ENDEMIC DISEASES COMBAT AGENT AND THE FAMILY HEALTH TEAM WORK PROCESS

Agente de combate às endemias e o processo de trabalho da equipe de saúde da família

Agentes de combate a las endemias y el proceso de trabajo del equipo de salud de la familia

Original Article

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ABSTRACT

Objective: To identify the activities of Endemic Diseases Combat Agents (*Agentes de Combate às Endemias - ACE*) in the work process of the Family Health Teams (FHT), from the reports of their activities. **Methods:** This is a descriptive, cross-sectional study, with 57 ACEs who work in conjunction with the FHTs in Patos de Minas, MG, and answered a self-administered questionnaire with closed and open questions, in February 2012. **Results:** The majority were female (n=46, 81%), between 31 and 40 years old (n=24, 42%), less than six years working as agents, each accounting for 800 properties on average, performing 31 daily visits, and who had not attended the Introductory Training Course. In the staff meetings, although they felt integrated into the FHTs, over 50% have failed to provide the information obtained, nor the needs of families. **Conclusion:** Most ACEs feel integrated into the family health teams but the absence of the introductory course, prior to starting work on the program, seemed to contribute to the lack of information regarding the work process in the Family Health Strategy (FHS). It was evidenced that the information and knowledge of the families' reality, which are seized by the ACEs during home visits or informally, have little appreciation on the part of the family health team. Despite that, they report that their work with the families stood out for bringing benefits to the community.

Descriptors: Primary Health Care; Health Promotion; Family Health Strategy.

RESUMO

Objetivo: *Identificar as atividades dos Agentes de Combate às Endemias (ACE) no processo de trabalho das equipes de Saúde da Família (SF) a partir dos relatos de suas atividades.* **Métodos***: Trata-se de um estudo descritivo, de corte transversal, com 57 ACE, que trabalham junto às equipes de SF de Patos de Minas (MG) e que responderam a um questionário autoaplicável, contendo perguntas fechadas e abertas no período de fevereiro de 2012.* **Resultados***: A maioria era do sexo feminino (n=46, 81%), com 31 a 40 anos (n=24, 42%), com menos de seis anos de trabalho como ACE, cada um responde em média por 800 imóveis, realiza 31 visitas diárias e não participou do Curso Introdutório de Formação. Nas reuniões de equipe, embora se sentissem integrados com a equipe de SF, mais de 50% não tem conseguido apresentar as informações obtidas, tampouco as necessidades das famílias.* **Conclusão:** *A maioria dos ACEs se sentem integrados às equipes de saúde da família, contudo a ausência do curso introdutório, antes de iniciar o trabalho no programa, pareceu contribuir para a falta de informações sobre o processo de trabalho na Estratégia Saúde da Família (ESF). Evidenciou-se que as informações e o conhecimento da realidade das famílias apreendidas pelos ACE durante as visitas domiciliares ou de modo informal, tem pouca valorização pela equipe de saúde da família. Além disso, relatam que seu trabalho junto às famílias foi destacado por trazer benefícios à comunidade.*

Descritores*: Atenção Primária à Saúde; Promoção da Saúde; Estratégia Saúde da Família.*

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RESUMEN

Objetivo: *Identificar las actividades de los Agentes de Combate a las Endemias (ACE) en el proceso de trabajo de los equipos de Salud de la Familia (SF) a partir de los relatos de sus actividades.* ***Métodos****: Se trata de un estudio descriptivo, de corte transversal con 57 ACE que trabajan en los equipos de SF de Patos de Minas (MG) y que contestaron el cuestionario auto aplicable con preguntas tipo test y de desarrollar en el periodo de febrero de 2012.* **Resultados***: La mayoría era del sexo femenino (n=46, 81%), 31 entre 40 anõs (n=24, 42%), con menos de seis años de trabajo como ACE, cada uno responsable por una media de 800 domicilios, que realiza 31 visitas al día y que no haya participado del Curso Introductorio de Formación. En las reuniones de equipo aunque los ACE se sintiesen integrados al equipo de SF, más del 50% no ha conseguido presentar las informaciones conseguidas y las necesidades de las familias.* **Conclusión:** *La mayoría de los ACEs se sienten integrados a los equipos de salud de la familia, sin embargo, la ausencia del curso introductorio antes de empezar el trabajo en el programa parece que ha contribuido para la falta de informaciones sobre el proceso de trabajo en la Estrategia Salud de la Familia (ESF). Se evidenció que las informaciones y el conocimiento de la realidad de las familias visitadas por los ACE en las visitas domiciliarias o de manera informal tienen poca valorización por el equipo de salud de la familia. Además, relatan que su trabajo con las familias se destacó por los beneficios a la comunidad.*

