly, as an imposition, but rather as an initiative that aims to warn them as for their safety. This allows them to anticipate potential threatening situations, which can be analyzed and avoided when necessary. The ACS can, therefore, understand the political situations of the place where they work and live:

*We maintain a good relationship, there are moments we can't enter the alley, things like that. They warn us, they won't prevent us from passing because we know how it works and what to do and how to behave at that moment. You can't get in when they have their things to solve and you never know if it's related to something that it's arriving or a greater sell of their products, which are illicit. We know we have to hear the recommendation and we follow [them] and then we get in, because the population is there and we need this open space to get in, we must have such access. We cannot even go against the flow, neither fail to fulfil our part; if they asked us for not to enter, we do not enter. (ACS 3, has been working for 9 years)*

In situations in which the police enter the territory to make roads, there are many questions in relation to the discriminatory conduct of the security personnel against the residents and the extra-legal behaviors commonly employed in the alleged claim to deal with “bandits.” In this process of understanding situations and conflicts that exist in the territory, the ACS themselves report constant fear of being confused with “bandits in disguise” with the worker’s uniform by security agents. These evaluations emphasize, on the one hand, the concerns and the difficulties in working in the territory, especially when the police presence is associated with any “complaint” – real or not – that some residents believe it was effected by the ACS. On the other hand, the ACS believe that, even with this mistrust, unexpected situations, such as shootings or reckonings, are minimized due to the presence of groups or persons linked to drug trafficking in the same micro area, which guarantee a certain predictability of the work routine even

under conditions and restrictions, unlike the police presence.

We highlight the social representations of the ACS because they situate the discussion about the establishment of bonds with users beyond the interpersonal relationships, that is, the community level. The established bonds are ambiguous, contradictory, and permanently tensioned. In relation to users involved in illegal activities, for the ACS, they are figures that have certain respect and esteem for the workers, also involved directly in solving some problems that took place in the UBS (Almeida, 2015). However, the therapeutic and relational bonds that bind them are permeated by suspicions that make these relationships subject to disruptions, depending on the circumstances of the territory. Bonds are, therefore, fragile, because workers themselves know they are in unequal condition in the contact and communication with people who have coercive means to enforce their will – such as the occurrence of curfews in the community, in which channels for communication with the service are fully closed. On the interpersonal perspective, what the bonding representations express are forms of reciprocity and relationship demarcated by limits through the adjustment of the language in the speeches of the ACS, in which concerns are manifested in trying to make their assignments clear.

*I enter the dealer's house and say: “Hey, I'm here to do my visit, okay? I don't care about your personal life, the only thing I wanna know about is dengue, tuberculosis, if there are any pregnant women, premature child, child aging less than 2 years, I don't care about your personal life.” (ACS 4, has been working for 11 years)*

In conflicts in which workers mention being the target of swearing, harassment, and accusations of gossip we also perceive that more bureaucratic forms of bonding are established, limited to general questions during the monthly contacts. As for situations in which workers were able to reverse these tensions, this was due to the preparation of a more-distanced perception on the suffered abuse, i.e., as a result of personal problems and dissatisfaction

of the users regarding the operation of UBS (Almeida, 2015). This bonding relationship developed with the residents seems, however, to focus way too much on the skills, experience, and personal decisions of each worker to carry on it, being able to overcome the experienced constraints, not enabling to be fully impacted by these problems.

On the speeches of the ACS, however, there are no other resources that could better sustain these bonds beyond personal predisposition and goodwill such as the importance of teamwork and of technical support as efficient strategies for resolution of conflicts.

When reviewing some discussions on the importance of light technologies, we verified the way bonds are suitable in the daily work depending on training, practice contexts, and individual skills mobilized by workers (Brunello et al., 2010; Carvalho et al., 2006; Carvalho, 2004; Fontanella; Setoue; Melo, 2013). Theoretically, however, these discussions bring different possibilities to positively explore the bonding dimension, connected with a perspective of individual empowerment, which is also intersubjective, familiar, communitarian, of autonomy and co-responsibility of users concerning their health situation (Ayres, 2004; Carvalho, 2004; Teixeira, 2005).

