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# THE WORK OF THE COMMUNITY HEALTH WORKER IN THE FACE OF THE COVID-19 PANDEMIC

# O TRABALHO DO AGENTE COMUNITÁRIO DE SAÚDE FRENTE À PANDEMIA DA COVID-19

# LA LABOR DE LOS AGENTES COMUNITARIOS DE SALUD ANTE LA PANDEMIA DEL COVID-19

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**RESUMO**

Com alta transmissibilidade, a COVID-19 representa um fator de emergencial preocupação aos sistemas de saúde por todo o mundo. A abordagem preventiva pautada em medidas de distanciamento social, combinada com o fortalecimento das redes de atenção à saúde, desenha-se como resposta efetiva à pandemia. A Atenção Primária à Saúde desempenha um importante papel neste contexto, com ações no combate ao aumento de novos casos e monitoramento àqueles que dispensam cuidados intensivos, auxiliando no gerenciamento correto das situações de agravamento e direcionando a continuidade da assistência aos serviços necessários. No lócus da Atenção Primária à Saúde, destaca-se o Agente Comunitário de Saúde, trabalhador com atuação amparada na lógica territorial do cuidado e que, diante da COVID-19, pode contribuir sobremaneira para o monitoramento da situação de saúde e acompanhamento de sinais e sintomas dos comunitários. As ações desenvolvidas no seu dia a dia constituem ferramentas essenciais para o enfrentamento à pandemia, imperando seu reconhecimento como ator fundamental nesta rede de cuidados. Contudo, transformações nas formas de organização e execução do seu trabalho observadas nos últimos anos, sistematicamente, têm gerado o esvaziamento de sua função vincular de articulação territorial e mobilização comunitária. Neste ensaio, reflete-se sobre como o momento pandêmico atual, ao situar novos desafios sanitários, pode também revelar oportunidades à reorientação da Atenção Primária à Saúde, retomando seu propósito assistencial em direção à integralidade do cuidado e universalização do acesso. Talvez, junto a isso, o trabalho do Agente Comunitário de Saúde possa reorientar-se em direção ao que já foi um dia: comprometido com a comunidade e focado na sua transformação.

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**Palavras-chave:** Agentes Comunitários de Saúde; Infecções por Coronavírus; Atenção Primária à Saúde.

**ABSTRACT**

With high transmissibility, COVID-19 represents a factor of emergency concern to health systems worldwide. The preventive approach based on measures of social distance, combined with the strengthening of health care networks, is designed as an effective response to the pandemic. Primary Health Care (PHC) plays an important role in this context, with actions to combat the increase in new cases and monitoring those who provide intensive care, assisting in the correct management of worsening situations and directing the continuity of assistance to the necessary services. In the PHC locus, the Community Health Agent (CHA) stands out, a worker with performance supported by the territorial logic of care and who, in face of COVID-19, can contribute greatly to the monitoring of the health situation and monitoring of signs and community symptoms. The actions carried out on a daily basis are essential tools to face the pandemic, and its recognition as a fundamental actor in this care network prevails. However, changes in the forms of organization and execution of their work observed in recent years have systematically generated the emptying of his link function of territorial articulation and community mobilization. In this essay, we reflect on how the current pandemic moment, when situating new health challenges, can also reveal opportunities for the reorientation of PHC, resuming its care purpose towards the integrality of care and universal access. Perhaps, together with this, the work of the CHA can reorient itself towards what was once: committed to the community and focused on its transformation.

