

HEALTH EVALUATION AND ITS CONSEQUENCES FOR THE COMMUNITY HEALTH WORKERS

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ABSTRACT: This paper presents the findings of a qualitative research which analyses the characteristics of the evaluation process of community health agents' work. The research was undertaken in three different municipalities. Community health agents, their supervisors, and Primary Health Care managers took part in the investigation, which consisted of semi-structured interviews and focus groups. The discussion was organized according to content analysis, and based on the concept of health work process. Four categories of analysis were proposed: work load minimization, productivism, disease control and supervision. These categories show the predominance of evaluation practices that emphasize quantitative results, particularly those related to coverage targets and to the performance of activities structured by the biomedical approach. Conclusions point to the importance of considering the limitations of the kind of evaluation practices used in Primary Health Care, and to the need for elaborating theoretical and methodological frameworks for evaluation that will effectively contribute to improve the health agents' work.

DESCRIPTORS: Community health workers. Health evaluation. Family health. Health education.

AVALIAÇÃO EM SAÚDE E REPERCUSSÕES NO TRABALHO DO AGENTE COMUNITÁRIO DE SAÚDE

RESUMO: Este artigo apresenta resultados de uma pesquisa qualitativa que analisa as características do processo de avaliação relacionado ao trabalho do agente comunitário de saúde. A investigação foi desenvolvida em três municípios, tendo nela participado agentes de saúde, seus supervisores e gestores da Atenção Primária com os quais foram realizadas entrevistas semiestruturadas e grupos focais. A discussão foi organizada com base na análise de conteúdo e apoiada na noção de processo de trabalho em saúde. Foram compostas quatro categorias: minimização da carga de trabalho, produtivismo, controle de agravos e supervisão. Estas apontam o predomínio de práticas de avaliação, que enfatizam o alcance de resultados quantitativos, sobretudo relativos às metas de cobertura e à realização de atividades com enfoque biomédico. As conclusões sinalizam a importância de pensar as limitações deste tipo de práticas avaliativas difundidas na Atenção Primária e de elaborar proposições teórico-metodológicas que contribuam para o componente educativo do trabalho do agente comunitário.

DESCRIPTORES: Agente comunitário de saúde. Avaliação em saúde. Saúde da família. Educação em saúde.

LA EVALUACIÓN EN SALUD Y SUS REPERCUSIONES EN EL TRABAJO DEL AGENTE COMUNITARIO DE SALUD

RESUMEN: Este artículo presenta resultados de una investigación cualitativa que analiza las características del proceso de evaluación relacionado al trabajo del 'Agente Comunitario en Salud'. La investigación fue desarrollada en tres municipios, teniendo como sujetos: agentes de salud, sus supervisores y gestores de Atención Primaria. Fueron realizadas entrevistas semi-estructuradas y grupos focales. La discusión fue organizada teniendo como base el análisis de contenido, apoyada en la noción de proceso de trabajo en salud. Fueron establecidas cuatro categorías: minimización de la carga de trabajo, productivismo, control de enfermedades y supervisión. Estas apuntan al predominio de prácticas de evaluación enfatizando el alcance de resultados cuantitativos, sobretudo relativo a las metas de cobertura y a la realización de actividades con enfoque biomédico. Las conclusiones señalan la importancia de pensar sobre las limitaciones de las prácticas de evaluación difundidas en la Atención Primaria y de elaborar proposiciones teórico metodológicas que contribuyan para el componente educativo del trabajo del agente en salud.

DESCRIPTORES: Agente comunitario de salud. Evaluación en salud. Salud de la familia. Educación en salud.

INTRODUCTION

Primary Health Care (PHC) in Brazil views Family Health as the main strategy to be adopted when restructuring the health care model. Elements deemed structural and functional for the PHC are also central to the Family Health Strategy (FHC), such as the fact that both are family and community-based, develop intersectoral actions, implement optimized management (including evaluation) and offer appropriate human resources. Like PHC, FHS is organized from a collective point of view, and its logic is territorialization.

