ORIGINAL ARTICLE

Cooperative interventions and the interaction of Community Health Agents within the Family Health team*

ARTICULAÇÃO DAS AÇÕES E INTERAÇÃO DOS AGENTES COMUNITÁRIOS DE SAÚDE NA EQUIPE DE SAÚDE DA FAMÍLIA

ARTICULACIÓN DE ACCIONES E INTERACCIÓN DE LOS AGENTES COMUNITARIOS DE SALUD EN EL EQUIPO DE SALUD DE LA FAMILIA

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ABSTRACT

This qualitative study examines the social relationships between the Community Health Agents (CHAs) and the Family Health team (FH), highlighting cooperative interventions and interactions among workers. A total of 23 participant observations and 11 semi-structured interviews were conducted with an FH team in a city in the interior of São Paulo, Brazil. The results revealed that CHAs function as a link in the development of operational actions to expedite teamwork. These professionals, while creating bonds, articulate connections of teamwork and interact with other workers, developing common care plans and bringing the team and community together, as well as adapting care interventions to meet the real needs of people. In communication practice, when talking about themselves they talk about the community itself because they are the community's representatives and spokespersons on the team. The conclusion is that the CHA may be a strategic worker if his/her actions include more political and social dimensions of work in healthcare.

DESCRIPTORS

Community Health Aides
Primary Health Care
Family Health Program
Patient care team

RESUMO

O estudo de abordagem qualitativa teve como objetivo compreender as relações sociais entre o Agente Comunitário de Saúde (ACS) e a equipe de Saúde da Família (SF), nesse sentido, destaca-se a articulação das ações e a interação entre trabalhadores. Foram realizadas 23 observações participantes e 11 entrevistas semiestruturadas com uma equipe de SF em um município do interior de São Paulo, Brasil. Identificou-se que o ACS, como elo, desenvolve ações operacionais para agilizar o trabalho da equipe. Como laços de ligação, desempenham ações articuladas ao trabalho da equipe, interagindo com os trabalhadores, construindo planos assistenciais em comum, aproximando equipe e comunidade, adequando ações de cuidado às necessidades das pessoas. Na prática comunicativa, ao falarem de si, falam da própria comunidade, pois é seu representante e porta-voz na equipe. Concluiu-se que o Agente Comunitário de Saúde pode ser um trabalhador estratégico se suas ações compreenderem uma dimensão mais política e social do trabalho em saúde.

DESCRITORES

Auxiliares de Saúde Comunitária
Atenção Primária à Saúde
Programa Saúde da Família
Equipe de assistência ao paciente

RESUMEN

Estudio cualitativo que objetivó comprender las relaciones sociales entre el Agente Comunitario de Salud (ACS) y el equipo de Salud de la Familia (SF), destacando la articulación de acciones e interacción entre trabajadores. Se realizaron 23 observaciones participativas y 11 entrevistas semiestructuradas con un equipo de SF en municipio del interior de São Paulo-Brasil. Se determinó que el ACS como eslabón desarrolla acciones operativas para agilizar el trabajo del equipo. Como lazos de comunicación desempeñan acciones articuladas al trabajo del equipo, interactuando con los trabajadores, determinando planes asistenciales en común, aproximando equipo y comunidad, adecuando acciones de atención a necesidades de las personas. En la práctica comunicativa, al hablar de sí, hablan de la propia comunidad, pues son sus representantes y portavoces en el equipo. Se concluye en que el ACS puede ser un trabajador estratégico si sus acciones comprenden una dimensión más política y social del trabajo en salud.

DESCRIPTORES

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INTRODUCTION

A world crisis was triggered in the 1970s as a consequence of reduced economic growth, with financial, political and ideological implications. A new order known as the “globalization of the economy” and the hegemony of the neoliberal proposal guiding economic policies was implemented and reflected in the social sphere. The health field, in response to the crisis and the need to broaden the possibilities of care coverage to the less privileged, promoted in 1978 the International Conference on Primary Health Care, in which the Declaration of Alma-Ata was written. As the main goal for all countries, it recommended that by 2000 all world citizens would be able to achieve a level of health that permitted them to have a socially and economically productive life. Such a goal became known as Health for All in 2000 and the Primary Health Care (PHC) was seen as a strategy for its achievement[1].

