

## Is the value of Community Healthcare Agents in Brazil's Family Health Strategy receiving full recognition?

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**Abstract** *This paper discusses meanings produced by Community Healthcare Agents (ACs) on whether or not they feel that ACs in Brazil's Family Health Strategy are receiving the recognition they deserve, considering their work with social networks. Discussion groups with 28 agents of six Health Units were held, sound-recorded and transcribed. Qualitative analysis of the material enables us to identify, in the discursive practices of ACs, a tension on whether proper value is attributed to their work, or not. There was attribution of value when they talk of their activity in close proximity with the community, and their potential for construction of human connections; but there was non-attribution of value when they talk of the system's macro-structural aspects, such as low salaries, and low recognition of their function, in comparison to higher-level professionals. We conclude that the view of their work – still involving fragmented work processes, and expectation by the population that they will be able to provide immediate solutions to demands – might be preventing them from taking on board a more wide-ranging concept of primary healthcare, as a structuring and communication agent of the Healthcare Network, and as an organizing agent of Brazil's Unified Health System.*

**Key words** *Primary Health Care, Family Health Strategy, Community Health Agents, Job satisfaction*

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## Introduction

Brazil's Family Health Strategy (*Estratégia Saúde da Família*, or ESF) has stood out among the elements of the country's Unified Health System (*Sistema Único de Saúde*, or SUS), and is considered an important element in the process of transformation of the healthcare model, which was previously – traditionally – marked by biomedical references<sup>1,2</sup>. Accompanying an international movement of increased attribution of value to Primary Healthcare<sup>2</sup>, this strategy seeks to plan actions guided by the needs of the communities served. Further, the Family Health Strategy shares a wide conception of primary care, including Primary Healthcare as a strategy of organization of the healthcare system, within Healthcare Networks<sup>3,4</sup>. As Mendes<sup>4</sup> sums it up, in this point of view, three functions articulated by primary healthcare stand out:

*the solution-providing function of attending 90% of the most common health problems, not necessarily the simplest; the coordinating function of ordering the flows and counter-flows of people, products and information through the Healthcare Network; and the function of assuming or allocating responsibility for the health of the user population which is restricted, in the Healthcare Network, to the teams of the Family Health Strategy.*

In the ESF provision of care is territorialized, and provided by multi-professional teams responsible for the planning of actions in accordance with the local needs of a community<sup>2</sup>. In this strategy, the figure of the Community Healthcare Agent (ACS) is distinguished by the fact that s/he lives in her area of activity, and has knowledge of the territory, and its peculiarities and needs<sup>5,6</sup>. The ACSs are central players for the good functioning of the ESF, in that they carry out actions ranging from involving and adding people of the micro-area to orientation of families on the use of the health system, educational action and monitoring of programs that are in place for transfer of income and dealing with vulnerabilities<sup>2</sup>. Considering the diversity present in the activity of an ACS, Nogueira et al.<sup>7</sup> defined the ACS as a *sui generis* worker. His/her involvement from within the territory enables identification with the community and construction of a relationship of proximity with it, often characterized by a propensity to solidarity, mutual help and community leadership.

According to Silva and Dalmaso<sup>8</sup>, two dimensions can be identified in the practice of an ACS. One is technical, relating to attending to users,

interventions to prevent worsening of situations, or monitoring of groups or problems; and the other is political, related to solidarity with the population, the involvement of healthcare in the context of people's lives, and organization of the community and transformation of its living conditions. This political dimension can result in two expectations about the role of the ACS: that s/he should act as an element of reorientation of the conception and of the model of healthcare; and at the same time play a role in fostering organization of the community, in a concept of social transformation.

As well as these aspects, we highlight the activity of the ACSs with social networks, that is to say, with networks of relationships that are perceived as significant in people's lives, including relationships of family, friendship, work, study and community, and including social and institutional agencies<sup>9</sup>. As various authors indicate, work in close proximity to communities can help organize and structure social networks, in such a way as to strengthen the relationships both between people of a similar territory and also between care systems<sup>10-12</sup>.