As regards which human resources should be appropriate to the PHC, it is suggested that multiprofessional teams should be formed. This entails a shift in the previous emphasis placed on exclusive medical care, including community health workers in the team. In international terms, as from the Alma-Ata Conference report, experiences with community workers became more frequent and were also institutionalized. At the time these agents were often lay workers, who worked under the supervision of graduate professionals.¹

In Brazil, since the 1970s several researchers²⁻³ have stressed the importance of female health agents, coming from religious institutions. Underlying their work was the concept of the Popular Health Movement, and there was an attempt to change the relations between health agents and popular classes. The first government project to include health agents dates from the 1980s. It was the Devale Project for the Expansion of Basic Health and Sanitation Services in Rural Areas, an extension of the Program for Expansion of Health and Sanitation Actions, in the state of São Paulo.⁴ Recruited from their own community, members of this project became responsible for community and for individual health care activities. These agents, like those of the international experiences, were lay workers who performed tasks considered to be of a low complexity.

In the late 1980s, the government of the state of Ceará developed a project, whose results were later used as the basis for the 1991 National Program for Community Health Agents. The local nature of these projects was thus overcome, in that they shifted to another level of institutionalization, forming a national program. The visibility obtained by these projects raised several issues, still subject to debate, such as: what precisely is the relation of these workers with the State? What should their tasks be? How should they be trained?

We believe that these issues do not concern only the uncertainties surrounding the role of these workers, but rather reflect the health sector and PHC projects undertaken in each country. Studies suggest that particularly in Latin America, PHC concepts differ, at times being geared towards a more comprehensive PHC model, at times towards a more selective one. The latter model focuses on a small number of health actions aimed at specific population groups, disregarding its coordination with, and possible continuity of, other levels of health care.⁵

Bearing this in mind, we now present the dilemmas that permeate the identity construction of the Community Health Worker (CHW) in the Brazilian National Health Care System (Sistema Único de Saúde/ /SUS), and which may be expressed by the following tensions: a) being a community agent or a service agent; b) undergoing a short-term training or a technical training; c) focusing on disease-associated risk control or on a broader concept of health, associated with citizen participation; d) having a stable or unstable job; and e) basing the work on voluntary or professional conditions.^{4,6-7}

It should be noticed that the health policies and practices institutionalized in the many different planning and implementation levels have their effects on the work process of the CHW. It is thus the purpose of this paper to present the evaluation methods available for the work performed by CHWs, using for discussion the results of an empirical research on CHW work evaluation.

The planning and analysis of this research were based on theoretical concepts related to the health work process, health evaluation and the different forms of health education, considering this to be the main objective of health work.

The first discussions on the concept of the health work process center on four components of the work process that should be jointly analyzed, in order to produce an understanding of certain aspects of reality, to wit: 1) object of the work; 2) tools; 3) purpose 4) agents.

Besides pointing out that these components have been historically constructed, the authors would like to stress that the intention/purpose which gives meaning to the work process is a basic element in the constitution of the work objects. In order to examine the issues presented in this research, health education was taken to be the main aim of the activities developed by the CHW. Thus the main issue discussed in our

work (How has the CHW's work been evaluated?) entailed a secondary issue: what are the possible consequences that an evaluation may bring to the CHW's educational work?

Some research projects have established a difference between two possible ways in which the CHW may conduct educational work. According to the first view, the professional tries to convince the population of something, since the professional is supposed to possess knowledge, thus assuming a normative prescriptive role. The second view is based on dialogue, on critical thinking, on strengthening autonomy, and on acknowledging that the other party also possesses knowledge.^{7,9}

We believe evaluation to be an important factor in the configuration of intentions for health work. Evaluation should be included among the regulation mechanisms present in the area. Evaluation is part of regulation, since regulation can be described "as the capacity of interfering in the process of rendering service, altering or guiding its performance. This interference can be done by means of induction, normalization, regulating or restricting mechanisms."^{10:26} The major mechanisms by means of which evaluation guides the work are the selection of the implemented practices that will be used as evaluation objects and the construction of the evaluation method that will be used. When value is attached to certain practices and when indicators are established as a means of approaching them, the evaluation will induce both actions and behaviour – thus influencing the work process. This influence can be more or less significant, according to the status attributed to the evaluation in the contexts in which it takes place.