**Keywords:** Community Health Workers; Coronavirus Infections; Primary Health Care.

**RESUMEN**

Con alta transmisibilidad, el COVID-19 representa un factor de preocupación de emergencia para los sistemas de salud en todo el mundo. El enfoque preventivo basado en medidas de distanciamiento social, combinado con el fortalecimiento de las redes de atención médica, está diseñado como una respuesta efectiva a la pandemia. La Atención Primaria de Salud juega un papel importante en este contexto, con acciones para combatir el aumento de casos nuevos y monitorear a aquellos que brindan cuidados intensivos, ayudando en el manejo correcto de situaciones que empeoran y dirigiendo la continuidad de la asistencia a los servicios necesarios. En el locus de la Atención Primaria de Salud, se destaca el Agente de Salud Comunitario, un trabajador con un desempeño respaldado por la lógica territorial de la atención y que, frente a COVID-19, puede contribuir en gran medida al monitoreo de la situación de salud y al monitoreo de signos y síntomas de la comunidad. Las acciones que se realizan a diario son herramientas esenciales para enfrentar la pandemia, y prevalece su reconocimiento como actor fundamental en esta red de atención. Sin embargo, los cambios en las formas de organización y ejecución de su trabajo observados en los últimos años, han generado sistemáticamente el vaciado de su función de enlace de articulación territorial y movilización comunitaria. En este ensayo, reflexionamos sobre cómo el momento pandémico actual, al situar nuevos desafíos de salud, también puede revelar oportunidades para la reorientación de la Atención Primaria de Salud, reanudando su propósito de atención hacia la integralidad de la atención y el acceso universal. Quizás, junto con esto, el trabajo de la Agente de Salud Comunitario puede reorientar se hacia lo que una vez fue: comprometido con la comunidad y enfocado en su transformación.

**Palabras clave:** Agentes de Salud Comunitaria; Infecciones por Coronavirus; Primeros auxilios.

## INTRODUCTION

### COVID-19 and the challenges posed to health systems

Coronavirus, pandemic, social isolation and health crisis are terms that have populated the daily lives of social groups across the country. There is no denying that discussions around COVID-19 are present in almost all spaces of human interaction, physical or virtual, occupying a large part of contemporary social concerns, not only in Brazil, but in the world.

This acute respiratory syndrome, originating from a new viral strain of the *Coronaviridae* family, has spread rapidly worldwide since its initial manifestation in December 2019, in Wuhan, China.[1] In a short time, what seemed to manifest itself as isolated cases of a new type of rapidly evolving pneumonia gained alarming epidemiological proportions, leading the World Health Organization (WHO), on January 30, 2020, to declare it as an Emergency in Public Health of International Importance, due to the spread of this new Coronavirus.[2]

Days later, the Brazilian Ministry of Health (MH) published Ordinance 188, of February 3, 2020, declaring a State of Emergency in Public Health of National Importance due to human infection with the new Coronavirus (2019-nCoV).[3] The exponential increase in cases led WHO to issue a new declaration on March 11, 2020, with the Coronavirus responsible for causing a worldwide pandemic.[4]

Currently, in the world, more than 3.44 million cases are reported, with more than 239 thousand deaths. The ranking of countries with the highest number of notifications of cases and deaths is led by the United States, Spain and Italy. This situation has worsened day by day, with the systematic increase of these numbers, albeit in a varied way among the different nations, considering the sanitary measures adopted.[5]

Brazil, at the end of April 2020, was in 10th position in relation to the number of cases of COVID-19, having even exceeded the number of deaths registered in China. MH data reported 85,380 confirmed cases, with 5,901 deaths.[6] Among the Brazilian, Southeast and Northeast regions, they accumulated, respectively, the highest number of reported cases. The states of São Paulo, Rio de Janeiro, Ceará and Pernambuco have the largest accumulation of notifications, accounting, together, for 61.6% of the national total.[6]

Faced with this scenario, state and municipal managers across the country have gone to great lengths to ensure the full functionality of their health networks, implementing measures to combat the pandemic almost daily. Among these, we highlight investments in reinforcing emergency care teams and in creating beds for comprehensive care to COVID-19 in medium and high complexity services, expanding the offer of health care to the population.

