Tensions and challenges between community health agents and their teams

Tensões e desafios na relação dos agentes comunitários de saúde com as equipes

Tensiones y desafíos en la relación de los agentes comunitarios de salud con los equipos

Roberta Carvalho Romagnoli[1]

Jania Lurdes Pires Samudio[2]

ABSTRACT

Primary Health Care (PHC) in Brazil consists of Family Health Strategy (FHS) teams, composed of medical professionals, nurses, nursing technicians, dentists, dental technicians and Community Health Agents (CHA). As a gateway to the healthcare model, the FHS is the first contact of users with the health system. Therefore, because of its proximity to the community and families, the CHA becomes the first professional to identify and accept cases. This article proposes to analyze the relationship between the CHA and the teams from a schizoanalytic perspective. The results point to an overload of work on the CHA and power relations based on knowledge leading to its devaluation by the team. We conclude that, despite these tensions, the work of the CHA is essential for the consolidation of Primary Health Care in Brazil.

Keywords: Primary Health Care. Community Health Agent. Power relationships. Biopower.

RESUMO

No Brasil, a Atenção Primária à Saúde (APS) é constituída pelas equipes de Estratégia Saúde da Família (ESF), cuja composição se dá por profissionais médicos, enfermeiros, técnicos de enfermagem, odontólogos, técnicos odontológicos e agentes comunitários de saúde (ACS). Como porta de entrada do modelo assistencial de saúde, a ESF é o primeiro contato dos usuários com o sistema de saúde. Assim, por sua proximidade da comunidade e famílias, o ACS se torna o primeiro profissional a identificar e acolher os casos. Este artigo se propõe a analisar a relação entre os ACS e as equipes, a partir de uma perspectiva esquizoanalítica. Os resultados apontam para uma sobrecarga de trabalho do ACS e para relações de poder calcadas no saber, que conduzem à sua desvalorização pela equipe. Concluímos que, apesar dessas tensões, o trabalho do ACS é essencial para a consolidação da Atenção Primária à Saúde no Brasil.

Palavras-chave: Atenção Primária à Saúde. Agente Comunitário de Saúde. Relações de poder. Biopoder.

---

[1] Doutora em Psicologia Clínica pela Pontifícia Universidade Católica de São Paulo e Pós-doutora em Análise Institucional pela Université Cergy-Pontoise, França. E-mail: robertaroma@uol.com.br

[2] Mestre em Cuidado Primário em Saúde (2016) pela Universidade Estadual de Montes Claros (Unimontes). Especialista em Saúde Mental e Atenção Psicossocial (2008) pela Faculdade de Saúde Ibituruna (FASI) e graduada em Psicologia (2005) pela Universidade Federal de São João del-Rei (UFSJ).

RESUMEN

En Brasil, la Atención Primaria a la Salud (APS) está constituida por los equipos de Estrategia Salud de la Familia (ESF), cuya composición se da por profesionales médicos, enfermeros, técnicos de enfermería, odontólogos, técnicos odontológicos y agentes comunitarios de salud (ACS). Como puerta de entrada del modelo asistencial de la salud, la ESF es el primer contacto de los usuarios con el sistema de salud. Así, por su proximidad a la comunidad y familias, el ACS se convierte en el primer profesional a identificar y acoger los casos. Este artículo se propone a analizar la relación entre los ACS y los equipos, desde una perspectiva esquizoanalítica. Los resultados apuntan para una sobrecarga de trabajo del ACS y para relaciones de poder calcadas en el saber, que conducen a una devaluación por el equipo. Concluimos que, aunque haya esas tensiones, el trabajo del ACS es esencial para la consolidación de la Atención Primaria a la Salud en Brasil.

Palabras claves: Atención Primaria a la Salud. Agente Comunitario de Salud. Relaciones de poder. Biopoder.

Introduction

The Organic Law of Health number 8,080, dated September 19, 1990, supplemented by Law number 8,142 of December 28, 1990, established the Unified Health System (SUS), in Brazil, as "a set of health actions and services provided by federal, state and municipal public bodies and institutions, direct and indirect Administration and foundations maintained by the Public Power" (Law 8080, 1990, p. 2). It is a public model of health actions and care, where health is treated as a universal right of the human being, throughout the national territory, and it is the duty of the State to guarantee this right (Giovanella & Mendonça, 2008).

