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Approaches to vicissitudes and overcoming of the work of the Community Health Agent.

Aproximações às vicissitudes e superações do trabalho do Agente Comunitário de Saúde.

Enfoques a los problemas y la superación del trabajo del Agente Comunitario de Salud.

Luciana Nogueira Fioroni [1]

ABSTRACT: The care model of the Family Health Strategy based on the role of the Community Health Agent (CHA) challenges to reflect on the working conditions and the health of this worker. The various sources of attrition and suffering at work and the lack of support methods in everyday life are highlighted. Considering this fragility, the work of 8 community health agents from the Focal Group Technique was investigated, seeking to know and analyze the sources and types of overloads arising from the work activity, the working conditions, the employment relationship, the training and the attributions of this worker in the Family Health Strategy. The corpus of analysis consisted of the transcription of six focal group sessions. The Results produced seven sense nuclei, organized from four thematic axes: Vitamins (motivations to exercise their professional role), Thorns (difficulties to perform work), Fruits (observed and valued results from work) and Tools (instruments used). The relevance of stability was emphasized; the greater recognition of the use of light technologies (affective bonding) than the technical success of the work, which is linked to a secondary action of the CHA, subordinated to the medical procedure; the double bond with the community (resident and reference professional) stresses the identity of the CHA. The identification of the sources of suffering made it possible to locally problematize the effects on the mental health of the worker and the quality of the work performed. The potential of the Focus Group as a strategy for research and intervention in basic care is confirmed.
Keywords: Health of the worker; Focus groups; Community health agents

RESUMO : O modelo de cuidado da Estratégia de Saúde da Família pautado no papel do Agente Comunitário de Saúde (ACS) desafia a refletir sobre as condições de trabalho e sobre a saúde desse trabalhador. Destacam-se as diversas fontes de desgaste e sofrimento no trabalho e a insuficiência

1 Departamento de Psicologia - Universidade Federal de São Carlos. UFSCar. Brasil

de métodos de apoio no cotidiano. Considerando essa fragilidade, investigou-se o trabalho de 8 agentes comunitários de saúde a partir da Técnica de Grupo Focal, buscando conhecer e analisar as fontes e os tipos de sobrecargas provenientes da atividade laboral, as condições de trabalho, o vínculo empregatício, a formação e as atribuições desse trabalhador na Estratégia de Saúde da Família. O corpus de análise consistiu na transcrição de seis sessões de grupo focal. Os Resultados produziram sete núcleos de sentidos, organizados a partir de quatro eixos temáticos: Vitaminas (motivações para exercer seu papel profissional), Espinhos (dificuldades para exercer o trabalho), Frutos (resultados observados e valorizados decorrentes do trabalho) e Ferramentas (instrumentais utilizados). Destacaram-se a relevância da estabilidade; o maior reconhecimento do uso de tecnologias leves (vínculo afetivo) do que o êxito técnico do trabalho, que está vinculado a uma ação secundária do ACS, subordinada ao procedimento médico; o duplo vínculo com a comunidade (morador e profissional de referência) tensiona a identidade do ACS. A identificação das fontes de sofrimento possibilitou problematizar localmente os efeitos para a saúde mental do trabalhador e para a qualidade do trabalho realizado. Ratificam-se as potencialidades do Grupo Focal como estratégia de investigação e intervenção na atenção básica.
Palavras-chave: Saúde do trabalhador; Grupos focais; Agentes comunitários de saúde