Despite their relevance, such measures have not been sufficient, as it is necessary to invest in the rationalization of resources and disease prevention, facing not only the spread of the virus, but also the worsening of the identified cases, since the gradual occupation of available beds points to the collapse of the health system in the near future, with a large number of people needing health care beyond the capacity of existing services.[7]

Investing in preventive and health promotion actions, with a focus on education and information, is essential to make the population aware of the risks of COVID-19. It can be reflected that those developed so far, of a universal character and based on encouraging the adoption of individual postures and behaviors focused on self-surveillance, continuous and systematic cleaning, seem to have already reached its ceiling, considering the systematic reduction of the social distancing indices reached until then, which are in decline.[8]

In the meantime, efforts must be mobilized in the qualification of the work performed by Primary Health Care (PHC), recognizing it as an important locus of care, by enabling greater capillarity to health actions, through approaching people and community groups.[9] Through it, it is possible, more than informing the population, to assist them in the process of social change, focusing on the co-responsibility of the user for caring for themselves and with others by demonstrating preventive behaviors with a focus on the community.

A strengthened PHC is able to identify early and provide more immediate assistance to symptomatic people, treat mild cases and monitor their evolution, guaranteeing the correct clinical-care management through the efficient use of the network's available resources, among other actions.

**Primary Health Care as a scenario**

Primary care is simplistically pointed as the first level of care in the health network, being the one that people seek to address their most immediate and

common needs, including the monitoring of chronic conditions. However, more than a level of care, PHC constitutes a model of strategic (re) organization of health systems, which expresses, among its main attributions, the organization of networks of territorial based services arranged hierarchically to guarantee comprehensive assistance to health of individuals and communities with guaranteed universal access.[9-10]

At the same time, it represents a clinical-care model that transmutes the practice of health professionals, breaking the hegemonic logic of care centered on treatment-cure, assuming, between subjects, relationships based on the bond and sharing of the clinic.[11] In Brazil, PHC is institutionally recognized for the political-ideological devices produced within the scope of the National Policy for Primary Care (NPPC), revealing, in its care model, management practices, service organization, care processes and health care provision.

Primary Care is the preferred gateway to the Unified Health System (UHS), being understood as fundamental for the implementation of Brazilian public health policy, a sphere that expands interventions in health care by bringing the population's daily life to the core care.[12] It corresponds, therefore, to health care closer to singular contexts, enabling the approach to health problems according to their social determination.

In this way, it breaks the notion of centralization of assistance, opening space for the development of actions shared with its users under the logic of co-responsibility, linking and promoting autonomy. In addition, working effectively, PHC provides the rationalization of resources available in the health network, organizing assistance flows and directing the monitoring of cases in a correct and orderly manner.[13]

In the Brazilian case, PHC is mainly operated by the Family Health Strategy (FHS), which has a reference for performance based on its essential and derived attributes.[10-11] Thus, the FHS plays a central role in the organization of the care network, being connected to it to order the provision of quality and comprehensive health services. Having territorial responsibility, it exercises continuous care and monitoring, over time, for an enrolled population and according to their needs, with high resolution power.

The work of the FHS is operated by a multi-professional team composed of a doctor, a nurse, a nursing technician and community health agents. Along with this team, the Family Health Units (FHU), surgeons / dentists, technicians and oral

health assistants cohabit, composing Oral Health teams. Occasionally, psychologists, nutritionists, physiotherapists, pharmacists can be found, among other professionals who are part of the Extended Family Health Nuclei and Primary Care teams (EFHN-PC), device of clinical-assistance and technical-pedagogical support to the FHS teams, which has suffered attacks on their subsistence through the increase in their specific financing.

It is in this scenario that the performance of the Community Health Agent (CHA) is designated, which, in view of complex and challenging objectives and the coexistence of clinics of different professional modalities, is essential for the implementation of health actions in the context of PHC, because it is in the territory and in its organizational logic that its primacy occurs.

**Highlighting the performance of the CHA**

An important aspect to reflect on the CHA is the recognition that this actor accumulates the confluence of two roles played in parallel: that of the health system professional and that of the community worker,[14] being, due to the latter, historically questioned about his professional identity, hindering his recognition as a health worker. The notion of "link", qualification constantly attributed to it, although it signals a solution to the dilemma, guaranteeing its binding function, ends up, on the contrary, reinforcing this separation, since, being the one that unites the health service to the community, it remains in the "between", half-in, half-out of this field.

