INTERNATIONAL SEVEN JOURNAL
OF MULTIDISCIPLINARY
ISSN: 2764-9547

Family Health Strategy: Reflections focusing on community health workers

Estratégia Saúde da Família: Reflexões com foco no agente comunitário de saúde

10.56238/isevmjv3n3-009
Receipt of originals: 05/11/2024
Publication acceptance: 05/31/2024

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ABSTRACT

The Family Health Strategy (FHS) translates into the insertion of a preventive care model, oriented towards the family in its physical and social environment as the nucleus of action, aiming at health promotion. The execution of the actions that are developed in the context of this health service, which is the population's gateway to Primary Health Care (PHC), is the responsibility of a minimal FHS team, consisting of a doctor, nurse, nursing technician and the Community Health Agents (CHA), the latter of whom are occupies a more prominent place, given its responsibility in establishing the bond between users and this public health service. In view of the relevance of this professional category for the work process of the Family Health Strategy, this investigation proposes a reflection on the performance of this professional in the current public health policy. The results discussed here come from a narrative review and documentary research carried out from May 2022 to November 2023. Through the analysis of identified researches, it was possible to confirm the importance of CHWs for the effectiveness of the proposed work in the context of Primary Health Care. The National Primary Care Policy (PNAB) of 2017 was a marker that brought harm to the work process of this professional, since it weakened the work of health education, by assigning clinical attributions to this professional.

Keywords: Community Health Agents, Primary Health Care, Family Health Strategy.

INTRODUCTION

The Family Health Strategy (FHS) translates into the insertion of a preventive care model, oriented towards the family in its physical and social environment as the nucleus of action, aiming at health promotion. It replaces the traditional health care model, based on the curative and hospital-centric perspective, which focuses on individual determinants, reproducing the biomedical paradigm, which considers that being healthy and not having any disease (Brasil, 2011; Siqueira-Batista *et al.*, 2015; Nepomuceno *et al.*, 2021**).**

The execution of the actions that are developed in the context of this health service, which is the population's gateway to Primary Health Care (PHC), is the responsibility of a minimal FHS team,

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consisting of a doctor, nurse, nursing technician and the Community Health Agents (CHA), the latter of whom are occupies a more prominent place, given its responsibility in establishing the link between users and this public health service (Brasil, 2012).

The FHS team is linked to the local Basic Health Unit (BHU). This level of care solves 80% of the population's health problems. However, if the person needs more advanced care, the FHS makes this referral. In this way, Family Health is strengthened as the gateway to the SUS, reorganizing Primary Care (PC) in the country, according to the precepts of the SUS (Brasil, 2012).

Each FHS team is assigned the responsibility of health follow-up of up to 4,000 patients in a given territory. In this context, each FHS should have a number of CHWs (12 CHWs per team is suggested) capable of providing coverage for 100% of the enrolled population, which should serve a maximum of 750 patients (Brasil, 2012).

In this sense, it is important to shed light on the fact that the work of the CHA, in articulation with the other members of the team, was responsible for changing the conception of health care that was previously present, now oriented to the territory of the population attached, considering the various determinants of health. Thus, this professional category, over the years, has stood out as essential to boost the trajectory of PHC consolidation and care based on the expanded concept of health (Silva; Dalmaso, 2004).

Although the importance of these professionals for the work offered in the context of PHC is already recognized, the latest publication of the National Primary Care Policy (PNAB), which took place in 2017, points to the probable reduction in the number of CHWs with the end of the mandatory 100% coverage of the territory, and this professional is the link between the service and the population. which, in turn, contributes to facilitating their access to the service. In addition, in this version of the policy, the focus of this professional's work is on care rather than health education, in which he reproduces the health model centered on the disease, such as: measurement of capillary glucose, measurement of axillary temperature and blood pressure, and guidance on the use of medications by patients (Brazil, 2017).

It should be noted that the CHA, in addition to having a bond with the population, which is one of the attributes that enhance comprehensiveness in health, is the professional who joins popular and scientific knowledge, translating the demands and health conditions of the population. This professional, in turn, provides strength for the development of health promotion and prevention actions, through the identification of health risks. This process is facilitated by the fact that these professionals live in the same territory where they work, identifying risks more quickly (Brasil, 2009).