RESUMEN: El modelo de cuidado de la Estrategia de Salud de la Familia pautado en el papel del Agente Comunitario de Salud (ACS), desafía a reflexionar sobre las condiciones de trabajo y la salud de este trabajador. Se destacan las diversas fuentes de desgaste y sufrimiento en el trabajo y la insuficiencia de métodos de apoyo en el cotidiano. En esta fragilidad, investigamos el trabajo de 8 agentes comunitarios de salud a partir de la Técnica de Grupo Focal, buscando conocer y analizar las fuentes y tipos de sobrecargas provenientes de la actividad laboral, las condiciones de trabajo, el vínculo laboral, la formación y las atribuciones de este trabajador en la Estrategia de Salud de la Familia. El corpus de análisis consistió en la transcripción de seis sesiones de grupo focal. Los resultados produjeron siete núcleos de sentidos organizados a partir de cuatro ejes temáticos: Vitaminas (motivaciones para ejercer su papel profesional), Espinas (dificultades para ejercer el trabajo), Frutos (resultados observados y valorizados derivados del trabajo) y Herramientas (instrumentales utilizados) . Se destacó la relevancia de la estabilidad; el mayor reconocimiento del uso de tecnologías ligeras (vínculo afectivo) que el éxito técnico del trabajo, que está vinculado a una acción secundaria del ACS subordinada al procedimiento médico; el doble vínculo con la comunidad (residente y profesional de referencia) tensiona la identidad del ACS. La identificación de las fuentes de sufrimiento posibilitó problematizar localmente los efectos para la salud mental del trabajador y para la calidad del trabajo realizado. Ratificamos las potencialidades del Grupo Focal como estrategia de investigación e intervención en la atención básica.
Palabras clave: Salud Laboral, Grupos Focales; Agentes Comunitarios de Salud

1. INTRODUCTION

This research-intervention is a product of systematization and the conclusion of a training

experience in the Multiprofessional Residency Program in Family and Community Health (PRMSFC-UFSCar), which aimed to investigate the daily work of Community Health Agents (CHA), the recurring wear and overloads (physical, emotional and social), considering its strategic role for the Family Health Strategy (FHS) and the need to produce new forms of intervention, aimed at worker health, in the context of Primary Health Care (PHC). The daily experience of in-service training in the health residency model allowed an approximate and critical look at the work of the CHA, as well as allowing these professionals to seek interlocution and support with residents who performed matrix support for two family health teams in a municipality in the interior of the state of São Paulo.

The FHS foresees a multiprofessional work team – a team of the Family Health Unit (FHU) – consisting of a family physician, nurse, auxiliary or nursing technician, community health agents, dental surgeon and auxiliary and/or technician in Oral Health[1]. The field and the work object of the family health team expand and become more complex, transforming the own territory and the family environment of the user into the workplace. There is, therefore, a need for tools and work strategies that support the actions of this care model, which includes the relationship of the team with the community, social participation and the production of autonomy of the target subjects of care. The FHS has its work organized from the territorial base care and families/households, which presupposes dealing with demands of different natures, developing community diagnostic skills, promotion and prevention actions, individual and collective care[2,3]. In this universe, are highlighted, for our interest, the work of the CHA and the resulting wear and overloads.

Lancman *et al.* [4] point out that the daily contact of the team with the users opens space for decisions in act, context in which, often, the protocols are not enough to plan and execute the integral care. This demands from the professional characteristics and differentiated capacities, that help him/her to deal with the unforeseen and the complexity of this new context, characteristics of the light care technologies[5].

The CHA figure constitutes a key point for the FHS, because of the proximity to the team and the technical knowledge and, at the same time, because of the real link with the community[6,7,8]. Costa and colleagues[9] emphasize the necessary investment that must be made in these actors to exercise their central role in care, in addition to allowing PHC to develop health promotion and education actions. For Lima and Moura[10], the CHA occupies a singular situation, insofar as he/she is valued by the social capital that he/she has, allowing greater knowledge about the health practices of the community, increasing the effectiveness of the care offered and allowing greater trust between the professional team and the user. The work of the CHA is characterized, in large part, using light care technologies, which implies the need for adequate training and follow-up of the work, especially for printing emotional overloads and demanding from the worker internal resources (psychic, affective) that are not possible to develop only with technical capabilities.

According to Law nº 10.507/2002[11], the specific assignments of the CHA are: i) to carry out

periodic home visits (HV) to monitor family risk situations; ii) promote educational actions for individual and collective health; iii) register data and information for the purposes of health action planning and control; iv) register the families and keep the data updated; v) guide the families regarding the use of available health services in the Health Care Network (HCN); vi) develop activities programmed by the team and meet spontaneous demand; vii) stimulate community participation in local public health policies; viii) use instruments for demographic and socio-cultural diagnosis of the community; ix) participate in actions that strengthen the links between the health sector and other policies that promote the quality of life. In addition to the specific assignments, the CHA must also carry out activities common to the FHU team, such as reception.