The professional action of the CHA is defined by regulations issued by the Ministry of Health (laws, ordinances and other documents), among them, the NPPC, also receiving influence from local management models, which direct how actions should be carried out in the assigned territories from the attributions recommended for this category.[12] Thus, regarding their work, directions given by local management teams about the place occupied by PHC in each context.

The range of attributions of the CHA includes community work and territorial coordination, educational activities focused on prevention and health promotion, monitoring the health situation of users and family, among others. Such actions were designated after the publication of Law No. 10,507, of July 10, 2002, which establishes the CHA profession and establishes the need for basic training for this professional.[15]

In their daily lives, the CHA(a) collects demands presented by users, still in its diffuse format, and provides the first guidelines in the territory. Subsequently, it conducts such demands to the FHU, where they will be signified with the team for the definition of referrals. In the opposite direction, if there is a need for trips to the territory, the CHA accompanies the other professionals to their homes, an action that sustains their bonding function, facilitating the entry of the FHS into the more "internal" contexts of the community.[16]

On the other hand, its proximity to the territory, while facilitating the monitoring of the local health situation, creates difficulties for itself, because, when acting as a reference closer to community members, they are sought primarily when they need answers to their needs health, which even occurs outside working hours, resulting in work overload.[17] Other difficulties are related to low investments in qualification, little incentive to improve wages, in addition to challenging teamwork, constituting barriers to be broken.[16,18]

Also part of their work is the involvement in collective activities developed by the FH team, such as clinical-administrative meetings, in which discussions about the health situation of families occur and referrals are outlined, and support for collective intervention actions, with emphasis on the maintenance of health education groups (often assumed exclusively by the CHA), waiting rooms, support for vaccination campaigns, quick response efforts to emerging issues and community mobilization and social control.[12] Therefore, a wide set of tasks that are confused in the meshes of the daily routine of the FHS.

This set of attributions has generated important questions by the class, which accumulates a wide contingent of functions in view of the changes occurred in the conduct of the country's primary care policy,[12,19-20] at the same time that it has been transmuting its actions, increasingly distancing itself from the territories to occupy itself on the premises of the FHU, performing administrative and bureaucratic functions such as filling out forms and production records.[18] In addition, it is not uncommon, in the services, to encounter ACS performing activities assigned to other workers, such as reception, scheduling appointments and dispensing medications, characterizing deviations from function.

Some authors[14,18,21] have revealed how the organization of this work has undergone changes over the years, with the systematic emptying of the CHA's functions, abandoning its place as an intercessory health agent. An example of this is the progressive modeling of home visits based on the prioritization of programs

based on the health conditions of groups of users, such as hypertensive, diabetic and pregnant women, adopting such conditions as criteria for organizing their work routines and visited homes.[21-23] It is also worth mentioning the organization of work through the goals attached to such programs, which leads the CHA to extend their work routine, adapting it to the life habits of the community members to achieve them, developing night visits and the end of week.[24]

These transformations in their work have led CHA to recognize themselves as "data collecting agents", according to a report by the 5th National Forum of the National Confederation of Community Health Agents.[25] This document lists the main changes in their duties identified by them: the increasing time spent in the activities of filling out forms and recording information; prioritization of actions within health units, with the consequent reduction of time to carry out home visits and educational activities in the community and the growing demand for activities related to priority health programs, generally focused on diseases.[14,21] In this scenario, guiding education, prevention and health promotion is an almost impossible task.

**The CHA's performance in the face of COVID-19**

Faced with the COVID-19 pandemic, the PHC scenario has changed. Recent institutional regulations have been issued to guide health workers to reduce the exposure of themselves and users to the risk of contamination, while they have to worry about a double task: monitoring suspected or confirmed cases of the disease and continuing to monitor other current health issues in the territory.[26]

Certainly, the current challenge would be greater if Brazil did not have a universal health system, with a wide network of capillary services and a PHC that allows the "filtering" of cases, helping in the control and occupation of emergency services. However, if such a network had guaranteed its effective functioning, the country's health situation could be better. This is because the maintenance of this system has historically been characterized by progressive underfunding and structural insecurity, with successive cuts in the resources necessary for its full functioning.