For the organization and direction of SUS' actions and services, the principles and guidelines were created by the Organic Health Law: Universal access for anyone at all levels of care – Equality in health care without discrimination of any kind, integrality of care considering preventive and curative, individual and collective actions and services, community participation through representative bodies in the formulation, monitoring, control and evaluation of health policies, actions and services, and also political decentralization with emphasis on municipalities and regionalization/hierarchization of the service network (Law 8080, 1990).

Knowing that health problems are not uniformly distributed in the population, territory and time, technologies of different specializations, complexities and costs are required. Therefore, the organization of SUS's service network is done through levels of care (hierarchy): a basic level made up of technologies, and professionals often needed by the entire population, and a more specialized level consisting of outpatient clinics, hospitals, and units of therapies and diagnoses (Giovanella & Mendonça, 2008).

The basic level in Brazil is called Basic Health Care, and it is consonant with the international proposal of Primary Care. It is the basis of the health system, responsible for the rationalization of resources, with a combined set of functions: the gateway to new health problems, longitudinal and integral follow-up, and coordination of health care for the most common problems within the communities. It also contemplates prevention, healing, and rehabilitation to maximize health and well-being (Starfield, 2002). This concept broadened what was established by the Declaration of Alma-Ata (2002) that characterized essential primary care, placing the community as more participatory and responsible for organizing and making decisions about the services that comprise it, which should promote, prevent, cure and rehabilitate within the needs demanded (Declaration of Alma-Ata, 2002).

To ensure the principles of SUS, after successful experiences in Ceará (1987) with the Program of Community Health Agents (Mendes, 2012), the Program of Community Health Agents (PACS) was created, implemented in 1991 by the National Health Foundation (FNS); primarily in the North and Northeast regions of Brazil, in urban and rural outlying areas. The objective was to ensure, as a matter of emergency, basic assistance to the population without access to medical services. However, due to the scarcity of medical-sanitary assistance, the agents began to carry out other activities, from registering the population to actions to promote and protect the health of children and women, with priority given to the most vulnerable cases (Giovanella & Mendonça, 2008). This led to the configuration of primary care with selective care, contrary to the principles of SUS. Due to the scope and coverage of the Community Health Agent (CHA), demand was generated for health services with

technology of a higher density. Faced with this, once again in Ceará, doctors and general nurses joined the CHA, forming teams responsible for a population that is territorially classified and organized by families (Mendes, 2012).

These experiences led the Department of Health to launch the Family Health Program-PSF in 1994, considered as an official policy for primary health care in Brazil (Mendes, 2012). With Ordinance 648/GM of March 2006, the National Basic Care Policy (PNAB) was launched and was revoked by Administrative Rule number 2,488, of October 2011, revising guidelines and standards for the organization of Primary Care for the Strategy Family Health (ESF) and the PACS. The expansion from program to strategy has broadened in-depth the character of Primary Health Care, because it presupposes a multi-professional team – composed of general professionals, nurses, nursing technicians, community health agents, dental surgeons, oral health technicians and assistants – responsible for a defined and registered territory and that accompanies an attached population. Therefore, as a practice supported by new foundations that replace the traditional model through the health and family approach, the team's work on the general determinants of the health-disease process was expanded, enabling to re-order the SUS model of care (Giovanella & Mendonça, 2008, Ordinance Number 2488, 2011).

In this sense, the Family Health team is characterized as a strategic element for the consolidation of SUS through participation, social control and municipalization. It is recognized as a substitutive and primary care reorganization model, part of the municipal health services network, whose objective is to organize the local health system, detailing implementation modalities and financial incentives for the Family Health teams, Oral health, and the Community Health Agents Program.

An extensive review of literature carried out from 2002 to 2011 highlights the contributions of the Family Health teams for the development of Primary Health Care in Brazil, as well as their challenges. As contributions were identified: expansion of primary care; expansion of services offerings (including oral health, in peripheral regions of municipalities), progress in comprehensive care and programmatic actions, improvement of multidisciplinary work, family focus, fostering, community guidance, production of care and performance; highlighting actions to promote health, prevention of diseases, active case search, health education, home care, increase in pre-natal consultations, childcare, guidance on breastfeeding, oncological colpocitology collection and reduction of low birth weight, infant mortality and hospital admissions. It also provides adherence to actions for treatment of hypertension, diabetes, leprosy, tuberculosis and sexually transmitted diseases, and important advances in the areas of oral health and pharmaceutical assistance (Arantes, Shimizu & Merchán-Hamann, 2016).