The institutionalization of health evaluation, particularly of PHC, leads to interference in a dimension that surpasses the planning and implementation of policies at the macro level; it leads to interference in the everyday life of services, affecting the way we plan (and manage) how the work "must be" done. The institutionalization of the evaluation aims at "(...) integrating it in an organizational system in which it can influence its behavior. In other words, it is a model geared towards action, necessarily linking analytical activities to the management of planning interventions".^{11:419}

Once the culture of evaluation is instituted it will affect the education of those subjects involved.¹² Relating evaluation to everyday life binds the possibility of institutionalizing evaluation to the interests that people might have in "evaluat-

ing their own practice" and in "transforming their work".¹³ This idea is supported by the premise that there is a decision-making level in which social actors interfere, mobilizing resources in order to solve the problems posed by the present reality. This level does not necessarily belong to the same sphere as that of the evaluator. Evaluation, as a practice that permeates this everyday life, would be able to entail professional development and positive effects in the work of the professionals evaluated.

METHODOLOGICAL ASPECTS

This study presents some findings of the research "Multicenter integrating studies on evaluation technologies of integrality in primary health care", developed jointly by the Research Laboratory on Integrality Practices in Health/Institute of Social Medicine – State University of Rio de Janeiro (Lappis/IMS/UERJ) and Joaquim Venâncio Polytechnic Health School, of the Oswaldo Cruz Foundation (EPSJV/Fiocruz), funded by Brazilian National Research Council.

The fieldwork was carried out between March and July 2007 in three cities, each with a different profile: Rio Branco-Capital of the State of Acre (300.000 inhabitants and 26.8% FHS coverage), Cuiabá-Capital of the State of Mato Grosso (550.000 inhabitants and 26.5% FHS coverage) and Pirai-State of Rio de Janeiro (25.000 inhabitants and 100% FHS coverage). The methodology adopted makes use of qualitative techniques taken from social research. Analysis of content¹⁴ was used in the treatment of the data collected. The concept of inference was added, that is, an interpretation of speeches was sought, rather than mere description. The purpose of content analysis, as well as that of other techniques in qualitative research, is basically to "reach a deeper level of the speeches, beyond the manifest meanings of the material".^{15:308} In the present research this movement of going beyond the manifest meanings was carried out by means of the construction of thematic categories, bearing in mind the relation between the evaluation of the PHC work, and the meanings that were most recurrent in the material and that could be attributed to evaluation practices.

Data collection techniques included interviews and focal groups. A script was used for semi-structured interviews. CHWs, nurses supervising CHWs, and primary care managers were interviewed. The second technique -- focal group -- was adopted since it permits that comprehensions,

perceptions, beliefs and attitudes on a certain theme be drawn out from the exchanges that take place in the group interaction. In order to prevent hierarchical relations, focal groups were limited to CHWs. Interview scripts contained open questions on the following subjects: comprehension of the role of the CHW in the PHC; forms of evaluating the CHW's work and their relation with supervisors; comprehension of the educational dimension and expectations as regards the aims of CHWs in the regions where the research was undertaken.

Discussions were proposed to the focal groups on the following situations: 1) contradictory viewpoints – the member of the community believes he or she has a health problem that the Programa Saúde da Família (PSF) (Family Health Program – FHP) health team does not acknowledge as such; 2) the member of the community has a health problem diagnosed by the team, but denied by the patient; 3) the health team and the member of the community agree on the existence of a health problem, which the unit is unable to solve or forward appropriately. The groups were asked to do a memory exercise, recalling and debating the situations that fell into these categories and their educational role. The objective of this stage was precisely to evidence the educational work. After this, discussion was continued, approaching directly the different ways in which the CHW's work was evaluated. The aims and the themes for the debate were as follows: 1) How do you perceive your work is evaluated? The purpose was to obtain context and concrete expressions; 2) What is deemed important in your work?, and 3) what do you think should be considered important?