Thus, the work process of the FHS drives and guides the CHA to develop their attributions in the initial care of individuals, at their home, bringing information and reorganizing the work processes of professionals at the highest hierarchical levels, in interaction with the community (Costa *et al.*, 2013; Fracolli, 2014).

Initially, the attributions of this professional category were instituted in 1997, through Ordinance GM/MS No. 1,886 of December 18, 1997. In 2012, these were ratified through the PNAB, which detailed the following competencies for this professional category: obtaining broad knowledge in relation to the territory in which they are working, through the registration and mapping of the population; the follow-up of families, in the light of the criterion of vulnerability, guiding individuals regarding access to health services; develop activities aimed at health promotion and disease prevention; develop health education actions; and, to enhance the connection of the other professionals of the team to the families of the enrolled population (Brasil, 1997; 2012).

Thus, in view of the prominent role of the CHA in the provision of health care, offered in the context of PHC, this investigation proposes a reflection on the performance of this professional in the current public health policy.

This research is justified in view of the recognition and importance of the CHA professional, who builds a legitimacy and consolidation of this area, improving patient care with a focus on the needs of the community and putting into practice the knowledge, valuing the category, as stated in the PNAB.

METHODOLOGY

A narrative review research was carried out, in order to enable the integration of the knowledge already disseminated by the scientific literature, in a synthesized way, as suggested by Souza, Silva and Carvalho (2010).

Thus, from May 2022 to November 2024, searches were carried out in the databases of the Catalog of Periodicals of the Coordination for the Improvement of Higher Education Personnel (CAPES), and in the database of Latin American and Caribbean Literature in Health Sciences (LILACS). The research was guided by the descriptors 'Community Health Agents' AND 'Family Health Strategy', in which the selected studies were analyzed descriptively.

In addition to scientific research, official documents of the Federal Government (ordinances, decrees, laws, notebooks and manuals) pertinent to the service of Primary Health Care and the performance of the ACS in this service were also reviewed.

RESULTS AND DISCUSSION

PUBLIC HEALTH POLICY

Throughout this section, it is necessary to make a brief contextualization about the transition of the health model in Brazil in the context of public policies that will be discussed in the sequence of this chapter, emphasizing the importance of PHC, materialized, above all, through the service provided by the ESF, with the CHA having a role of great relevance in the teams of this health service. as will be evidenced later.

The need for the creation of the current public health service was established in the seventies. In the early years of the 1980s, there was a scenario of scarcity in the municipalities for the provision of health services, and those that did have them were emergency services. In this context, a significant part of the population was on the margins of health care, being at the mercy of philanthropic services and distant from primary care. At that time, those linked to Social Security, which provided urgent and emergency services and outpatient services, had access to such actions (Pinto; Giovanella, 2018).

Thus, in the 1970s and early 1980s, the Alma-Ata movement was responsible for the first experiences of health service institutions at the municipal level. Later, the process of making the SUS effective began to gain more and more strength, and not only financial but also operational instruments were instituted, aiming to make municipalities responsible for the provision of health care (Gil, 2006).

It should be noted that the SUS, conquered by social movements, represents a historical achievement of society, and can be considered the greatest public policy generated from social movements. It is one of the largest and most complex public health systems in the world, which is put to the test at its different levels of health care, from the simplest services, such as blood pressure measurement, capillary glucose measurement, through primary care; as well as in major surgical procedures, such as organ transplantation and oncological treatments (Paim, 2008).

In view of this, a great political, ideological and social movement to reconfigure health care culminated in the creation of the Federal Constitution of 1988, in which the right to health was guaranteed as a

> Right of all and duty of the State, guaranteed through social and economic policies aimed at reducing the risk of disease and other health problems and at universal and equal access to actions and services for their promotion, protection and recovery (Brasil, 1988, p. 116).

Thus, Sousa (2003, p 43) reports that the 1988 Constitution was a milestone in the history of Brazilian public health, by defining health as "[...] the right of all and the duty of the State." The implementation of the SUS was carried out gradually: first came the Unified and Decentralized Health System (SUDS). Then, the incorporation of the National Institute of Medical Assistance of Social

Security (INAMPS) into the Ministry of Health, through Decree No. 99,060, of March 7, 1990. And, finally, the Organic Health Law that established the SUS, in the light of the 1988 Federal Constitution, establishing its principles and guidelines, through Law No. 8,080, of September 19, 1990 (Brasil, 1990a).

