

The formation for SUS, opening new trails for the production of the common

A formação para o SUS abrindo caminhos para a produção do comum

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Abstract

Faced with the challenge of turning ourselves around to the subjective dimension of the practices of health care and health management, in this article we propose the problematization of the subject of the constituent movement of the SUS. How is the subject of this movement formed? How can one think of qualification as a social practice that produces subjects 'in relation' and care, associating clinical practice and management? What interests us here is what is produced in the relationship between the subjects, what calls them over to different methods of contraction of the collective and the creation of zones of communal activity. The notion of 'care of the self' as developed by Foucault, especially in his last work *The Hermeneutics of the Subject*, shall be the technical and conceptual framework that is to guide our path, so we may stay in the place where the paths meet for the production of the common.

Keywords: Health Qualification; Production of the Common; SUS; Care of the Self; PET-Health.

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Resumo

Diante do desafio de nos voltarmos para a dimensão subjetiva das práticas de atenção e gestão do trabalho em saúde, propomos neste artigo problematizar o sujeito do movimento constituinte do SUS. Como se forma o sujeito desse movimento? Como pensar, associando clínica e gestão, a formação como prática social que produz sujeitos “em relação” e o cuidado? O que nos interessa é o que se produz na relação entre os sujeitos, o que os convoca para diferentes formas de contração de coletivo e de criação de zonas de comunalidade. A noção de “cuidado de si” desenvolvida por Foucault, especialmente na sua última obra, *A hermenêutica do sujeito*, será o arcabouço teórico-conceitual que orientará nosso percurso a fim de nos atermos no lugar onde os caminhos se encontram na produção do comum.

Palavras-chave: Formação em Saúde; Produção do Comum; SUS; Cuidado de Si; PET-Saúde.

Starting the path... in the SUS...

The Brazilian National Health System (*Sistema Único de Saúde - SUS*) is our historical legacy, and we need to take care of it just like we take care of a youngster (after all, it has only been around for 24 years) which brings in his or her eyes the courage to make innovations together with the younger generation's power of rebellion against different forms of authoritarianism.

In Brazil during the 1960s and 1970s there was the advent of several expressions of resistance against the state authoritarianism which had enforced itself with the civil-military coup in 1964. In the health area, together with what was produced in other fields such as the arts, in the clandestine organizations fighting against the dictatorship, in the trade union movement, there was the definition of specific ways to fight against authoritarianism within health practices. If in many cases authoritarianism takes on the appearance of centripetism - the concentration of knowledge and power in centres for organization of culture and society - the resistance of workers in the health area against the centred medical and hospital-centred models showed a unique inflection of the fight for democratization in the field of health practices. The movement for sanitary reform, ever since it took root at the end of the 1970s, laid the foundations of the SUS by creating conditions for the possibility of health services becoming a right of all people and a duty of the state, in a clear wager placed on the restoration of democracy in the practices of health production.

With the Brazilian Constitution of 1988, the restoration of democracy became a political guideline in Brazil. The reforms in the health sector, in Brazilian contemporary history, propose to consolidate the process of restoration of participative democracy, through special methods that force the limits of the model of representative democracy, expanding the right to health services, which acquire not only a legal but also an experiential meaning. It shall not suffice just to have the constitutional assurance of a right to health; there is also a need for it to be actually executed within the concrete practices as shown by the SUS.

The issue of right shall become an issue of fact: there is a movement from the formal dimension of the right to the political exercising thereof; from rights as an expression of the Law to rights as a subjective experience - my acknowledgement as a subject in my own right and also the sheltering of the other under these same conditions.

In this regard, the subjective dimension, which is always present in any process for production of health, gains additional relevance, whether as a result of the complexity of the health area, or because tackling health problems of such complexity requires commitment both from hard technologies as from relational technologies, which imply a subjective dimension of the practices for health care and health management (Merhy, 2002).

