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Work Process in Primary Health Care: action research with Community Health Workers

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Abstract *The aim of this article was to describe and analyze the work of community health workers (CHW). The main objective of study was to analyze the development process of primary health care practices related to drug consumption. The study is based on the Marxist theoretical orientation and the action research methodology, which resulted in the performance of 15 emancipatory workshops. The category work process spawned the content analysis. It exposed the social abandonment of the environment in which the CHWs work is performed. The latter had an essential impact on the identification of the causes of drug-related problems. These findings made it possible to criticize the reiterative, stressful actions that are being undertaken there. Such an act resulted in raising of the awareness and creating the means for political action. The CHWs motivated themselves to recognize the object of the work process in primary health care, which they found to be the disease or addiction in the case of drug users. They have criticized this categorization as well as discussed the social division of work and the work itself whilst recognizing themselves as mere instruments in the work process. The latter has inspired the CHW to become subjects, or co-producers of transformations of social needs.*

Key words *Primary health care, Community health workers, Family health strategy, Work, Action-research*

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Introduction

Nowadays the main model of primary health care in Brazil is the Family Health Strategy (FHS)[1]. Community Health Worker (CHW), who lives in the area served by the Family Health Unit (FHU), joins the team as a worker of the health institution, which is located close to the other residents of neighborhood. The work process in the FHU is organized by a team, which is composed of a doctor, nurse, nursing assistant and the CHWs[1].

Health workers have to continue education, as it is part of the public policy established by the Brazilian Unified Health System. However, such a process is not moving forward in primary health care in sufficiently adequate manner. This is especially true in the case of CHWs since obtaining necessary skills has being feeble.

The Ministry of Health anticipates an elaboration of the programs employed for the purpose of obtaining technical and professional training since 2004. The programs would aim at improving professional qualification, education level, and financial possibilities. Their incorporation would also help to regulate the employment relationships of the CHWs[2]. The primary plan in terms of such programs was to have three modules. However, only the first module was developed by 2010[3].

Therefore, some occasional training is conducted in a form of quick and operational lessons with regard to the service and supervision sessions, which does not enable critical reflections on the work process[4]. A systematic review carried out by the WHO regarding the experience of CHWs in underdeveloped countries has also found that CHWs have obtained little training for work[5].

The qualification of Brazilian CHWs is currently addressed in the interface between the fields of health and education[3,6]. According to regulation documents provided in terms of the work and training of CHWs[3], their work is considered simple since it does not require any specific and complex training, which is required from the other workers.

However, work-related stresses have been mentioned in literature as a result of complex activities. The following subjects are discussed: work overload, tiredness and stress related to the fragmentation of work, lack of workers' participation in the decisions of units as well as the absence of spaces for debate and reflection on the service in addition to precarious work conditions[7].

Although these questions are studied in a fragmented manner, they demonstrate reiterative practices, which are performed by the whole health team based on public health. Public health employs technologies, which correspond to so-called prevention levels comprising part of the multi-factor health-disease perspective[8]. Furthermore, the FHS reproduces the medic-centered model in spite of the innovative concept for primary health care. At that, teams face serious limitations in terms of establishment of the intersectoral projects that seek to act upon the determination of the health-disease process[9,10]. It has been found during a course of an integrative review conducted with American CHWs[11] that the health team experienced certain difficulties when trying to define which practices would produce the expected results that would support currently employed practices.

In face of the lack of preparation of professionals, the challenges in primary health care include overcoming complaint-based behaviors, the lack of space for education, and the depreciation of the users' knowledge and culture. In addition, the professionals are frequently blamed for not meeting the objectives defined by the administration[9].

It is typical challenge for the primary health care to solve the problems related to the harmful drug consumption. This is exacerbated by the distorted media coverage of the theme[12]. There are still greater issues brought about by the strong moral judgment of users and by common-sense attitudes that increase the alienation of drug users keeping them away from the social institutions that serve as the references for residents of the particular area and its neighboring areas. The health teams have serious problems handling this issue and have little or incorrect training to administer health care to the drug users[13].

The objective of this study is to describe and analyze the work of CHWs while focusing on the development of primary health care practices related to the harmful drug consumption.

Method

We adopted Historical and Dialectical Materialism, or Marxism in order to obtain knowledge on harmful drug consumption and health practice proposals, which would be coherent with this understanding.

In this sense, we begin with understanding of the fact that there are also licit or illicit drugs[8,14]

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inside the group of products that address the need for capital accumulation, which put drug users in the position of consumers. This matter defines them as being something else than sick or "deviant". Therefore, indicated that actions for handling this problem go beyond incorporation of behavioral changes in relation to drugs. Hence, we support elaboration of the state policies that address the health needs of various social groups along with special attention for those from class divisions that are explored to a point where they are almost completely removed from enjoying social goods. We propose actions focused on guaranteeing access to health, education, dwelling, work, amongst other rights, which would have the potential to change social situations that are at the base of harmful drug consumption[15,16].