In parallel, publications within the PHC[12] have been pointing out the modification of their way of organization, replacing the universal care rationality, for the strengthening of a selective logic centered on a notion of resolvability that

emphasizes the execution of biomedical procedures. Among the setbacks is the validation of different FHS team models, recently encouraged by Ordinance No. 2,539, of September 26, 2019,[27] establishing the "Primary Care team". This, even, rules out the presence of the CHA in its composition.

Despite this, and although the feeling of generalized risk in the face of illness by COVID-19 is imminent, PHC has increasingly been challenged to act according to its original conception: as a gateway that orders the network and is able to coordinate care for users.[9] Thus, in the face of the crisis, opportunities are revealed to defend its organizational model and operational logic, especially considering the longitudinal monitoring of the comorbidities associated with the worsening of COVID-19, such as diabetes, hypertension and tuberculosis, conditions that are sensitive to the approach by the FHS.

PHC activities in territorial and community logic make it possible to monitor the health situation of the population, monitoring the appearance of signs among risk groups, in addition to guiding the effective intervention to the pandemic, proposing preventive actions, making it possible to stop transmission chains. To this end, understanding the forms of community organization and the characteristics of its inhabitants, in particular, their living conditions and vulnerabilities, constitutes a fundamental aspect to promote adequate and efficient social distance measures, one of the main strategies to contain the pandemic.

They are made possible, considering the characteristics of the disease and the manifestation of its symptoms, similar to other common conditions, such as colds and flu, by the presence of the FHS with active posture in longitudinal monitoring, the differentiation and disposal of suspicious and possible aggravating cases, ordering the trips to the specialized network in a rational manner, giving the necessary support to home care and reducing the burden of emergency services.

Another important aspect is the accumulation of information generated in the daily work of the FHS. It is a live database, updated at each meeting in the territory, between team members and users. Thus, even though home visits are restricted by distance measures, making it impossible to obtain new information, those already available in the historical records of the health conditions of the monitored families and the (re) knowledge of their social determinations are important devices to order the work in PHC and build intervention agendas for

vulnerable population groups[28] not only in the scope of health care, but also in an inter-sectoral dimension.

All of these actions have in common the direct involvement of the CHA, which can intensify community intervention by strengthening the adhesion by the local population to the protection and prevention measures. This support is fundamental to the work of the other team members due to the leadership relationship established in the territory, enabling links and knowledge that can be accessed only by those who live there. It can also contribute to the operation of activities at a distance, via mobile telephony and applications, for example, in permanent channels already established by him, providing reliable information about the disease to the population and, at the same time, obtaining data about his health situation. In these terms, his performance would certainly make a lot of difference in tackling the pandemic.[28]

Despite this, public health policy in the country continues to be guided in another direction. An example is the publication of the document "Recommendations for adapting the actions of Community Health Agents to the current epidemiological situation regarding COVID-19",[29] which aims to guide the reorganization of its work process in the context of the pandemic. In it, 11 competencies for the performance of the CHA are presented, which can be grouped into three types of action: (1) guidance to users about the disease; (2) assistance to other team members in the performance of their activities (identifying and monitoring suspected cases, fast-track and vaccination) and (3) carrying out activities in the unit's daily life (organizing service flows and educational activities in waiting rooms).

Exits to the territory are foreseen in the active search for suspected cases of the disease, with emphasis on the request by other professionals of the team and in home visits restricted to priority groups (children under five years old and people over 60 years old). The rest of the document reiterates individual and collective prevention measures focused on infection control and hygiene habits, such as care to be taken during visits, boxes that teach correct hand hygiene and the use and disposal of protective masks.[29]

Therefore, although the current moment demands and provides a logic of work organization supported by expanding access and recognition of territorial demands for the control of the pandemic, what was considered about the CHA dialogues with changes already observed in its work process. It is only a question

of proposing activities with a bureaucratic and administrative profile, supporting the other members of the FHS and with a view to controlling pre-existing conditions in the territory.