About 30 years after the Conference, the proposed goals and outcomes have yet to be fully achieved and new challenges have been introduced. Hence, a theoretical and practical review of PHC has been undertaken worldwide to critically reflect on the health needs and the development of people in order to produce a renewed concept of PHC. The renewed PHC stands out with the establishment of essential values, principles and elements, while equity and solidarity are aspects to be pursued. The renewed PHC approach is intended to guide the transformation of health systems with a legal, institutional, and organizational basis, and human, financial resources that are technologically sustainable and appropriate to cultural, social, political and economic aspects of each country and region[2-3].

A technical dimension and a political dimension are discussed concerning the work of these agents.(...) However, these two dimensions are not yet synthesized in the practice of CHAs; one or another is more frequently employed, depending on the context.

The Brazilian Unified Health System (SUS) was created in 1988 based on the Sanitary Reform movement. The SUS, based on PHC, is a strong legal and political structure whose doctrinal and organizational principles are grounded in integrality, universality, equity, problem-solving capacity, decentralization and social control and participation. However, it also faces challenges and limitations for its practice to constitute effective implementation in PHC in Brazil.

Theoretical Support

There were experiences and proposals in Brazil regarding the implementation and strengthening of the SUS and PHC. The Family Health Strategy (FHS) is currently considered a priority for the reorganization of healthcare in Brazil. Care within the FHS is provided by a multidisciplinary team composed of one nurse, one nursing technician or auxiliary, one physician and up to 12 Community Health Agents (CHA)[4].

CHAs are workers who emerged from a national experiment in the state of Ceará, Brazil in 1987 and are currently included in the FHS team. Since July 2002, it has been a profession characterized by the exercise of activities related to the prevention of diseases and health promotion[5]. The main activity of CHAs includes home visits, followed by health education concerning guidance on hygiene; immunization schedules; the correct use of medication; and care provided to newborns, pregnant women and puerperal women[6].

A technical dimension and a political dimension are discussed concerning the work of these agents. The first refers to care provided to individuals and families, to the prevention of diseases, and the monitoring of groups or specific groups. The second encompasses a proposition to organize the community to transform its health conditions. CHAs are a more ethical-communitarian interpretation as an element promoting the organization of the community toward citizenship from a perspective of social transformation. However, these two dimensions are not yet synthesized in the practice of CHAs; one or another is more frequently employed, depending on the context [7].

Despite difficulties, CHAs are workers with unique characteristics because they are in constant contact with people in the community and with workers from the health staff. It contributes to changing the health model since it can facilitate communication, exchange of information, and the establishment of trust ties between these two actors. It is important to note that CHAs should not merely act as informants but be active agents in this process[7-10].

Representing the knowledge and practice of CHAs as a ‘link’ (seen as part of a chain and an industrialized, rigid, cold piece closed in itself) and as a ‘bond’(understood as a notion of mobility, a ribbon tie, a craftwork that can be adjusted according to the need), to be a link of chain only when conveys information or as a ribbon tie when interaction and dialogue is established among subjects and their different types of knowledge, bringing together the community and the staff through human relations[11].

Positive aspects and limitations emerge in the work of CHAs when they become part of the health staff. If, on one hand, the opportunity to acquire new knowledge, easy access to professionals and health services, feelings of appreciation, belonging, self-esteem, prestige and acknowledgement are positive characteristics, on the other hand, dissatisfaction with qualifications and inappropriate training, difficulty interacting and communicating with the team’s other professionals, frustration, uncertainty, helplessness, and a feeling of worthlessness are posed as limitations[7, 9,12-13]. Considering that a team is a structure in a

process of constant disruption and re-structuring, not only a group of professionals working together[14], this study sought to understand the social relations established between CHAs and the FHS team based on the work process of the health staff, highlighting the aspects of joint action and interaction among workers.

There are differences between a *team group* and *team integration*. Both have two dimensions: one of actions and tasks and one of agents. There is in the *team group*, as explicit in its own name, only the grouping of actions and agents, while in a *team integration*, actions are connected and agents are in interaction[15].