As a result of the above-mentioned law, which provides for the conditions for the promotion, protection and recovery of health, Law No. 8,142, of December 28, 1990, was enacted, which brought the need for social control as an indispensable part of the execution of the policy studied here, through the participation of civil society in the management of the service (Brasil, 1990a).

In this context, Laws 8.080/90 and 8.142/90 are singularly relevant to the new health model, and correspond to a kind of health statute in Brazil. While Law 8.080/90 establishes the constitutional guidelines of the SUS, Law 8.142/90 deals with the involvement of the community in the conduct of health issues, creating health conferences and councils in each sphere of government as collegiate guiding and deliberative bodies, respectively (Brasil, 1990b).

The conferences, which should take place in four years, count on the performance of various social segments. In these, propositions are raised for the three spheres of government, aiming at strengthening public health policy. Law 8.142/90 also defines the transfer of financial resources directly from fund to fund without the need for agreements, such as direct transfers from the National Health Fund to State and Municipal Funds (Brasil, 1990b).

Thus, the approval of the 1988 Constitution was an important step in the process of changing the paradigm of Brazilian health policies, as it began to address the concept of health as a right of all citizens and an obligation of the State. This prioritization led to the creation of the SUS (Paim, 2011).

It is emphasized that the actions and services that make up the SUS must be developed in accordance with the guidelines provided for in article 198 of the Federal Constitution, in the light of ethical-doctrinal (universality, equity and integrality) and organizational (decentralization, regionalization, hierarchization and social participation) principles (Pontes *et al.*, 2009).

Thus, the principle of universality corresponds to the right to health for all individuals, and the State must provide the conditions to guarantee it. In this sense, everyone should have access to and care in SUS services where the State has the duty to provide this care to the entire Brazilian population, regardless of gender, race, occupation or other social or personal characteristics (Pontes *et al.*, 2009).

In this context, comprehensiveness is understood as a principle that grants the right to care in a full manner due to its needs, through the articulation of curative and preventive actions that unfold in the three levels of care. Equity, on the other hand, aims to reduce social differences, providing unequal care

for unequal needs, invested where there is more need, and is therefore conceived as a principle of social justice (Pontes *et al.*, 2009).

Finally, the Brazilian health system is organized around the SUS, which is financed through resources collected from taxes and social contributions, and which is administered at the national level by the Ministry of Health. The ministry is also responsible for creating and monitoring policies and activities that are implemented according to the needs of municipal managers, in accordance with the principle of decentralization (Paim, 2011).

The Family Health Strategy: a model for the organization of Primary Care

The trajectory of the FHS began in 1990, with the implementation of the Family Health Program (FHP). In this context, the service corresponded to a policy created from local experiences, in which, even if partially, there were already indications that this program was powerful to offer primary health care to the population (Oliveira, 2023).

In 1991, the Ministry of Health instituted the Community Health Agents Program (PACS), in conjunction with the state and municipal secretariats, and with the National Health Foundation, in order to promote the redirection of services, so that the focus of actions could be on the family and not exclusively on the subject (Viana; Dal Poz, 1998; Souza, 2002).

The purpose of the PACS was to promote improvements in the ability of individuals to take care of their own health. This work was carried out by the CHAs, who transmitted knowledge and information and linked the population to the health services that were offered at that time (Souza, 2002).

Two important aspects, considered innovative, supported this program: the first concerns the formation of local multidisciplinary teams, in which the territories of operation were clearly inscribed; and the second refers to the form of financing, which was shared, through federal fund-to-fund transfers, which had as conditions the criterion of implementation and the performance of the actions (Oliveira, 2023).

It was from the PACS, materializing the articulation of the community, municipalities and the Federal Government, through the Ministry of Health, that pointed to a new alliance in health policy. Thus, because it was an innovative strategy, in the second half of the 90s, it began to receive priority in the public health policy agenda, culminating in the definition of the bases of the PHC policy, through the assumptions of the PSF (Morosini; Fonseca, Lima, 2018).