Descriptores*: Atención Primaria de Salud; Promoción de la Salud; Estrategia de Salud Familiar.*

INTRODUCTION

In 1994, in order to strengthen primary health care, the Ministry of Health (MoH) announced the adoption of the Family Health Program (*Programa de Saúde da Família - PSF*), in an attempt to expand coverage and access to the health system and to replace the traditional model of assistance, aimed at curing diseases in hospital settings[1-3].

Nevertheless, it was not until 1998 that the program became consolidated as a structuring strategy for a healthcare model that prioritized actions supported on the principles of territorialization, intersectoriality, decentralization, co-responsibility and equity, in compliance with the principles of the Brazilian Unified Health System (*Sistema Único de Saúde - SUS*). Interdisciplinary and team work were also included in the proposal, considering that defeating the hegemonic model of health work required the re-adaptation of the work processes within the Family Health Teams (FHTs)[1-3].

Initially, the teams were composed of a physician, a nurse, a nursing assistant and four to six Community Health Workers (CHW). From the year 2000, the Oral Health teams were included. Multiprofessional health teams develop actions of health promotion, prevention, recovery, rehabilitation for the most frequent diseases and injuries, and maintenance of health. The responsibility for the monitoring of families renders the FHTs in need of overcoming the classically defined limits for primary care in the context of the Brazilian Unified Health System (*Sistema Único de Saúde - SUS*)[1,4-6].

The Family Health (FH) unit works with the definition of a territory of comprehensiveness, which means the area under its responsibility. A FH unit may work with one or more professional teams, depending on the number of families connected to it. It is recommended that, within the coverage of the basic unit, a team be responsible for an area where 600 to 1,000 families live, with a maximum limit of 4,500 inhabitants. This criterion should be flexible because of the socio-political and economic diversity of the regions, taking into account factors such as population density and accessibility to services, as well as others considered of local relevance[7].

The teams work based on the Basic Health Units and include home visiting activities with the objective of monitoring the families' health status. The team should carry out programmed visits or those aimed at meeting spontaneous demands according to epidemiological criteria and related to the identification of risk situations[7].

Considering these aspects, the Family Health Strategy (ESF) has been in relief as a strategy to reorganize basic health care in the logic of health surveillance and education, representing a health concept focused on health promotion[1,6,7].

In 2003, the Ministry of Health (MoH) reorganized the area of epidemiology and disease control, with the creation of the Health Surveillance Secretariat (*Secretaria de Vigilância em Saúde - SVS*). The Health Surveillance (*Vigilância em Saúde - VISA*) was in charge of the surveillance and control of communicable diseases, noncommunicable diseases and injuries, and health situation; the environmental health surveillance; the worker health surveillance and sanitary surveillance[8].

The SVS has assumed as a political-institutional priority the integration between basic care and health surveillance, as described in the 2008 Annual Work Plan[9]. In this context, an important step established for the integration and strengthening of health surveillance actions in primary care, more specifically in the FHS, was the inclusion of the Endemic Diseases Combat Agents (*Agentes de Combate às Endemias - ACE*s) in the teams.