Joint actions involve instances in which agents put into evidence the connections existing among actions and the various types of technical knowledge. Such actions require agents to have a conscious and active attitude, showing connections among the technical interventions of the various professionals and jointly constructing a common intervention project based on negotiation, sharing and solidarity. Interaction *depends on linguistic communication that becomes familiar*, that is, communication, mutual comprehension and understanding are required among the subjects so that interaction is established[16].

Considering *team* as a structure in constant disarray and in a constant restructuring process, this study sought to understand the social relationships established between CHAs and the FHS team based on health teamwork, highlighting the aspects of joint actions and interaction among workers.

METHOD

The setting of this qualitative study was a health unit in a city in the interior of São Paulo, Brazil. The study's subjects included all members of the FHS team and its respective Oral Health team: four CHAs, one dental office assistance, two nursing auxiliaries, one dental surgeon, one nurse, and one physician and the manager of the health unit, totaling 11 health workers.

A total of 23 participant observations and 11 semi-structured interviews were conducted. There was a specific script to guide the participant observation together with the CHAs and another for the semi-structured interviews, individually held with each worker of the FHS team. The script for the participant observation contained data to contextualize the observation and four main aspects to be observed: those related to the participants, to the development of actions, to the complementarity and interdependency of actions, and interaction and communication among health workers. The script for the semi-structured interviews addressed the characterization of the interview, of the interviewee, and of the interview *per se* with eight guiding questions. Its final version was reached only after observations, which indicated the most pertinent and relevant questions for the study. The observations were recorded in a field diary and interviews were recorded and transcribed verbatim. Observations were held from March to June 2008 (four months) and the interviews were held from July to August 2008 (two months). The empirical material was thematically analyzed[17].

Qualitative analysis was conducted to identify the presence of meaningful elements to construct core meanings. Even though, the stages of exploration of material, treatment of results, and interpretation follow a certain count of frequency of core meanings to develop the themes, they were mainly based on the search for elements that addressed the study's objective or were able to make unexpected facts emerge from the empirical data. The core meanings were grouped into the following themes: the history of the health unit and the FHS team workers, the team work process, and the CHAs in the FHS team from the perspective of joint actions and the interaction of subjects. The latter was more exploited in the development of this study.

Ethical issues were complied with in accordance with Resolution 196, National Council of Health[18]. The study was approved by the Ethics Research Committee at the University of São Paulo at Ribeirão Preto, College of Nursing (protocol 0764/2007), and authorized by the City Health Department. All the participants consented to it.

RESULTS

The Community Health Agent as a link

The *link* nature of CHAs' work is reinforced when they perform essentially operational tasks aiming to expedite teamwork and the health unit's functioning. These activities are related to the work's technical and operational aspects such as delivering referrals or messages from the heath unit to people without connecting these tasks to more integral care actions:

> Uh, like when we have to deliver an urgent referral, or an ID card, call a patient for an appointment with the doctor right away, give a message (…) (Silence). Well, this is not exactly our job, but we do it willingly (Interview 4, CHA).

Actions connected only at the activities' technical and operational level may convey the idea that the work of CHAs is restricted to making appointments or delivering messages:

> Since it is a bit far away, they [users] want us to do it for them. They don't want to go to the unit. (…) I mean, make appointments, check things for them, send them messages, you know? (Interview 4, CHA).

These activities can, in a certain way, show concern and care for the uniqueness of each individual in specific situations. However, delivering messages or scheduling appointments in a mechanical manner without dialoguing or interacting with the individuals should not be the focus of the CHAs' activities.

> A good job is when you dedicate yourself and do your best to solve someone's problem. Because it doesn't help if you go there and transmit information, you just transmit information and that's it. I guess you should also seek a solution (Interview 3, CHA).

> They [CHAs] go there, and when the campaign starts they report *Look, the campaign to prevent the flu*, then ... sometimes, they bring the immunization card for us to see… to check whether the patient is going to get the shot, whether he needs it or not, you know? And we note the day of the vaccination campaign, the day of the home visit, it's the agent who goes there, informs the family, who then waits for our visit (Interview 9, health worker).

