Community workers in Primary Health Care in Brazil: an inventory of achievements and challenges

Os agentes comunitários na Atenção Primária à Saúde no Brasil: inventário de conquistas e desafios

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ABSTRACT The article analyzed the construction of the profile of professionals internationally known as Community Health Workers, supported in the discussion about the disputes surrounding their work. Health policy documents were examined, with emphasis on the inflections produced on their attributions and professional training. It was sought to comprehend the rationality and the arguments that sustain the changes induced by the policies and their possible results on the practices. It was identified that this work has assumed conformations increasingly close to health education in a biomedical aspect, aggravated by management mechanisms that promote its fragmentation and simplification. There was no progress in the implementation of the Technical Course of Community Health Worker and, in parallel, short qualifications have been introduced and driven by specific demands. It is understood that the policies directed to this worker are guided by a short-term perspective and express, in the current Brazilian context, the very weakening of the Unified Health System. It is observed the reduction of the role of the Community Health Worker in the consolidation of strategies that could contribute to implement Primary Health Care as a space for strengthening universality and integrality.

KEYWORDS Community Health Workers. Primary Health Care. Family health. Health policy.

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RESUMO *O artigo analisou a construção do perfil de atuação profissional dos Agentes Comunitários de Saúde – conhecidos internacionalmente como Community Health Workers –, apoiado na discussão sobre as disputas em torno do seu trabalho. Foram examinados documentos das políticas de saúde, com destaque para as inflexões produzidas sobre suas atribuições e formação profissional. Buscou-se compreender a racionalidade e os argumentos que sustentam as alterações induzidas pelas políticas e seus possíveis resultados sobre as práticas. Identificou-se que esse trabalho tem assumido conformações crescentemente próximas da educação para a saúde em uma vertente biomédica, agravada por mecanismos de gestão que promovem sua fragmentação e simplificação. Não houve avanço na implementação do Curso Técnico de Agente Comunitário de Saúde e, em paralelo, vêm se instituindo qualificações breves e impulsionadas por demandas pontuais. Entende-se que as políticas dirigidas a esse trabalhador se orientam por uma perspectiva de curto prazo e expressam, no contexto brasileiro atual, o próprio enfraquecimento do Sistema Único de Saúde. Observa-se a redução do papel do Agente Comunitário*

de Saúde na consolidação de estratégias que poderiam contribuir para concretizar a Atenção Primária à Saúde como espaço de fortalecimento da universalidade e da integralidade.

PALAVRAS-CHAVE Agentes Comunitários de Saúde. Atenção Primária à Saúde. Saúde da família. Política de saúde.

Introduction

The Community Health Workers (CHA) totaled, in August 2018, 263.756 workers, who were present in 98% of the Brazilian municipalities, integrating the Family Health Strategy (FHS)[1] teams. Established in the Unified Health System (SUS) in 1991, through the Program of Community Health Workers (Pacs), they have contributed to the extension of coverage and structuring of Primary Health Care (PHC) in the Country.

Since previous experiences to the Pacs, it has prevailed, as a central element of the CHA's work, the articulation between the health services and life in the territory, based on the understanding of the social determinants of the health-disease process and the need to conjugate care actions, prevention and health promotion. Over the 27 years of its trajectory in the SUS, important indicators of the profile of the category have changed, particularly schooling. In the first decade of implementation of the Pacs/Family Health Program (FHP), the requirement of schooling was restricted to 'knowing how to read and write'. Since Law nº 10.507/2002[2], it was necessary to require elementary education. In that context, only 18.2% of the CHA had completed Secondary School (SS); and 0.6%, Higher Education (HE). Currently, data from the research of Pinto, Medina and Pereira et al.[3] present a picture with significant changes: 70.97% of the workers have complete SS, and 12.71%, the complete HE.

