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RESEARCH

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# O papel do agente comunitário de saúde no fortalecimento da educação popular em saúde

## The role of the community health worker to strengthen popular education in health

## El rol del agente comunitario de salud en el fortalecimiento de la educación popular en salud

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## ABSTRACT

**Objective:** To discuss the Community Health Agent (CHA)'s role as a popular educator. **Methods:** Qualitative methodology, based on dialogic conception of action-research, using as methodological procedures focal group's interview and workshops, and content analysis. Subjects were 14 CHA from two Programmatic Areas of Rio de Janeiro city, that participated in a focal-group in november of 2010. **Results:** The analysis showed that the CHA performs activities based on popular education's assumptions, also permeated by normative conception and "banking education", as an attempt to obtain acknowledgement inside health team. **Conclusion:** The CHA is a potential popular educator that can contribute to Primary Care's success. For that, CHAs should seek their qualification and collective empowerment and think about the contradictions of their work.

**Descriptors:** Community Health Workers, Health education, Primary Health Care.

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## RESUMO

**Objetivo:** Refletir e discutir sobre o papel do Agente Comunitário de Saúde (ACS) como educador popular. **Métodos:** Pesquisa qualitativa, centrada na concepção da pesquisa-ação, utilizando procedimentos de grupo-focal, oficinas e análise de conteúdo. Os sujeitos desse estudo foram 14 ACS de duas Áreas Programáticas do Município do Rio de Janeiro, em grupo focal realizado em novembro de 2010. **Resultados:** A análise evidenciou que o ACS desenvolve práticas com base em pressupostos da Educação Popular em Saúde, permeadas de modo ambíguo por uma concepção normativa e bancária de educação como forma de reconhecimento e valorização dentro da equipe. **Conclusão:** O ACS possui um potencial educativo capaz de contribuir para a efetivação das ações da Atenção Básica. Para isso, deve buscar sua qualificação profissional e fortalecimento coletivo, e refletir criticamente sobre as contradições do seu trabalho.

**Descritores:** Agentes Comunitários de Saúde, Educação em saúde, Atenção Primária à Saúde.

## RESUMEN

**Objectivo:** Discutir el rol del Agente Comunitario de Salud (ACS) como educador popular. **Métodos:** Investigación cualitativa, en la ciudad del Rio de Janeiro, con el enfoque principal de la investigación acción, articulada a la metodología de los grupos focales y de análisis del contenido. Participaran 14 ACS de dos áreas de del Municipio de Rio de Janero, Brasil, que participaran de una entrevista en grupo-focal en noviembre de 2010. **Resultados:** El análisis evidenció que ellos desarrollan practicas con basis en los principios de la Educación Popular y Salud (EPS), ambiguamente permeadas por la concepción normativa y bancaria de la educación, para que sean reconocidos y valorados dentro del equipo. **Conclusión:** El ACS tiene potencial de educación para contribuir a la realización de acciones de atención primaria. Para eso debe buscar su calificación profesional y el empoderamiento colectivo, y reflexionar sobre las contradicciones de su trabajo.

**Descriptores:** Agentes Comunitarios de Salud, Educación en salud, Atención Primaria de Salud.

# INTRODUCTION

In the public health field, it is assumed that the health education theme has highlighted the importance of setting public policies and health practices. Reviews produced over the years are not normative and dialogical practices of educating, proposing that these practices are focused on questioning the everyday life, in appreciation of the experience of individuals and social groups and on the reading of different realities. One of the strands that embraces these principles is that of the Popular Education and Health (PEH), as reflections and educational practices. It is based on the assumptions of critical social theories, which understand that the educational process is an important mediation for social transformation, playing a key role in the reconstruction of society.[1,3]

In the analyzes within the PEH, it is considered that health and its attention and care projects are themselves in disputed fields. From a historical perspective, there is a conformation of the Brazilian health system primarily focused on the actions of health campaigns in the early twentieth century, in which attention was focused on the disease, with basically healing health practices. From the health reform movement, in the 80's, it enters this arena of disputes the concept or extended conception of health that considers the health-disease process critically, seeking to establish a link between this and the life and work conditions.[4-5]

In this design, the primary health care level is understood as the *locus* of the main educational activity. For this contributed heavily to International Conference on primary health care in Alma-Ata health, to include among his actions health education focused on the confrontation of the prevalent problems and its social determinants.[6] It was also at this Conference that a social actor, the Community Health Agent (CHA), won appreciation and visibility, which led several projects and local governments to develop proposals including CHA healthcare network. Later, in Brazil, the CHA becomes a unique health professional of SUS, with a history of professionalization still ongoing.