Faced with the complexity of the task, the training provided to the CHAs does not allow them to have enough tools to deal with the complexity of the daily demands of the work[12,13,14]. The experience of the authors emphasizes that, in addition to the specific and common attributions of the CHA, a situation that can be defined as 'deviation of function' is observed, since the great majority of these professionals assume administrative and reception responsibilities in the unit that are not foreseen in its attributions. It is assumed that, due to the complexity mentioned above, the skills required to the development of the light care technologies, the fragile condition of strategic planning of the family health teams to organize more effectively and effectively the roles, responsibilities and goals of care, to the weaknesses of training and qualification of the CHA, in addition to the precarious work links, devoting more to the administrative functions can be a search for security and more protected spaces of work.

Silva and Dalmaso[15] point to the two dimensions of knowledge that involve the work of CHA: the technique and the policy, paying attention to the fact that the training centers emphasize the technical aspect to the detriment of the politician. They make explicit the fragility of professional training in relation to the skills needed to carry out the work and the lack of preparation for the execution of the political role of this worker, that is entirely linked to the search for better living conditions and citizenship; as well as being the basis for effective social control.

Merhy and Franco[5] point out, beyond the technical knowledge, the importance of knowledge in the scope of the relations to produce care. These, which comprise the light technologies, when predominant in the relations of care, characterize Living Work. The involvement of the professional in an active, present and creative way allows greater appropriation of skills and resources, constituting a source of professional growth and work satisfaction. Health actions centered, hegemonically, on technical procedures, executed in a repetitive way, that do not allow the involvement and the creative participation, characterize the Dead Work – a source conducive to the wear and suffering of the worker.

The CHA training and work model can be a source of wear and suffering, as it does not provide enough instruments to act on the reality experienced. There is lack of guaranteed spaces in the teams for hosting and problematizing the vicissitudes of work. To deal with such gaps, CHA often

relies only on his/her 'know-how', based on their life experiences, common sense, religion, and more rarely with the knowledge and resources of families and communities[9,13,15].

According to Ferreira and collaborators[16], in the daily work, the reality is cut short in the foreground by the affects that occur in various flows of intensity and are formed in the encounter between workers, users and community. Depending on how these encounters happen and are signified by health professionals, they can increase their potential for work or diminish it, generating wear and suffering. Some important studies have been done regarding the mental and physical health of the CHA, evidencing aspects of vulnerability and suffering linked to its practice[4,7,17,18]. Factors identified as possible sources of emotional exhaustion and suffering would be the feelings of impotence faced with precarious situations of the population, the feeling of invisibility in relation to the efforts made, the porosity of the boundaries between professional and personal aspects.

Jardim and Lancman[19] point out, also, that the fact that the CHA resides in the community where he/she works generates an additional source of suffering, as it increases the contact and exposure of the professional, mixing the public/private experience and making possible a possible distancing from the work situations. Martinez and Chaves[17] and Mendes and Ceotto[7] highlight the emotional overload of this worker, due to the numerous complications that exist in the daily life of the profession; it can be seen that, in most FHU teams, there is not enough backing and support for this professional to carry out his/her work.

Such data corroborate what the authors experienced in the PRMSFC-UFSCar in FHUs of a municipality in the interior of the state of São Paulo, observing the wear and complaints of these professionals regarding the development of their own work, which often do not find space and appropriate place to be treated in an extended way, considering the subjectivities and the affections involved. These needs have led to initiatives such as: caring groups of the caregiver, joint home visits (CHAs and residents of different health areas), discussion of cases and joint follow-up following the logic of matrix support in health, in addition to support offered by the residents from the singular and private search that some CHAs addressed them. It is highlighted, also, that, at the time of the study, the municipality had a Health Care School Network, through which undergraduate and postgraduate students (sensu lato – PRMSFC), linked to the university, were organically inserted into the local health services, strengthening and stressing the interprofessional work in health, especially with regard to the PHC matrix support model.