Regarding the challenges, the same research refers to: insufficient funding, professional training disconnected from the centrality of PHC in the care model, precariousness of the professionals' link with institutions, restricted development of intersectoral actions, difficulties in accessing ESF as a gateway to the health care system, and its integration into the service network, planning and social participation. There are also difficulties in the development of complementary integrative practices, actions for adolescent health, in the area of mental health, carriers of HIV/AIDS, drug users and obesity. The risk of maintaining biomedical actions in the work process is

another challenge faced by the SHF in its care process (Arantes et al., 2016). Regarding teamwork, there seem to be difficulties in sharing knowledge and conducting an interdisciplinary practice by professionals (Scherer, Pires & Jean, 2013).

In the latter half of the 1970s, an experiment was carried out in Montes Claros (North of Minas Gerais State) with the purpose of transforming the health system, known as "Montes Claros Project." This experience has transcended its local dimension, and also stands out nationally for its intention to democratize health, the basis of the Health Reform process in Brazil. The project had this strength due to its capacity to articulate critical dimensions of health, such as the production of knowledge, political-institutional restructuring, and reorganization of service delivery (Giovanella & Mendonça, 2008; Teixeira, 1995). Currently, the county has services completely linked to SUS that are part of the Health Care Network: 17 Health Centers, 97 Family Health teams, approximately 04 Specialized Polyclinics, 01 University Hospital and Mobile Emergency Care Service – SAMU (Department of Health Care, 2017).

Aware of the singularities of the territory, with the production of knowledge that follows, inseparable from intervention and the combination of theory and practice, we seek to investigate the insertion of CHAs in Family Health teams to understand the macro and micropolitical realities that arise when meeting with other professionals.

Methodology

We carry out a cartography, methodology supported by the philosophical theory known as Schizoanalysis, by Gilles Deleuze and Félix Guattari. The cartography accompanies processes and not realities given. In this sense, the data are produced and not collected, once it investigates processes and production of subjectivity (Kastrup, 2012). Its objective is "to draw the network of forces to which the object or phenomenon is connected, considering its modulations and its permanent movement" (Barros & Kastrup, 2012, p 57). This network of forces is composed of the forms and forces affecting the object of study, indispensable to be mapped, so it is possible to know how they are presented and how they are organized, when they strengthen and when they produce life through their rearrangements (Romagnoli, 2014).

Cartography is to consider the complexity of reality and the in-dissociability of subject-object, theory-practice, being attentive to the different functions of reality, sometimes acting for the reproduction (forms), sometimes composing inventive agencies (forces). The cartography also presupposes a reading of the subjectivity that sustains this complexity; the subjectivity is understood as composed of multiple components of subjectivation that intersect. Its production is "[...] continually constituted from the bonds and re-bonds that their ramifications make and remake with intra-psychic and extra-psychic, individual and pre-individual, human and nonhuman, organic and inorganic elements[...]" (Parpinelli & Souza, 2005). Therefore, subjectivity makes rhizomatic connections, being composed both by segments of identity that refer to the interiority, the psychic and the individual, both by the relationships they establish and leading us to externality, to the level of the intensive forces that exist before the composition of the individual, that is "pre" forces. Thus, to maintain what already exists refers to the interiority and to create new forms lead us to exteriority, to processes of inventive

subjectivation, through assemblages that we do on the outside.

We conducted a field survey to trace the forms and the forces in the relationship between the CHA and the FHS team in Montes Claros. There were 11 CHA participating in this research from different Family Health Strategy (FHS) teams through interest and availability, and who have been in the exercise of this function for at least one year. The CHA of FHS teams from the rural center of the county of Montes Claros were excluded from the study because the amount is lower than the urban area. For the production of data, three groups of collective interviews took place, lasting 90 minutes, in consecutive weeks in June 2015. The groups were recorded, filmed and later the speeches of the CHA were transcribed in full. On the interview in cartography, Tedesco, Sade and Aclimam (2013) pointed out that it works as a device, acting beyond representation, of the network of meanings, to trace the modulations of experience, summoning the plane of forces that generate ruptures, deviations, precisely because of their connection with externality, aiming to destabilize the instituted, the pole of reproduction of interiority. We tried to summon these forces in our collective interviews with the CHA.