The challenge is now the inclusion of the subjective dimension in practices for health care and health management. Hence the challenges raised by the SUS, which force us to stay attentive regarding the processes of subjectivation which sweep across all health institutions, to what is produced in the relationship between subjects, the different ways of contraction of group features, the subjective repositioning generating protagonism, autonomy and co-responsibility among the employees, the managers and also the users of health equipment.

Thus, the main challenge facing the Brazilian National Health System (SUS), since 1990, has been that of the creation of a State policy to ensure that all citizens in national territory are entitled to health services, considering the differences between the different regions of the country, health demands, and ways of life: the heterogeneity of needs at the unit of citizens' rights. The unit, according to the difference as assumed by the SUS, contrasts with the fragmentation and low communicability which are often present in the operation of health institutions that are segmented in their areas, sectors, or programmes. How can this unity be assured? How can one change the standards of communicability in the State machine? The concept of transversality is a methodological principle which is complementary to the main target principles of the SUS: universal access to health services; integrity of the health system; equity of health offers considering diversity of demands. In addition, the principles of participa-

tion and territoriality require the establishment of health policies that no longer operate along the two main axes of institutional practice: verticality, which establishes a hierarchy of communication between different elements, and horizontality, that imparts a corporate feature on the communication between equals. Between the axes of verticality and horizontality, Guattari (1981), in 1964, pointed to this other axis of the diagonal that produces a muddling of codes and also what he called 'transversality', placing different elements side by side. This is the *princeps* methodological principle that shall be alongside the principles of indissociability between clinic and policies (between health care and health management); between subjects and collective elements, and also the addition of value to networks; between health production and the production of subjectivity. The formula of the challenge is therefore that of how to ensure the indissociability between what can be distinguished?

The SUS and health qualifications...

Talking about the SUS is, indeed, talking about an established form - the text which implements the SUS based on the Brazilian Constitution of 1988 -, which shall not and cannot be separated from the constituent movement from which it arises and which we have historically identified with the critical force of the movement of sanitary reform. How can we think of this paradoxical situation in which form and power, constitution and constituting movements can be distinguished but not separated? Or, on the other hand, how can we maintain the movement for renewal that has ensured the constituent force of which the SUS is an effect?

When we talk about the constituent movement of the SUS we have to bear in mind that there are principles at the base thereof. A principle refers to what is a cause, what is an origin, what triggers a movement. To say that **health is a right of all, and a duty of the state**, as is writ in the Brazilian constitutional text, forces us to subdivide this legal statement in principles that expand the meaning of the idea of 'all' as present in the text of the Law.

First of all, saying that **health is a right of all** is the idea of defending **universal access**: everyone

has the right to health services. On the other hand, the 'all' as mentioned in this statement about the right to health shall be understood as a right to **all health**, which is defended with the idea of **integrity**. If we defend universal access and also integrity of health care, we must make this final subdivision of the legal text, ensuring that the 'all' concept of universal access and the 'all' concept of integrity of health care do not lead us to a standardized and homogenizing concept of the offers in the health sector: more supply for those who need it most. **Hence**, there are three core principles: **universal-ity** of access, **integrity** of health care, and **equity** of offers, starting a movement for production of health services in a field that is organized with the operational principles of decentralization, territorialization and participation.

Talking about the SUS also commits us, therefore, to a reality which has two sides: an instituted format and an instituting force; State and process; constitution and constituent power - to use the formula as proposed by Toni Negri (2002).

The question that now comes before us is the definition of the subject of this constituent movement of the SUS. Who is the protagonist, or how does the subject thereof get formed? Qualifying health care and health management processes means new attitudes on the part of the workers, managers and users, overcoming problems and challenges of the daily work routine; the queues; the insensitivity of workers with regard to people's suffering; treatment showing lack of respect; isolation of people from their social and family networks in procedures, medical appointments and admittances to hospital; the practice of authoritarian styles of management; the shortcomings of the concrete working conditions, including the degradation of environments and work relations. These problems are, indeed, the expression of certain ways to conceive and organize work in the health segment; more than individual ethical faults (of one worker or manager, or another), they show certain concepts of work and of the way in which it is organized.