Adequate investment and care for the health worker should be fundamental strategies for strengthening PHC[14,20] and for health care that addresses the complexity of the population-user relations and the reality itself of the services, contributing to a more effective health care and for better working conditions. The objective of this study-intervention was to identify the main needs and workloads of CHAs of two family health teams in the interior of São Paulo, to enable more effective and specific interventions of care to this health worker.

2. DEVELOPMENT

2.1. Method

It is a qualitative investigation designed as a research-action developed from the Exploratory Focal Group technique, a tool that allows us to understand processes of construction of reality by certain social groups, to know the main representations, perceptions, beliefs, languages and symbolisms referring to a given object or phenomenon studied[21]. The moderator-researcher of a focal group should facilitate the process of interaction and discussion of the participants[22].

For this study, the exploratory type of Focus Group was chosen, justified by the interest in producing contents that could support our hypotheses about the work process of the CHA, besides allowing the production of new meanings, identifying needs and expectations about the referred object. The Focus Group as an instrument of research and intervention allows that, in so far as different views about a phenomenon can be placed, the interaction with the representations and previous conceptions mediated in the group process can favor not only the sharing of knowledge and forms of living, but also, displacements and transformations of such previous representations[23,24].

The Research was approved by the CEP-UFSCar under opinion nº 139/2012.

2.1.1. Empirical context of the study:

The definition of the empirical field has as criteria the practice and training scenarios of the authors, the Health Care School Network (especially the FHUs), which, at the time, had 11 health equipment.

The territory of coverage of the FHU is located on the periphery of a medium-sized city in the interior of the state of São Paulo and covers three districts. In this FHU, work two FHS teams, composed, at the time of the study, by: 02 doctors, 02 nurses, 04 nursing assistants, 02 dentists, 02 dentistry assistants, 11 CHA, covering the total assigned area. 01 CHA did not assume the post, 01 CHA left the job because he changed profession, 01 CHA was on maternity leave). The two teams worked in the same physical space, but presented their own work dynamics; such differences were often triggering conflicts, discomforts and comparisons, generating demands for the management of teams. Another unique factor of this FHU is its location, which is external to the area of coverage, which brings a series of repercussions to the work of the CHA, since he/she has in the territory and in the HVs his/her main place and instrument of work.

The subscribed population is composed, for the most part, of children and young adults. The families are predominantly nuclear, consisting of 3 to 4 people, with monthly income of, approximately, R$ 600,00 to R$ 1.500,00. The neighborhoods that make up the territory have existed for 35 years, and its population comes mainly from Paraná and Northeast.

2.1.2. Participants and operationalization of the study

All the CHAs (10) of two family health teams in which one of the authors worked during the two years of their multiprofessional health residency (PRMSFC-UFSCar) were invited to participate in the study. 08 CHAs accepted to participate in the study. The inclusion criteria in the study were: being CHA in the FHUs in which the resident had performed matrix support and accepting to participate in the focal group.

Six focal group meetings were carried out, lasting 90 minutes each, considering that the first two encounters would raise the main themes associated with physical and emotional overload at work, and the following meetings would be intended to deepen the themes raised. The final meeting aimed to evaluate the use of this technique as a support tool for the development of CHA work.

Data from the focus group meetings were manually audio recorded and registered, and were submitted to thematic content analysis[22,24], aiming at systematizing sense cores and analytical categories, which would elucidate the different and relevant ways in which the participants relate to the theme proposed.

A moderator-researcher led the focus group, responsible for bringing a trigger element to be worked by the group from the objectives of the study, aided by an observer, responsible for capturing the nonverbal information expressed by the participants and for helping the moderator-researcher to analyze possible biases caused by the form of coordination.

2.2. Results and Discussion

The analysis of the data produced seven sense centers, distributed in four thematic axes, named after the inspiration of the most prevalent senses in each axis:

Axis 1: Vitamins: it refers to the main motivations found by the CHAs in their work, as well as the conditions pointed out by them as favorable to their achievement. The sense centers that made up this axis are: Motivations in Working Daily, Working Conditions, Affective and technical recognition of the work itself.

Axis 2: Thorns: refers to the difficulties and needs identified to develop the work. The sense centers that composed this axis are: Work Structure and Daily Life, Structural Fragilities and work contradictions, Overload and wear (physical, technical, emotional).