Analyzing the work of ACSs with social networks, Pinheiro and Guanaes-Lorenzi<sup>9</sup> highlight two central functions that they exercise: that of articulator of the social network of an individual, considering his/her health needs; and that of mediator of interpersonal relationships, intermediating tensions and conflicts, especially in the context of family relationships. According to these authors, these forms of activity characterize interventions in networks of relationships and sociability, and are thus different in kind from an individualist conception of healthcare; and they also demand from the ACSs skills in communication and negotiation. Thus, in the ACSs' practice, the fact of territorialization goes beyond a merely geographical dimension. Since the ACS lives in the area of his/her work, s/he participates in the local culture, and this favors the establishment of links and construction of a relationship of trust with the residents, who feel more at ease to talk about their reality of life and difficulties<sup>5</sup>.

According to Fontes<sup>13</sup>, the work done by ACSs favors democratization of information, and can stimulate participation by the population in health – both in care, and in policies, which is indeed envisaged in the legislation of the SUS. The ACSs live and interact with different people and circles, which can be described as different fields of sociability – and this, when these cross over, expand the view on health practices.

In spite of the recognition of the central nature of the work of the ACSs and their important role in construction of networks – favorable to integrality, intersectoriality and social participation – studies on the practice of ACSs point to tensions and difficulties in their daily routine. Jardim and Lancman<sup>14</sup>, for example, reflect on the complex relational dynamic established between the ACSs and the community. Among other aspects, they report that the roles of health worker and of friend or neighbor are frequently confused, which can generate stress and suffering. Further, because they are the link with the community, the ACSs receive the population's responses in relation to the SUS (positive or negative) more strongly, which can directly influence the way in which the population conceive their practice.

Difficulties related to the dynamic of work in teams also occur in the daily practice of the ACSs. Peres et al.<sup>15</sup> discussed the creation of a hierarchy structure that is present in health teams, in which those who have a specialized technical knowledge or superior training occupy a highlight position, and emphasize the need for horizontalization of actions in the ESF, with responsibilities shared between the members of the health teams. Sakata and Mishima<sup>16</sup> put forward a discussion on the relationship of the ACSs with people who have more technical knowledge, such as in situations where they might feel deterred from questioning or taking a position vis-à-vis workers with university education. Pupin and Cardoso<sup>6</sup> report non-attribution of value to the work of the ACSs, who complain, among other things, of the low remuneration, considering their working hours and their many responsibilities.

This paper interacts in a dialog with this literature, which points to various different meanings surrounding the work of ACSs: sometimes pointing to their being attributed higher value (e.g. due to their action in the ESF, or recognition of their potential for construction of a link of trust with the community); and at other times attributing them lower value (e.g. in the demand that agents experience from the community for them to have solution-providing power; and in relation to the hierarchy that the agent feels in professional relationships). Considering the challenges that are a part of the ACS's daily practice, especially in his/her work with social networks, we ask: In its relationship with the community and with the teams of the ESF, how does the ACS construct meanings about his/her practice – and does s/he attribute more or less value? This pa-

per aims to understand through what meanings ACSs refer to their work with social networks, focusing especially on the meanings they make on the subject of whether or not they are well recognized within the context of the ESF. Based on the analysis of the tension between meanings of greater or lesser attribution of value to the practice of the ACS, we seek to reflect on the implications for the social construction of the ESF in day-to-day working practice.

## Methods

This is a qualitative study based on a social constructionist epistemology, emphasizing the quest to understand the ways in which people explain, describe and narrate their lives and the world in which they live, and the resulting implications for the construction of ways of living and social realities<sup>17</sup>. This view underlies the method chosen for this study, of analyzing the discursive practices of ACSs, focusing on comprehension of the meanings they present about their practice with social networks in the ESF.

This study was carried out in a small town in the interior of São Paulo state (population under 20,000), which has 100% coverage by the ESF, through six family health teams and a Family Health Support Center (*Núcleo de Apoio à Saúde da Família* – NASF). 28 ACSs of six family health teams took part in the study; 27 of them were women. Only 2 ACSs were unable to take part, due to vacations. Ages of the participants varied from 18 to 57, and their time in the profession from six months to eight years. Their schooling varied: four had completed primary education; 15 has completed secondary education; one had a nursing course; seven were in higher education (courses in teaching, nursing or physiotherapy); and one had completed higher education.

The proposal for this study was approved by the Research Ethics Committee, and the study was carried out in accordance with the guidelines of National Health Council Resolution 466/12, on research with human beings<sup>18</sup>. All the participants of the study voluntarily accepted to take part, and signed an Informed Consent Form. To protect the identity of the participants, the family health units were referred to by colors; and the names of individual ACSs, health professionals and patients finally used in the analysis are fictitious.