Considering that many CHA complemented their education after entering the profession, it is concluded that the work boosts the continuity of the studies. Health education predominates, with 30.5% of the CHA studied trained as auxiliaries and nursing technicians. This information reflects the inclusion of the CHA in the classes of the Professionalization Project of Nursing Workers (Profae). In addition, nursing is a professional group that, in its daily life in the FHS, maintains strong links with the activities of the CHA[4].

As for higher level courses, besides nursing, social services and psychology stand out, also linked to community demands and important for intersubjective work, which characterizes the educational actions carried out by the CHA. It is clear that there is a yearning for professionalization that did not find space to be effective through specific training, as proposed by the Curricular Framework of the Technical Course of Community Health Worker, published in 2004[5].

Modifications concerning the form of hiring and admission to work point to less vulnerable conditions. Among the most stable contractors, we have the statutory CHA that add 55.53%, and the public employees via CLT with 26.33%. Admission to work

is mainly through a public tender (54.02%), followed by public selection (39.56%). However, there is a disproportionate situation in the Southeast, where the statutory percentage is 22.54%, and the public-sector employees is 27.23%3, a worrying fact due to the presence of important Brazilian capitals, mainly São Paulo and Rio de Janeiro, in which outsourcing is predominantly intermediated by Social Organizations (SO).

Despite these important changes, many conditions have remained: it is a category predominantly composed of women residing in the area in which they work, with a workload of 40 hours per week. The Home Visit (HV) continues as the activity that the CHA assigns greater importance and that composes their work routine[3,6].

The fact that there is a defined day in the National Primary Care Policy (PNAB)[7,8,9] and control mechanisms, such as punching the card, does not elide the problem of these workers working beyond their hours. At least three factors combine, to increase working time: housing in the community, the need to demonstrate availability as a way of legitimating the residents, and the difficulty of access to health services, especially aggravated in the second shift of operation of basic units. There is a fourth element that concerns the logic of management of services, based on the measurement of productivity that implies the monthly reach of a certain number of families visited. When a property is closed during the day, there are reports of CHA who make the visit at night to find the residents.

A first moment of reconfiguration of the work of CHA was its insertion in the FHP, when it became part of a multiprofessional team. More recently, the increasing incorporation of new models of service and work management in PHC have been the main vector of changes in their work.

The analysis of these modifications covers several aspects. We highlight the effects on the conditions in which the worker acts, the rights associated with work and the contributions to the process of health care and realization of SUS principles. Here, we will consider the work of the CHA as a sensitive indicator of the disputes that arise in the field of PHC regarding the way of understanding the health-disease process; which is the object of health care; definition of the scope and coverage of services and actions; as well as the configuration of the practices and the work process.

In this article, we reflect on the changes that have been made in this work, relating them to important points of PNAB inflection around the care model and the effects projected in the configuration of the PHC. This is a necessary reflection particularly at the moment they are in progress: the implementation of a new PNAB and changes in the regulation of the work of the CHA and its formation, in a context of deepening the dismantling of the SUS as a public and universal system.

The CHA in the Family Health Strategy: a plot of achievements, losses and challenges

Health workers were initially responsible for the development of health activities considered to be of low complexity and high impact, such as oral rehydration therapy, stimulation to vaccination and breastfeeding, as well as the monitoring of pregnant women and the growth of children, reaching significant improvements in indicators such as maternal and child morbidity and mortality.

A considerable change in the work of the CHA is when this worker joins a multiprofessional team and his/her performance is addressed to the needs of the work organization, based on the dynamics of health care units, in which medical, nursing

consultations and dental care predominate, when there is one. In a complementary plan, there are the procedures performed by nursing and oral health technicians and auxiliaries. It is in this context that their role as mediator between services, health professionals and the inhabitants of the territories is exalted, and the reference to CHA as a link between services and the community becomes an idea that, although vague, is propagated as a synthesis of their role in SUS, converging with most of the international profiles of the community health worker[10].

Nowadays, instead of witnessing a greater integration of their attributions with those of the health teams, we observe the progressive dependence of the CHA before the work process designed for these teams, whose objectives are increasingly submitted to the logic of monitoring results and productivity indicators.