It is worth remembering that all the privacy of the data was guaranteed, as well as observing and respecting the CHAs' work routines as not damaging their daily work. The information was used only for scientific purposes, and the CHA was granted the right to revoke the decision to participate in the research at any time. We respected all the ethical-legal precepts that govern research with human beings, as recommended by Resolution 466 of the National Health Council – Department of Health. This research was also approved by the Research Ethics Committee (CEP), under registry number CAAE 39687014.0.0000.5146.

When conducting the interviews, one of the most pressing issues that emerged from the field of research concerns the relationship between CHAs and their Family Health teams. The reflections carried out are presented below.

Macropolitics and micropolitics between cha and teams

In the text "Micropolitics and Segmentarity", Deleuze and Guattari (1996, p. 90) affirm when presenting the functioning of reality by connections and production: "everything is political, but all politics is both macropolitics and micropolitics", focusing both the molar as the molecular as coexisting plans, always in process. They operate intrinsically in the day-to-day health plan of public health. The distinction between these two dimensions refers to the mode of operation: the macropolitics acts by overcoding, producing classifications and exclusions, cutting and territorializing life, de-limiting the functions of each professional in their teams, the activities of the services, the actions with the users, among others. On the other hand, the micropolitics persists and insists on escaping from overcoding to produce new realities, to deterritorialize and to displace life, despite also acting for reproduction in certain circumstances. The forms, the strata engendered by macropolitics to manage life, are visible and instituted. On the other hand, the micropolitics is the order of the invisible, and has two functions: at the pole of micro-fascism, it acts to oppress, at the invention, it produces agency with unprecedented forces. In micropolitics, the stratification is also due to fine segmentations, through micro-fascisms sustained by our fears and insecurities against the unknown. Thus, in the invisible, in the molecular, emerge micro-

formations that seek to equalize, compare, exclude and disengage from difference, according to the understanding of reactive micropolitics, as Rolnik (2016) points out. But following the course of life, these forms are often transient, and from the encounters effected from the relations that are made with reality, the forces break out and what was attempted to equalize sustains its difference and produces something new. The fissures in the forms allow to leave them so other assemblages can be made, forms operate, and the micropolitics is active and no more reactive (Rolnik, 2016).

In this context, we can affirm that the daily life of primary health care is in the mainstreaming of macropolitics; forms and micropolitics; micro-fascisms and forces, exercising in an immanent and juxtaposed way among homogenization devices (operational norms, programs, registers, teams and users' prescriptions, among others) and inventive agencies that produce movements, singling out relationships. Macropolitical functioning is based on health institutions and manages time and space, establishing work routines, distinctions between professions, shifts and tasks, forms that territorialize the practices, actions and expectations about the families enrolled. Micropolitics is exercised in the way these professionals are strained between anti-personification and between connections of expansion of life in their different actions. In this process, the juxtaposition of macropolitics with micropolitics produces friction, tension, as in the relationship between community agents and the teams.

The work of health professionals in primary care is focused on the integral and continuous care of all family members, linked to the Basic Health Unit (BHU). In this team, the CHA is the one making the link between the team and the territory, responsible for the registration and orientation of the families about the use of the offered services. To this end, CHA is a resident in the community which BHU is inserted, carrying out programmed activities, alone or in teams, and responding to spontaneous demands of its micro-area. In this context, this professional will develop education, health promotion, disease prevention, grievances and health surveillance activities through home visits, keeping in constant contact with families (Brasil, 2011).

The work of CHAs is a key part of health promotion and can be understood as "(...) community empowerment process to work on improving their quality of life and health, including a greater participation in the control of this process." (World Health Organization, 1986). Thus, the incentive to autonomy is fundamental to ensure decent living conditions and enable individuals and collectives to broaden their domain over health determinants. In this sense, the population becomes co-responsible for their own health and, the CHAs exercise their role as health educators, fostering changes in the care model. In the same way, the community starts to exercise its citizenship, as an actor of social transformation.