Displacements in the community conditioned to the active search for symptomatic patients and visits focused on strategic groups reinforce the category's recognition as a "data collector", resuming complaints already mentioned here.[25] Therefore, the MH document repeats what has been outlined for the category for some years.

Another problem is the loss of work singularization, denoted by the repeated use of the verbs "to guide" and "auxiliary", placing the CHA in a generic and accessory position in the FHS, as his actions appear in line with the order defined by the other team members and directly dependent on them. In addition, these verbs are arranged in an unclear manner, denoting the possibility that these workers may be displaced to "assist" their colleagues in different ways, since multiple interpretations are open.

Therefore, instead of the protagonism and its power to act as a territorial mobilizer / articulator, builder of bonds and facilitator of entry into the community, the CHA is indicated to perform functions submitted to the performance of other professionals. In the face of a health context in which economic measures have made the less favored populations even more vulnerable, it does not seem prudent to invest in community mobilization as a health strategy?

The contingency measures compel to produce innovative mechanisms, using creativity to develop new health interventions. Increasingly, there is a need to guide health education as an instrument of social transformation. In this direction, initiatives have been identified, such as the enhancement of community radio stations, remote assistance and guidance via digital platforms, among others. Counting with the CHA in the development of these activities would be essential to enhance their reach and singularize their effects.

## CONCLUSION

### Building a new storyline...

Focusing on PHC work and its potential in this pandemic context offers important objects for reflection. It is known that some authors have already dedicated themselves to this in recent works and their readings are considered

quite interesting.[28,30,31] Thus, trying not to repeat arguments and problematizations previously presented, the aim of this essay is to take a look at the work of the CHA, one of the actors who play roles in this space-stage, or rather, care territory.

Reflecting on their performance at that moment implies, at the same time, thinking about the PHC organization and the place assigned to it in the health system. It has been observed, in the last decades, the reorientation of its design, characterizing the emergence of rationalized health models that emphasize aspects such as productivity, resolution and the development of new results-oriented public management practices through the establishment of goals and indicators little perennial to the health needs of the population.

Thus, there is a change in the attitude of PHC in the sense of abandoning listening to the territories to organize itself in the midst of assistance packages defined by the attention to priority groups. Health programs guide the formulation of agendas, which are now focused on monitoring and combating diseases. This routine makes PHC little sensitive to the identification of emerging and singular issues in the communities, making some subjects and their demands almost invisible.

The COVID-19 pandemic reveals the imperative of a PHC refocusing, (re) taking it as an organizational model and device for introducing new practices and relationships in the health field based on the production of a clinic centered on the subject and their needs. Before COVID-19, PHC provides essential support to combat the increase in new cases and to monitor those who have given intensive care, but also to correctly manage worsening situations, properly directing the continuity of assistance to the necessary services.

In this process, the importance of the CHA is highlighted in contributing to the monitoring of the health situation and monitoring of signs and symptoms in the territories. The actions developed on a daily basis (home visit, active search, connection to the user, among others) provide essential tools to face the pandemic, reining its recognition as a fundamental actor in the web of care that is woven since PHC.

It is observed that, in the face of COVID-19, the work of the CHA, as well as that of the entire FHS, has undergone changes, with the prerogative of maintaining its own health. However, the proposed activities seem to maintain, or even deepen, a series of attacks on the category, aiming to mischaracterize the essence

and the importance of their work, something that has been happening in the last decades through reformulations in the management of PHC in Brazil.

It is recognized that, in the current health context, in which the central imperative is that the doors are literally closed, windows of opportunity can open up to the CHA, even among shrill squeaks, enabling the rescue and strengthening of the importance of its performance in the community-based care. It is from the gaps that are projected in this movement that, throughout this essay, we sought to shed light on this health worker, pointing out, who knows, the construction of new plots to be performed by them in an increasingly "coronated" path.

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