Axis 3: Tools: identification and use of tools/technologies needed for the work. The sense centers that composed this axis is: Structure and Daily life of work.

Axis 4: Fruits: recognition regarding the products/results of the work itself. The sense centers that composed this axis is: Products of the work.

Below, a descriptive table of the Analytical Categories is presented: The Thematic Axes and their respective sense centers.

1. Descriptive table of Analytical Categories and their respective sense centers.

The Thematic Axes were organized from the objectives of the study, and the thematic centers revealed contents and meanings that, although common from the point of view of description of phenomena, can gain particular meanings from the position in which the participants place themselves. For example, the "work recognition" category emerges both as a potency and as an indicator of the invisibility of CHA work.

For the **Vitamins axis**, there is the sense center **motivations in the daily work**, in which salary, safety and stability in employment stood out. These indicators go face to face with the findings of Bachilli and collaborators[25], when they point out that the option for the CHA profession stems much more from the limitations and gaps of the choices made earlier than from the conscious appropriation of this professional space. Interpersonal relationships in the team, recognition for the work done and professional appreciation emerged as motivators for professional choice. As a counterpoint, the invisibility of the efforts made and the lack of professional valorization as a source of emotional suffering at work were observed[7,17,18]. It is worth emphasizing, here, that the acknowledgment mentioned positively is in the field of interpersonal relations at work, linked to the form of work organization in the FHS, where the teams, in general, build ties of proximity. On the other hand, there is dissatisfaction with the recognition of the technical work and a knowledge of the CHAs, which, in formal spaces of discussion and decision, suffer the impacts of the logic of verticalization of specialized knowledge linked to differences in social and professional classes.

The **Working conditions** that facilitate and guarantee their achievement with greater quality and competence stand out: the importance of a work environment with quality interpersonal relationships, where people are cordial and where one can count on the support and unity of the team; management and mediation of interpersonal relations at work, which are guaranteed through spaces of expression and resolution of conflicts. The quality of the relationship of the team with the user and the commitment to the territory were highlighted in the focal group meetings, to motivate the CHA to carry out his/her work in the best possible way.

The Affective and Technical Acknowledgment of the work itself came as a reference to the relations established with the users, often demonstrated in the language of appreciation, in the preparation of the home for the HVs and the delivery of gifts. However, the recognition of technical success does not appear clearly. This evidence points to the relevance of the link and the effects of light care technologies, while at the same time putting the challenge of balancing this power of ties with the technical competence, of both CHAs and other professionals of the FHUs. Often, CHA only recognizes as a fruit of the work results of referrals made to other professionals, such as, for example, when he/she convinces the user to go to the doctor's office, to take the exam, to take the

medication. These actions of mediation between user and health team are necessary and important. The Guanaes and Pinheiro study (2016) moves in the same direction. Nevertheless, it is observed that the recognition of the work is restricted to this unidirectional mediation, in which the CHA reproduces the technical (biomedical) discourse, in general, without positioning himself/herself in a more reflexive way regarding the orientations that must do. Still in CHA's chain of actions, he/she needs to take to the FHU the demands, the data about the daily life of the family or the user and possible risks to the health of the territory. In general, this data set is shared in protocol form, indicating that the authorial voice of the CHAs could be considered horizontally in health work relations.

The technical recognition of the work itself is conditioned to the health actions related to the objective procedures to organize the flow in the health service, anchored in an assistance often reductionist and punctual, losing sight of one of the most important faces of the FHS – the care actions expanded and integral, such as prevention and promotion, which require an extended, contextualized and procedural view of the health-disease process.

In the **Thorns Axis**, the **Structure and the routine work** are highlighted, consisting of: HVs, delivery of consultation guides, orientation to users, attending meetings and training, filling the SUS regulation systems, recording activities performed, scheduling a patient in the services of average and high complexity, reception activities to receive and refer users, registration of medical agenda, prepare and save medical records and exams, issue the SUS card. The reports pointed to the incoherence of the massive investment of time devoted to the functions called by the group as 'reception functions', which have the sense of nonproductive work, a specifically administrative activity. Feelings of discouragement, fatigue and stress accompany these tasks.