Specifically, at the time of the research, municipal management had instituted productivity for all primary care professionals, including CHAs. So, they would have productivity entitlement under the conditions laid down: they completed 100% of the home visits, three health education groups with the community, participation in all the training offered by the family health team, typed some data that integrate the National Health Information System (SNIS) – such as Sisvan, SisPreNatal, E-SUS AB and didn't present medical certificate and/or had unauthorized absence referring to the month worked. These data would be added, resulting in a score between 55 and 60 points, a hundred and fifty eight reais

(R$ 158,00) would be added to the salary as productivity. If their scores were between 50 and 54 points they would receive half the productivity and, if they scored 49 points or did not make 14 home visits, they would not receive the productivity.

Even with this initiative to reward productivity in our study, CHAs perceive an overload of work and the consequence of this is: the overload can happen by performing functions that go beyond their attributions and are not recommended by the Department of Health, such as delivery of referrals, schedules, off-hours and reception activities (Costa et al., 2013, Silva, Cazola, Cheade, Picci, 2012). In this sense, in the micropolitics of daily life we perceive an increase in the work of CHAs, beyond what is determined by the documents in the macropolitical dimension instituted by technical norms. This tension appears in the speech of one of the community health agents:

> Sometimes people think it's just a visit and it's not just a visit... there are millions of things that we do... right now it's there just arrived the Bolsa Familia to weigh, weigh the people from the Bolsa Familia, then comes the reception, comes (...) do not know in your Unit, then comes central booking, then comes the delivery of the referrals, then comes high cost, then comes team meetings.

In this way, there is a sum of activities added to what already exists. Moreover, what must often be done is associated with an urgency matter, which wears out the worker, as another community agent says:

> They take you and put you on a shift at the reception twice a week, and then comes a training, then comes patient visits, soon they call you back to the Health Unit because you have released a high-cost exam and you have to find the patient NOW because the exam is tomorrow at six thirty in the morning... my God, this is very tiring.

However, it is not only “the extra” work that is responsible for this overload, but the very regulation of what should be done. In this respect, CHAs complain about both quantitative and qualitative aspects. In the quantitative aspect, interviewees often feel accountable for the quantitative aspect to the detriment of the quality of the work they are doing. So they say that if “(...) work only on numbers…only numbers, and you have to give those numbers”. In the qualitative aspect, the coverage of various diseases and various phases of life seems to weigh on the daily life of the CHAs, their home visits and their encounter with the families. This overload is aggravated by the fact that the professionals do not listen to them, as one of the agents says:

> (...) Because there is a great overload on the agent and..., we see that the agent does not only take care of mental health... from gestation to aging there... In the elder, the agent is involved in all stages (...), and the overload is excessive and the agent does not have support (...) it does not exist (...) sometimes a colleague of the team does not stop to listen to the agent ... and the units do not have this support to the agent... what we are seeing is the agents are taking leave or asking to leave...

This difficulty in listening leads us to two analyses: the relationships of power that pervade the day to day work of the CHAs and their insertion in the team; and the possibility of transformation of this practice. Regarding the power relationships, we turn to Michel Foucault's thoughts to analyze how the CHAs’ relationship with the team and the value or not the value of their work, having the knowledge as the axis of this discussion. For the philosopher, the modern individual is constituted as the subject of knowledge and results of relationships of power, shaped by the subjects and supported by scientific discourses. This reading allows us to support a critical look at the forms of

man's subjection in different institutional fields, and strategies and discourses. Foucault (1999) believes that the power can be constituted by relationships, by processes that affect subjectivity, not only repressing but, above all, producing realities based on scientific discourses. In this way, forms of subjectivization are produced supported by disciplinary power, in which mechanisms of domination internalized are exercised in subjects' daily lives, both to shape passive modes of existence and to establish places of superiority, in relationships based on knowledge and scientific titles. This is because the knowledge of specialists is based on rules and media built by the subjects granting the status of truth. This process encourages people to shape and fabricate their lives, being "controlled" by scientific models, monitored by everyday powers that operate anonymously in relationships (Foucault, 1999).