The information was obtained through discussion groups, an investigative technique based on interaction between the participants as a

source of information for the research. The technique enables interactions and enlargement of discourse between participants and researchers<sup>19</sup>. The aim was to use the context of dialog to development concepts that would provide the information of the investigation.

Two discussion groups were held with each of the six teams of ACSs – a total of 12 groups. The first meeting in each unit was of a more general nature, in an effort to understand the relationships that the ACSs understood as being created between social networks and health. The discussions of the first meeting were taken deeper in the second, following the particularities of each group. Usually the second meeting explored the ACSs' work with social networks in practice, with practical examples of their daily work routine with the community and as a part of the health system. Each group meeting lasted about two hours. These meetings were held in the health units themselves, and were audio-recorded and transcribed. The transcriptions aimed to preserve the participants' ways of speaking, maintaining colloquial expressions and any grammatical errors.

For qualitative analysis of the transcriptions, we adopted the proposal of Spink and Medrado<sup>20</sup>, of analyzing the conversational flows and interactions between the participants, considering the analytical categories as discursive practices emerging from the contact between the investigator and the material. Initially, we made a close reading of the transcriptions, seeking to record regularities – noting themes that seemed to be more common and recurring – and also irregularities, highlight singular moments or moments that pointed to aspects that were yet little explored in relation to the practice of the ACSs. In this first analysis we noted that in many dialogs the ACSs referred to the importance of their activity with social networks in the ESF and emphasized their role as a 'link' or 'intermediary bridge' between the population and the SUS, as defined in official documents<sup>21</sup>. However, at other moments this concept of attribution of value experienced a tension with an opposite meaning, of non-attribution of value. These were moments in which the ACS pointed to a possible distancing between what 'the SUS' (as official discourse) specifies and what, in reality, they feel in their day-to-day work activity, both in relation to the families attended and also in relation to the other professionals of the team. It was identification of this tension that led to the proposal title and concept for this paper: 'Is the value of Commu-

nity Healthcare Agents in Brazil's Family Health Strategy receiving full recognition?'

Taking this decision on theme as a starting point, the transcriptions of the groups were then analyzed in the following stages: (a) identification of moments of dialog where, when talking about their practice with social networks in health, the ACSs referred to attribution of value, or absence of attribution of value, to their work; (b) recognition of the meanings that are present in these reported attributions (or non-attributions) of value to the work of the ACS, with repercussions on their implications for building the Family Health Strategy in daily routine; and (c) choices of excerpts that illustrate the tension between discourses on recognition (or otherwise) of the value of ACSs.

## Results and discussion

### **Nobody gives any value. Neither the SUS, nor anybody**

The tension between meanings that attribute value to the ACS, and those that do the opposite, appeared in the references, by ACSs, to their participation in construction of the care model. At these moments, at the same time that they repeated their having learned about the importance of the ACS as the 'link' or 'intermediary bridge' between the population and the health system, as the official discourse of the ESF specifies<sup>21</sup>, they questioned the real importance of their role, based on elements of the daily routine, such as the low level of appreciation attributed to them by the community, or their low salaries.

A dialog that illustrates this tension took place in the first group meeting held at Red Unit, which had begun with an invitation for the ACSs to discuss what view they had about the concept of a social network, based on the overall definition of a social network as 'people who an individual recognizes as important in his or her life'<sup>9</sup>. Elisa raised the question of what is meant by 'important', setting off a discussion about the practice of the ACSs, with a view to assessing whether they could be considered as 'important' in the social networks of the people of the community:

Paula: *We who are community agents go to a person's home, and teach that person. Perhaps the person learns from us. But that doesn't mean that we are important in the life... in that person's life.*

Vitória: *Nor that that person is important in my life.*

Tereza: *No, but it happens that for the health system, for the SUS, we are important for that family.*

Elisa: *For the SUS. Not for the families.*

Tereza: *We are a link that joins the families... the families with... with the health system.*

Paula: *You think that your families recognize you as important for them?*

Tereza: *Ah, yes – many of them do!*

Elisa: [Irritated tone of voice] *My area... huh! They don't even care!*

Tereza: *It could be that the family doesn't recognize... but the SUS recognizes.*

Vitória: *Nobody recognizes, Tereza. Neither the SUS, nor anybody.*

Tereza: *Vitória... Girls, if they didn't they wouldn't have done this, they wouldn't have done the... that is... they would not send so much funding to make, to put together a PSF.*

