PERSPECTIVES OF THE INTERSECTORAL ACTIONS DEVELOPED BY THE COMMUNITY HEALTH WORKERS TOWARDS SOCIAL INCLUSION AND PARTICIPATION

Perspectivas das ações intersetoriais, de inclusão e participação sociais desenvolvidas por agentes comunitários de saúde

Perspectivas de las acciones intersectoriales, de inclusión y participación social desarrolladas por agentes comunitarios de salud

Original Article

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ABSTRACT

Objective: *To identify the frequency of intersectoral actions, social inclusion and social participation, developed by community health workers (CHWs).* ***Methods:*** *Cross-sectional, descriptive and qualitative study, with data collection performed at the Regional Management Collegiate (RMG) of Alto Capivari, in the state of São Paulo, Brazil. Questionnaires were self-filled by 81 community health workers (CHWs), comprising questions about the five skills proposed by the Ministry of Health for the CHWs: Team integration with the population; planning and evaluation; health promotion; prevention and monitoring of environmental and health hazard; and prevention and monitoring of specific groups and morbidities.* ***Results:*** *Intersectoral actions, social inclusion and participation are still under construction in Alto Capivari RMC, pointing out that there are difficulties in implementing these actions. It is observed that social inclusion initiatives are developed by the CHWs, whereas intersectoral actions are identified and proposed but are poorly implemented; and the social participation of CHWs does not occur.* ***Conclusion:*** *This research allowed identifying that the CHWs acting in High Capivari RMC carry out social inclusion initiatives and propose intersectoral actions; these actions, however, are poorly executed. As for the social participation, CHWs do not participate in the Local Health Councils.*

Descriptors: *Health Promotion; Family Health Strategy; Intersectoral Action; Social Participation.*

RESUMO

Objetivo: *Identificar a frequência das ações intersetoriais, de inclusão e participação sociais desenvolvidas por Agentes Comunitários de Saúde (ACS).* **Métodos:** *Estudo transversal, descritivo e qualitativo, com coleta de dados realizada no Colegiado Gestor Regional (CGR) de Alto Capivari, São Paulo, Brasil. Questionários foram autopreenchidos por 81 Agentes Comunitários de Saúde (ACS), contendo questões sobre as cinco competências que o Ministério da Saúde propõe para os ACS: integração da equipe com a população; planejamento e avaliação; promoção da saúde; prevenção e monitoramento de risco ambiental e sanitário; e prevenção e monitoramento a grupos específicos e morbidades.* **Resultados:** *As ações intersetoriais, de inclusão e participação sociais ainda estão em processo de construção no CGR de Alto Capivari, apontando que há dificuldades para sua implementação. As ações de inclusão social são desenvolvidas pelos ACS; já as ações intersetoriais são identificadas e propostas, porém, pouco executadas; e não ocorre participação social dos ACS.* **Conclusão:** *A presente pesquisa permitiu identificar que os ACS que trabalham no CGR de Alto Capivari realizam ações de inclusão social e propõem ações intersetoriais, no entanto, essas ações são pouco executadas. Quanto à participação social, os ACS não participam dos Conselhos Locais de Saúde.*

Descritores: *Promoção da Saúde; Estratégia Saúde da Família; Ação Intersetorial; Participação Social.*