The FHP considers people as a whole, in view of their working and living conditions, their relationships with the family and the community, and the role of the CHA was to perform a community diagnostic test under the supervision of the nurse (Morosini; Fonseca, Lima, 2018).

> The first ten years of the program included the improvement of its institutional arrangement, initially framed in the general plan of the Organic Health Law, through the Basic Operational Norms (NOB). The NOBs of 1993 and 1996 stand out, which, respectively, led to the management of the local health network by the municipalities and the expansion of the then PSF through incentives incorporated into the financing (Oliveira, p.5, 2023).

The satisfactory development of the FHP culminated in the creation of the PNAB, which formally instituted this program as a remarkable way to enable the consolidation of PHC and expand the scope of this level of care to replace the subject-centered model only (Giovanella *et al.*, 2009; Oliveira, 2023).

It is noteworthy that the PSF was a strategy that

> It prioritizes actions to promote, protect and recover the health of individuals and families, from newborns to the elderly, healthy or sick, in a comprehensive and continuous manner. Its objective is the reorganization of care practice on new bases and criteria, replacing the traditional model of care, oriented towards the cure of diseases and in the hospital. Attention is centered on the family, understood and perceived from its physical and social environment, which has enabled health teams to have a broader understanding of the health/disease process and the need for interventions that go beyond curative practices (Brasil, 2000).

The professionals working in the FHP were responsible for obtaining knowledge of the population residing in their territory of operation, through the registration of families, carrying out the social, demographic and epidemiological diagnosis of the latter; They were also responsible for identifying the most common health problems and situations of risk to the health of the population; Together with the community, the professionals should formulate a plan to address the determinants of health identified in the territory; offer comprehensive care, not only in the Family Health Unit, but also in the community and in the families' homes, as well as monitoring patients treated by outpatient or hospital services; propose health education actions; and to act, in an intersectoral manner, aiming to face the health problems identified in the territory (Brasil, 2000).

Thus, under the influence of the FHP, the FHS was created, whose main characteristic is the constitution of a team composed of several professionals, such as: general practitioner or family health specialist, nurse or family health specialist, nursing assistant or technician and CHA, and the establishment of a coverage territory, in compliance with the principle of regionalization. making it possible for the team to know the local reality and the needs of the population (Brasil, 2012).

With the influence of the Pact for Health, in 2006, through Ordinance No. GM/648, the first edition of the PNAB was approved, which established the change in guidelines and norms for the structuring of PHC for the PSF and the PACS, designating family health as a priority strategy for the reorganization of PHC, in the context of the SUS. Based on this, the scope and understanding of PHC were broadened, integrating essential attributes of a comprehensive PHC into the service. In addition,

this ordinance was responsible for promoting changes in the attributions of the UBS, which can be of different typologies, that is, they can be with or without ESF (Brasil, 2006a).

This ordinance defined Primary Care:

> As a set of health actions, at the individual and collective levels, which encompass health promotion and protection, disease prevention, diagnosis, treatment, rehabilitation and health maintenance. (...). It is carried out in the form of teamwork, aimed at populations of delimited territories, for which it assumes sanitary responsibility, considering the dynamics existing in the territory in which these populations live. It uses highly complex and low-density technology, which should solve the most frequent problems (...) and is guided by the principles of universality, accessibility and coordination of care, bonding and continuity, comprehensiveness and accountability (Brasil, 2006a).

After this edition, there were two more changes in the PNAB, one in 2011 and the last in 2017. The first edition of the PNAB was in 2006, with the second edition in 2011, and the third in 2017. The revised version in 2011 sought to keep the centrality of the FHS unchanged, as a way to enhance the consolidation of a PHC, which is stronger and has the potential to expand its coverage, promoting comprehensive health care, and increasingly becoming the population's gateway to the services offered by the SUS. In addition, it included the role of PHC in the Health Care Networks (RAS) of the SUS (Brasil, 2011; Faria, 2020).

The latest edition, published in 2017, points to elements that drew the attention of several researchers in the area of public health, as they are seen as setbacks for the achievements in the context of PHC. Among these elements, there are threats regarding the division of the work process, and the commitment of PHC to the longitudinality of care, which is an imminent reduction in the number of CHWs (Morosini, Fonseca, Lima, 2018).