Elisa: *D'you earn a lot of money? [Silence for some moments]. No you don't, do you? So... (Laughter). (Red Unit, Group 1)*

At this moment, there is a tension between different discourses: at one moment there are meanings of recognition of value, and at another, meanings of denial of value. Tereza argues that the ACS and the PSF are given value, since the government sends funding for their installation and maintenance. She also believes that some families give value to the work that they do, an aspect which, to her, appears to be indicative of attribution of value. On the other hand, Paula, Vitória and especially Elisa highlight the lack of attribution of value to the ACS herself, perceived both in the relationship with the community and in the relationship with the health system. On this aspect, the question of salary appears as a concrete argument in favor of non-attribution of value to the ACS; and this exercises the rhetorical effect of persuasion in the group, closing the discussion on the subject.

Santos et al.<sup>22</sup>, in a study carried out with ACSs of units of the ESF in the interior of São Paulo State, reports that they cite the low remuneration as one of the principal negative points of their practice, and causing a sensation of non-attribution of value to the work by the ACSs themselves. At the same time, the authors discuss that the ACSs also defined their practice as very important, providing elements of solution-providing, link with the community, and trust of the population, which they say sustains a feeling of realization. In this present study, just as in the work of those authors, both these aspects appeared in the groups, indicating attribution of

value to the work of ACSs, both in the relationship with the community and in the relationship with the health system. However, at this specific moment of the dialog, the weight given to salary questions seems to have the function of pointing to a 'contradiction' or failing in the policy of the ESF. If the ACSs were in fact so important for 'the SUS', as Tereza enunciates it, the ACSs should be recompensed for this –this is what Elisa argues. The silence after Elisa's speech, and the laughter at the end, appear to have delivered a certain consensus between the ACSs at this moment of the meeting: independently of the recognition experienced in the relationship with some families, the low remuneration reveals the absence of attribution of value to the work of the ACS in the policy of the ESF.

The dialog on attribution, or lack of it, of value to the ACS continues in this same group. Now, Elisa expands the argument of non-attribution of value to the ACS, reflecting on the low recognition of her work for the community in comparison with the other professionals with higher levels of qualification. Once again, Elisa's speech finds support from Vitória and Paula:

Elisa: *I'll just say one thing – which indeed happened. [...]. I visited a woman's home. You might say, that I gave her some orientation. But then after a time, I went there with the doctor, and the doctor said: "Okay, and how are you going?" "Ah, I'm well. The doctor said such-and-such to me". This was actually the same orientation that I had given her, before – and she hadn't given it any importance...*

Paula: *He was important. He was important.*

Elisa: *What he said was important. Me, no.*

Paula: *You aren't important. [...] you're important to God – only.*

Vitória: *We're important only to our own family. Understand? And no one else. (Red Unit, Group 1).*

Paula makes the comparison with the value given to the orientation when it comes from the doctor, showing that her own technical knowledge was diminished when compared to this position that was socially valued. This illustrates how the transition in the healthcare model is still suffering difficulties. The centrality of the doctor in the process of care is a relic of the biomedical model and of the practices centered solely on medicalization and on cure<sup>23</sup>. The change in the model has brought in the importance of other health professionals, and of their technical competence to exercise care, into the official discourse. However, in the daily routine, there is still a running tension between the new and old discourses.

In the excerpt recorded above, *Elisa* feels that her technical capacity for orientation was not recognized, when compared to the value that is given a priori to the doctor as a holder of knowledge.

At the same time, it is often the ACS herself who does not attribute value to her own technical competence –and indeed attributes greater responsibilities to the professionals of the team that have higher qualification. At these moments, the ACS may question her potential for action and feel pressured by the demand from the community, that the ACS herself experiences, for problem-solving capacity. One significant moment when this happened was in the first group discussion meeting held at the White Unit, which we present below.