In the CHA routine, the predominant activity is the HV, which consists of monitoring the health conditions of the families of their micro-area and the active pursuit of specific situations. In the HV, the workers register the members of the family (condition for access to the units), carry out different orientations, inform about the dynamics of the functioning of the services, among other actions. The HVs are the main expression of the presence of the CHA in the territory.

In these encounters with the residents, the CHA identify health situations, often not manifested as demands, that only come to express themselves to the health system through the action of the CHA. Although this is an object of criticism to the medicalization promoted by the FHS[11], we assume that reducing or reversing this possible medicalization depends on the investment in formative processes that can problematize this question, as well as on the preservation of the spaces of discussion of the work process of the teams.

Within the units, CHA support collective activities associated with traditional health programs, such as hypertensive groups, as well as other activities related to health promotion, such as physical education. They should also participate in team meetings and with the Family Health Support Center (Nasf). Another activity assigned to CHA in the unit is the reception, that is, he/she has been the first person to receive, listen and interpret the needs of the users.

The heavy workload of the CHA has been focused on carrying out activities that reflect a more limited scope and have a greater interface with supporting and bureaucratic tasks. To illustrate them, we mention: the separation of the user's files/promptuaries, the annotation of the weight in collective consultations, the organization of physical spaces for the activities, the orientation of queues and even the cleaning activities. These activities were repeatedly observed in the research 'Working Process of Health Technicians in the perspective of knowledge, practices and competences'[6].

The activities carried out in the units also unfold in bureaucratic activities in the territory, such as the delivery of results of tests, Dental-kit and appointments. This set of actions, associated with those related to the production and recording of information, has been growing and concurred with the availability of the most elaborate health education work in the territory. It commits the time and direction given to activities in the community. The HVs, for example, tend to be brief and simplified, with a predominance of actions that can be more easily quantifiable, to the detriment of subjective interaction with the residents. Social mobilization and intersectoral action, which require discussion, planning and dialogue with people and institutions, are also relegated to the background, waiting for an opportunity to be inserted in the agenda, which is rarely confirmed[12].

Between policy and regulation, the professionalization of the CHA

In relation to entering a sphere of formalization, the achievements in the legislative sphere that create the profession of CHA are highlighted and are regulated by them[2,13] (Laws nº 10.507/2002 and 11.350/2006). Such position is confirmed, from the PNAB 2006, by the definition of specific attributions for this worker. There is a displacement process of the CHA from a situation of informality to integration in the social relations pertinent to a SUS worker. Conditions are created for the organization and for the collective struggles that have resulted in important advances, such as the increasing deprecarization of the contracting ways and the institution of the national minimum wage for the category. We can also state that CHA are and recognize themselves as a political force with national participation[14].

Vocational training represented, at a certain point, a space for advancement that was not confirmed. The preparation for work, initially without defined parameters, has a trajectory that includes the introductory course, of workload and varied contents and the qualification in service, with the participation of the oldest nurses and CHA. These short and intermittent forms of qualification arise as an alternative to the permanent demand for services by more professionals with conditions to make their innumerable activities viable[15]. Thus, they are taken as an immediate solution, but, in the medium term, they become a problem, as none of them converge to a de facto professionalization, nor does it promote consistent training.

The publication of the Curricular Frameworks of the Technical Course of Community Health Worker, in 2004[5], has contributed to the fact that technical training would represent a potentially consistent path to ally work and education, in a context of appreciation of both. This formation has become a reality in few municipalities, having not reached the great majority of the CHA. Therefore, it means more an expectation than an advance as such[4].

The deprecarization process of the bonds gained momentum with Law nº 11.350/2006 which determined the direct hiring of these workers by related institutions "bodies or entities of the direct, autarchic or foundational administration"[13(1)]. In many municipalities, the CHA began to be hired as statutory or public employees, through the Consolidation of Labor Laws (CLT)[3]. Although the percentage of CHA with precarious ties has diminished, concern remains due to the importance of outsourcing in large urban centers, and the recent modification of labor legislation that strengthens this type of linkage and points to the reduction of rights and the increase of insecurity in the job. Added to this scenario are the modifications designed for Primary Care (PC) in the PNAB 2017[9,16].