The ACE has as attribution the performance of activities of surveillance, prevention and control of endemic and infectious diseases and health promotion; health

education and communication activities; and the execution of health programs, all developed in accordance with SUS guidelines and under the supervision of the manager. These actions are meant to be complementary and shared with the professionals of the FHTs, based on the reference territory[10,11].

The criteria that regulate the incorporation of the ACE or the agents that perform these activities, but under other denominations, can be found in Ordinance no. 1007, of May 4, 2010 of the Ministry of Health[12].

This Ministerial Ordinance reveals the seek for health care comprehensiveness through the insertion of this new agent and provides the basis for legalization and insertion of this professional in the FHTs. However, one of the necessary conditions for its accomplishment regards the representation that the ACE have of their activity[12].

Representations enable the understanding of the social knowledge of a given group, since they act as a system capable of capturing also the complexity of the teams' work process, considering the individual's relations and actions in their context[13].

The organization and management of health work processes, especially concerning the teamwork in basic health care, is one of the central axes of health care reordering within the SUS. Based on studies of health work processes, it is assumed that the instruments and the agents are elements that need to be examined in an articulated way, since only in their reciprocal relationship do they constitute a specific work process[14,15].

Thus, the objective of this study was to identify the activities of the Endemic Diseases Combat Agents (ACEs) in the work process of the Family Health (FH) teams from the reports of their activities.

METHODS

This is a cross-sectional descriptive study that sought to identify, from the ACE reports, their perceptions about the activities developed with families and FHTs.

The set and the relations of perceptions, opinions and attitudes that a certain group establishes with regard to a given social phenomenon end up giving it its own meanings, thus establishing the representation of that social phenomenon. Social representations can then be defined as a socially elaborated and shared form of knowledge[16].

The notion of social representation refers to a system of values, ideas and practices about a particular fact or object that is socially built and anchored in the experiences of the group that has elaborated them. These are not mere reproductions or reactions to certain external stimuli; rather, they are systems that have their own logic, with a particular language and with different levels of critical apprehension of reality and expectations[17].

Indeed, the representation of a given object is not built in isolation and must be studied by articulating affective, mental and social elements; and by integrating, along with the cognition, language and communication, the consideration of social relations that affect the representations and the material, social and ideal reality in which they intervene[16].

The study was developed in the municipality of Patos de Minas, Minas Gerais. The Municipal Health Secretariat has 206 Community Health Workers, 88 of which act as Endemic Diseases Combat Agents (ACE). In order to participate in the research, the inclusion criteria were: ACEs that had been employed through a public contest, then working in Family Health teams, and agreeing to participate in the study by signing the Informed Consent Form (ICF), which resulted in 70 ACEs.

Of this total, 13 agents were excluded, eight of them for working as supervisors of endemic areas, four agents for being on health leave, and one agent for being on maternity leave, thus resulting in 57 participants, which represents a sample of 64.7 % of the population.

The health services of the municipality comprise basic and specialized services, outpatient and hospital, urgent and emergency care, and diagnostic support services, serving the public and private sphere. They are organized into five (5) hospitals, one (1) of them public, two (2) private ones and two (2) of them assisting the public and private system.

The public health network consists of 17 (seventeen) Basic Health Units, 1 (one) specialty outpatient clinic, 1 (one) type 1 Emergency Care Unit (*Unidade de Pronto Atendimento - UPA*) with 24-hour care, and 38 (thirty-eight) FHS units.

Each FHS unit is composed of a multiprofessional team, namely a doctor, a nurse, a nursing technician, a dentist (in most the FHS units), 05 community health workers and 02 ACEs per ESF on average.

To accomplish the proposed objective, a self-administered, semi-structured questionnaire was developed with closed and open questions, consisting of three parts: demographic and personal characteristics; developed activities; and integration of the ACEs with families and FHTs.

The questions in the first part dealt with demographic and personal data, including age, sex and level of education. Next, eight questions addressed the previous professional activity; time period working as ACE; initial vocational education and training; the subsequent training courses; the number of families under their responsibility; the number of

home visits per day; access to the results of their work for the team; and who, in general, receives the ACEs in their homes. Finally, questions were included to address the self-perception of their performance in orientation activities, the receptivity and interaction with staff and families; result of the work with the families and the importance of the ACE's work.