> The discontinuities can be perceived when one reads the possibility of reducing the number of CHWs per EqSF (at least one), in order to link this number to the so-called highest risk and most vulnerable territories, while at the same time providing the possibility of increasing their attributions; including the recommendation to unify their actions with those of the ACE (and to incorporate the latter as part of the EqSF) and, also, to provide skills currently performed by nursing technicians (such as: blood pressure measurement, capillary blood glucose, axillary temperature measurement and clean dressings) (Melo *et al*., p.45, 2018).

It is noteworthy that, even in the face of some setbacks in public health policy in recent years, PHC is still notably recognized as a service capable of enabling improvements in the health of the population, reducing several causes of mortality and morbidity in Brazil (Macinko; Mendonça, 2018).

Mendonça *et al.* (2023) reflect that, in the scientific context, the advances that are perceived in the SUS are mainly due to the consolidation and expansion of the FHS, which has multidisciplinary teams, which develop health care, intervening in the various health panoramas and demands, through the dimension that is not only individual, but also family and collective/community.

Such advances are strongly related to the work developed by the Oral Health Teams (OHT), by the Family Health Support Centers (NASF), and by the work of the CHA, which contribute to making more problem-solving practices aligned with the health demands of the territory possible (Mendonça *et al.*, 2023).

The Community Health Worker

The CHA, which recently became legally considered a health professional, through Law No. 14,536, of January 20, 2023, is a professional who has been contributing to changes in the scope of the SUS, in which their practice can modify the problems that have a harmful impact on the quality of life of individuals, families and the community, through health surveillance (Brasil, 2009; 2023).

Regarding the profile of the CHA, the research by Silva *et al.* (2020) found in their sample that the universe of professionals was predominantly composed of female subjects, with time working in the FHS between 1 year and 5 years, with complete high school, followed by people who reported having completed higher education or in progress.

As already highlighted, the work of the CHA has its roots in the PACS, which has existed since the early 1990s, and was effectively instituted and regulated in 1997, when the process of consolidating the decentralization of resources within the SUS began (Brasil, 2000).

The first experience of the above program took place in Ceará, in the context of the drought that occurred between June 1987 and June 1988, giving it an emergency character, through the Emergency Program, which was later discontinued. Despite this, due to the success of the experience, the National Program of Health Agents (PNAS) was instituted, which later expanded its actions, aiming to guarantee the principles that guide the SUS (Mendes, 2012).

In 1991, the Ministry of Health, based on the positive results achieved with the PNAS, proposed the creation of the National Program of Community Health Agents (PNACS). The initial area of operation of the PNACS was the Northeast Region, due to the existence of higher indicators of diseases, deficiencies and misery. In the North Region, however, the implementation occurred on an emergency basis, to deal with the cholera epidemic (Minayo *et al.*, 1990).

Thus, the trajectory for the creation and regulation of the ACS profession in Brazil began with Ordinance No. 1,886/1997, which approved the rules and guidelines of the PACS and the PSF (Brasil, 1997).

Subsequently, Decree No. 3,189/1999 was published, which established the guidelines for the exercise of the activity of ACS. On July 10, 2002, Law No. 10,507 was instituted, which created the

profession of CHA, which was repealed by Law No. 11,350, of October 5, 2006 (Brasil, 1999; 2002; 2006b).

The United Nations Children's Fund (UNICEF) supported the initiatives for the training of CHWs, as it is a long-standing institutional position, decided at the PHC meeting held in 1979 in Alma-Ata, USSR. In this event, the fundamental role of the CHA in improving the living conditions and health of the population was reiterated, due to the link between the needs, desires, and demands of a community, in which their participation is essential for the exercise of changes (Souza, 2003).

With regard to the requirements to work as a CHW, from 1991 to 2002, in order to work as CHWs in the PNACS, PACS and then PSF, it was necessary: to live in the territory of operation, to have a spirit of leadership and solidarity, to know how to read and write, to have full-time time availability, and a minimum age of 18 years. Historically, the priority areas of CHA's work have been community and home (Souza, 2003).