Other studies corroborate this administrative bias addressed to the CHAs[26,27] in detriment of the reduction of the working time dedicated to the care functions predicted for this professional. The administrative functions appear as an automated work, in which the CHA becomes mere function executor and flow maintenance of the FHU. It is characterized as a mechanical activity, distanced from the worker who performs it, insofar as the norms and demands of work impose a rhythm on the worker who restricts his/her space of creation and autonomy, evidencing the predominance of dead labor, as described by Merhy and Franco[5], causing a significant injury in the relationship CHA-user. Nevertheless, it is observed, in some circumstances, little willingness to perform the HVs, the main activity foreseen for the CHA, which places him/her in direct contact with the population and its social-family context:

Reis and collaborators[26] emphasize that, in the work at home, the professional loses the protection of the walls of the office, confronting the singularities of the family, their anguish and subjectivities. Therefore, this activity, which, at the same time, enables a greater understanding of the health and illness processes and of care, also provokes in the professional an encounter with emotional situations of the users and of themselves with which they are not prepared to deal,

constituting, therefore, a greater challenge. Care actions require more complex skills and demand greater investment of technical and human work, in the sense of using light technologies in a competent and adequate way.

The fragility in the appropriation and in the use of these necessary tools, which would equip these professionals to confront the community health issues, and the sufferings arising from difficulties in work and living conditions, help the CHA to distance from his/her main function, in an attempt to defend themselves from situations that cause them suffering and impotence. These mechanisms of defense have already been pointed out by Dejours[27] as attempts by the workers to deny or minimize the perception of the reality that makes them suffer, in an attempt to maintain a psychic balance in work and personal life. Mendes and Morrone[28] affirm the contradictory role of defense strategies, since they, at the same time that are necessary to maintain the psychic balance, can lead to the immobilism and the alienation of the professional. As they move away from the distressing situations, they lose, also, the possibility of knowing and acting on the context of suffering of the user, compromising, thus the effectiveness of their health actions.

Regarding the **structural weaknesses** and **contradictions** of the work, the CHA's double bond (professional and personal) with the community was highlighted, which produces ambivalent effects: it approaches the population, but it restricts their privacy and their moments of rest and distancing from work. To separate these roles, both for themselves and for the community, presented itself as a task that only the most experienced could organize, so that it did not disturb them so much in personal life and, at the same time, did not undermine their field of professional activity. Despite the change in the next living requirement (the CHA no longer needs to reside in the scope of FHS), at the time of this study, such a requirement was in force, and even today most of the CHAs reside in the area they must care for. This also places these agents in situations of vulnerability because they suffer from the same needs and risks as the population of the territory.

The bond, a so dear strategy to the Family Health, does not appear as a tool to be worked and thought with these professionals, but is understood as a characteristic already given, a priori, and it is up to them to account for this complexity of situations to which they are exposed. Regarding these training gaps, there is a simplification of the potential of the work of the CHA, in particular, the conception of territoriality of actions and the link with the user[26].

In the context in which prevails a focused procedural and professional logic, there is a feeling of impotence, since the CHA recognizes as the fruit of work only the actions of the core of medical care and its derivatives. When faced with the various limitations of the service network, the feelings of lost work and frustration stand out.

The frailties of the Health Care Network, that should compose the care with the Family Health Units, are a source of wear since they do not allow a continuity of the care provided, generating feelings of impotence and frustration, damaging, also, the bond of trust of the population with the

CHAs, whose speech is weakened[24]. Parallel to this, it is important to discriminate health actions carried out by the CHAs that are not directly linked to referrals within the network, but which are presented as a source of well-being and support to users, such as, for example, reception, qualified listening and the accompaniment of the subjective experiences of families in the face of difficult situations faced. These health actions are not usually recognized as such by the CHAs themselves, with feelings of impotence and frustration prevailing.

The difficulties of expression in clinical and administrative meetings were highlighted. Six, among the eight CHAs, did not feel comfortable expressing themselves in the team or sharing cases and concerns as they would like, increasing their anxieties about success at work. It is important to have an attentive view of the managers for these aspects, to allow spaces for expression and appreciation of the various voices present in the team that, in addition to enriching exchanges and learning, enable the development of new care tools and important support to professionals involved with the case.