The Community Health Agent as a bond

CHAs as a *bond* seem to perform actions linked to the health staff, interacting with other workers in order to enable integral care for people and individuals in the community. This *bond* dimension between people and health workers occurs due to the fact that CHAs know the individuals, their families, their homes, and seek to identify their needs. Additionally, CHAs live and work in the context of this community, go to people's houses and have the opportunity to identify needs, which normally would not be recognized in the context of the health unit. Such needs go beyond biological disease and can be intra-family conflicts, domestic violence, need for food, sexual abuse, child neglect, or mistreatment of elderly individuals, among others. These situations are extremely complex and imply that there is a great distance for CHAs to reach an opportunity to identify them based on the construction of bonds with the family and longitudinality of care:

> We are a link between the community and the professionals there (…). I guess it's great. (…) Because the professionals know how the patients act in their homes, with their families, with their children… (Interview 2, CHA)

> Uh, I guess we cooperate a lot, you know, with the entire team, if it is not the entire team, if there's not the agent to care, you see? Because each one sees from a different perspective; our perspective shows what is real outside the unit, you see? What we show them is real, and they know that, because they don't know what happens outside (Silence) (Interview 5, CHA).

The other members of the FHS team spend more time inside the unit, hence, possibilities to come into contact with people in a more favorable and less institutionalized environment, such as their home, are limited. The CHAs, in turn, are those who have more reliable information concerning the social inclusion of people in their home environment and in the community, factors that influence the health-disease-care continuum:

> The community agent is that element, you see, that person who brings information we aren't able to get here inside the health unit (...). The agent goes to the patient's house; we see whether the problem is lack of food, or lack of hygiene…he sees a lot of things we have no means to know otherwise (Interview 1, health worker).

Such work seems to provide a certain sense of security and peace of mind to the other workers because they are able to know people better and the territory in which they are working through the work of CHAs.

> They are our arms and eyes. (...) It gives us some peace of mind, because we work in a place where we recognize, we know what is happening. It's a known territory (Interview 6, health worker).

The work of CHAs as a 'bond' means they are also part of the construction of the care plan developed by the staff. Their work seems to occur from the perspective of the joint construction of a common care project:

> Sometimes, there's a person who has a very severe asthma, goes to the doctor, uses an inhaler all the time and it doesn't go away. But sometimes, they don't know there's a cat in the house… there're lots of rugs, curtains, dog. (…) Then, we usually say 'No, but there, oh , there're damp walls, there's this and that (Interview 3, CHA).

> Then, I came into contact with the community agent; she informed me of everything, she said "This patient did physical therapy many years ago in such a place. And this and that…"she told me everything how she did it. I got the file, saw the last two visits of [name of the team's nurse], the records, everything. So, we already knew everything, you know? I found it interesting. She [CHA] knew everything that was happening with that patient. So, we went to her house, I went to see her, she regularly used oxygen therapy, you know? Regularly, uh… I explained exactly what we were doing there. Why we were there. So, it was very nice, because we are already committed to take some action, you know? When we went back, I mentioned to her *Oh, let's talk about this with the doctor who comes back on Monday from vacation* so, she takes notes, you know? Records everything. When we got there, we also reported the case to the auxiliary of that specialty. So, like, we end up informing everybody, you know? (Interview 6, health worker).

In the same way CHAs are asked by the team to contribute to a care plan, they also seek other workers when they are faced with needs of the population that they are not able to meet by themselves:

> Sometimes, the problems they [CHAs] are not able to solve. (...) He says like "Let's go there because you can better convince him. I've already invited him, I'm talking to him, but it's not working" (Interview 9, health worker).

In addition to the opportunities that are designed for the exchange of information among health workers, such as team meetings, communication also takes place outside these more formal places, i.e. in the corridors, depending on the decision-making of workers in the face of situations they encounter.

However, an excess of tasks and a lack of time seem to be factors that hinder the establishment of more effective communication:

> For her [the physician], it's more… she sometimes comes in the middle of the meeting, sometimes, at the end. (…) Sometimes, they [nursing auxiliaries] are doing something else, sometimes they arrive in the middle (…). They [Oral Health team] are doing some procedure, something, and can't participate (Interview 5, CHA).