In this program, more than six thousand workers, most of them women, from different cities in the hinterland of Ceará were hired. As a form of selection, they were elected by the population that lived in the areas covered by the program, and had to live in the same territory in which they would work. Their training took the form of short trainings, under the supervision of the municipal health departments, and the contents focused on health promotion and community participation (Morosini *et.al.*, 2007).

In the first years of the implementation of the PACS/PSF, in order to assume the role of CHA, it was only necessary to 'know how to read and write'. However, as of 2002, through Law No. 10,507, the prerequisite became to have residence in the area of the community where they operate, to have completed the basic qualification course for the training of CHWs and to have completed elementary school. Law No. 11,350 changed some requirements for working as ACS, establishing the completion of high school as necessary, but setting precedents for hiring professionals with elementary education, and the completion of an initial training course of at least forty hours (Brasil, 2002; 2006b, Morosini; Fonseca, 2018).

Regarding the issue of CHAs having to live in the community where they work, Riquinho *et al.* (2018) mention that this requirement puts the professional in a two-way position, since at the same time that he lives in the territory, he is part of the health team. Thus, it is possible that the demands of the population come to the attention of this professional more quickly, but it is not always possible to solve problems that arise from the 'daily life lived'. In addition, the broad knowledge of the territory, its culture and customs, are also obtained. Another point that deserves to be highlighted concerns the professionalization of the CHA. On this, Méllo, Santos, Alburquerque (p.3, 2023), discuss:

> However, the professionalization of CHAs is peculiar, as they are the only health professionals who do not need previous training to work in the sector. Their training, despite being instituted in a national curriculum framework, goes through disputes ranging from the laws regulating the profession, to economic obstacles, either for the financing of the technical course, or to ensure the increase in salaries corresponding to this level of training.

In 2004, the National Curriculum Reference for the Technical Course of Community Health Agents (CTACS) was instituted in order to enable specific training for this area, in order to reduce training through short courses. This document delimited the following attributions for this professional category: home accompaniment of families and groups; identification and intervention of the various determinants and conditioning factors that permeate the health and disease process, aiming to promote health and reduce risks for the population; map and register social, demographic, and health information; foster communication between team members and the community; and, to guide professional practice according to the guidelines and structuring principles of the SUS (Brasil, 2004; Mello; Saints; Albuquerque, 2023).

In addition, it is important to detail the specific attributions contained in the current PNAB:

> I - Work with the enrollment of individuals and families on a defined geographic basis and register all the people in their area, keeping the data updated in the current Primary Care information system, using them systematically, with the support of the team, for the analysis of the health situation, considering the social, economic, cultural, demographic and epidemiological characteristics of the territory, and prioritizing the situations to be monitored in local planning; II - Use instruments to collect information that support the demographic and sociocultural diagnosis of the community; III - Register, for the purpose of planning and monitoring health actions, data on births, deaths, diseases and other health problems, ensuring ethical confidentiality; IV - Develop actions that seek integration between the health team and the population enrolled in the UBS, considering the characteristics and purposes of the follow-up work of individuals and social groups or collectivities; V - Inform users about the dates and times of scheduled appointments and exams; VI - Participate in the regulation processes from Primary Care to monitor the needs of users with regard to scheduling or giving up appointments and requested exams; VII - To perform other duties assigned to them by specific legislation of the category, or other regulations instituted by the federal, municipal or Federal District manager.
> Activities of the Community Health Agent may also be considered, to be carried out on an exceptional basis, assisted by a health professional with a higher education, a member of the team, after specific training and provision of appropriate equipment, in their geographic base of action, referring the patient to the health unit of reference: I - measure blood pressure, including at home, with the aim of promoting health and preventing diseases and injuries; II - perform the measurement of capillary glycemia, including at home, for the follow-up of diagnosed cases of diabetes mellitus and according to the therapeutic project prescribed by the teams that work in Primary Care; III - axillary temperature measurement during the home visit; IV - perform clean dressing techniques, which are performed with clean material, running water or saline solution and sterile dressing, with the use of passive dressings, which only cover the wound; and V - Indicate the need for hospitalization or home hospitalization, maintaining responsibility for the person's follow-up; VI - Plan, manage and evaluate the actions developed by the CHWs and ACE together with the other members of the team; and, VII - Perform other duties that are of responsibility in their area of expertise (Brasil, 2017).