Participants were invited by the Secretary of Health and the head of the Environmental Surveillance Sector of the municipality for a meeting, in which the researcher presented the research, its objectives and, subsequently, the invitation for participation in this study. Those who accepted had the day, place and time scheduled for signature of the ICF and application of the questionnaire. The ACEs who, for some reason, did not attend this meeting, were once more contacted, by telephone call, and invited to participate in the study.

Data collection took place in February 2012, at the Health Training Center (*Centro de Treinamento em Saúde - CTS*) of the Health Secretariat of the municipality in question, from 1:00 pm to 5:00 pm The ACEs were divided into eight groups and, each day, four groups answered the questionnaire, at different times. The scale for attendance containing the names, dates and times was posted in the ACEs' workplace by the sector coordination. For those who had accepted but could not attend on the date, other day was scheduled, maintaining the same data collection procedures. After completion, the unidentified questionnaires were placed into a sealed box with a small opening, which was opened only after delivery of the last questionnaire.

To preserve the anonymity of the interviewees, the questionnaires were named by the letter V, followed by the numbering in which they were presented. The main statements of the ACEs were grouped in an attempt to detect difficulties and expectations regarding the families and teams.

Considering the characteristics of the research, the quantitative data of the questionnaires were transcribed, stored in Microsoft Excel 2007 spreadsheets, and submitted to the analysis of absolute and percentage frequency, being presented in a descriptive way through tables. As for the qualitative data obtained from the open questions, these were fully recorded and analyzed through Content Analysis[18] based on the conceptual framework of Health Promotion[19].

The study was approved by the Research Ethics Committee of UNIFRAN, according to protocol no. 11230112.7.0000.5495, considering the Resolution 466/2012, and in compliance with the ethical precepts of the National Health Council for research on human beings.

RESULTS

Among the 57 participants, 46 (81%) were women. The age group distribution showed predominance in the range of 31 to 40 years, and with complete high school (Table I).

The recruitment and startup date of activities with 36 (63%) participants was in 2006. With regard to the ACEs' training process, the Introductory Training Course to begin working at the FHS was not carried out by 29 (51%) participants, even though 49 (86%) reported having participated in training courses promoted by the Municipal Health Secretariat, with the majority being offered at intervals longer than one year. As for the meetings promoted by the FHTs, 43 (75.5%) ACEs reported participating.

It was observed that more than 35 (61.5%) participants are responsible for 800 to 1000 properties, and that 54 (95%) perform daily more than 31 HVs (Table I).

The home visit provides a moment of meeting with families. For this activity, questions assessed the reception at the property. It was verified that, in 49 (86%) HVs, the ACEs were received by the housewives. In 7 (12%) testimonials, the ACEs reported being well received.

"(...) I am always well received" (V7).

"(...) I did not actually receive any refusal" (V8).

"(...) I do not have this type of problem; I am always well received in my area" (V9).

However, in 50 (88%) reports, the ACEs stated that they were not well received by the family members, as shown in the following statements:

"(...) sometimes they are afraid, because so many things have been happening lately, like robbery, violence etc. Most of the times, it's only in upper-middle class homes, because they feel they do not need our work and guidance, and because they think they have money and can never get sick" (V10).

"(...) I believe that, for the most part, the reason for refusal is the lack of information about the combat work that is being carried out in your neighborhood" (V11).

"(...) perhaps out of fear or shame that their yard is dirty" (V12).

The reception in the residences involves several situations, but the refusal of the visit prevents the work of the ACE. When asked about the conduct they adopt, they reported:

"(...) I try to explain what my service is in their house, I'm polite. I try to insist on doing my job, if she does not allow it, I stop insisting. I get in touch with my supervisor and he makes the necessary arrangements" (V13).

Table I - Profile and characteristics of the work performed by the community health agents (ACEs) according to sex. Patos de Minas, Minas Gerais, 2012.