> It was late in the afternoon, one community agent was waiting a nurse near by. She seemed to want to talk about something while the nurse was assisting a mother with her child. For a moment, the nurse looked at the agent, who started to tell about the case of a user who had a urinary infection but didn't want to take the medication. The nurse, while talking to the agent, continued to provide care and left the room in a hurry with the mother and the child. She kept talking to the agent while she followed the doctor and talked about the case. The nurse was walking ahead and seemed to give little importance to what the agent was saying. The agent was following the nurse and talking to her in the corridor. At the end, the nurse only told the agent she had already talked to the user. The agent said ok and left but seemed not to be very satisfied with the talk she just had with the nurse (Observation 5).

The fact that CHAs can access the staff and establish communication in a dialogical relation can help them facilitate access to the health services for people. If on the one hand, they take the workers to the people's houses, on the other hand, when people go to the unit they also first look for the agents, because they acknowledge they are able to meet their needs or organize the demand for the other health workers:

> They (health service users) seek the community agent, stop by to see what can be solved, (…) because they know that if it is necessary, I go with the nurse, I go with the nurse; if there is a need to go with the physician, I schedule to go with the physician (Interview 3, CHA).

When the community health agents talk about themselves, they talk about the people in the community.

Seeing CHAs as the representatives of the community in the health unit implies considering that the elements present in their relationship and the health staff, whether in joint actions or interaction, can also indicate elements present in the relationships between workers and users in the intercessory spaces of care. The following observations exemplify this:

> During a meeting between the CHAs and one worker with a college degree, the latter talked most of the time while the CHAs kept silent. One CHA tried to establish communication with the worker twice, asking questions about the subjects they were discussing, but the worker would provide brief explanations not making sure the CHA had understood it and without giving her a chance to express herself (Observation 5).

> One CHA was waiting to go make home visits with a worker with a college degree, while the latter was rapidly assisting one user who had gone to confirm the result of an exam. There were times the user seemed to want to ask a question but when she would talk, the worker would interrupt her, mechanically reading the exam's results. Then, after many attempts and much insistence, the user asked a question at the end of the consultation, whether the result was related to a change observed in another blood test she had taken months ago. The answer she got from the health worker was *It has nothing to do with it… the important thing is that you keep following my recommendations* (Observation 4).

Neither the CHAs from the first observation nor the user from the second observation were able to effectively participate in the conversation, establishing a dialogue with the health worker. These two observations are similar in the way the agents and users are trying to put themselves before the staff as active agents co-responsible for the plans of implementation and development of care.

CHAs are part of the communities they monitor; they live in the covered area and often share the same needs of the individuals from the community and experience the same problems in the neighborhood:

> One CHA was saying that her three-year old child experienced intense vomiting and she took him to the emergency department; he was already showing signs of dehydration. She said that the physician on duty was negligent and sent them home only with medication for pain. When she asked about the need for offering saline solution, the physician answered aggressively in a loud voice *Do you know how many years you have to study to become a physician?* (Observation 22).

This observation reveals aspects related to accessibility and care delivery that do not meet the needs of the CHA who experiences situations that are similar to those experienced by health service users.

DISCUSSION

In the *link* dimension, the CHAs and other workers are not interacting among them because the communication required to construct a common care project is not put into practice. When it is, it occurs only as a means to optimize the activities' techniques and operation. CHAs should not have the mere function of transmitting messages; they need to be involved with an attitude of being co-responsible for the care provided. The health staff and managers need to take care that CHAs do not work from the perspective of a *team group*, merely reproducing mechanical practices without the possibility of being agents that transform the care provided to people. Strategies are needed to ensure the inclusion of CHAs in the FHS team focused on interaction and cooperation, enabling the potential to change the health model and care practices.

It seems that, when acting as a *bond*, CHAs establish communication free of constraints with other health workers and *vice-versa*, enabling plans for action to be

developed together, because there is a mutual search among them in order to obtain information or ask for help to improve the care provided to individuals and families.

It seems that interaction between CHAs and other health workers, when the initial action in this dimension, happens in an instance of communication intrinsic to the teamwork that is revealed in the development of a common objective[20]. In this case, the common objective is the care provided to the individual, which is considered together with other workers and CHAs.