The wage floor has not been implemented in all municipalities and remains as strategic guideline for the organized movement of these workers. This problem is related to the financial constraints that affect municipalities and tend to expand in the context of Constitutional Amendment 95 which freezes the public budget for 20 years.

Municipal managers repeatedly argued that the Fiscal Responsibility Law was an obstacle to the deprecarization of the bonds, to the implementation of technical training – which was supposed to be associated with salary increase – and to the institution of the category floor. As for linkages, these arguments have diversified. The concern with the payroll has lost its position in view of the possible advantages that flexible contracts bring to management[17].

In the case of obstacles put in the way to the achievement of technical training, one

cannot ignore the influence of a conception that values the subjective attributes, connected to the community origin of the CHA, and considers that this formation could produce a distance between this worker and the reality of the people of your community. This argument, reiterated for many years, today, has lost momentum. The increase in general education of the category mentioned here, on the one hand, contributes to demystify this argument against the vocational training of the CHA, but, on the other, it brings a new problem. It is noticed that many CHA have already pursued their own path of professionalization, including higher level, further weakening the project of own formation, represented by the Technical Course of Community Health Worker.

The technical training proposal of the CHA, which did not obtain the endorsement of the Tripartite Interagency Committee (TIC), gradually lost importance in the agenda of the Ministry of Health (MH) and always occupied a subordinate position, on the agenda of the organized movement of workers, in view of the urgencies regarding salary and bonds.

Regarding the attributions of the CHA, normative documents of national scope – programs, ordinances, decrees and laws – have dealt with its definition. The following stand out: Ordinance nº 1.886 of the MH, published in 1997[18], Decree nº 3.189, of 1999[19], Law nº 10.507, of 2002[2], and Law nº 11.350, of 2006[13]. Since 2006, the configuration of the work of the CHA become object of the definitions established in the National Policies of Primary Care of 2006[7], 2011[8] and 2017[9].

Until 2006, in the normative documents, the attributions of the CHA emphasized the educational nature of the work, with activities of orientation and accompaniment of the families and of specific groups, of social mobilization, intersectorial articulation and information production. The locus of priority action was the territory, and the home visit was the main strategy. Two perspectives of educational work coexisted: one, based on the conception of health education, strongly limited by biomedical parameters, aimed at the dissemination of healthy behaviors; and another, more extensive, linked to social participation, implying political mobilization and assuming as a work horizon to intervene in the social determination of the health-disease process[20].

From the publication of the first PNAB, a redirection in the guidelines of the work is made explicit. The actions of education that are presented as means to carry out other main activities of promotion, prevention and surveillance lose their centrality. In 2011, with the second edition of PNAB[8], this tendency is accentuated. In exemplifying the educational activities carried out by the CHA, the text of the policy mentions only diseases, and associates them with the prevention and control of risks.

The activities of the CHA that focus on popular participation are excluded from the PNAB texts and, with them, the expression 'quality of life', which is so expensive in the field of health promotion, is also suppressed.

Although published in the same year as the 2006 PNAB, Law nº 11.350 assumes a broader perspective on the role of the CHA. This difference is based on the participation of the organized movement of the workers in its formulation, especially the National Confederation of Community Health Workers (Conacs), and the support of the Work and Health Management Secretariat (SGTES) of the MH, whose political agenda turns toward, at that time, the strengthening of workers and the valorization of public management in SUS[4].

The political substratum of the work of the CHA is progressively weakened in policy documents. The term 'political' itself disappears from the definition of its attributions in the 2006 and 2011 PNABs. Once again, Law nº 11.350 represents a counterpoint, establishing activities of 'encouraging

community participation in public health policies'[13(1)] and the participation of this worker in "actions that strengthen the bonds between the health sector and other policies that promote the quality of life"[13(1)].