This study is based on action research in the Marxist perspective, which suggests investing into research in association to change since knowledge is produced in a way that exposes the contradictions which are not always clearly presented in concrete reality resulting in changes in the social praxis[8].

In accordance with the theoretical framework, we used emancipatory education in health, that is, a construction conducted inside collective health and inspired by methodological propositions of Paulo Freire[17] and by the historical-critical education of Dermeval Saviani[18], among other critic authors[19].

Saviani, a Marxist educator, acknowledges education as a work, a kind of social practice. He asserts that the educators have the function of instrumentalizing, even in the participatory perspective, which involves the effective participation of everyone in the educational process, since they initiate the educational praxis bringing content that was previously accumulated by knowledge acquired from books, insights and/or previous experiences[18]. Therefore, the researchers who proposed the action research had the function of directing and mediating the proposed activities whilst bringing instrumentalizing elements based on the discussions that took a place since the first workshop and on the theoretical bases that guided research.

Freire's humanistic contribution begins by recognizing the political and ideological character of the relationship between subjects ("one that learns by teaching and another who teaches by learning") and objects (content). For Freire, education is a mutual and horizontal process of learning through dialog, which supports reflection and transformative action. Horizontality refers to the human condition itself since there are concretely differences that oppress. This relationship is based on pertinence, which causes feelings and subjects to move toward actions[17]. Thus, it was for researchers who proposed the action research readiness for dialogue and humility to try to understand the logic of the participants.

Saviani locates the social contradictions on the mode of production in society while Freire does locate them on the man oppression. Saviani recognizes the concrete differences among social classes while Freire points to equality among men as an ideal. However, both present social contradictions as bases for the development of the educational process and outline the propositions inside capitalist society with the goal of their transformation. In this sense, they influenced the design of emancipatory education in health. Hence this design states that the educational process is not spontaneously generated, but that it must be drawn from concrete reality, which creates the context and social practice of participants involving all subjects who are part of the reflection, discussion and development of instruments for the purpose of transforming reality and/or social practice[19]. It intends to enhance knowledge related to a given health-disease phenomenon not originating from empirical control or breaking down reality in measurable factors or the isolation between researchers and research objects. This concept is consistent with the methodological refusal that creates a gap between research subjects and objects[20], proposing the "effective participation of the researched population in the knowledge generation process, which was designed fundamentally as a collective education process"[19].

Among the various participative methodologies, we chose action research since it enables and employs the participation of social groups in the decision-making process[21] as main principle. Generally speaking, action research is a theoretical-methodological procedure that varies according to various epistemological routes. It is more focused on research that explicitly calls involved subjects to action and it has two main goals such as problem solving and knowledge-building[21].

In this investigation, action research was developed through conduct of fifteen emancipatory workshops, understood as the instruments that enable the opportunity for reflections on practice and the contradictions in reality so that social transformation may happen[16].

The action research was divided in two stages. First stage comprised of nine workshops. The

main goal of these workshops was to analyze the drug consumption in contemporary times and to instrumentalize participants through the development of an education process based on the fundamentals of collective health employing strategies able to problematize the reality of their neighborhood. Second stage comprised of six workshops conducted with the goal of building support materials for FHS workers to handling harmful drug consumption. The resulting material was titled as "Alcohol and drugs: one million actions. A Workbook for Community Health Workers: in focus Health needs and Harmful Drug Use", which is available at the following address: http://www.ee.usp.br/noticias/2013/alcool_drogas.asp.

The action research concept considers all the subjects as participants; therefore, we did not previously define themes and proposals during the course of this investigation. This happened because of what was problematized in the immediate previous workshop. In other words, the assessment of theoretical-practical needs, which were presented by participants and led to the next investigation stages, was the primary reason for occurrence of such an event.

The educational process, that is, the driving force behind action research, was described and evaluated in other spaces[22,23].

All moments were recorded in audio. The participants' speeches were transcribed as we sought to follow the content analysis stages proposed by Bardin[24] with support derived from the dialectical method, which emphasizes analyses drawn from theoretical categories that manifest themselves in reality through other empirical categories.

We analyzed the CHWs work practices through the category work process in accordance with the Marxist proposition as understood by Ricardo Bruno Mendes-Gonçalves[25]. In this understanding, they were seen as social practices whose elements (object, aim, work itself and means and instruments) were learned during the educational process, which guided the action research. We used a previous study by Santos et al. as a reference. The goal of this study was to analyze daily work of the FHS workers[26]. Therefore, this research analyzed the practices, their criticisms, and proposals for changes. We tried to highlight during the workshops the CHWs' discoveries on the structures and dynamics of their work process.