The material obtained from all interviews and focal groups was transcribed for analysis. Five supervisors from three FHP local managers, five PHC managers, eight CHWs, and seven focal groups with CHWs were interviewed.

After reading the collected material and after examining the literature, the constitutive elements of the research field were sorted into types. This article thus treats analytically the theme "how is the CHW's work evaluated?" As a means of assuring anonymity, and for the sake of presentation, we have chosen to describe and discuss without any distinction whatsoever the experiences observed in the cities where the research was conducted. The only difference will be between the professionals groups interviewed. We would like to point out that the research was approved by the Research Ethics Committee of IMS/UERJ (nr. 22/2006) and

that interviewees have signed the Term of Free and Notified Consent complying with the regulations of the National Council for Research Ethics.

PRESENTATION AND DISCUSSION OF RESULTS

Based on the analysis of the speeches of interviewees, categories were created to support the discussions on the relation between the work practice and the evaluation practice: (1) Minimization of the work load, (2) Productivism. (3) Risk Control, and (4) Supervision.

The first category was established in view of a recurrent set of diversified activities that take place in the work process and that showed up in the speeches, but that are considered as one single action in the evaluation. What obtains visibility in this situation is the final result, and what is minimized is the effort undertaken to carry out the tasks. The main activities whose work load is minimized in the evaluation are related to home visits, active search for cases, and administrative activities.

Take her family, for example, you can't just go there and pay a short visit, which takes the usual time. Her husband is an alcoholic, and refuses treatment; the wife has lost any interest in life; he doesn't care for her any more. I keep telling her she has to take care of herself, she has to dress up, but she won't do it. Her daughter has anemia, severe anemia, rickets. We have tried to treat everyone in the household, but they refused treatment and they wouldn't take their daughter to be treated. We go back and talk, and talk, and complain, but it's no good. I spent many days working only for this family but it was useless. (CHW).

This speech tells us that the performance of activities such as the active search and the home visit are associated with a phenomenon that sociology calls "work intensification".^{16:69} This concept is used in situations in which, in order to reach a certain work result (usually one focused on evaluation), more intense efforts – either quantitative or qualitatively – are required from a worker. In both intellectual or emotional work these results "may be found in an improvement of services, either in quality or quantity".^{16:69}

The category Productivism was formulated bearing in the mind that monitoring practices, often used to quantify the CHW's work, aim at interfering in their organization and eventually end up being the main form of evaluation. The major elements that compose this category are: the

number of exams and visits, vaccination coverage, reduction in specific indicators of morbid-mortality. The emphasis on understanding the CHW's work by means of their productivity may result in distortions in the quality of their work. These distortions often go unnoticed even to the professionals themselves. The following speech shows the consequences this kind of practice may have on the quality of the educational work, which loses its importance when compared with the priority given to reaching targets.

Ana [CHW] is the champion [of indicators]. She always wins, she always wins... and she tells us that she sees a very poor community and that the indicators are associated to the Bolsa Família (support money provided by the government), she keeps telling people this. If you don't do what the health team tells you to do, you will lose your Bolsa Família. Because these people are broke, sometimes the only money they get is the Bolsa Família, the person gets a larger one (CHW).

References to the pressure placed on productivity permeate most interviewee's speeches, such as the following:

[...] all productivity is forwarded to us, for me to evaluate the 53 Health Modules. Because I think we have to see each and every item: the number of nurse consultations; the number of out-patient consultations; the number of bandaging [...] if there is a diarrhea or acute respiratory infection outbreak in the region, there should be at least a high number of nebulizations [...] So productivity has to be calculated at least monthly, we have to observe the productivity of the units and then talk to this professional - nurse, physician, technician, CHW, and so on and so forth... So I am always evaluating productivity (PHC Manager).