Although they do not suppress the term 'community', PNABs use it less frequently and restrict its meaning to the place of promotion and prevention activities – 'in the community'. Previously, 'community' indicated the subject of political participation that the work of the CHA should promote[4].

The demographic and socio-cultural diagnosis of the community is no longer attributed to the CHA, as well as actions aimed at strengthening the relationship between the health sector and other areas of public policies. It is not a matter of verifying punctual losses, but of characterizing the change of meaning that is produced around the work of the CHA. The commitment to fragmented activities, such as 'registering all the people in their micro-area and keeping the registers up to date', is consolidated. The transition from an activity with a broad and complex scope (diagnosis production) to a predominantly operational task (registration) is characterized. Studies developed within the scope of the National Program for Improving Access and Quality of Primary Care (PMAQ) warn of negligence with the socio-cultural context in the production of the mapping of territories[21].

This change of direction is redefining not only the scope of CHA practices, but also the meaning of the territory for its work. By allowing CHA to carry out activities within the unit, PNAB 2006[7] legitimizes the displacement of its work axis from the territory to the institution. Working time in the territory is doubly affected: on the one hand there is a subtraction to carry out the tasks in the unit; on the other, it is gradually oriented by objectives with very punctual cuttings. The work begins to organize from a rationality that serves very specific purposes, whose links refer more strongly to the managerial logic, to the detriment of structuring principles of the FHS, that point us the territory as a space of relations in multiple dimensions and not the reduce the place of health intervention[4].

Developing some of the work in the unit is not, in itself, a problem. This could be an opportunity for integration of the CHA in the technical team, since the multiprofessional work has the articulation as a requirement. However, it is the nature of the activities that have been attributed to the CHA within the units that underlines the need for criticism regarding the way this work process has been transformed. In general, the CHA is in charge of performing tasks that approach a generic auxiliary of the other professionals. Sometimes these actions can be performed to fill the absence of other workers or be incorporated into the dynamics of work organization.

It is verified a transition of the work direction of the CHA. Previously, a specific purpose was identified, focused on health education, and a role of articulation with the actions developed by the services. Today, this work tends to be characterized as a medium, instrumental and utilitarian activity, more committed to immediate objectives than structuring a new model of attention.

The problems aggravated by the new management models

Several inflections in the work of CHA result from the adoption, in the public sector, of logic, practices and instruments based on New Public Management (NGP), originally designed for private sector management. In health, the implementation of NGP promotes the restructuring of the work process, directing it to reach goals whose design allows the measurement of measurable results; instituting instruments of control;

and constructing forms of contracting between the public and private sectors for the provision of services[22].

PHC is not exempt from this rationality which is made possible through management mechanisms that are inserted in the evaluation logic, but are limited to monitoring practices. Results, indicators and goals become components that organize the reflection on what has value in the work and are integrated to the vocabulary that mediates the professional interactions. This management concept includes the adoption of financial incentives, with predictions of differentiated remuneration, for professionals, teams, services and, even, intermediate levels of management, depending on the productivity achieved.

This logic requires the distinction of events on which cause and effect relationships apply and for which quantitatively measurable activities can be directed. To reinforce them, management establishes stimulus, control and collection mechanisms that privilege them. It was in this way that 'care lines' achieved priority status, in an explicit relationship with disease prevention: cancer, diabetes, hypertension care line, for example.

The quantitative measurement requires an important degree of division of activities and gives a fragmented recognition of the work, with the resultant allocation of installments to each of the professionals. This elaboration about work and management has a very harmful effect on the CHA, since their work is already treated as less complex and more diffuse, being more permeable to the varied demands of the services. The main effects of this process are the simplification of its attributions and the reinforcement of polyvalence. Such combination is supported by occasional qualifications often driven by health emegencies[4], whose logic is based on the instrumentalization of knowledge and not on the construction of solid knowledge to support professional practice.