**What will be done has to be come from ‘them’. Not from the agent!**

This dialog took place when the ACSs were discussing the importance of knowledge about the limits of their practice. They were talking about the importance of knowing how far to go in the relationship with the community; respecting people; knowing how to listen and not to give direct advice about their lives; and to take cases to discussion with the other professionals of the team. They described a potential stress in their relationship with the community due to a demand for solution to problems, which often cannot be met:

*Larissa: A lot of stress. Because... it's, often, like I said, there are some people who want us to solve their problem, while we don't have... The agent, he is the population's intermediate bridge to the PSF, so, what do we have to do? Take his problem to the PSF, to our... to our bosses, isn't that right? We make a case study, things like that, to see whether... ... What will be done has to come from them. Not the agent. And in this case the... the person doesn't understand, the person wants... He saw the agent, he wants the agent to resolve the whole of the situation. Like the case of Carmen, with the water. [...]*

*Helena: She's from my area, she lives in my street. And everyday she comes to my house at... she sees me arriving at lunchtime, in the afternoon she comes to home and says that her husband is putting poison in her water. She has a mental problem, she's doing treatment and everything. She wants me to talk to her husband. I can't intervene in that. So, I've already brought it here, and she is doing psychiatric treatment... But everyday, she's there! And then, everyday, I say: "No, I won't talk to him"... [...]*

*Larissa: Yes, it's stressing.* (White Unit, Group 1).

In this excerpt, *Larissa* describes the ACS as a ‘bridge’ between the community and the PSF, which for her defines her function as one of bringing problems back to be discussed in the unit, it being up to the ‘bosses’ (in the case of the units researched, doctors or nurses) to decide the actions to be taken. In the definitions of function of the ACS, it is specified that the ACS should identify risk situations and take them to the sectors responsible<sup>1</sup>.

*Sakata and Mishima*<sup>16</sup> discuss that the activity of the ACSs focusing principally on operational aspects of the work, as in the excerpt transcribed, reinforces a rigid, closed conception of work – as a link in a chain, something immovable, cold. On the other hand, attribution of value to the inter-relationship between the ACS and the rest of the health team could result in value being attributed to integral care for families, and be part of an activity with greater mobility, adjustable to the community's needs. In the view of these authors, when the ACSs carry out actions integrated with the work of the health team, there is more potentiality in their work, and this can help the team to go forward to a place beyond a purely biomedical focus. Based on reports of other members of Family Health teams, these authors discuss how the ACSs' greater knowledge about the families that are served can result in greater security and tranquility for the team to carry out its work. This recognition of the importance of ACSs in health teams also helps them to be included in the planning of health actions, which causes increased value to be given to dialog between different areas of knowledge in the context of the ESE. However, in the previous excerpt, *Larissa* has described the ACSs as professionals who only listen to complaints and deliver them to the rest of the team, saying that the initiatives on what to do should come from the bosses. This would seem to reduce the potential for ACSs to contribute to a type of care that integrates the various areas of knowledge within the ESE.

As regards the example given by *Larissa* (of care for a user with mental health problems): *Ribeiro et al.*<sup>24</sup> indicate that often health professionals do not recognize their resources for work with mental health in Basic Healthcare, leaving out of account fundamental dimensions of the process of care, such as accompaniment, involvement, availability, recognition of the health needs, actions for prevention and construction of partnerships with specialized services, capacity for

listening and dialog, and indeed construction of links of trust and respect with the residents of communities. According to these authors<sup>24</sup>, “there is an expectation of ability to solve problems that is very little aligned with the seriousness of the cases attended to and an apparent hierarchical structuring of the therapeutic actions, which tends to give pride of place to actions of a medication-based type to the detriment of the light care technologies”.

We highlight that the practice of the ACS has particular features that help establish a link of proximity to the population<sup>5,7</sup>. However, as Jardim and Lancman<sup>14</sup> point out, this relationship is not always harmonious, and it is necessary to establish a relationship of credibility and trust between the ACS and the population. We agree with these authors that the credibility of the ACS is dynamic and relates directly to the solution of the problems raised by the community, which, often, is made impossible, not by a specific technical difficulty of the ACS, but by the very complexity of the organization and functioning of the health system, and also difficulties in the transition of the type of care model. Complementing this, Pupin and Cardoso<sup>6</sup>, based on an investigation involving ACSs, discuss that the proximity with the people of the community can also be experienced by the ACSs as a negative element, especially when they are unsuccessful in establishing distinctions between their role as worker and resident, outside working hours.

At the same time there were many moments of dialog in which meanings of attribution of value to the work of the ACSs appeared, especially considering their central role in the relationship with the community, and the quality of the link established with the families served. In these cases, the ACSs feel the attribution of value to them as professionals and people, part of a community that knows how to recognize their value.