When communication is intrinsic to the teamwork, people see CHAs as facilitators of access. In this respect, one can say that agents acting as *bonds*, included in the FHS team as a worker, can contribute to care delivery as being integral and meeting the needs of individuals and families based on a core competence and responsibility, even if these are yet poorly defined. By core competence and responsibility, we mean *a set of different types of knowledge and responsibilities specific to each profession or specialty*.[19] By itself, the core competence of each professional is not able to meet the complexity of health needs presented by individuals and families.

Each worker in the FHS has its specific core competence and all of them are important to the process of constructing integral care. For this reason, teamwork from the perspective of integration is not an easy or rapidly completed task, nor a responsibility of a single professional[21].

In the process of division of labor in health, the various specialized jobs are related and complementary topics, which when combined, extend the possibilities to recognize and meet the needs of people[15].

The core competencies and responsibilities of CHAs may be taking shape in a historical and social process of this profession, in actions of constructing bonds with the community and with other workers, adapting the production of health care to the needs of people, as *connecting links*.

The manner of CHAs' behavior is included and how they include themselves in the FHS team influences the way they are seen and accepted by the community. If, on the one hand, they mean easier access to the health service when they are integrated into the FHS team, on the other hand, they may be seen as mere deliverers of messages and people who make appointments only when they are individuals grouped with a team. If in the first case, they reinforce the characteristic of *connecting bonds*, in the second case they are rigid links forcing a relationship without dialogue and without a more intense use of light technologies between communities and workers.

It also encourages us to reflect that difficulties of interaction among health workers and CHAs may represent communication difficulties with the community itself, because CHAs are the representatives of the community within health services.

It is important to take care that language in the team is not used as a form of power and a means to exclude workers, such as when using *codes* or technical terms with those who do not share the same technical skills, hindering mutual comprehension[22].

There seems to be a certain fear on the part of CHAs in questioning and positioning themselves in the face of situations or workers with a college degree. It may be due to the presence of power relationships, a hierarchy or social inequalities. At the same time, it reveals the difficulty FHS workers have dealing with new forms of care, with the presence of new workers (CHAs), and new actors (users) with a desire to be more active in their work and care processes.

For conflicts, dissatisfaction and difficulties should be made public and shared by the team with the intent to jointly improve work. For this, an opportunity to dialogue needs to be created, reinforced and valued in the routine of teamwork. These opportunities need to give a voice and expression to CHAs within the team, because they are the presence and the voice of a population that still has its rights repressed, including rights to health and citizenship.

The team's health workers need to pay attention to the various manners in which CHAs establish communication with the team in order to interact and expose people's needs. After all, they are members of the community and their proximity to it make them a spokesperson within the team in the health unit.

When CHAs talk about themselves while communicating with other workers, they are also talking about the community. When they talk about their own health needs, they are exposing the needs of the population they care for.

CONCLUSION

When CHAs work with the 'bond' characteristic, they seem to perform joint actions in terms of health teamwork and when they interact with other workers, they help construct common care plans that can enable integral care to be delivered to individuals and families in the community. As *links*, CHAs develop activities that are essentially operational: the individuals do not interact among them and actions are not connected. The actions and activities performed by CHAs sometimes assume a configuration of integration and other times one of being part of the group. It leads us to conclude that the way agents are inserted and the way they insert themselves into the FHS team is dynamic, because the team itself has a dynamic that is inherent to teamwork itself, with relationships of hierarchy and subordination, different and unequal work, common care projects, interdependent and complementary work.

In addition to the fact that the presence and voice of CHAs within the FHS team represents the presence and

voice of the community itself, they can be strategic workers. If their actions comprehend a more political and communitarian dimension, then teamwork may be influenced by noise that allows workers to think critically about their work in health. However, if the work of CHAs is only captured by the technical dimension of the biomedical model, their actions will not have the potential required to implement the desired changes in care practices.

Intercessory spaces among the health workers themselves need to be created and strengthened so that the FHS work becomes more pleasant for health workers and more welcoming for individuals. These spaces, in which being available for the knowledge or the lack of knowledge of another, can conform new ways of producing care and conform the worker him or herself. These spaces are able to give more power to the voice and expression of CHAs in the communicative action with the staff.

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