If, from the management point of view, at its most central level, productivity may present clearly enough the elements that should be better investigated to improve the quality of care provided, from the point of view of the CHW's work, this emphasis on productivism indicates that expectations for this kind of work fall exclusively on the more easily measurable results. This mensuration stems from the central position given to the data collected for the Primary Care Information System (SIAB). This reflects at a local level the importance attached by the Ministry of Health to this database as a means of monitoring/evaluation. Although SIAB is useful for planning activities, especially because it provides important data at the decision-taking level, its use as a privileged means of evaluation may result in the idea that importance should be placed only on monitoring

of productivity in FHS and that the perspective of advancing the improvement of quality in the work process should be abandoned.

Instead of this, evaluation of health work with an emphasis on education should take into account the social benefits which are not directly related to health.¹⁷ The authors would like to point out the importance of community strengthening, without denying the importance of objectives such as increasing coverage, combining high impact and low costs. Objectives which display this characteristic, however, are not easily adjusted to unidimensional measures.

It becomes evident that, although we acknowledge the centrality of these aspects in the work of the CHWs, they lose their importance in that they are not incorporated to more systematic evaluations. Findings from research performed in the state of Ceará reinforce this concern, since it point out that evaluations carried out in health services employ almost exclusively a traditional quantitative approach. The innovation posed by FHS requires a correspondent innovation in evaluation practices.¹⁹ Including the community in the evaluation is an element singled out as necessary if "transformation of local health practices"^{19:719} is to happen, reinforcing the pertinence of qualitative approaches if this objective is to be achieved.

The experiences narrated, and which gave rise to the category productivism, show a strong relation with the emphasis placed on the performance of biomedical guidance. It is thus not by chance that the analysis of the speeches led to the third category in our study, 'risk control', which includes activities aimed at obtaining results defined by their clinical dimension, from a biomedical viewpoint. Examples include the diagnosis of breast cancer 'cases', vaccination, follow-up of underweight children and of people suffering from hypertension and diabetes, among other diseases.

The discussion brought forth in this paper, concerning the CHW's work, takes into account the consequences of an evaluation centered on criteria that combine productivity and acts of a biomedical nature. It is thus necessary to consider how this type of evaluation may contribute to maintaining the care model which the FHS basically seeks to replace. It is also necessary to consider the degree to which the evaluation has minimized not only the activity load but also the complex nature of the CHW's work.

A distinction should be drawn between the evaluations that are created and implemented at

central levels and those that seek to express the peculiarities of local experiences. The CHW's work, particularly its educational dimension, should be considered as one of these peculiarities that should be included in regular evaluation proposals. Redirecting everyday practices should be the central point in this evaluation. This requires discussion of the difficulties and potentialities of the work. The identification of the difficulties encountered in the evaluation of the CHW's work has been partly developed in private supervision settings, consisting of what we have named 'asystematic evaluations'.

The category Supervision emerged from the interviewees' speeches as a whole. This category refers to the context in which the evaluation of the CHW takes place. Managers' and supervisors' speeches recurrently mentioned supervision events as the setting privileged for this evaluation. Thus, supervisions are mainly responsible for the emphasis on evaluations that seek to fulfill goals related to priorities established by programs. These include both priorities created by FHS and those incorporated by FHS, but that stem from traditional health programs. This context is reproduced in team meetings, which "are very quick and must follow a controlling agenda (...). This reduces the possibility of active participation of the group, undermining one of the objectives of the team work, which is the continued education of the team members".^{20:685}

The supervision and evaluation carried out by nursing professionals are often identified by the health team professionals as having a punitive and disciplinary nature, as failing to promote the decision-making process and as not aiming at the rearrangement of the care project²¹. Besides, supervision events often become an unsystematic process of evaluating the work. In line with this author, our study reveals that many CHWs hardly acknowledge this moment as an institutional place for evaluation.²¹