The study was approved by the Research Ethics Committee of the Department of Health of the city of São Paulo. Participants signed a informed consent form.

Results

Eighteen CHWs took part in the action research. They were employed from four Family Health Units of the district of Sapopemba, city of São Paulo. Most of them were women (17) aged between 22 and 59 years.

CHWs discussed their daily practices and criticized the work process in which they participate. The latter has made it possible to recognize the rich process of awareness raising through discussing the FHU's routine, the work they perform and the cases they experience. This process increasingly revealed the social abandonment of their area and proposed complex practices beyond the FHU space and disease-prevention advice.

CHWs shared difficulties related to the hierarchical structure and lack of credit from the technical team among the other issues concerning the work process. It was especially true in difficult cases, where the team found itself "with no way out".

The CHWs discussed their precarious training by contemplating contradictions that exist in the work since they perform its most complex parts even though they have the least amount of technical training in health. Participants became aware of how frequently they stop mediating the relationship between neighborhood residents and technical team to serve as buffers for the social problems that exist in the area they serve and for which the team has no answer, given their highly clinical training.

We noticed that the CHWs have brought their woes related to work as a whole to the educational space while not bounding themselves to the issues related to interventions concerning harmful drug consumption. The CHWs reported that trainings performed in service were focused on diseases that were to be treated in primary health care (hypertension and diabetes, for example). In that sense, the CHWs have also stated that they do not lessen their discomfort with the total lack of instruments for dealing with the social demands of their area.

Furthermore, the CHWs exposed contradictions in their work in a very clear manner. These contradictions were previously seen as mere feelings that caused discomfort. An example of contradiction is that their practice is based on the

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repetition of content that was taught to them in a hurried manner, which is drawn from clinical knowledge that comprises part of the training of the nurses and physicians who studied in universities.

In addition to that, participants resent the fact that their knowledge, approaches and contributions in terms of the case discussions with the technical team receive very little attention. Participants stated that they are not even able to share the fact that they are the only ones who suffer the greatest occupational stresses in the FHSs whether it is conducted by means of handling police action in the areas or visiting households in unhealthy conditions or during the other situations.

As result of such a dynamic, the CHWs undertook an attempt to handle all sorts of issues individually. In this sense, practice tends to become stressful and to involve an individual as an object rather than involve the entire collective. Thus, they seek the preservation or protection of some residents in an individual manner believing into efficiency of such an act.

The CHWs also debated that great amount of their work is permeated by private logic with assessments being based on quantitative quotas (visiting a given quantity of families and detecting a given percentage of sick individuals). Participants reflected on the interests of private enterprises, which motivate and invest in their workers.

In the beginning of the educational process, the CHWs felt that their practices were fragile and did not address the volume of work and neither the issues that were in demand. As the workshops went on, they identified the causes of this fragility, which enabled better support for their criticism and the proposition of less precarious health actions, with creative and expanded practices in comparison to clinical practice. This synthesis, which they built, has made it possible for them to approach the discussion about the roots of health problems which, thus, initiated a search for solutions. Moreover, this comprehension has made the participants feel less frustrated about their work and also encouraged them to create new proposals for work.

Discussion

Data analysis, which was conducted through the category "work process", has revealed the stress endured by CHWs in the service daily routine.

The CHWs pose themselves as the health workers and so does the technical team. However, they would rather be a separate group due to their devotion, commitment and ties with the population, as described in literature[27].

Seeking interaction not only between various workers, but also between them and users[1] despite the attribution of developing an interdisciplinary work in basic health, , the CHWs report lack of support from other workers of the FHS[24]. The FHS teams work with different dynamics, which reveals the inexistence of a collective responsibility, which leads to discontinuity and disarticulation in actions performed in their area[27-30].

Therefore, barred from participating in case discussion and in the planning of the FHUs' activities, the CHWs play an instrumental role in the work process basically reproducing codes of conduct for the neighborhood residents. In this context, the technical team monitors this instrument, which reproduces the population's sanitary control logic with no consideration for local needs or the families' demands that do not correspond to the directions and protocols previously defined in the health units[27,29]. For that end, the WHO suggests that the CHWs should be continuously supervised so that they can actively participate in the decisions and proposed practices. Furthermore, they should receive adequate equipment and supplies for performing their work[5].

Since the CHWs reside in their working areas, they can experience both ends of the imposed hierarchical relationship. Thus, they hold an instrumental position in the FHU team, with inferior of little knowledge. They are the knowledge keepers being responsible for transmitting technical-simplified knowledge to the population in the area and in home visiting. The argument used for proposing behavior change is persuasion, and this is based on the possibility of death or disastrous consequences in case their directions are not followed[6,31].