In the speech of the CHAs, we perceive this anonymous exercise in the disqualification of their work, because he is the member of the team that holds a popular knowledge, dominated, as the author calls it, by the professionals who have a higher education, by the norms, by the ideas constructed giving status of truth. Ideas that stimulate people to shape and fabricate their lives, being "controlled" by the scientific model, taking the place of those who know nothing about themselves (Foucault, 1999). The relationship between the team is permeated by a series of mobile power relationships that dominate without punishing and often triggered by the level of education, professional training and the hierarchy of knowledge. Crossings carried out micropolitically through micro-fascisms sustain a reactive micropolitics, often preventing a work of fact, which is collective and an exchange of different pieces of knowledge. In this sense, power relationships can even lead to a failure to assist the population, since the CHA can stop sharing knowledge and demands on the community with the health team, as identified in the following speech:

> (...) sometimes we discover (...) and feel that the patient is a little strange and we come to the team to share, and there is no answer, not even that we are going to study this case or we will schedule a visit, sometimes we share the case and it is the same as if we didn't and the agent ends up discovering other cases, but does not share them.

As we have seen, this overload has effects not only on agents but also on patients, hindering the follow-up, whose goal is to promote health. In fact, this is one of the difficulties of SUS, highlighted by Campos (2007), noting that this system has many gains and achievements, but still presents impasses, such as: "(...) insufficient funding; primary care growing, but at speed and quality below those required; regionalization and integration between municipalities and services almost virtual; as well as the effectiveness and efficiency of hospitals and specialized services less than expected." (p. 301). The necessary quality of primary care must rely on all the work of the health teams and also the CHAs, who report in our study, situations that end up hindering their work. Among them, the lack of listening to their impressions, the relationships in the team and with the community, often restricting productivity. These contradictions are shown in the following speech:

> (...) We hear so much, it's so much questioning and nobody listens to us right. So, in my unit there was a job that the psychologist ended up listening to us right away and talked so many things that we got it off our chest, we offload all the weight that was on our shoulders. We were having a disagreement within the team, all because of this productivity, you know?

But still, there is creativity in how CHA seeks to know, to learn, always with the intention of performing health care, as identified in the following speech:

> I'll get information about schizophrenia, right from the time she informed me… I'd try to find out what it is to check… where I can help (...) I'll get it in the internet, in the books or even with the psychiatrist to get this kind of information to see how (...). I'm going to deal with it (...)

In this way, we can affirm the existence, intrinsically, living side by side with the overload of micropolitics, with the relationships of power and the overload, also micropolitical, of an inventive stance, an active micropolitics. In this direction, besides the agents' searches and their autonomy, we can highlight that the fact of conducting collective interviews led to listening and exchanges, enhancing the CHA because we believe that the production of knowledge also occurs in a context of transformation and intervention. The idea of researching and associating theory and practice, field of research and research subjects guided us throughout our study.

The meeting in the group among the CHAs allowed to facilitate flow and to see new possibilities of care. But since reality is rhizomatic, comprised of inventions and also strata, it has been found that these fastenings appear and need to be taken care of, so they do not capture the life necessary for health care. Listening to the CHAs so that they can talk about themselves, their relationships among their colleagues, the team and the community, all this seems to enable the production of forces capable of producing the new, in the sense of relationships with all those involved in their work process, as well as for health care to happen. This is because they can experience daily work, as Larrosa (2002) points out, in the sense of producing meaning and knowledge, capable of producing a proper way of being in the world, at work, in life, since they are empowered to act in everyday life: knowledge emerges in the path of ethics (a way of conducting oneself) and esthetics (a style).

Final considerations

Based on these analyses, we conclude the importance of the work of the CHAs is to consolidate primary care in Brazil and to support SUS. Although issues related to the daily work of the CHAs showed out in a broader form, and their relationships established between them and the team, we highlight, in this interaction, the overload of the work of the CHA, and their devaluation, for not having a specific and academic knowledge.

Through the mapping of flows, the macropolitical and micropolitical dimensions, from the beginning of the research, we perceive the CHAs are willing to learn to care better and, as agencies were created in the group, they demonstrate the need to invent new ways to relate to the health team, since they have suffered from the overload of work and the place they occupy, often as an administrative worker, distorting from a position of knowing to care, knowing guided by experience and insertion in the community, nor inferior or less powerful. They seem to be willing to change; however, the working conditions in which they are inserted do not favor these subjective inventions, since they are part of health teams that are based on relationships of power. In this sense, it seems to be fundamental that professionals with a higher level have a reflexive formation that values interdisciplinarity, as well as permanent education in the workspace, to change the way they perceive and relate to CHAs, intercessor professionals between the community and the team.