Also in the **Thorns Axis**, **Overloads and wear** (physical/technical/emotional) are identified, especially with respect to the challenge of managing conflict relations with users. Instrumenting the CHA to deal with conflicts and look at the user more broadly appears as a fundamental need of the FHS. This clash with such a strategic character of the PHC – considered a link between the team and the population – is a reason for wear and suffering, because agents take on the role of depositaries of community dissatisfaction. The possibility of identification between users and CHAs approximates and also produces overload for the worker. The physical delimited space of the FHU and working hours do not fully apply to the community health agent. This condition leaves him/her vulnerable because he/she works 'on the street' part of the time (HVs, territorialization, registration) and lives in the community. Demands can occur at any time, including when the CHA is out of work and without the support of the team.

It was highlighted, also, the difficulties in dealing with situations of suffering, illness and death, situations that require differential care, such as severe psychological distress, use/abuse of psychoactive substances, or families in very precarious situations of family and social ties. Faced with a situation of technical and human unpreparedness that generates suffering, the professional tends to disregard the user and the situation, moving away. The Ministry of Health indicates that one of the aspects that stand out most in the evaluation of health services is the lack of preparation of professionals and other workers to deal with the subjective dimension that every health practice supposes[20]. These demands have in common the challenges of psychosocial risks, which have complex determinants and require an articulated set of actions, and, in general, represent the greatest challenges pointed out by family health teams. The nature of territorially based care imposes these types of challenges, which need to be shared by the whole team and supported by HCN. It is often the case that CHAs are directly linked to these risks and are unable to identify the support needed in the team, as well as being fragmented and fragile in the service network.

The poor internal management of the units and the excess of administrative functions have contributed to the removal of the relations with the user and to a possible mechanization of the work, which keeps the professional affectively distant from this activity, without many spaces of autonomy and creativity. There is also an environment that leads them to work under pressure, which originates in both the users and the team. In addition, the diversity of demands in a short period of time also causes emotional exhaustion, characterized by feelings of discouragement, tiredness, fatigue and emotional withdrawal. Discouragement was observed for the performance of the HVs, justified by the distance traveled on visits, excessive exposure to the sun and rain. However, it is important to contextualize this discourse of emotional suffering resulting from the lack of tools to deal with the reality experienced by users and their families, which often originates defense strategies such as affective detachment, impersonality, decreased communication with the user and his/her family, the minimization or denial of the reality that generates suffering and the preference for technical procedures to the detriment of the interpersonal relationship[30,31].

The emotional overload of CHA has sources that transcend the fact that they are health workers, but because they act specifically because of the role they play in the community. In addition to aspects common to health workers, such as: difficulty in dealing with situations of illness, death, suffering, conflicts and misunderstandings, feelings of impotence and frustration, it is observed that these feelings are aggravated by being targeted at people who, at the same time, are users of their service and their families, friends and neighbors.

Pupin[30] and Mendes and Ceotto[7] point out the importance of spaces for listening and elaboration of the conflicts and difficulties coming from the contact with the target subjects of the care, they emphasize the importance of the group to construct such spaces to reconstruct the labor relations and the social identity of this group of workers. Silva and Menezes[18] highlight the professional exhaustion and mental disorders common to CHAs and point out the importance of organizational and individual intervention strategies, such as training, qualification and supervision, aiming at minimizing the damages to their health and improving the quality of life at work, which also have repercussions on the quality of services provided to the population.

It is important to highlight the spaces of Permanent Education (PE) as fundamental to instrumentalize the CHA to face the day-to-day reality[12,33,34]. Considering the insufficiency of PE actions, the CHA ends up seeking his/her own resources such as religion, the conversation with co-workers and the psychology resident, in order to attenuate and elaborate feelings that express insecurity, impotence, countertransference with suffering and needs of the families of the territory, denoting the absence of spaces to work these issues collectively and institutionally[13]. The formalization of PE aimed at supporting the work of CHA would favor the development of emotional skills and tools appropriate to the challenges of his/her work.