Variables	n=57 (%)	Sex	
		Male n=11 (%)	Female n=46(%)
Age range (years)			
20 to 30	17(30%)	5(45.5%)	12(26%)
31 to 40	24(42%)	1(9%)	23(50%)
41 to 50	11(19%)	3(27.3%)	8(17.5%)
Over 50	5(9%)	2(18.2%)	3(6.5%)
Schooling			
Elementary School	2(3.5%)	0	2 (4%)
High school	41(72%)	8(73%)	33(72%)
Incomplete high school	8(14%)	1(9%)	7(15%)
Superior	6(10.5%)	2(18%)	4(9%)
Distribution of properties			
Below 800	2(3.5%)	0	2(4%)
800 to 1000	35(61.5%)	3(27%)	32(70%)
Over 1000	11(19%)	8(73%)	3(6.5%)
Did not answer	9(16%)	0	9(19.5%)
Visits made			
Less than 10	0	0	0
Between 11 and 20	1(1.5%)	0	1(2%)
Between 21 and 30	2(3%)	0	2(4%)
Over 31	54(95%)	11(100%)	43(94%)

“(...) I pass the information to my supervisor” (V14).

“(...) I thank for their attention and move on. Customarily, in the attempt to accomplish, I repeat the visit, until I find another person who lives in the house and who is more understanding” (V15).

When asked about the difficulties with orientation activities, whether with themes pertinent to the function or themes that go beyond the health guidelines, the following situations were reported:

“(...) about other diseases, politics, any subject that is not of my service” (V16).

“(...) about the FH program, because I do not know how it works” (V417). “(...) about consultation scheduling, we can not deceive the dweller. There’s a shortage of doctors in the units and it varies a lot (substitution of professionals)” (V18).

The difficulty in broaching subjects in which they are not prepared can also trigger difficulties in the work of the ACE. Nevertheless, through observation and listening to problems, they seek to give answers to solve them. Among the reports, we highlight:

“(...) I give guidance on where she should seek help and I try to get information whether there is anyone to help” (V19).

“(...) I usually restrict myself to just doing my job as an ACE.” (V20).

“(...) I inform my supervisor, who passes it on to the coordinator to take the necessary measures. Note: if it involves violence, I call the police without identifying myself, so as not to compromise the service” (V21).

As for the team meetings, the ACEs reported on their participation:

“(...) in the meetings the actions we practice are commented” (V1).

“(...) I must confess that I should, as a health and citizen servant, question and interact with the results, have common interests” (V2).

“(...) they have no interest, neither do I” (V3).

For the technical component of teamwork, the accomplishment of the work without a feedback on the result of their actions seemed to discourage the ACEs. Even though they do not manage to have visibility at the team meetings, their perception of their work with families

was highlighted for bringing benefits to the community, as observed in the following testimonials:

> *"(...) when I come back and they remove recyclable material from the yard or have provided the water box cover" (V4).*
>
> *"(...) the organization, the customary behavior, the respect for the residents, the interest in helping. (...) The friendship conquered during the visit. The confidence. The rights and duties of the citizen" (V5).*
>
> *"(...) when you arrive at the residence or company, and can not find anything that accumulates water, nor a dirty yard, that is, then you see that your requests are being well accepted" (V6).*
>
> *"(...) to advise on dengue prevention and control" (V24).*
>
> *"(...) this is where I earn the salary to take care of my family, so I value it and I really enjoy what I do, and I try to do it with responsibility; I dedicate myself wholeheartedly, since the people's health depends on my work, I must always be thinking about the other, in the quality of life" (V26).*

With respect to the social component of the teamwork, we observed a positive aspect in the interpersonal relationships between the ACEs and the professionals of the FHT. When asked about the integration with the FHT, it was verified that, in 39 (70%) reports, the ACEs feel integrated into the teams.

DISCUSSION

The sociodemographic characteristics of the present study revealed that the majority of ACEs are female, under the age of 40, have completed high school, and have a maximum of six years of work experience as ACE[(20,21)].