Being aware of these crossings that permeate the work of CHAs in the daily life of the health unit is necessary so we can increase the capacity to sustain difference and alterity. In this way, we can

also bet on processes of subjectivity, creative, collective and powerful. This is a micropolitics of intensification of subjectivities, professionals and patients; which can generate health.

References

Arantes, L. J., Shimizu, H. E., & Merchán-Hamann, E. (2016). Contribuições e desafios da Estratégia Saúde da Família na Atenção Primária à Saúde no Brasil: revisão da literatura. *Ciência & Saúde Coletiva*, *21*(5), 1499-1510. Recuperado em 14 maio, 2017, em http://www.scielo.br/pdf/csc/v21n5/1413-8123-csc-21-05-1499.pdfhttps://dx.doi.org/10.1590/1413-81232015215.19602015

Barros, L. P. da, Kastrup, V. (2012). Cartografar é acompanhar processos. In E. Passos, V. Kastrup, L. Escóssia (Orgs.). *Pistas do método da Cartografia: pesquisa-intervenção e produção de subjetividade* (pp. 52-75). Porto Alegre: Sulina.

Campos, G. W. (2007). Reforma política e sanitária: a sustentabilidade do SUS em questão? *Ciência saúde coletiva*, *12*(2), 301-306. Recuperado em 29 outubro, 2014, em http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232007000200002&lng=pt&nrm=iso. http://dx.doi.org/10.1590/S1413-81232007000200002.

Costa, S. M., Araújo, F. F., Martins, L.V., Nobre, L. L. R., Araújo, F. M., & Rodrigues, C. A. Q. (2013). Agente Comunitário de Saúde: elemento nuclear das ações em saúde. *Ciência & Saúde Coletiva*, *18*(7), 2147-2156. Recuperado em 14 maio, 2017, em http://www.scielo.br/pdf/csc/v18n7/30.pdfhttps://dx.doi.org/10.1590/S1413-81232013000700030

Declaração de Alma-Ata (2002). Conferência Internacional sobre cuidados primários de saúde; 6-12 de setembro 1978; Alma-Ata; USSR. In Ministério da Saúde (BR). Secretaria de Políticas de Saúde. Projeto Promoção da Saúde. Declaração de Alma-Ata; Carta de Ottawa; Declaração de Adelaide; Declaração de Sundsvall; Declaração de Santafé de Bogotá; Declaração de Jacarta; Rede de Megapaíses; Declaração do México. Brasília (DF): Ministério da Saúde. Recuperado em 9 abril, 2017, em http://bvsms.saude.gov.br/bvs/publicacoes/cartas_promocao.pdf

Foucault, M. (1999). Aula de 17 de março de 1976. In M. Foucault. *Em defesa da sociedade: curso no Collège de France (1975-1976)* (pp. 285-319). São Paulo: Martins Fontes.

Giovanella, L., Mendonça, M. H. M (2008). Atenção Primária à Saúde. In L. Giovanella, S. Escorel, L. V. C. Lobato, A. I. Carvalho. *Políticas e Sistema de Saúde no Brasil* (pp. 575-625). Rio de Janeiro: Editora Fiocruz.

Kastrup, V. (2012). O funcionamento da atenção no trabalho do cartógrafo. In E. Passos, V. Kastrup, L. Escóssia (Orgs.). *Pistas do método da Cartografia: pesquisa-intervenção e produção de subjetividade* (pp. 32-51). Porto Alegre: Sulina.

Larrosa, J. (2002). Notas sobre a experiência e o saber de experiência. *Revista Brasileira de Educação*. Rio de Janeiro, 19, 20-28.