The issues presented by the research make pertinent the question of how the reference service in the territory composed of healthcare teams is mediating those bonds and contributing to change the status quo that comprises multiple vulnerabilities existing in the territory. We can also extrapolate the questioning to other contexts, such as the possibility of thinking about the challenges that are placed on services in face of the urban violence in a country that has alarming rates of homicide and exposure to other traumatic events that undermine the sense of personal and community safety and affect the health of the population, resulting in several problems. After all, what is the role of the ESF when faced with these phenomena? How do primary healthcare services are structured to respond to these health problems, which are traditionally not part of its scope of practice, but are provided for in the general guidelines, which aim at a broad concept of health and disease, working in different areas, including the promotion of a culture of peace and prevention of violence?

Another issue that the survey allows us to raise concerns the possibility to qualify and define the bonding notion - interpersonal and communitarian - from another perspective, unlike that which situates it as a resource capable of generating empowerment (Carvalho, 2004). Community violence and representations in this respect interfere with the production of intersubjective and community bonds and, at the same time, they produce them. That is, they comprise dimensions that create the conditions for bonding employees to certain experiences that influence them in their actions and decisions, consciously or not. Following this perspective, those bonds are also able to strengthen and foster certain relationships, but in a direction contrary to the development of empowerment, redefining contexts and interactions whose possibilities of "negotiation" are conducted in a more restricted and asymmetric way. We must recognize, therefore, that the symbolic and factual dimension comprising urban violence does not necessarily produce a decrease in contacts, isolation, and breakup of bonds. It may work as a productive instance, in such a way to engender certain interactions and bonds based, for example, on the feeling of insecurity and threat.

## Final considerations

From the presented discussions, we would like to conclude by emphasizing the importance and responsibility of the work process of the teams in relation to the planning, monitoring, and decision-making in the fight against urban violence and other conflicts that affect all those involved in the implementation of public policies on health in the territory, including other professionals, even though we have not worked in this article with an analysis of other professional categories.

The development of work and healthcare strategies, adapted to the different local realities, is a great challenge to the APS, which depends on a vast and dense networking. The more internally strengthened and structured the services to deal with social determinants in health through actions and partnerships with the community and intersectoral support, involving permanent exchange of experiences and knowledge, the lesser

the risks individually reverting to the workers themselves, who feel more supported and safe in their interventions. Researchers should seek to produce data and information for the very involved professionals, in such a way that it can be shared with other UBS managers, members of the board of health managers of the communities, community safety councils, guardianship councils, the Social Welfare Reference Centers (*Centros de Referência de Assistência Social* - Cras), non-governmental organizations (NGOs), and churches, among others. We cannot neglect the weight that takes the influence of contextual factors of the territory in the process of work of the teams, which may facilitate or not the opening of channels of interlocution of workers with the population. This can be considered one of the aspects that most weaken decision-making. However, by our findings, we argue that this insecurity is associated not only with the own characteristics of the territory, but also with the fact of not being collectively discussed and addressed by the themes regarding some issues that end up emotionally overburdening the workers, who seem to have some individual skills based on common sense to try to circumvent the problems that emerge.

The non-recognition of urban violence and the various conflicts that pervade the interaction with the population as object of intervention can make the scope of practice of APS limited, compromising other essential assumptions for their consolidation, such as the integrality of the health care and the reversal of the biomedical model, centered on a curative, specific, and fragile practice for promoting human rights and reducing social inequalities in health.

For the purposes of this article, we aimed at giving greater visibility to the implications of urban violence in the development of the work and the establishment of bonds, contributing to the discussion on the collective health interface with wider social problems that structure the debate in the Brazilian society.

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### Authors' contribution

Almeida designed the study, collected and systematized the data, and wrote the article. Almeida and Peres reviewed the manuscript. All authors analyzed the collected material, contributed to the literature review, and approved the version to be published.

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