In the various reports made by ACEs inserted in the FHTs of this study, the conflicts that arise from the position of the actors and services, through the logic and the conditions of the work process in which they are inserted, were evidenced. It was also observed that the object of work is complex, the agents are not fully prepared for work, and the instruments seem to be insufficient to account for the apprehension of and response to the health needs of the population[(22,23)].

In the health sector, situations are complex, as the object of work would be the fulfillment of the needs of individuals who require, among other things, instruments that are also complex, since dealing with people's health means dealing with something unexpected[(24).]

The FHS employs fundamentally the epidemiology to build its knowledge on the world of health needs and to instrumentalize its actions around health surveillance. Moreover, the complexity of the world of health needs is such that many other knowledges, other than epidemiology and clinic, should be invoked. Other fields of competent knowledge would need to be mobilized, for instance, the human sciences, which study man as an individual in relational processes, involved with the production of welcoming actions, links, qualified hearkening, and even with the responsibilities and commitments contained in these processes[(2)].

Regarding the actions of the ACEs in the FHT work process, it should be considered that each team member's actions and activities to be carried out in the work process of the FHTs are not individual, but rather collective, joint and complementary to the various individuals composing the FHT. Furthermore, it must be considered that all these professionals have different backgrounds and belong to a particular society[(25,26)].

It was found that the ACEs of this study received little training to accomplish their performance, which causes them to develop their work based on their life experiences. They presented serious limitations in the fulfillment of their activities. The absence of the introductory course before starting to work in the program seemed to contribute to the lack of understanding of their role in the team work process[(27)].

The training process of the ACE should include knowledge about diseases of public health interest, as well as basic knowledge of sanitation and environment, in order to contribute to the health of the population as regards disease prevention and health promotion. The National Policy of Permanent Education in Health is a proposal of strategic action intended to transform and qualify health care in formative processes, in addition to encouraging the organization of actions and services. The implementation of this policy implies the articulated work between the health system and the educational institutions. Capacity building would be one of the most used strategies to tackle problems related to the development of health services[(18,25,28,29)].

Therefore, the qualification of the health professionals' practice is a tool that enables the change in the approach of the patient, family and community, and the reorientation of the attention, mainly because these are the professionals who carry out the actions of health education, important for the FHS purposes, for health promotion and health surveillance[(23,30)].

The ACEs participating in this study work in delimited areas with an average of 800 to 1000 properties and make more than 31 visits/day, considering 8 hours of work per day, in compliance with the National Guidelines. The MoH Ordinance 1007/2010 defines criteria to regulate the incorporation of ACEs in the primary health care to

strengthen health surveillance actions along with the FHTs. In Article 4 of that ordinance, it is emphasized that they must fulfill a workload of 40 (forty) hours per week. The teams' working territories are expected to be compatible for integrated planning, programming, monitoring and evaluation[12].

It is worth pointing out the difference regarding this type of action when performed by ACEs. The HV should be carried out in accordance with the resident's schedule, so that they can be present at the inspection, thus allowing the ACE to transmit the information about the work performed and care for the property. The data concerning the HV should be recorded in a specific form, which would record the date, complete address, and procedures adopted during the inspection of the property.

In Basic Health Care, several actions are performed at home, such as registration, active search, surveillance and health education actions, among others. The instruments of the work process of the teams analyzed in this study were the HVs and the team meetings. In each HV, the ACE collects significant information not only for the control of diseases, because in each encounter with the community, it is possible to know a little more about the reality of the families[31-33].

It is in the family space that the ACE, as well as the FHT members, should strengthen the links and, in interpersonal relationships, create bonds with the population. This assistance provided in the private environment of social relations should be able to contribute to the humanization of care, as it involves people in the care for their family's and community's health, enhancing the active participation of the subject in health surveillance and promotion, and also allowing the agent to know more about the people and the daily life of the families in their area of coverage[34].