Tackling such problems must not be limited to localizing them in individual attitudes and behavior patterns considered inappropriate. Making the problem an individual issue would lead us to

moral judgement, which would then fall upon the subjects as a prescription of 'a correct way of doing something'. From the standpoint of the qualification processes, this would mean an exercise of prescriptive pedagogical action, with offer of strategies of skills training and qualification.

Pedagogical strategies in this direction derive from a concept of what a good health practice would be, and present themselves as resources to solve the issue of what to do so that the workers in the health sector act in the correct way. For there to be correspondence between the worker's actions and what is taken as correct, educational action is defined as skills training, in turn taken as the transfer of information so that the 'unqualified' may acquire certain skills. Along the same lines, the workers are 'trained' so they may repeat and exercise the correct way of doing things. For those that, even so, do not fit this pattern of normalization, there is a proposal of refresher activities: a remodeling of the subjects. In any case, training thus becomes a form of correction (in the orthopaedic meaning of the term) of those workers in the health sector who are allegedly inappropriate: qualification would have this sense of adaptation.

This border-marking process is important to distinguish people with more traditional training from those which the SUS has sought to construct, in line with its ethical and political policies. Understanding that the alleged 'inadequate practices' are expressions of precarious forms of labor organization, and that they are therefore relevant to the issues of management and of concrete working conditions, the agenda of qualification for SUS immediately shifts to new proposals for qualification.

This shift also occurs for another reason, of a methodological character. Understanding the method as a 'way of walking', the SUS takes inclusion as being their own way of doing things, betting on the social practice of expansion of the bonds of solidarity and co-responsibility, a practice which unfolds following the method of triple inclusion: 1) inclusion of the different subjects involved in the processes of production of health (users, end workers, and managers); 2) inclusion of the institutional analyzers coming from the placing of different subjects alongside each other; 3) inclusion of the

collective subject that results from the two previous inclusions (Barros; Passos, 2005a, 2005b; Pasche; Passos, 2010).

This method is implemented in the spaces for management, health care, and qualification, including individual subjects and groups, as also the analyzers (disturbances) that these inclusions may produce. The SUS calls us, in the health care and health management practices, as also in pedagogical practices, to ensure the participation of different subjects, in their singular characteristics, planning, implementation and assessment of the processes for health production and for the qualification of the worker in the health sector.

With the exercising of this method in the process of qualification, what effects are produced? To answer this question, it is necessary to consider that the principles of the SUS are subdivided into methodological guidelines: transversality (expansion of communication; production of the common); the indissociability between health care and management; the nurturing of protagonism of individual and group subjects; the indissociability between health production and the production of subjectiveness.

The exercising of the method of inclusion shall always consider that there must not be separation of health care from health management; that there shall be the promotion of communication processes extending well beyond the hierarchy and corporativism, and that a bet shall be made on the subjects being capable of transformation through shifts in their most immediate interests, constructing processes of negotiation, allowing the establishment of zones of communal activities and common projects.

This inclusion also has the aim of producing new subjects that can expand their communication networks, changing the borders of knowledge and also of the territories of power. Inclusion is connection between the management and the practice of health production by leading workers, as work in the health sector results from the institutional conditions that set the ways in which the organization shall operate, this being a responsibility of health management.

However, inclusion itself is not enough. It is also necessary that this inclusion, as also the process for the production of subjectivity associated with it, shall be guided by principles and guidelines. For

SUS, these guidelines are of clinical, political and ethical likes and also take up meaning in sheltering, in the expanded clinical activity, in the democracy of relations, in the added value given to the worker, in the guarantee of user's rights, and also the nurturing of networks.

It is in this articulation between principles, methods and guidelines that the processes of qualification shall be proposed and organized. The guidelines for the formation processes for SUS are based on the principle that qualification is inseparable from the processes of change, meaning that qualification is necessarily a type of interference, and interference, in turn, is the act of intercession in reality or promotion of acts of intercession together with this reality, as Deleuze (1992) proposes with the concept of 'intercessor'.