The increased disqualification of the work of CHA deepens in the same proportion in which the predominance of biomedical rationality is resumed. Health education actions are particularly sensitive to this type of inflection and increasingly tend to become health education actions. Not only the time, but also the energy of the CHA come to be disputed by two logics: one that values the educational work itself and the other that circumscribes the condition of access to the territory and the achievement of goals.

Regarding the bonds, despite the advance of regular contracts, the outsourcing of management has been confirmed as a trend in some capitals, mainly through the hiring of SO[3]. Although minorities in relation to the total of Brazilian municipalities, Rio de Janeiro, São Paulo, Salvador and Porto Alegre are examples of this trend, which, due to their political and economic importance, must be observed with attention. This reality makes it difficult to generalize what is provided for in Law nº 11.350 for the hiring of CHA: directly by public entities, either as statutory employees or as public employees, via CLT.

Recent changes in the work and training of the CHA: PNAB 2017, Law nº 13.595/2018 and Ordinance nº 83/2018

In mid-2017 and early 2018, three documents made significant changes to the attributions and training of the CHA: PNAB 2017[9], Ordinance nº 83/2018[23] of the MH which deals with the technical training in nursing of health workers, and Law nº 13.595, of 2018[24] – Ruth Brilhante Law, which modified Law nº 11.350/2006[13]. By analyzing these documents together and the arguments that sustain them, we perceive the influence of two force-ideas publicly conveyed

by managers of the SUS, especially in the scope of the MH, at least since 2016, when the VII National Forum for the Management of Primary Care occurred. Such ideas can be summarized as follows: 1) the CHA is not a necessary worker in all contexts; 2) the CHA is little resolutive.

The changes promoted by each document in line with these strength ideas-force are the follows:

1) The CHA is not a necessary worker in all contexts – the non-definition, in the PNAB 2017, of the minimum number of CHA per family health team and the prediction of federal funding for PC teams that do not include CHA in their minimum composition; the presidential veto to Law nº 13.595[24], in the item that defined the mandatory presence of the CHAs in the PC structure;

2) The CHA is little resolutive – the inclusion, by PNAB 2017, of typical nursing activities in the list of attributions of the CHA (blood pressure measurement, capillary blood glucose measurement, axillary temperature gauging and accomplishment of clean dressing techniques); the publication of the Training Program in Nursing for Healthcare Workers (Profags), instituting technical training in nursing for community health workers and endemic agents, according to the provisions of Ordinance nº 83/2018 of the MH[23]; the presidential vetoes filed against Law nº 13.595 of 2018[24], in the items that demarcated specific assignments of the CHA and Endemic Diseases Combat Agents (ACE), and regarding the offer of technical training in CHA.

The second idea is directly linked to the first one, assuming that, in order to remain relevant, the CHA must assume attributions of the clinical field, characteristics of the follow-up of chronic health conditions and simplified procedures. This question refers to the delimitation of the scope of practices among professionals, more specifically of the CHA in relation to the nursing category and evidences conflicts that cannot be disregarded.

Before it can be concluded that the CHA has become dispensable or de-characterized as a community worker, this set of concerns should lead us to dialogue with structuring principles of the reformulation of the health care model. The idea of a not decisive CHA evokes a notion of resolutivity still supported by a narrow conception of the clinic, in which effectiveness depends on assistance in its narrowest sense, materialized in simplified procedures, as is characteristic of the profile of the community worker in countries of the Africa, for example[25]. This is to the detriment of the perspective of integral care and understanding of the health-disease process as an expression of social determinations.

Compromising on the presence of CHA in the teams indicates a regressive movement in relation to the horizon of transformation of the care model, associated with an increase in access to health, aiming at its universalization. As for the model, the FHS has represented the commitment to a health care oriented by the conjugation between health needs, territorialization, clientele assignment, bonding, sanitary responsibility and person centered care. In a context in which PNAB admits the composition of teams with a reduced number of CHA (or even without them), it eases the coverage and segments the health system by the differentiation of service provision patterns (essential and expanded), the conception of selective PHC is strengthened. Simultaneously, the perspective of replacing the care model and network ordering from PC is weakened, recovering the traditional modality of basic health services, structured according to the logic of 'complaint-behaviour'.