According to the primer of the MoH, the ACE should regularly meet with the FHT to plan joint actions and exchange information on cases of suspected dengue fevers; on the evolution of Aedes aegypti infestation indexes in the area of coverage; on pendency indexes; on preferred breeding sites and the measures being or to be taken to improve the situation. The meetings should be held with the participation of all the team members and it is recommended that they occur at the beginning or end of the periods, at different and pre-established times for each team[35].

Regarding the participation of the ACEs of this study in the ESF meetings, it was verified that 24.5% (14) did not participate in any meeting and 75.5% (43) participated once a week (58%). Although they attended the meetings, the ACEs did not realize that their information would be able to contribute to the health actions proposed by the FHS. It is noted, through the reports of the ACEs in this study, that the information obtained in the HVs did not find space between the team meetings.

Regarding the social component of teamwork, a positive aspect was observed in the interpersonal relations between the ACEs and the professionals of the FHTs. When asked about the integration with the Family Health teams, it was verified that, in 70% (39) of the reports, the ACEs feel integrated into the FHTs.

For the technical component of teamwork, the accomplishment of the work without the feedback on the result of their actions seemed to discourage the ACEs. Although they do not manage to have visibility in team meetings, their view of their work with families is highlighted for bringing benefits to the community.

It would be necessary a type of management that would not lead the professional to become disinterested in the caregiving act. A health professional who works automatically tends not to be interested in health promotion and the quality of care tends to fall[24].

Working as a team would mean working in a horizontal way, developing integrated actions, agglutinating the knowledge and the subjects of this knowledge, and considering the singularities of the practice of each profession, with a view to building proposals and actions consistent with the population's needs. Communication among professionals would be the common denominator of teamwork, as it arises from the reciprocal relationship between work and interaction[34,36].

The FHS, which is intended to oppose the current biomedical model, would require professionals with the profile proposed by the program. The insufficiency of such professionals, especially in the management of services, makes it difficult to plan actions and hinders the discussion in a collective work dynamics, and compromises the information flow of its multiple agents[37,38].

It should be considered that the activities attributed to the ACEs are not only the activities of an individual, but also the collective, joint and complementary activities of several individuals composing the team, to be carried out in the work process of the FHTs. Moreover, it must be considered that all these professionals have different backgrounds and belong to a given society.

This could be facilitated by the use of mechanisms to allow involvement and participation in new ways of operating the program. The work process in the FHS requires multiple subjects to account for the totality of the actions, demanding the recomposition of the works with a view to comprehensive assistance[39,40].

Considering the objective of the research, the findings are related only to the perception of ACEs that participated in the study and are limited because they are not representative

of all professionals. After the study was concluded, there was still a need to return to the field to better understand the interrelationships established in the daily life of the FHS, in which the work process of the ACEs takes place.

The modification of care for people, replacing conventional care practices with comprehensive care, implies a new work process, which requires, among other things, flexibility in the limits of professional competencies and spaces of training and capacity building, since the mere inclusion of another professional will not be able to guarantee the effectiveness of actions in health care. The articulation between the subjects and the knowledge is necessary, as well as greater dedication to the families on the part of the teams.

The incorporation of the ACE into FHTs, with disease control actions and proximity to the population, seeking the participation of families in health promotion and the resolubility of health problems, demonstrates the potential for the accomplishment of collective, joint and complementary actions for health care in a comprehensive way in favor of health promotion.

CONCLUSION

Most ACEs feel integrated into family health teams; however, the absence of the introductory course prior to starting work on the program seemed to contribute to the lack of information about the work process in the Family Health Strategy. It was evidenced that the information and knowledge of the families' reality seized by the ACEs during the home visits or in an informal way have little appreciation on the part of the family health team. Additionally, their work with the families was highlighted for bringing benefits to the community.

In this sense, it is suggested a movement of recognition and appreciation of these actors, since the incorporation of the ACE into the family health teams demonstrates the potential for effective health care in an integral way, problem solving, endemic control and family participation in favor of health promotion.

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