Qualification as a strategy of group intercession also assumes the production of changes to the working conditions based on the relationship between the subjects that participate in the process for health production. Without seeking a consensus or harmony between different subjective positions, the bet is on a relationship of intercession rather than intersection, which means less creation of a common space because it's homogeneous, rather than communality in the difference. The relationship between the different positions may be taken up in its force of disturbance of what has been implemented, thereby releasing the instituting forces that promote changes to the health sector. Thinking of qualification in the health sector based on the concept of intercession means the need to use pedagogical strategies that overcome the mere transmission of knowledge. as there would not be a correct way to do this, but ways that, guided by ethical, political and clinical assumptions, shall be recreated considering the specific features of each reality, institution and health team.

The processes of qualification should be understood as an important resource for the capillarization of the ethical and political directives of the SUS in the health network, with the rapid multiplication of social agents that are involved in the *susista* movement. However, this action does not occur only due to sensibilization processes, but rather through the experimentation in acts within the work

processes, which allows the production of concrete movements involving the way to get things done in services and also in health practices.

In this way, the processes of qualification are a precious resource for experimentation and also for the necessary construction of the extensivity of the SUS. The agents of this strategy, in general, are institutional supporters, agents who contribute to the problematization of institutional realities, constructing, together with the health teams, changes to perceptions, the manner of dealing with conflicts, expanding the processes of group feelings and, as a result, changing attitudes and producing the conditions so that the problems, and also the challenges of daily work in the health sector, may be overcome.

Qualification also includes supporting the teams in work processes, not transmitting apparent knowledge in ready form, but rather in a relationship of collaboration with the agents of the practices. Supporting is the act of producing social analysts and ways of dealing with new problem situations involving the teams, to leave the feeling of blame and impotence, when faced with the complexity of the challenges of work in the health sector. Supporting is also the act of nurturing collective experiences to exercise the analysis, the first effect thereof being the expansion of group feelings between those in a work situation. The construction and sustenance of the feeling of belonging to the group and collective co-responsibility are essential for the hiring of tasks through which it is sought to expand the effectiveness of the practices and, at the same time and undissociably, qualify work spaces, establishing them as an important locus for professional accomplishment. These are the main proposals and challenges of the process of qualification in the health sector.

In the field of health policies, SUS takes up, as its main challenge, the construction of a policy which one wants to be public and transversal, thus affirming the subjective dimension of health practices. This dimension refers not so much to the resumption or valuing of a subject as already given, but rather the inciting of the process for production of new existential territories, of new subjective experiments, whether in practices for health care or health management.

The challenge of qualification in the health sector is that of tuning in, so as to proceed with health care and health management with the democratic bet placed by the SUS, Ensure the participation of the subjects involved in the health practices is one way of ensuring its protagonism in the process of production of their health and also the qualification of SUS workers. From mere patients or users of the health services, these subjects take up a position right beside the worker, which changes the way in which health practices are organized, often marked by the hierarchy of the different and the corporativism of equals. The challenge is that of transforming health practices **on subjects** into practices **with subjects**.

“Care for the self” and health qualifications

“Care for the self” is a Greek notion that is very complex and potent, which indicates practices of being occupied with the self. Foucault (2006) defines it as “[...] a kind of sting that shall be implemented in people’s flesh, wedged into the person’s very existence, and is also a principle of agitation and movement, a principle of permanent restlessness along the path of existence” (page 11). This is an idea that was present throughout Ancient Philosophy up to the dawn of Christianity, even though it has multiplied and changed its meaning throughout this period, but which was later lost. This is why Foucault dedicated himself to this idea. What the philosopher wants to show, and what interests us in our debate on qualifications, is that **occupation with the self** is also something that unfolds within the realm of thought, “[...] a decisive moment in which even our way of being, that of modern subjects, is jeopardized [...]” (2006, page 11), which shall produce ways of conception and of being in the world, a theme which is directly related to that of qualifications.