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RESUMEN

Objetivo: *Identificar la frecuencia de las acciones intersectoriales, de inclusión y participación social desarrolladas por Agentes Comunitarios de Salud (ACS).* **Métodos:** *Estudio transversal, descriptivo y cualitativo en el cual la recogida de datos fue realizada en el Colegiado Gestor Regional (CGR) del Alto Capivari, São Paulo, Brasil. Los cuestionarios fueron contestados por 81 Agentes Comunitarios de Salud (ACS) sobre cuestiones de las cinco competencias que el Ministerio de la Salud ha propuesto para los ACS: la integración del equipo y la población; el planeamiento y la evaluación; la promoción de la salud; la prevención y el control del riesgo ambiental y sanitario; y la prevención y el monitoreo de grupos específicos y morbidades.* **Resultados:** *Las acciones intersectoriales, de inclusión y participación sociales aún están en proceso de construcción en el CGR del Alto Capivari señalando que hay dificultades de su implementación. Las acciones de inclusión social son desarrolladas por los ACS mientras las acciones intersectoriales son identificadas y propuestas pero poco ejecutadas y sin participación social de los ACS.* **Conclusión:** *Esta investigación permitió identificar que los ACS que trabajan en el CGR del Alto Capivari realizan acciones de inclusión social y proponen acciones intersectoriales, sin embargo, estas acciones son poco ejecutadas. Respecto la participación social, los ACS no participan de los Consejos Locales de Salud.*

Descriptores: *Promoción de la Salud; Estrategia de Salud Familiar; Acción Intersectorial; Participación Social.*

INTRODUCTION

Health promotion has been discussed for over 25 years, with the proposal of responding to the health medicalization process in society and within the health system[1]. It is noteworthy that, among the actions that have been incorporated by the Brazilian Constitution of 1988, health promotion arises, indeed, as a reaction to such accentuated medicalization[1].

In this context, the Ministry of Health proposes to the professionals working in Primary Health Care, in accordance with the National Primary Care Policy, the "health promotion" competence, as a basic activity in the work process[2]. At this conjuncture, the Family Health Strategy (FHS) was established to serve the population, with focus on the family and practices supported in the health needs of each territory, strengthening the principles of the Brazilian Unified Health System (*SUS - Sistema Único de Saúde*), as regards the universality of access to health services and the integrality, by regulation of access to the various healthcare levels in an equitable way[2].

From that perspective, the incorporation of Community Health Workers (CHWs) in the Family Health Teams can be seen as an attempt to facilitate the recognition of the population's health needs and social vulnerabilities, and to promote health as well[3].

The "health promotion" competence, assigned by the Ministry of Health to the CHWs comprises a number of actions, such as: intersectoral action, for them "to establish partnerships with day care centers, nursing homes, schools, merchants, and other social groups"; action towards social inclusion, "to guide the family and/or people with special needs regarding facilitation measures for their full social inclusion"; and action towards social participation, "to participate in meetings of the local health collegiate or other local councils"[4].

Based on the intersectoral actions, and the actions towards social inclusion and social participation, it becomes easy to understand how important is the work performed by the CHWs within the Family Health Strategy, as they stimulate the understanding of empowerment among the social groups[5].

The concepts of intersectoriality, social inclusion, and social participation emerged from the assumptions that intersectoriality refers to the integration of health services and other public agencies, in order to articulate policies and programs of interest to health, whose implementation involves areas that are not included within SUS context, thus potentizing the financial, technological, material, and human resources as well as avoiding duplication of means for identical purposes[6].

Regarding social inclusion, it can be incorporated as a set of means and actions to combat exclusion to the benefits of life in society, caused by differences in social class, geographical origin, education, age, and existence of disability or racial prejudice. Inclusion aims to provide the most needy with opportunities to access goods and services, within a system that benefits all, not just the fittest[7]. In this context, popular participation is considered the most suitable instrument of government to build a democratic regime, and the state should "create a set of participatory mechanisms", aiming at the incorporation of citizens to local government programs[8].

For health promotion operationalization, one must consider that the health-disease process is the result of social, economic, cultural, ethnic/racial, psychological and behavioural determinants, which can contribute to the onset of diseases and represent risk factors to the population[9,10]. Therefore, promoting health requires coordination between the various social sectors, besides health, thus ensuring users the empowerment for social control, social inclusion, and emancipation of the subjects[10,11].

Although intersectoriality, social inclusion, and social participation are complex issues, this research seeks to

demonstrate whether the intersectoral action, and actions towards social inclusion and social participation are being held, and what is the involvement of the CHWs in the implementation of these actions, given that this professional has great influence in the community where they operate, owing to their sociocultural peculiarities and ability to empower people to fight for their rights in the pursuit of their quality of life[3].