It is worth highlighting the context in which the CHA work becomes interesting to the municipal health systems: in the early 90's when the experience in the state of Ceara took place, difficulties in SUS implementation due to political neoliberal economic hegemony project with consequent downsizing of state resources overlap the strengthening of initiatives of territorial processes and expansion of popular participation. The CHA, which can be considered a low-cost worker, did not require complex training or schooling, and had an average ability to weave activities for expansion of access, with flexibility to accept various tasks. It was, thus, gaining, little by little, more space at the local level, and also organizing collectively as a professional, until in the second half of the Decade, proposed the program of communitarian health agents.[7]

The Family Health Program (FHP) established in 1994 includes the CHA because of its peculiar performance of mediator between community and health service and, at the same time, professional team and a resident of the place where he works. Later called the Family Health Strategy (FHS), explains the purpose of reorganizing health care practice on new bases and replace the traditional model aiming to establish link between professionals and families aiming at continuity in assistance. For some authors, however, it is a reconfiguration of focusing proposals induced by international financial institutions[8], in a context of social and economic reordering marked by the withdrawal of the state, reduced resources for social policies, flexibility and precariousness of work relations, among other factors

Among the duties of the CHA in the FHS we can highlight the conduction of home visits, guidance activities and educational activities at individual and collective level for the promotion of health and prevention of diseases as defined.[9] For this professional educator role is made explicit, without highlighting its potential to strengthen a critical educational mediation, as the prospective of the PEH. This, as an articulated social movement that came to strengthen

since the 90's, recognizes the CHA as a popular educator, since this meets and experience directly the culture, living conditions and history of the community.[10-1]

In educational practices different educational concepts are expressed. Among these, two opposing perspectives, but not excluding each other, can be highlighted: the first has been called bank education, which promotes the transfer of knowledge in a vertical way and sees the educator as the one who owns the knowledge, in turn "deposited" in the "students", whose participation tends to be passive in this process. The second design, defined as problematical, is based on a critical understanding of social reality, and is based on cross-cutting relationships between educators and students. Requires, therefore, dialog and exchange of knowledge with a view to the recognition and processing of reality through reflection and action.[12]

The prospect of PEH in its tessitura originated in relations between academia, social movements, and health professionals on various projects and initiatives, points to the non-recognition of persons seeking the services of SUS as historical subjects and producers of knowledge, a detachment that has been compared to a cultural divide.[4] these questions, however, are not so explicit in the everyday reality of services, which tend to reproduce bank education. This brings, for professionals who seek to develop the PEH, the need to develop practices that collectively problematize the health-disease process and their determinations.

Health education is a process of social mediation that contributes, through critical reflection, that conscious and effective changes are sought, as a collective response, bringing closer professionals and users.[13] One way that can be attributed to this mediation is the access to social rights, to the extent that the educational action is crafted as a social practice of stimulating reflection and strengthening of subjects, and not as a mere persuasion tool.[2,4,14]

In the context of primary care, it is argued that the CHA is a professional with a critical educational potential that is underrated, and that can contribute to the realization of understanding processes and performance of teams within an expanded concept of health, as your life and the people in the community in which it operates are in historical and direct relationship[15]. However, given that the CHA is both a member of the health team, the explanatory power of the biomedical model, combined with the normative force of health education within the bank design mark their educational practices in order to reproduce the same models of education, in case no questions are raised in the teams, or if already exists accumulations in terms of critical reflection on the role of health education.

This article discusses the role of the CHA as a popular educator. This is an excerpt of the Research Project "The interdisciplinary approach of the new conditions and health work processes: the case of Community Health Workers", developed between 2008 and 2010 in the city of Rio de Janeiro, and the results are based on a series of stories focusing on the daily work.

The assumption is that the work of the CHA can sign up as an activity of the PEH, this being a professional who works in Basic Care, and a mediator between the user and the health services, implementing actions of education whose contents include knowledge.[15] On overcoming the idea that understands the educational practice as the process of providing individuals with knowledge for the improvement of their health, admits that the prospect of the PEH is able to go beyond recognizing the transformative potential of CHA educational action, highlighting the collective response capability under the limit situations.

## METHOD

This is a qualitative research, in which the main approach was based on dialogic conception of action-research[16], supplemented by methodological procedures of individual interviews and focus group mode, with the support of the thematic content analysis technique. As a wide research project, led to cut outs whose objectives were to provide a perspective for multidisciplinary analysis of the relationship between work and health of the CHA, focusing on their work, in their varied, complex and multiple dimensions, material and symbolic, objective and subjective, macro and micro-structural. Thus, dimensions as gender and work, international policy influence, role of health information and care model change constituted in themes to guide the analysis of the results.