It was not by chance, therefore, that the notion of care for the self was lost for a long time. This is a notion that goes back to an aesthetics of existence, in someone’s relationships with self and others. It is in the Modern Age, especially in the “Cartesian moment”, that this “forgetting” becomes more evident. There was a clear separation between ‘care for the

self' and 'knowledge of the self', which were complementary ideas for the Ancient Greeks. Foucault raised two different hypotheses about this change: the first results from a distortion of the very meaning of 'care for the self', of an ethical and moral nature; the second came from a greater value given to 'knowledge of the self', more significant than 'care for the self' because it gets installed in the plane of truth.

The text where Foucault finds this notion is in Plato's *The Banquet* - written in about 380 BCE, with the main theme being Eros, which is the personification of love -, in the dialogue between Socrates and Alcibiades. This latter person was a young orphan and was about to enter adulthood and political life, but did not feel ready to take on the challenge of governing others. He decides to speak to Socrates, known as the person who would arouse people for a certain style of existence in the world, for the need for them to pay attention to what they think and what goes on within the people's thought, while, at the same time, observing their actions towards themselves, actions for which we assume ourselves, change and transform.

Socrates prepares Alcibiades for Government. He feels responsible for teaching the young man to take care of himself. Then starts the section of the dialogue which interests Foucault: "[...] if you govern the city, there is a need to tackle two types of rivals", says Socrates: the internal rivals (there are others who wish to govern the city) and then "on the day when you govern", the enemies of the city (Socrates, *apud* Foucault, 2006, page 45). Then the Greek philosopher compares Alcibiades with the enemies:

"[...] however rich you may be, can you compare your riches with those of the King of Persia? Regarding education, what you receive, can you really compare it with those of the Lacedaemonians and the Persians? On the Spartan side [we find] a brief description of the Spartan education presented not as a model, but in any form, as a reference of quality: an education which assures good manners, a grand soul, courage and resistance, which gives young people a liking for exercise, a liking for victories and honors etc. Also on the side of the Persians [...] the advantages of the education received are very significant; education concerning the King, the young prince that since the [...] age of understanding - is surrounded by four

teachers: one is the teacher of knowledge (Sophia), another is the teacher of justice (Dikaiosýne), the third is the master of temperance (Sophrosýne) and the fourth the master of courage (Andréia [...])" This is just a recommendation of prudence (Foucault, 2006, page 45).

Here, it is worth pointing out that the inferiority that Socrates mentions is not limited to wealth and education, but in the fact that Alcibiades is not able to compensate the two problems with 'a knowledge, a *tékne*'. In this excerpt, Foucault calls attention to the fact that the need to take care of oneself is directly linked to power. If in Sparta taking care of oneself was a consequence of a statutory status of power, the issue of 'care for the self' appears as a "[...] condition to pass from the statutory privilege which was that of Alcibiades (rich and traditional family, etc) to a definite course of political action, the effective Government of the City" (Foucault, 2006, page 48).

The point of emergence of the notion of 'care for the self' is therefore between the privilege and political action; in the insufficiency of education; the need to learn how to occupy oneself with the self when leaving the hands of pedagogues to start political activity; and when one ignores how to occupy oneself with "[...] well-being and agreement of citizens between themselves" (Foucault, 2006, page 49). And the French philosopher then interrupts the reading of the text to pore over two core issues: "[...] therefore, what is the self that I need to take care of, when it is said that I must care for my own self?" (Foucault, 2006, page 50) and also highlights that the dialogue brings the subtitle "of human nature". This is an essential issue for us, nowadays, as it applies not to the 'nature of man' but rather to what we call a 'problem of the subject'. The second question that is raised by Foucault, "[...] which self should I occupy to be able, as is convenient, to occupy myself with the other people who I should govern? [...]" This is the question that, after all, brings the first emergence of the discussion about 'caring for the self' within Ancient Philosophy.