The objective of this study is to identify the frequency of intersectoral action, and actions towards social inclusion and social participation, developed by Community Health Workers (CHWs).

METHODS

This is a cross-sectional, descriptive, and quantitative study, conducted in 2011. The Regional Management Collegiate (RMC) in Alto Capivari, São Paulo, Brazil, chosen as the study setting for the survey, belongs to Regional Network for Health Care No. 11, of Presidente Prudente. This RMC comprises the municipalities of Iepê (7,628 inhabitants), João Ramalho (4,180 inhabitants), Nantes (2,750 inhabitants), Quatá (12,909 inhabitants), and Rancharia (28,809 inhabitants).

Of 97 Community Health Workers enrolled in Family Health Teams of Alto Capivari RMC in January 2011, 81 agreed to participate.

Data collection was performed through the application of a questionnaire with Likert-type questions[12] concerning the five competencies proposed by the Ministry of Health to the CHWs, namely: integration between team and population; planning and evaluation; health promotion; prevention and monitoring of environmental and health hazard; and prevention and monitoring of specific groups and morbidities[4].

In this study, we sought to perform a particular examination of six facets that compose the "health promotion" competence: A1 - Proposes actions using the various existing departments in the municipality; A2 - Executes actions that work in partnership with other existing departments in the municipality; A3 - Establishes partnerships with day care centers, nursing homes, schools, merchants, and other social groups; A4 - Guides family and/or people with special needs regarding facilitation measures for their full social inclusion; A5 - Supports social actions to improve literacy among children, adolescents, youths, and adults; A6 - Participates in meetings of the local health collegiate or other councils.

During scheduled visits to the health unit, researchers provided the questionnaires to the Community Health Workers who agreed to participate. In this case, questionnaires were self-filled by the workers within 20 minutes on average and collected by the researchers.

Data was organized and analyzed according to the single frequency of occurrences, with use of SPSS.

This research was approved by the Ethics Committee in Research of the University of São Paulo School of Nursing, under Opinion No. 963/2010/CEP-EEUSP, and by the Municipal Health Secretaries of the five municipalities.

RESULTS

In the municipality of Iepê, it was observed that intersectoral action A1 has higher frequency of monthly conduction; intersectoral action A2 is mostly performed daily; while action A3 is usually held monthly (Table I).

Other important point to emphasize in the municipality of Iepê is that action A1 has the percentage of 53.8% corresponding to never performed, and action A2 shows the percentage of 46.1% for that category (Table I).

As for the intersectoral actions in the city of João Ramalho, concerning action A1, there was a pattern of greater daily conduction; action A2 showed higher daily and monthly performance frequencies, while action A3 is mostly held every month. In the city of João Ramalho, intersectoral actions A1 and A3 are rarely performed, with percentages of 40% and 50%, respectively, and action A2 is never performed in a percentage equal to 50% (Table I).

In Nantes, actions A1, A2, and A3 are more frequently held every month. It is noteworthy that A1 and A2 are rarely carried out under the percentages of 80% and 60%, respectively. In the municipality of Quatá, it is observed that actions A1, A2, and A3 are rarely conducted, with respective percentages of 73.7%, 84.2%, and 78.9% (Table I).

The city of Rancharia had a higher frequency of actions A1, A2, and A3 with daily accomplishment, and it was observed that actions A1, A2, and A3 are rarely held with respective percentages of 32.3%, 52.9%, and 35.3 % (Table I).

Table I shows that, in the municipality of Iepê, A4 is daily performed in the percentage of 46.1% and rarely carried out in the percentage of 46.1%; A5 is carried out with low frequencies and is never performed in a percentage of 61.5%. In João Ramalho, actions of social inclusion, A4 and A5, have significant achievement frequency, reaching 80%.