As a research field, two Programmatic Areas (PA) were selected in the city of Rio de Janeiro, the PA 2.2 and 5.2. These are large areas composed of neighborhoods with a demography marked by the presence of urban working classes and also territories whose history is not composed of legalized occupation, with further development and urbanization. They are still areas in which urban facilities, defined as all goods and services provided by the government for the proper functioning of the city, are insufficient to meet popular demands. The CHA are mostly women, with high school education, and who sought this job for different reasons, in general by the proximity to their home and the care of the children, because they are unemployed and for the prospect of working in a public job.

The methodological procedures sought to capture the narratives of the CHA about their work, using devices like triggers workshops of readings and discussion of e-health communication materials, and interviews in focal groups with specific themes. An interview in batch mode-focal themes work discussion, formation and change of template was created as the main source of data for the preparation of this study. Were held four workshops in the two AP chosen, two in each, including a total of 120 CHA, between August and October of 2010. After the workshops, 14 CHA were invited to an interview in a focal group, held a

month later, in an area ceded by a technical training school in health. All subjects were workers and residents of two Programmatic Areas.

At school, we used a library room, with privacy and comfort enough for the development of the interview, conducted by two undergraduate students under the supervision of the Advisor, all of them authors of the article. The activity was facilitated by the use of photographs, previously selected by students from large magazines, showing situations, objects or elements that are part of the daily life of the CHA work: people talking of medical consultation, elders, a large, poor family a flood situation, a person bedridden, among others. The CHA were asked and encouraged to talk about their day to day work, highlighting its relationship in the work team and the users of the services. The protected environment, prior knowledge of the researchers and the opportunity to talk about their work led the CHA to talk through dialog and participatory form, sometimes overlapping lines, for about 70 minutes.

The thematic analysis of the narratives collected in these interviews and focus groups sought to identify some educational practices developed by the CHA, and which directions assigned to them. These results were then analyzed in the light of the guiding principles of Popular Education and Health.[4-5, 13-4]

After transcribing the speech, the data were analyzed using the method of thematic analysis of content, which includes the steps of pre-analysis, material exploration, processing and interpretation of results.[17] The subjects were grouped into two categories: educational concepts present in the practice of the CHA and the People's Health and Education as a challenge to the CHA.

The project was approved by the Research Ethics Committee of Municipal Health and Civil Defense, through the 34A/2008 Opinion, subjects were previously informed about the study and study on the condition of researched and voluntariness in research participation.

## RESULTS

The CHA spoke about their work, explaining what they do day in and day out, and were encouraged to talk about how to perceive the relationship between the living conditions of the people and their health. They describe situations in which the community problems where they act go beyond specific health issues, and mentioned other elements that directly influence the health of the population:

> *"It's not just the disease. The social problems reflect very, very much. Even more than the health problem. If you are diabetic, you go to a clinic and get medicine. But if you are out of work, where do you go if you don't have any qualification to enter the labor market? It's complicated." (ACS6)*

In the description about their work, they also highlighted the role of listening intently. The CHA realize how important they are as supporters for the people, by means of listening. Many times this appears to be the only goal of the home visits:

> *"I listen a lot. You have to know how to listen. The assisted wants to talk, then the best way to solve their problem is by letting them speak. I like to talk, but I learn a lot from listening to [...]." (CHA 2)*

> *"We're kind of social workers, psychologists... I mean, the elderly like to open up, tell about their life, talk about their sorrows. We listen." (CHA 8)*

When encouraged to talk about their educational practices, the reports were contradictory. Some CHA were emphatic about the difficulties experienced by assigning them to students, i.e. people of families that they meet:

> *"There are families that can't be fixed." (CHA 1)*

> *"Elderlies don't understand what we are talking about. They are stubborn." (CHA 4)*

> *"It's not that I lack information. It seems that they don't want to learn. I explain things a million times!" (CHA 2)*

Others sought to maintain a more understanding and seeking consensus. They referred to popular practices such as the use of medicinal herbs, and how they deal with these in everyday life, through a negotiated educational action. The CHA, on these occasions, try and join the popular knowledge on the use of herbs to the need for the use of prescription drugs:

> *"There is a tea for this and for that. There's a lot of those things there. Then, depending on the situation, you have to guide them: look, you can have the tea, but you have to take your medicine also [...]." (CHA 3)*

About their own ability to develop educational practices, the CHA seem miss a more scientific to the exercise of their profession, which, coupled with practical knowledge of the health disease process in their community would result in a more effective monitoring of the families. There is a criticism of the CHA on the type of training and guidance they receive from their supervisors. It is possible to notice a vertical relationship with the team:

> *"Once we made a small play for children about lice and nits at school and they asked a lot of things that we did not know." (CHA 5)*