Assuming that the resolutivity of CHA depends on the incorporation of clinical practices leads us to a reflection that evidently is not restricted to this professional, but it covers the health system. Although it is true to say that a shift of hospital-centered attention to PHC has been achieved, the same cannot be said for the structuring of work, which remains strongly guided by biomedical rationality. With the critique of the limits of this model in the production of better levels of quality of life being sustained, it is asked if it would not be appropriate to reinvest in the potential of the CHA to bring, for health care, practices that value the various dimensions conditioning the health-disease process. This perspective imposes ideas consistent with the profile of a community worker prepared to act in health promotion, support the expanded clinic and subsidize popular organization and participation.

Such ideas combine with the question of the formation of CHA. Ordinance nº 83, of January 2018[23], when establishing a technical training program in nursing for 250 thousand CHA and ACE, puts into practice what appears to be a large-scale transformation of CHA into nursing technicians, disregarding the existence of the Curricular Framework for the Technical Course of Community Health Worker that the MH itself published in partnership with the Ministry of Education (MEC)[5]. The distortions involved in this transformation are clearer when comparing the completion profile of the respective technical courses[20].

Chart 1. Profiles of completion of the Technical Courses of Community Health and Nursing Worker, according to the National Catalog of Technical Courses/MEC, 2016

Course	Completion profile
CHA Technician	Guides and accompanies families and groups in their homes. Identifies and intervenes in the multiple determinants and conditioners of the health and disease process, in order to promote health and reduction of risks to the health of the collectivity. Carries out mapping and registration of social, demographic and health data. Develops its activities guided by the guidelines, principles and organizational structure of the Unified Health System. Promotes communication among multidisciplinary team, health unit, authorities and community.
Nursing Technician	Performs dressings, administration of medications and vaccines, nebulizations, bed bath, anthropometric measurement and verification of vital signs. Assists in the promotion, prevention, recovery and rehabilitation in the health-disease process. Prepares the patient for health procedures. Provides nursing care to clinically and surgically ill patients. Applies biosafety standards.

Source: National Catalog of Technical Courses[23].

The Technical Course of Community Health Worker is based on a profile of complex activities, located at the interface between the social area – with emphasis on education and communication – and clinical/epidemiology. From the point of view of knowledge and the political perspective, it requires an understanding of the social determinants and dynamics of life production and of the specific health problems of the territories, as well as the development of the capacity to articulate with health institutions and other sectors. It has an interface with the clinic, but the directionality of prevention and health promotion predominates[4,20].

The Nursing Technician Course[26] is based on a profile of activities related to clinical care, with emphasis on nursing practices. From a knowledge point of view, it requires the understanding of health care, aiming at mastering techniques of support, preparation and follow-up of diagnostic, treatment and rehabilitation procedures[4,20].

In view of this new profile, the condition of a community resident, required to the CHA and maintained in the normative documents analyzed, seems to be restricted to the institutional interest of having a worker able to move in the territories and to access the homes. This is to the detriment of valuing their power to understand the dynamics of life in these territories and to place this knowledge in articulation with the needs of the people/collectivity, raising the potential of action of the services.

The choice for nursing training indicates the purpose of increasing the participation, in PC, of the professional profile and the scope of clinic-based practices, with assistance nature. It has, therefore, the ability to negatively impact the still fragile process of implementing a new model of care, and not only the work of CHA.

In addition to these changes, PNAB 2017[9] defines common attributions between CHA and ACE, justified by the need to integrate surveillance to health care. Some arguments point out by the MH itself refer to the possibility of making more rational use of the presence of workers in the territory. The imminent risk is that one worker is overburdened by the work of the other and a probable decrease of working places. Faced with a nursing training program, funding by the MH, this risk appears to be compounded by the 'creation' of a worker over who three scopes of practice will emerge: the ACS, the ACE, and the nursing technician.