Table I shows that in the municipality of Iepê, A4 is an action carried out every day, in the percentage of 46.1%; A4 rare accomplishment was also reported in a percentage of 46.1%; A5 is performed with low frequency, as never performed reaches the percentage of 61.5%. In João

Ramalho, the actions of social inclusion, A4 and A5, have significant accomplishment frequency of 80%.

In the city of Nantes, the CHWs reported monthly and daily conduction of A4 and A5 actions, respectively. Regarding A4, rarely being performed appears in a percentage of 60%. In Quatá, it is noteworthy that A5 is rarely achieved, in a frequency of 57.8%. In the city of Rancharia, the CHWs participating in this research answered that A4 and A5 are daily actions (Table I).

As shown in Table I, A6 is developed in low frequencies in the municipalities of Alto Capivari RMC. Nantes stands out with the best performance, with 20% of the answers reporting that A6 actions are performed on a daily basis. The municipalities of João Ramalho and Quatá reported rarely conduction in percentages of 80% and 73.68%, respectively, thus indicating that the CHWs have little participation in the social control of SUS.

Analyzing the monthly frequency of CHWs' social participation in their respective municipalities, it was found that, in Iepê, 7.7% of them reported participating in the Local Health Councils (LHC); in João Ramalho, 10% of the CHWs referred participation in the LHC; in Nantes,

Table I - Frequency of intersectoral actions, and actions towards social inclusion and social participation according to the community health workers. Regional Management Collegiate of Alto Capivari, SP, 2011.

IEPÊ						
Actions n(%)	**A1**	**A2**	**A3**	**A4**	**A5**	**A6**
Every day	1(7.7)	4(30.8)	2(15.4)	6(46.1)	3(23.1)	0(0)
Every week	1(7.7)	0(0)	0(0)	0(0)	1(7.7)	1(7.7)
Every month	4(30.8)	1(7.7)	3(23.1)	1(7.7)	0(0)	1(7.7)
Rarely	0(0)	2(15.4)	5(38.5)	6(46.1)	1(7.7)	1(7.7)
Never	7(53.8)	6(46.1)	3(23.1)	0(0)	8(61.5)	10(76.9)
JOÃO RAMALHO						
Actions n(%)	**A1**	**A2**	**A3**	**A4**	**A5**	**A6**
Every day	2(20)	2(20)	1(10)	8(80)	8(80)	0(0)
Every week	1(10)	0(0)	0(0)	1(10)	0(0)	0(0)
Every month	1(10)	2(20)	3(30)	1(10)	1(10)	1(10)
Rarely	4(40)	1(10)	5(50)	0(0)	1(10)	8(80)
Never	0(0)	5(50)	1(10)	0(0)	0(0)	1(10)
NANTES						
Actions n(%)	**A1**	**A2**	**A3**	**A4**	**A5**	**A6**
Every day	0(0)	0(0)	1(20)	1(20)	1(20)	1(20)
Every week	0(0)	0(0)	0(0)	0(0)	0(0)	0(0)
Every month	1(20)	1(20)	3(60)	1(20)	2(40)	1(20)
Rarely	4(80)	3(60)	0(0)	3(60)	2(40)	2(40)
Never	0(0)	1(20)	1(10)	0(0)	0(0)	0(0)
QUATÁ						
Actions n(%)	**A1**	**A2**	**A3**	**A4**	**A5**	**A6**
Every day	1(5.3)	0(0)	0(0)	4(21)	3(15.8)	0(0)
Every week	3(15.8)	1(5.3)	0(0)	1(5.3)	0(0)	1(5.3)
Every month	0(0)	1(5.3)	0(0)	8(42.1)	5(26.3)	0(0)
Rarely	14(73.7)	16(84.2)	15(78.9)	5(23.3)	11(57.9)	14(73.7)
Never	1(5.3)	1(5.3)	12(35.3)	1(5.3)	0(0)	4(21)
RANCHARIA						
Actions n(%)	**A1**	**A2**	**A3**	**A4**	**A5**	**A6**
Every day	16(47)	6(17.6)	7(20.6)	22(64.7)	21(61.8)	1(2.9)
Every week	3(8.8)	2(8.8)	4(11.8)	3(8.8)	1(2.9)	0(0)
Every month	2(5.9)	3(8.8)	10(29.4)	5(14.7)	2(5.9)	10(29.4)
Rarely	11(32.3)	18(52.9)	12(35.3)	4(11.8)	9(26.5)	19(55.9)
Never	2(5.9)	2(5.9)	1(2.9)	0(0)	1(2.9)	4(11.8)