#### **Not only as an agent, but as a person too...**

The following excerpt occurred in the first group meeting held in the Yellow Unit. The ACSs were making a close comparison between the notion of social networks and their own history; and reflecting on who would be the ‘most important people’ in their own lives. In this exercise, they initially cited, as people significant in their social network, only their own family, afterwards expanding this meaning to colleagues and friends. At this moment Cláudia brought up, in the group, the case of Carmélia, a user with

whom the team had a close and affectionate relationship. The conversation moved to the view that the ACSs are a fundamental part of Carmélia’s social network, which is important for her health, and that the reverse, also, is true:

*Cláudia: Everyone knows Carmélia. [...] She’s in fact in Jarbas’s area [Jarbas is an ACS who did not participate in the group], but in fact everyone has a great affinity, friendship and affection for her; Maurício [the unit’s doctor] also has, and Ângela also has, and I have too. [...]*

*Rafael: And there’s a contact... like, almost everyday, she’s here in the unit. [...] She has contact with all the people of the team, so... [...] She’s a person who... I think that she considers the health service as a social network. [...] She sees that it has importance in her life. And thus, for us too, I think that she also has importance, because outside the... the community agent service, we also converse with her (Yellow Unit, Group 1).*

The ACSs describe Carmélia as a person who considers the health service as a social network, which takes place not only at moments of work, but also in other contexts. In this aspect, the ACSs highlighted their relationship with people whom they know, with family, with friends, and also users, giving value, based on the example of their relationship with Carmélia, to the involvement of affection that exists in this relationship.

In this excerpt there is recognition of positive elements of the practices carried out by the ACSs and their participation in the life of the community. It is exactly this vision of the ACS as part of the social network of the community, that is, as a person who is close and significant, who, according to the original proposal of the ESF<sup>1</sup> and studies in the literature<sup>10,15,16</sup>, can favor the establishment of links of trust, increasing the possibility of the practice of the ACS offering to the health team elements for a healthcare that is linked to the needs of the population. In the context of this investigation, building this meaning appeared to have the function of empowering the ACSs about the importance of their work, enabling them to see themselves more than a mere vehicle of information between users and other professionals of the health team.

In the same way, the following excerpt expresses meanings of attribution of value to the relationship between the teams (especially the ACSs) and users. At this moment, the ACSs were conversing between themselves and with the researcher on the realization of groups in the family health unit and the participation of ACSs in this type of proposed action:

Ângela: *Well, you know, they arrive, they hug each other. [...] And, then I think – like, between the group, there's, like, a friendship that's solidifying, like, very... It's... For example if one of them isn't there one day, the other says: "Hey, but why... You mean So-and-so didn't come today?" [...]*

Rafael: *People... think the presence of the agent is important. Not just as agent, but as a person, also. It's like you said, it's not only the function, the work that is carried out, but it's the presence of the person, it's also important in the group.* (Yellow Unit, Group 1).

The attribution of value to the relationship between the community and the ACS is built based on the recognition of the relationship of friendship and proximity between them. This proximity favors the carrying out of actions that consider the users as human beings inserted in context and as co-builders of the health system based on a more horizontal relationship.

The meetings between ACSs and the population that take place in the unit itself, such as the groups referred to in the example, can help make this relationship closer. These meetings favor the sharing of lives and histories, with the peculiarity that, when they happen within the health system, they show the relationship of the ACSs with the population as health professionals, which can help increase the credibility of the professionals<sup>16</sup>. In turn, this credibility helps at the moments of home visits, making it possible for them to have better access to families.

### Final considerations

Attribution, or absence of it, of value to the practice of the ACSs is not a dimension that can be precisely specified, with well delineated frontiers. In their discursive practices, the ACSs move between meanings of attribution and non-attribution of value to their work, using different social discourses to sustain their arguments in relation to each of these two aspects. Reflection on when the discourses on attribution, or non-attribution, of value to their work become more significant in the dialogs on their day-to-day practice can be a fertile resource for thinking about how to continue to build the Family Health Strategy in daily routine, and its relationship with the wider plan for Primary Healthcare – that it should be an important element in the coordination of the RAS (the Health network) and in organization of the SUS as a whole.