The author is describing the way in which the subject has experience of the self, how the subject relates to self and others and, at the same time, how he or she is a subject of action. The 'care for the self' is a translation of a line of thought in which the

truth can be accessed through acts and practices that transform the whole of the subject's being. It is the subject that undergoes reconstitution. This is the subject of the action, ethical and political, that must undergo reinvention. This is a concept of Greek origin that means what we need to do for ourselves. In this regard, Foucault was concerned with bringing the ethical subject back to our days.

The programme for education through work in the health sector (PET-Health)¹ and 'care for the self': a scene²

Care is a notion and discussion that appears in the later context of Brazilian health reform. Required by full attention to health and a need for the humanization of health practices, this led to the appearance of subjects where there were previously objects (illnesses, organizations and functions); it also promoted dialogue as a counterpoint to monologues and prescriptions; it added meaning to what was formerly dispersed in fragments.

In Foucault, it is possible to identify some aspects of epistemological, political and ethical nature through issues that have been naturalized, especially in health education. There is a split between knowledge and care, thought and practice, oppositions which establish ways of thinking and acting. As a counterpoint, the concepts of 'care for the self' and 'subject of action' may help us to propose a qualification that considers the process for the establishment of an "ethical subject" in the movement to defend the SUS.

"Care for the self" is a notion which helps us to see health practice beyond the discussion of the individual, interpersonal interactions and also procedures. This is a proposal for care that requires us to think about

the issue of qualification and education in health sciences together with the field and the nuclei of collective health (Campos, 2000) with health practices, health services, work processes and clinical practice, together with all those who make up the SUS. This notion involves us with the political dimension of the action and, thus, helps us to resist the processes by which there is disappearance of values, for example.

PET-Health is a strategy that problematizes issues that are naturalized about teaching, services, and relations. In this direction, the pedagogical practice here does not only mean the supply and the organization of activities for recognition of territories and the daily activities of the professional, but also taking the process of health work as an object in order to stimulate other types of work, attention and health education.

Assessing the mechanism for production of this policy, a policy regarding the means of existence and other types of qualification, it requests 'in an act' the demand for the production of collaborative networks and also bets on the lives of others. It is, in the end, a society bet because it takes on the biopolitical machine, confronting inequalities that result from the interdiction of more life in the other.

However, the results are limited in terms of function, especially the public characteristic of the bet in health education. The public sphere still enjoys little value or is understood in the wrong way, meaning that there is resistance to think of the public dimension of health education: we have difficulty to teach what is public health policy within the scope of the SUS, in the same way that it is not easy to teach academics from health courses what collective health is and also the issue of Basic and Primary Health Care in a direct relationship with the realm of practice. It is difficult to produce movements and approximation with SUS, beyond the project; and qualification to be at the level of frailties of the other as a problem posed by life is still a mystery.

¹ The Programme for Education through Work in the Health Sector (PET-Health, or in Portuguese PET-Saúde), aimed at nurturing groups for tutorial learning in the Family Health Strategy, is a strategy set by the Brazilian Ministry for Health and Ministry for Education, seeking the qualification and the education in services provided by health professionals, as also work initiation, internship and hands-on experience, aimed at students of all areas within the broad Health Field, according to guidelines set by the Brazilian National Health System (SUS). For further information, we recommend research in periodicals from the collective health area which, once again, have an open space for the reports on successful experiences with the PET-Health project in several parts of the country.

² The scene described below has been systematised based on several experiences with the Contact and Improvisation Dance, but I would like to mention that this idea was initially developed by a courageous Physical Education student who, at the same time, was sensitised by what the experience of PET-Health at USP made possible, Gabriele Bernardoni, in 2011 and 2012.

We admit that the impact of the Pro PET-Health programme is not significant, considering the high number of students and teachers who are not aware of the policies and experiences that have been produced. However, we are persisting, understanding that the zones of tension and discomfort generated by the 'meetings' of the participants of the Pro PET-Health programme produce knowledge and practices that are more responsible and more humanizing, meaning that they produce micropolicies that are more strongly committed to the fight in defence of the SUS and of life.