A1 - Proposes actions using the various existing departments in the municipality; A2 - Executes actions that work in partnership with other existing departments in the municipality; A3 - Establishes partnerships with day care centers, nursing homes, schools, merchants, and other social groups; A4 - Guides family and/or people with special needs regarding facilitation measures for their full social inclusion; A5 - Supports social actions to improve literacy among children, adolescents, youths, and adults; A6 - Participates in meetings of the local health collegiate or other councils.

20% of them reported participation; 30% of de CHWs acting in Rancharia referred monthly participation, and the CHWs in Quatá referred monthly participation in the LHC. In this context, it is evidenced that the CHWs have little participation in the LHC, boards whose purpose is to ensure the participation of users and team members, along with administrative agents, in health management and in the control of the Health Unit activities and services (Table I).

DISCUSSION

For the resolution of complex issues, it is often vital to carry out intersectoral actions and understand health taking its determinants in consideration[3]. In this context, for being closer to the population and knowing their needs and vulnerabilities, the FHS can better accomplish the development of partnerships with other sectors. However, the operation of intersectoral actions is not favoured by the policies governing the various social sectors, because of the inflexibility and lack of congruence points that facilitate the development of such actions[3].

Intersectoriality is a strategy under construction, which the different actors, sectors, and social groups are still appropriating[13]. This information corroborates a study conducted in the municipality of Rio de Janeiro, which found that the CHW's biggest concern was to reveal the health system commitment to the community[13]. However, the CHWs perceived themselves unable to promote individuals' and communities' health, faced with the need for intersectoral actions meant to reverse poverty and other important health-disease determinants[13]. In this regard, this study evidenced that intersectoral actions are proposed by the CHWs who act in Alto Capivari RMC; however, when it comes to the implementation of these actions, it was found that they are poorly performed. When conducting home visits, community workers are faced with problems that go beyond the health sector. After identifying the problems, they pass the information to the healthcare team, which they are part of; then the health team, for being unprepared, lacking training, and facing ongoing difficulties in the coordination between health and other sectors, does not solve problems nor improves the population's health status.

Situations that require intersectoriality to be resolved are often left out by health professionals, because they think they are unable to develop intersectoral actions, applying an approach mainly based on chronic disease management and prevention of other diseases[3].

Health professionals often feel powerless before social determinants of health, facing problems such as poverty, unemployment, lack of hygiene, and hunger, among many other situations, for which there is no immediate cure, but still demand to be cared for, given their severity[13].

For the development of an intersectoral working culture, the FHS needs, among other things, to know the factors that regulate the population's quality of life, and to promote integrated actions and partnerships with different organizations for a combined combat to all the identified problems[14].

In this sense, training and continuing education for the multidisciplinary team, especially the CHWs, are crucial, so that the professionals seek to meet families' needs, directing the look and health actions beyond curative practices[3]. It is also necessary that the health service and its employees adopt a form of innovative, contextualized interaction, and in line with the families' values within the social and political environment[15].

Despite the many challenges for operation and construction of intersectoriality, the implementation of intersectoral public policies to solve the problems found in the communities must be a goal and priority for health managers in the three spheres of government[3].