Lei nº 8.080 de 19 de setembro de 1990 (1990). Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras

providências. Recuperado em 9 abril, 2017, em http://www.planalto.gov.br/ccivil_03/leis/l8080.htm

Lei nº 8.142 de 28 de dezembro de 1990 (1990). Dispõe sobre a participação da comunidade na gestão do Sistema Único de Saúde (SUS) e sobre as transferências intergovernamentais de recursos financeiros na área da saúde e dá outras providências. Recuperado em 9 abril, 2017, em http://www.planalto.gov.br/ccivil_03/leis/l8142.htm

Mendes, E. V. (2012).*O cuidado das condições crônicas na atenção primária à saúde: o imperativo da consolidação da estratégia da saúde da família.* Brasília: Organização Pan-Americana da Saúde.

Parpinelli, R. S., Souza, E. W. F. de (2005). Pensando os fenômenos psicológicos: um ensaio esquizoanalítico. *Psicologia em Estudo*, Maringá, *10*(3), 479-487. Recuperado em 14 maio, 2017, em http://www.scielo.br/pdf/pe/v10n3/v10n3a15. https://dx.doi.org/10.1590/S1413-73722005000300016

Portaria nº 2.488, de 21 de outubro de 2011 (2011). Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes e normas para a organização da Atenção Básica, para a Estratégia Saúde da Família (ESF) e o Programa de Agentes Comunitários de Saúde (PACS). Brasília. Recuperado em 14 maio, 2017, em http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt2488_21_10_2011.html

Resolução nº 466 de 12 de dezembro de 2012 (2012). Aprova diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. Recuperado em 28 maio, 2017, em http://bvsms.saude.gov.br/bvs/saudelegis/cns/2013/res0466_12_12_2012.html

Rolnik, S. (2016). *A hora da micropolítica – Entrevista Suely Rolnik*. Recuperado em 15 setembro, 2016, em https://www.goethe.de/ins/br/pt/kul/fok/rul/20790860.html

Romagnoli, R. C. (2014). O conceito de implicação e a pesquisa-intervenção institucionalista. *Psicologia & Sociedade*, *26*(1), 44-52. Recuperado em 14 maio, 2017, em http://www.scielo.br/pdf/psoc/v26n1/06.pdf. https://dx.doi.org/10.1590/S0102-71822014000100006

Scherer, M. D. A. , Pires, D. E. P. de, & Jean, R. (2013). A construção da interdisciplinaridade no trabalho da Equipe de Saúde da Família. *Ciência & Saúde Coletiva*, *18*(11), 3203-3212. Recuperado em 14 maio, 2017, em http://www.scielo.br/pdf/csc/v18n11/11.pdf. https://dx.doi.org/10.1590/S1413-81232013001100011

Secretaria de Atenção à Saúde/Datasus (2017). *Estabelecimento de Saúde no Município: Montes Carlos.* Recuperado em 16 abril, 2017, em http://cnes2.datasus.gov.br/Lista_Es_Municipio.asp?VEstado=31&VCodMunicipio=314330&NomeEstado=MINAS%20GERAIS

Silva, E. R. P. da, Cazola, L. H. de O., Cheade, M. de F. M., Pícoli, R. P. (2012). Atuação dos Agentes Comunitários de Saúde na Estratégia Saúde da Família. *Cogitare Enfermagem*,*17*(4), 635-641. Recuperado em 14 maio, 2017, em file:///C:/Users/User/Downloads/30359-111441-2-PB.pdf.

http://dx.doi.org/10.5380/ce.v17i4.30359

Starfield, B. (2002). *Atenção Primaria: Equilíbrio entre Necessidades de Saúde, Serviços e Tecnologia.* Brasília: Unesco.

Teixeira, S. M. F. (Org.). (1995). *Projeto Montes Claros: a utopia revisitada.* Rio de Janeiro: Abrasco.

Tedesco, S. H.; Sade, C., & Caliman, L. V. (2013). A entrevista na pesquisa cartográfica: a experiência do dizer. *Fractal, Revista Psicologia*, *25*(2), 299-322. Recuperado em 20 março, 2017, em http://www.scielo.br/pdf/fractal/v25n2/06.pdf. https://dx.doi.org/10.1590/S1984-02922013000200006.

World Health Organization (WHO). (1986). *The Ottawa Charter for Health Promotion*. Geneva: WHO. Recuperado em 9 março, 2016, em http://www.who.int/healthpromotion/conferences/previous/ottawa/en/

Recebido em 23/06/2017

Aprovado em 20/10/2017