The CHW's speeches that make up the research material do not include the relation between evaluation and supervision. The opposite idea is found in interviews with those responsible for the supervision. These professionals say they are able to perceive the circumstances around supervision as a privileged moment in the work evaluation. In the words of an interviewee: *we evaluate all the time, don't we? Because when we sit down with each and every person, we evaluate the data from his or her area, we make him think together with us, some strategies, some ways that may be taken* (supervisor).

The asystematic evaluation undertaken by the CHWs is mainly produced from a set of implied elements, which, as observed in our research, fall on not very precise aspects of elements of the relation that the CHWs establish with their own work and with the patients.

The theory on evaluation distinguishes the types of evaluation taking into account the implied or explicit nature of three of its components: the evaluation process, the judgement, and the use made of this judgement.²² Thus, when the CHW work evaluation takes on an explicit and formal nature, especially in relation to the information production process, it is done based on traditional quantitative criteria and tools, of the planning guided by epidemiology.

In all research fields, both managers and supervisors and CHWs acknowledge reduction in the morbidity rate, early detection of clinical events, and scope of community coverage goals aims as criteria for evaluation. As regards the second component, the judgement, it may be difficult to determine in the CHW work the extent to which this element has been explicit in its formulation or has been made explicit only by its effects, that is, by the decisions taken using the evaluation results. Thus, it can be said that the very repercussion of the FHS evaluation deserves further investigation.

When the FHS was implanted, the Ministry of Health defined some operational principles that should be followed by municipalities and that "allowed the establishment of bases and criteria to be used in the definition of quality standards that might be applied to evaluation processes".^{23:65} The existence of explicit evaluation criteria is definitely one of the major elements in this practice. However, when attention is focused on the thirteen operational principles quoted in the text mentioned above and from which the criteria is derived, we notice the central position of items related to coverage, registration and input of the information system.

While there are evaluation procedures based on the criteria described above, that is, based on a rationality guided by the relation objectivity-quantification, the supervisors's speech made it possible to understand that appreciation of the CHW's work is based on not very precise (and not explicit) elements, such as "hearing the patient", the "approach" used or, simply "humanization". According to the supervisors interviewed, improvement of the evaluation should focus exactly on this "personal" dimension.

I think it's a person who is committed, who likes what he or she does, isn't it? This does not always mean that a person who gives us excellent data at the end of the month is a good CHW. Sometimes a person goes on home visits, but this person shows no commitment. This person only does this because data must be presented at the end of the month. So, it's the person who shows a commitment, who likes to get involved with the Unit, with the technical team, with physicians, nurses, who interacts with everybody, and not that person who only shows 100% data (CHW supervisor).

In conceptual terms, this would not be considered an evaluation. The idea of an evaluation must include at least two characteristics. The first is the systematic collection of information on the work performed and the results obtained; the second consists in the elaboration of judgements on the material collected, so as to aid the decision-taking process. This evaluation, then, as performed here by the supervisors, only becomes an evaluation according to the concept of evaluation defined above if the second characteristic is considered: judgement.

Because the collective dimension is not considered important for the definition of its patterns and criteria, nor for the sharing of its results, this form of evaluation is doubly subjective: by establishing as references the personal perspective of the evaluator and by focusing on individual action, dissociated from the team work process.²⁶ Evaluation experiences with this profile would actually weaken the formative role, whose meaning would be that of evaluating the intrinsic or extrinsic value of the object in order to improve it. This would mean supplying information on the development of programs, which would especially benefit the team.

In this sense, the CHW work evaluation, systematically undertaken and incorporating the specificities of the educational work, might fit in as a pedagogical element, contributing for the qualification of the team work as a whole. This evaluation practice differs from the one usually developed by supervisors in that it requires team participation and criteria definition. A logical repercussion of this is the involvement of the intended results with the work performed by CHW in FHS.