The research by Alonso *et al*., (2021) draws attention to the lack of definition that exists in relation to the profile of CHWs, marked by two perspectives, one that discusses the attributions of this professional from a more romanticized perspective that disregards the mishaps and weaknesses of their activities, and another that attributes to these professionals a role of saviors/superheroes, in which they are responsible for consolidating the prerogatives of the SUS, neglecting the political, social and technical aspects that have repercussions on this desired consolidation.

For the authors above, the lack of delimitation of the practice of the CHA contributes to the insertion of innovative practices in the work process of the health field, but also places these professionals in a line of tension that is marked, sometimes by the norms and guidelines of the SUS, sometimes by the reality of the daily work, which is presented in the territory and services. In view of this, due to the collective construction of the actions developed by the CHA, not being fully structured, aspects arise that go beyond issues related to the professional identity of the category, issues related to the constitution of the professional, to the ways of thinking, planning and practicing.

In the context of the work, the functions and role of the CHA are highlighted, among which it is worth mentioning being close to the families and providing direct and indirect care to the community they assist. The role of this professional as a facilitator has been unanimous and recognized as relevant to perform the functions in the implementation of the FHS (Andrade *et al.*, 2015).

As suggested by Alonso *et al.*, (2021), in the context of scientific research, several roles are attributed to the CHA, such as: mediator, interpreter, educator, professional who supports the ESF teams and the social movements of the community. However, the main characteristic of this action refers to the link that it enhances between patients and the health service.

A significant part of the CHA's work comes from home visits, which are understood as the instrument to sustain the FHS, and considered one of the main activities of the CHA, as it makes it possible to know the social context of the user and identify the health needs of the families (Kebian; Acioli, 2014).

Regarding this activity, the 2017 PNAB details that it is up to the ACS

> III - Carry out home visits with periodicity established in the team's planning and according to the health needs of the population, to monitor the situation of families and individuals in the territory, with special attention to people with diseases and conditions that require a greater number of home visits (Brasil, 2017).

Home visits refer to the follow-up carried out by these professionals regarding the health conditions of the families in their micro-area, and the active search for specific situations. During home visits, the CHAs register family members, which is the condition for access to the FHS, provide various orientations, pass on information about the dynamics of the functioning of the services, among other

actions. For this reason, home visits are the most important expression of the presence of the CHA in the community (Morosini; Fonseca, 2018).

Based on this work resource used by the CHA, it is possible that these professionals can intervene on a given problem identified during the home visit, which is the reason why their relationship with the subjects assigned to their territory makes it possible to understand them as social mediators between popular and scientific knowledge (Brito; Ferreira; Santos, 2014).

During the home visits, the families are registered, which, according to the Ministry of Health, is the initial stage of the CHA's work. Through this, the health team becomes aware of the real living conditions of the families, housing conditions, prevalence of diseases, sociodemographic diagnosis, among other pertinent information to understand the reality of the community. The CHA, when registering, contributes to the planning and organization of the actions to be offered to the population, respecting their needs (Costa *et al.*, 2013).

As reflected by Fernandes *et al.*, (2023), the CHA, when part of the FHS teams, are prominent actors with regard to the promotion, prevention, and control of diseases. The performance of this professional category, in turn, gives strength to the community orientation, which is constituted as a derivative of PHC. In addition, these professionals are relevant to enhance the strengthening of PHC, stimulating the link between the enrolled population and the health system, acting in the estimation of leading patients in the search for health so that they can receive preventive care in their own territories (Fernandes *et al.*, 2023).

The research by Alonso, Béguin and Duarte (2018) also shows the role of CHWs in the expansion and consolidation of PHC, with a view to their performance in actions to identify risk situations, provide guidance to patients and refer them to team members, in the face of risk cases and situations. This work contributes to the organization and development of health actions, not only at the micro level (in the local territory), but also at the macro level (at the national level), by inserting data into the information system of the Ministry of Health.