Such expressions of the current government policy in the field of health, both PNAB 2017 and Profags, have been contested by several important collective political subjects in the scenario of the SUS, with emphasis on the National Health Council. This participatory body that assembles party representations of management and users and mobilizes national entities, academic institutions and workers have rejected the intended changes. In its diagnosis, the SUS itself is in danger of being unfeasible, and the measures on screen are added to others aligned with the privatistic interests. At the present time, the public notice of Profags was suspended by the MH. In addition to the proposal of impugnation presented by a private entity, it is accepted the hypothesis that this suspension is due also to the contrary reactions and the most recent cuts in the funding of the SUS.

Law nº 13.595[24] also has controversial issues, but coming from the organized movement of the CHA, especially Conacs, it gets a good accession of the workers. It is justified as a reaction to measures that put the CHA and its attributions in check, anticipating the proposition of changes on which they have the greatest agreement. The presidential vetoes brought against the referred Law were partially withdrawn, in response to the struggle of the workers. Among the vetoes highlighted in this text, it was maintained what refers to the mandatory provision of technical training in CHA by the federated entities. The maintenance of this veto emphasizes how specific training of workers represents a threat to management, perhaps because it condenses the possibilities of configuration of a professional, community-based profile, with greater autonomy and resilience to measures, sometimes authoritarian and distanced of a health project as universal and integral right.

Final considerations

The presence of CHAs in the most different contexts already achieved by the FHS and to which it is still intended, as well as the nature

of its work, is at risk and finds in PNAB 2017 the most forceful expression of a crisis. The analysis of this question cannot be made lightly, under the urgency that a restrictive context imposes. It is understood here that it is always necessary to recover the perspective of universality and integrality as ethical principles that mark the reflection and the proposition of directions.

Assuming health education as the main focus of the work of CHA and commitment to a strong PHC, the need to produce public policies aimed at qualifying this work is reaffirmed in order to take into account the different configurations of life and social relations, in the various territories and contexts in which the health-disease process is constructed and expressed.

A necessary path for this future construction is the resumption of the technical training of the CHA. Assuming it as a process that needs to be fully implemented and offered to all CHA is a condition for strengthening national parameters for their training and professionalization.

On the contrary, what has prevailed for the workers is the delineation, by the daily work, of an activity profile submitted to a utilitarian logic, through which fragmentation is combined with the simplification and intensification of work. These configurations of the work have been strengthened by management models focused on the achievement of goals and that work in a way that is more in harmony with the biomedical rationality, in which emancipatory health education is displaced by health education. One of the direct implications of this configuration of the work of the CHA is the danger of it becoming, in the territory, an advanced instrument of an action with markedly medicalizing traits, with a questionable impact on the quality of life of the population.

The notion of resolutivity from which the work of the CHA has been disqualified deserves a critical reflection. Confirming accession to the understanding of the health-disease process as relative to the multiple dimensions of human life, with individual and collective expressions, the notion of resolutivity that guides the guidelines of the PC must express this understanding. Thereby, it does not dissociate itself from the perspective of a strong PHC, conceived as the gateway and organizing axis of care, articulated with a service network that allows access to other levels of care. This has proved to be a critical node for both the work of the CHA and the FHS teams.

It is important that the reflection on these issues be inserted in a larger context of analysis and discussion of the work process of the FHS teams, the attributions of its members and the institutional arrangements that support it, in particular the Nasf, considering the need to articulate the perspective of expansion of coverage to the perspective of reconfiguration of the care model.

In a democratic environment that values popular participation, the construction of an agenda of confrontations related to the work field of the CHA requires construction in dialogue with the workers. One could not think differently, especially in the face of a highly organized professional category, though dispersed and pressured by the conjuncture of threats that affect all workers and affect social rights in general.

Collaborators

Morosini MV and Fonseca AF contributed to the conception, elaboration and writing. ■

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