Our study indicates that the ACSs frequently have recourse to the 'official discourse' of the ESF to define and conceptualize their practice, defining their role as central for successful activity of the ESF, because of their being the 'intermediary bridge' between the health unit and the population. However, the sense given to this official discourse varies in accordance with the negotiations in progress. Sometimes, the official discourse is brought up as a form of praising the work of the ACSs and strengthening their particularities, especially giving value to their skill in building links and articulation of social networks –which are fundamental aspects for construction of healthcare, based on the health needs of the communities served. At other moments, however, this discourse is brought up as an indication of the contradiction that is present in the SUS, where it is expected that health professionals should act in an articulated, horizontal and interdisciplinary manner with the community. In practice, however, there seems to be little sustaining of this 'horizontality' in other aspects of this relationship, especially those relating to policies of recognition in terms of salary. At these moments, the comparison of the work of the ACSs with that of other professionals (especially doctors and nurses) seems to serve a double function: to denounce the continuing existence of a doctor-centered healthcare model; and to reduce the importance of the work of ACSs with the community, as they come to be seen as not very responsive to the efforts to implement a new way of providing healthcare.

Among the many possibilities of discussion of this tension on the question of attribution, or not, of value to the work of the ACSs, we highlight two related aspects that we judge to be fundamental: the fragmentation that exists in the micro-processes of work; and the expectation of capacity to resolve problems in the cases attended based on individual actions, usually centered on the practice of the ACS him/herself, in the exclusive context of the ESF and without articulation from other services of the RAS.

As we have discussed, the concept of the ESF emphasizes work as a team as a way of articulating different knowledge and practices in production of healthcare. This is to state that the work of the ACS (or of any other professional in the ESF) in isolation will not succeed in covering the whole of the complexity of the questions that emerge in the daily work. In spite of this, the ACSs who participated in our study deny value to their practice

by evaluating their actions in an isolated manner, presenting an expectation of immediate capacity to solve problems that is hardly in line with the complexity of the cases dealt with, and which leaves out of account the various dialog resources used by them in care for the community<sup>24</sup>. Based on a criterion of assessment that considers the result of the process of care as an objective product, absence of attribution of value to their practice clearly prevails – this practice which is traversed by so many aspects that interact with it (both in the relationship with other professionals in the ESF itself, and in the relationship with other services and instances that make up the RAS).

Another factor that complements this discussion is the strong hierarchy that is present in the professional categories, which has been indicated as a prejudicial factor in the literature<sup>15,16</sup> and also in the reports of the ACSs in this study. An organization of the family health units that gives value to the different knowledges and practices involved in the diversity of functions carried out is a fundamental aspect. Such organization can be important for the ACSs that perceive themselves as important in the teamwork, perceiving their function as central to the good functioning of the ESF – not as a mere transmitter of information to the higher-level professionals, but because of the qualities inherent in their activity itself (such as local knowledge, capacity for dialog, and acceptance). Thus, the way in which the work team itself builds its practice in the daily work, often sustaining distinctions between which actions are more or less important in relation to the community, to the detriment of a global vision of healthcare offered by the group of the profes-

sionals, contributes to less value being given to the ACSs. On the contrary, recognition by the team in relation to the work of the ACSs can help to build attribution of value to ACSs in the daily routine, above all helping the ACSs in development of resources to deal with the population's demand for capacity to resolve problems immediately. If the unit organizes itself horizontally, and there is communication between the team, as discussed by Peres et al.<sup>15</sup>, the logic of healthcare in a biopsychosocial health model can become clearer, too, for the population, and the practice of the ACSs can be carried out with emphasis on their resources for strengthening of links and a close relationship with the community, while at the same time recognizing the functions and limitations of their practice. On this aspect, it is fundamental to consider that the demand for capacity to resolve health problems immediately is characteristic of the change in the healthcare model, but tends to dilute as the community, with the help of the health teams, acquires a broader understanding of the concept of Primary Healthcare and its role in the coordination of the Healthcare Network and in the organization of the SUS.

We hope that this present study, by giving visibility to the ACS's making of meanings, in their discursive practices, in relation to the degree of recognition (or otherwise) given to them, can contribute to reflection on the construction of the Family Health Strategy, thus helping to strengthen Primary Healthcare as a public health policy that is being built, in day-to-day practice, on the tense relationship between meanings and practices.

## Collaborations

C Guanaes- Lorenzi participated in all text development steps, including its design, data analysis and writing, having guided the research project that gave rise to the same. RL Pinheiro conducted field research (data collection and analysis) and collaborated in the design and revision of Article.

## Acknowledgment

To Fundação de Amparo à Pesquisa do Estado de São Paulo (Fapesp) for financial support.

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Article submitted 27/09/2015

Approved 23/11/2015

Final version submitted 25/11/2015