The evaluation perspective under scrutiny in this paper has as reference and rationale a certain way of producing and validating knowledge, which is formed beyond local contexts. It may be said that evaluation methodologies do not originate in an autonomous sphere of the production-reproduction of scientific knowledge, nor even

of the health area in particular. Thus, evaluation, considered as a social practice, may establish itself as a setting for reproducing values of the current health production mode. The characteristics of CHW work evaluation focused in this study are in tune with the predominance shown by the epidemiological area in collective health, and which reflects itself in the different territories where this influence spreads itself.

In setting down this piece of criticism, especially criticism on quantitative aspects, it is not our intention to question the validity or relevance of this type of evaluation, since it satisfies the need to produce information that may guide the establishment of policies at central management levels. However, we repeat its limitation: by itself it is unable to interact with practices which need to be complemented by issues that tend to be analyzed in the interaction between social sciences and health.

CONCLUSIONS

The analysis undertaken in this research shows the CHW work evaluation as a social practice located in a setting where three unconsolidated, relatively recent, and still subject to dispute, processes overlap. These processes are: the PHC approach implemented in Brazil, the function profile of the CHW, and the health evaluation carried out at the different levels of the health care system.

In order to overcome the lack of consensual references and in order to create methodological and conceptual structures that may be applied to the evaluation, public health resorts to the references proposed by traditional areas of knowledge which, in this particular case, are clinical practice, epidemiology, and medicine. Thus, from the point of view of scientific research, emphasis is placed on quantitative methods. Although the health evaluation practice that takes place in SUS is not necessarily characterized as scientific research, the procedures adopted have been strictly bound to scientifically structured areas.

These considerations help to clarify the results obtained in this research, and which were summed up in the categories: minimization of the work load, productivism, risk control, and supervision. When integrated, the first and second categories may contribute to understanding the CHW's work evaluation. Both minimization of the work load and productivism are the consequence of focusing on final, measurable results. These

predominate among the everyday management practice, which constitute the basis of the evaluation, despite the criticism they have received.

The third category, risk control, is related to the epistemological traditions from which clinical epidemiology is derived. It is also permeated by an objectivism which, instead of discussing health education practices in order to qualify them, maintains its prescriptive nature. Though entailing its dissociation from an emancipatory concept of education, the centrality of clinical events, in the social context in which the CHW work takes place, engenders results that may be evaluated in the light of an objective and prescriptive viewpoint, to which a positive value is attached.

In opposition to this view, we believe that propositions which differ from this practice and from these epistemological traditions would result in overcoming the limits raised when the CHW's work is linked to disseminating specific behavior based on the identification of risk factors. We also believe that this view of the CHW's work has guided evaluations centered on activity production, in line with vertical health program policies.

The analysis of the supervision category revealed the subjective and hierarchical nature of the CHW's work evaluation. These evaluations are restricted to values and perceptions of supervisors – often exclusively nurses – in terms of the quality of the interventions developed, lacking explicit criteria. These informal, sometimes improvised and unclear, evaluations may at times present important and useful knowledge, but they tend to be undemocratic and to stress the asymmetric nature of relations in the health team in that only the evaluator is the one who actually produces knowledge; the person being evaluated can only produce the information required.

When the categories formulated in the research are reconsidered, we notice that they reveal specific ways of acting on CHW work management. In this case, management tends to make the work focus on the production of measurable phenomena rather than focusing on the discussion of processes that may qualify this work in its educational role.

This is subject to concern, since this attitude tends to weaken the possibility of changing this model, and tends to maintain the emphasis on the biomedical nature of health care. It also perpetuates the ambiguity that characterizes the professional profile of the CHW. As discussed in this text, the ways of evaluating the CHWs strongly influences

the way these workers carry out their activities. We believe that this situation limits the benefits that may be obtained when the potential offered by the educational work in health care is considered.

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