In this text, we bring a scene, out of the many that have been experienced. It is not the best, or the most authentic, the most impacting, or even a model to be followed. It is just a scene...

Location: A Basic Health Unit in the neighborhood of Butantã, in the Western part of the city of São Paulo. A student of the course in Physical Education and Sport of the University of São Paulo (USP), a group of SUS users and an experiment with the 'contact-improvisation' dance³. The experience has a definite duration: weekly meetings of two hours each, over nine months. Opening meetings with child users, women users, young users, sad users, timid users, happy users, blocked users, fun users, different types of users of the SUS. While we were planning the meetings, the meetings invented means of contact and improvisation beyond what we had learnt about body work. There was provocation from all sides, generating movements, thoughts, affection, tension, changes, discomfort and agitations... that were not in one person, but in everyone. A type of 'clinic', of care and of means of leading and operating the relationships that caused sighs and sharing in moments of difficulty, frustration and accomplishment or amorousness. This is something we can only do when we are together.

There was an intention: that of proposing body practices, articulated with SUS principles, with a

view to valuation of the users' potential while, at the same time, bringing about a new significance of the specific contents of the training course in Physical Education, considering the health needs of individual people and also of the collectivity. We sought the experience of diversity and also the increase in the repertoire of gestures; the autonomy of subjects and also the collective; and the production of creative movements, free from stereotypes. The "contact-improvisation dance" is a proposal for permanent experimentation, connected with other perceptive forms. We have brought the elements of daily life - everything that we have brought to the meetings from our own lives - to the dance and thus have been recognizing small gestures, the most commonplace, to perceive the relationships and the opportune moments when we shall be able to release the movement, detach ourselves from the purely mechanical and automatic, to find the authentic, the intense, the full, to express the way in which we have entered the flows of forces and movements.

The repetition of this experiment teaches us about the quality of the meetings and also about the meetings with the other - to know who the other is, why the other is there, placing oneself in the other's place and collecting what comes with it - instigate us to discover how far we can go while still together. This is a type of action - a qualification - which is a kind of political action. The appropriation of such concepts as improvisation, happenings and sensitivity, and the transformation of these concepts into practices of improvisation and dance, is caring for self and caring for others. Presence is fundamental. Doing is fundamental, to know what is important so that the meetings may be transformed into a real event.

Recognition of the different needs of the users of the service, working on the limits and also the possibilities of moving bodies is also the allocation of other meanings for the service, for the professional

³ 'Contact-Improvisation' is a body technique that was created back in the 1970s by a group of dancers and choreographers from the United States, linked to modern dancing. The artists, intrigued by the pre-set and hardly original forms of the dance schools and companies, and experiencing counterculture, opened a new dance company, the Grand Union company, which has a base methodology of group improvisation. For further information, we recommend the work of Steve Paxton, who was a member of the group in its original formation and who presented, for the very first time, a spectacle put together based on this technique, *Magnesium* (1972) which officially introduced Contact-Improvisation (CI) within the universe of dance.

people involved, as also students and users and also for health practices. These are initiatives that are still little exploited, well attentive to the desires and betting on lives of others and on 'caring for oneself'.

Production of the common, communality zones and crossroads

Crossroads are those territories where several paths cross each other. This is where we have to face ourselves. Where are we going? What do we want? What are we taking? What shall we leave behind? And so on...

Crossroads are energy fields. These are fields brimming with energy forces, coming and going in several directions. They meet, join and continue on their way. These are zones of opportunity and changes. Powerful forces for transformation, towards the trans... formation... of action...

These are also the fields of vibration of the forces that can inhabit inside us. However, they cannot stay there forever. There is a need to move forward. Points of contact, points of communication and of improvisation. Surprises: who will I bump into? There is always more than one option and, for this reason, they are also fields beset with problems.

The common is no-one's land, land which, for this very reason, can and should be inhabited by all. How do we take care of what is common? Through listening, talking and sheltering; taking in alterity; establishing bonds; working as part of a team; composing and creating associations...

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Authors' Contribution

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