The **Tools Axis**, composed of the sense core **Structure and everyday work**, has as its key element the origin and preparation of the CHA to assume his/her role. Of the eight CHA participants

in the study, two took a mandatory six-month course for admission, five took a two-week course and one did not receive any training. All the interviewees considered the training received as insufficient to prepare them for their function and point out as their source of learning their own contact with the user. It was pointed out in the focus group the urgent need for training to develop their functions adequately and competently.

With respect to previous training for work, it is observed that there is no fixed and specific training pattern for the function, which was also observed by Figueiras e Silva[31]. According to the authors, most of the CHA pointed out as important for their training the experience acquired with the time of practice. Considering the complexity of the situations encountered in the day-to-day work, it is demonstrated the importance of a training connected with the practical experience that can be built through the experiences of the CHA, in a dialogical, reflective and formative way.

For the **Fruits Axis**, formed by the sense core **Products of work**, it was observed that the recognition and perception about the fruits of the work itself appeared in a diluted, unclear way, with difficulties in discriminating the direct products of their work. However, during the group meetings, it was possible to recognize these products, since the work was perceived as continuous, at all moments of contact with the user: when they access the FHU, in the waiting room, before the consultations, in the post-consultation, community-based activities (in general, health education activities). These actions are, for the most part, welcoming, extended listening, orientation, mediation of the demands of families with the team, among others. The most cited fruits of the meetings of the focus group were: to promote a better understanding of the user about FHU, to promote greater understanding and correct use of medications, to promote self-care (exams, preventive actions, attendance at schedules), greater link with the health unit. It is highlighted here the dimension of collective care and actions to promote health and prevent grievances, denoting the development of legitimate actions of the FHS, valuing the strategic role of the CHA.

Despite the visibility built up during the focal group meetings, these activities were diluted in the actions of other professionals and were not always valued by the CHA and the health team, which is demonstrated in comments when they receive gifts from users: "*even without having done anything but going to your house*". The actions of listening, attention and bonding are not easily recognized as health actions – light technologies. This may be a consequence of a context that is still very much focused on valuing the technical knowledge, to the detriment of other knowledge, and on an operation still based on the biomedical model.

3. CONCLUSION

The predominance of a technicist and productivist care model in health services prevents the recognition of promotion and care actions in the relational and subjective spheres, devaluing this type of activity and, consequently, making it difficult to appropriate this field of work for CHAs. The little recognition and lack of autonomy over the work itself contributes to the feeling of professional

devaluation, present in the context of this study.

It is stressed that the technique of the Focus Group to address the work of the CHA, from action research, did offer a space for reflection about the work itself and the relationships established with it. It was observed a good appropriation of this device, which made possible the expression of worries, thoughts and feelings. The main gains obtained by the technique of the Focal Group were: i) space to take care of one's own work: power of the group technique to favor the management of subjective aspects in the work; ii) possibilities of exchange and learning, so that the knowledge acquired by the professionals serve as a support and tool for thinking about new positions as professionals and new health practices; iii) space for self-care: they provided the opportunity to look at themselves, besides the professional aspect, allowed the expression of the anxieties and overloads of the day to day work; iv) space of bond: opportunity for care and strengthening of bonds in the work and of recognition of the other; v) space for strengthening and autonomy, developing an expanded view of the work itself and its resources, enabling a critical look at reality and greater autonomy.

These findings point to the need to rethink the spaces of training and in-service qualification, considering the importance of more dynamic spaces for discussion and construction, valuing the practical experience and the diverse knowledges of the multiprofessional team, as already affirmed by Dall'Agnol and Trench[32]. This strategy, in line with the principles of PHE, provides a micropolitical intervention in social experience and confirms itself as an instrument for transforming socio-political reality in the context of health work.

Searching for a synthesis of the fragilities and potentialities of the work of these CHAs, the technical and intersubjective dimensions stand out. It is worth noting the predominance of Dead Work over Living Work, since the CHA devotes less time to the HVs, its main work tool, taking many administrative functions, collaborating for the predominance of superficial and bureaucratic relations with the user[5], being source of demotivation, discouragement and fatigue. The technical recognition of the work itself is conditioned to the medical and punctual procedures, marking the absence of actions of extended and integral care or the recognition of these. It is defended, therefore, the need to strengthen expanded health practices in the training centers and in the services already existing, involving their workers in a more profound and active way.

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