Since the CHWs work in and are part of the area, they are commonly summoned by the population to be ombudsmen of the health service, becoming receivers of their demands[32]. Furthermore, they are frequently approached by the FHU users outside of their work hours to answer work-related questions for which there are not always resources allocated by the administration. We recognized the Toyotist components of work organization such as exploitation of workers' subjectivity as it has been demonstrated in another study done in the FHS[26].

The role of the CHWs is not clearly defined; their work is not always documented even though it causes high expectations[11]. Furthermore, the uncommon collective and educational actions carried out in the services, which are seen as having potential for strengthening, receive little appreciation in EST in general since focus is on productivity that is measured using the set quotas[26,31].

The CHWs are solicited by the technical team and by the population, and they face challenges in both ends. They are frequently asked by residents to solve their social problems even though they have no solid training nor, in many cases, appropriate supervision, and have no consolidated spaces to debate these issues[28]. "The workers find themselves imbricated in work that goes beyond their competences and possibilities of resolution"[32].

Then the CHWs find themselves in the front line of the FHS and face the ambiguity of being the less trained workers with the lowest salaries in the FHS and simultaneously being perceived as the "super-hero"[33] for the expectations of the population and of the institution itself. This position causes contradicting feelings and stress.

As highlighted by the participants of this research, it is common for them to feel frustrated due to committed failures. This is especially true when they cannot refer the problems detected in the area (for example, making appointments with specialists), taking upon themselves the institution's and the state's responsibilities as identified in another work[26] concerning a research about the work process of FHS nurses.

The stresses suffered by CHWs in their work, which were reported by this investigation's participants and also commonly reported in literature, are results of the elaborated work conditions incorporated in the production process of health. This production process follows others production processes in general, enabling precarious work, with an increase in informal work, flexible types of hiring and unemployment, and transferring responsibilities to the worker[32]. Thus, it is clear how private logic has entered the public service sector with the so-called productive restructuring, the work flexibilization process that deregulates social and labor rights through decreasing the number of workers, increasing productivity, outsourcing services and prioritizing multitasking workers[34].

Authors point to precariousness and instability in the hiring process of FHS workers, especially CHWs[7,9,35]. Taking into consideration the fact that the health-disease process is socially determined or directly related to the types of social reproduction[36], it is a consensus that submission to precarious and unstable work conditions, beyond compromising quality of service, leads to workers' frequent illness.

Complex factor of work fragmentation in the production process of health diminishes the role of workers in specific or various fragmented tasks. Thus, the workers loses the understanding of the totality of the work process, becoming simple production instruments[33] as it typically happens in all the capitalist productions, which steal the intention of transforming the object.

Final Considerations

Social and technical division of work defines the conditions to which the CHWs are submitted in the work's daily routine as reported here: occupying the lowest position in the hierarchical relationship established in the FHS and having little acknowledgement from the rest of the team; disregard for their knowledge; fragile training; scarcity of technology and other work resources; reiterative practices; productive quotas as goals of work. These have stress potential for the workers, having direct impact on the production of health service.

The CHWs have the lowest salaries in the FHS team since their work is considered to be the most simple or having the lowest demands in terms of qualification. This situation is related to the position they occupy in the social division of labor. In other words, they have the lowest access to infrastructure being the residents of the most marginalized urban spaces. In the opposite side of the "weakest link in the chain", research shows the complexity of the work in which CHWs are involved since they face the most serious social problems, which makes them use a significant set of emotional and affective resources going as far as using material resources as well.

In addition to participating only in task execution, it is visible that the CHWs do not relate to the object of their work in primary health care and become mere instruments as expected in capitalist production processes in general. We anticipate that revealing of this condition of instruments enables the discussion of what would be the condition of subjects or co-producers of transformations of the work object.

In this sense, the educational process, i.e., the driving force of this investigation's action

research has made it possible for the CHWs to formulate organized criticisms of the position in which they are placed in the FHS. The presented results contribute to the knowledge in the area by showing that it is possible to politicize the discussion about the work process in health through educational processes.

As a challenge for primary health care, especially when it comes to the FHS, we emphasize the need for establishing spaces for debating the work process that contribute to strengthening workers and the development of intersectoral creative practices, which have an impact on the causes of the sector's problems. In the field of harmful drug consumption, these spaces could contribute to the establishment of emancipatory harm reduction practices encouraging political acts that aim for social transformations.

Collaborations

L Cordeiro and CB Soares participated equally in the conception, analysis and interpretation of data and in writing the article.

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