The work process of the CHAs is a strategic resource to weaken the biomedical model of health care, since it is their duty to guide their actions based on a guideline, which is political and social. In addition, the recognized importance of this study stems from the fact that these professionals do not base their work on a rigid set of theoretical and technical guidelines, when a parallel is established with other professionals who work in the FHS, as is the case of physicians and nurses, who conduct their practice through the subsidies received in undergraduate courses (Alonso *et al.*, 2021).

In the current scenario, it has been evident that there has been a greater integration of the CHA's attributions with those of the other members of the FHS team, who, gradually, are becoming

conditioned to develop their practice, guided by the work process proposed to the teams, which is increasingly based on the field of monitoring of results and productivity indicators (Morosini; Fonseca, 2018).

The professional category discussed here has dedicated most of its work to the development of activities that have been developed within the UBS, which are support and bureaucratized tasks, among which are the organization of patient records/medical records, weight recording on days of collective consultations, and organization. The bureaucratic activities external to the UBS correspond to the delivery of test results, dental kits and appointment scheduling, at the patient's home. Such activities draw a scenario of dispute for the CHA between the practice guided by a bureaucratic logic and the practice that is essentially intended for this professional: health education in the territory, so that it compromises the actions aimed at the territory, such as, for example, the performance of simplistic visits with a short period of time (Morosini; Fonseca, 2018).

As they point out (Morosini; Fonseca, p. 268, 2018). "not only the time, but also the energy of the CHWs are disputed by two logics: one that values the educational work itself and the other that circumscribes it to the condition of enabling access to the territory and the achievement of goals".

Méllo *et al.*, (2021) also discuss the difficulties that have been posed to CHA professionals, which are perceived by the national representations of the category and by other researchers in the area, as setbacks to the category and model of health care. Among these difficulties, the authors mention the attributions and the profile that has been projected for these professionals, in the light of the work of other professional categories, for example, nursing. In this sense, the authors mention that the 2017 PNAB was a marker for this change in the professional profile of the CHA, when it assigned them clinical attributions. Another point that influenced this change was the creation of the Technical Training Program for Health Agents (PROFAGS).

Mello *et al.*, (2021, p. 7) reflect that, with the establishment of PROFAGS, "the macropolitical dispute around the professionalization of CHAs in the Brazilian context became explicit, seeking to distance them from socio-educational attributions to the detriment of biomedical practices.

PROFAGS, established in 2018, through Ordinance No. 83, of January 10, revoked in 2020, through Ordinance GM *No.* 105, of January 17, was considered a reprocess, as it opens and evidences the risk of professional mischaracterization of the CHA, through the nursing training proposed by this program, to the CHAs (Nogueira; Barbosa, 2018; Brazil, 2018).

As a result of this professional mischaracterization that has been affecting the professional category, its

> [...] practices have been crossed by managerial rationality, a process that deepens with the implementation of health work evaluation systems subsidized by criteria of individual performance, competitiveness among teams, remuneration for performance, and work orientation based on quantitative goals centered on biomedical procedures (Nogueira, Barbosa, p. 394, 2018).

In the context of the challenges that the professional category of CHWs faces, Méllo, Santos, Alburquerque (2023), cite the reduced legitimacy granted to them, which goes far beyond salary and labor aspects. The challenges are diverse, such as: experiencing embarrassing, threatening and violent situations, lack of recognition of the work by the management or other team members, as well as the absence of social support.

Faria and Paiva (p. 13, 2020) bring as a challenge for the CHA, the lack of training for the acquisition of subsidies about the various elements that cross the health/disease process. The authors cite that when training processes are offered to these professionals, they are usually guided by a bias that focuses more on biological aspects, to the detriment, mainly, of the guidelines and orientations that the Ministry of Health proposes, in relation to the attributions and competencies of the CHA. Thus, the authors point out that "the educational programs of CHWs should be composed and based on the development of competencies. The teaching-learning methods used need to be innovative, reflective and critical, student-centered."

FINAL THOUGHTS

Through the analysis of the various studies identified, it was possible to confirm the importance of the CHAs for the effectiveness of the proposed work in the context of Primary Health Care. It was also evident that the 2017 PNAB was a marker that brought harm to the work process of this professional, since it weakened the work of health education, by assigning clinical attributions to this professional. In addition, all the material synthesized here can contribute to a critical reflection on the way in which the practice of CHWs has been visualized in the context of the PHC work process.

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