In the present study, the intersectoral actions are rarely performed by the CHWs and the other professionals acting in health, in general terms[16]. With that aim, the implementation of intersectoriality requires a political decision, since it envolves modifications in the organization of the power estructures and demands, in addition, changes in the government reasoning and in work organization, for the prevention or solution of the existing problems in a geographical territory[16].

In this research, it was observed that the CHWs enrolled in the FHS of Alto Capivari RMC do perform actions for social inclusion. In this way, the knowledge of the population's health needs by these professionals allows information to be disseminated to families and incorporated in practice.

Today, in Brazil, thousands of people with some disability are being discriminated in the communities where they live or are being excluded from the labour market[17]. The process of social exclusion of people with disability or special needs is as old as the socialization of man[17]. Each deficiency ends up resulting in a type of behaviour and giving rise to different forms of reactions, prejudices and concerns[17]. The situation becomes more serious, given that health professionals always tend to emphasize, in the diagnosis, the limiting aspects of disability, as they are invariably the ones first called to settle a conclusive diagnosis[17]. Doctors seldom provide explanation or information to the family of a person with disability about the development possibilities, strategies to surpass difficulties, institutions for family guidance, early stimulation techniques, and education and therapy centers[17]. These family members are asked to accept an undesired and unpredicted reality, a reality that is poorly

addressed by the social elements and the media, or else, when approached, is performed in a superficial, sometimes prejudiced manner, and lacking the disclosure of strategies for social inclusion[17].

Based on the actions undertaken by the CHWs, it is very important that they carry out actions that promote social inclusion through the training of the population in the knowledge of their rights and the clarification of doubts relating to the social inclusion activities available in the municipalities[3].

The social participation of CHWs in political spaces of decisions concerning the regional health policy has been scarce, as shown by the results of this research. CHWs are professionals who can encourage participation and social control; however, it is hard to imagine how they would stimulate such participation without being involved in the process[3]. The Local Health Council is known as a forum for the planning, execution, and evaluation of the actions, not only at the local level but in the municipal, state and federal levels as well[3].

From this perspective, social control constitutes an important tool for the improvement of the population's health status, as it represents a political space that, for its proximity and experience within the reality of the enrolled region, deals with the needs, interests, difficulties, and desires of the community[18,19]. Therefore, it can be a change propeller, directly related to health promotion, understanding people's participation as crucial in the election of priorities, in decisions, and in the development of strategies to achieve the best health level, developing policies based on health problems and needs[18,19].

The CHWs must develop their political ability to stimulate social control on the part of the community in which they operate and develop the autonomy and empowerment[20]. These professionals' political ability confers them great autonomy in actions related to solving the population's health problem[20].

In this respect, CHWs play an important role and, even if they do not get participate in the councils as members, they should attend the monthly meetings to communicate to the population the information discussed in these spaces. After all, they are the FHS professionals who make daily contact with the population[22].

From this perspective, health promotion requires the mobilization of political, human, and financial resources that go beyond the scope of health, establishing intersectoriality as a challenge to implement health promotion practices[21]. Other important point is that social participation is considered one of the pillars for health promotion, aimed at autonomy and empowerment of users, for maximum social inclusion[14].

This research contributes to depict the frequency of the intersectoral actions, inclusion and social participation, with the limitation of not describing how these actions are carried out in practice. Other weakness of this study is that it only includes the participation of the CHWs, excluding other members of the FHS team. Given the observed aspects, the encouragement of intersectoral actions, and actions towards inclusion and social participation, constitutes an important measure to strengthen health promotion. Efforts are thus needed in the pursuit of political and sectoral reorganization, in order to facilitate the implementation of intersectoral and social inclusion actions by the health professionals. Therefore, social participation should be an experienced and spread culture by health professionals and managers for the empowerment of the health system users.

CONCLUSION

This research identified that the CHWs who act in Alto Capivari RMC develop social inclusion initiatives and propose intersectoral actions. Such actions, however, are poorly executed. As regards the social participation, CHWs do not participate in the Local Health Councils.

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