*"[...] they had a training that's very far from qualification, but they had it." (CHA 4)*

*"It becomes interesting as the information is passed in a way that we understand, too, because the CHA is often imposed certain things… Oh, is it supposed to be that way, we start to do it that way, then no, you don't do it that way, doesn't it, is otherwise, there as changing the concept of them upstairs, things get muddled for us down here, for now we're still kinda confused with it." (CHA 5)*

A limiting factor for the development of participatory educational activities described by the CHA is related to the lack of human and material resources in the unit in which they work:

*"The team is not big enough to meet the needs. We lack work instruments. Because there's no point in me coming in the waiting room and giving you a piece of paper. Most people don't even know how to read. So, I guess you had to have a slide, or something big." (CHA 5)*

The need to fill in the electronic information systems and achieving goals does not favor a process of communication with the community in their own time, being a limiting factor for the development of health education activities. And the ACS receives the contradiction between an output logic care and the mere production of procedures for financial cost purposes. They also identifie a contradiction between what is provided as a guideline for the development of actions in the Family Health Strategy and the concrete daily practice of the teams:

*"Nowadays only numbers prevail, if you send a good statistic that's what matters, it doesn't matter the quality of the VD you do. You can make 100 VD in 20 days, it matters to them, but if you did 60, but with quality, to them it doesn't matter. What matter is the amount." (CHA 14)*

*"[...] PSF, so, in theory, on paper, is very nice, but in practice it's not working. People don't understand that we work with prevention and health promotion, they don't understand that. They want an emergency; she wants the doctor. She doesn't care that you go there to guide her so she doesn't get so sick, so she doesn't need to go to the doctor, they don't understand that. So, I think that's also kind of distressing." (CHA 2)*

*"[...] They want a doctor. And they think I am the channel to the doctor, that I'm going to talk to the doctor and the doctor will solve their problem." (CHA 5)*

From these lines, it can be identified a narrative content that highlights contradictory aspects of the work process of the CHA, the team and the community, suggesting a bias about the directions of some practices, such as popular knowledge versus scientific knowledge, health production versus production procedures, and hegemony of medical knowledge versus amplified conception of health. All of these themes relate to the prospect of recognition of the CHA as a popular educator.

# DISCUSSION

## Educational concepts present in the practice of the CHA

While carrying out their work, the CHA is faced with the various ways that people find to deal with health issues, which means, in a unique and subtle way, forms of expression and construction of popular knowledge.[10-11,15] On these ways of coping by the population, the field of People's Health and Education has developed reflections on the limits of technical and scientific perspective to identify, in the laterality and seemingly scattered and unfocused practices, resistance dimensions of the popular groups while facing adversities.[4-5]

This perception is diffuse and ambiguous – the CHA expresses a malaise for failing to give answers to the questions, through health services, and at the same time, you realize that the field of social determinants is broad and that many cases relate to one social order marked by inequality.[18] This ambiguity appears as a dilemma in the CHA work and influences their educational practices. It can be considered that when feeling confused and little resolutive, the CHA moves away from their role as a popular educator.

However, we have to discuss to what extent the CHA ends, so contradictory, incorporating also the normative perspective of services, as a way of legitimizing themselves, since very often they express a feeling of recognition within the teams. Some lines express the reaffirmation of both a normative and banking education conception, as the libertarian perspective of PEH.

As a counterpoint to what has been regarded as banking education, the CHA, based on his experience as a resident, realizes the need to consider as a starting point of the educational action the prior knowledge of the community. It is a special way of conducting the educational process taking into account the subjectivity of individuals, their ways of thinking, acting and feeling that will provide greater political engagement and critical reflection of reality, aimed at their transformation.[4,15]

This open stance can counter to the objectives of the work of the teams of the FHS, based on epidemiological information and the concept of risk. The normative point of view, the CHA must identify the factors relevant to the construction of indicators based on risk factors to guide and prioritize their activities. In a permanent education

experience with the CHA, we found that it is possible to develop dialogic processes in order to provide the collective examination about the multiple relationships between health problems and life contexts, replacing the issue of risk as a social arbitration device answers to limit situations.[15] This kind of experience brings to the discussion what is risk, not only what is preset and standardized as such, but also what, in daily life, is placed as a condition for which there are no immediate answers: broken families, with various problems, violence, among others.

In this perspective, the concept of risk dialogues with the limit situation in Paulo Freire[5], which seeks to shed light on the situations or conditions unworthy of life, results of social processes marked by oppression and exclusion, for which the basic critical educators must get the questioning as a way of unveiling, in dialog with the students, these processes, bringing to consciousness of the subject a greater understanding about the ways of determination about their lives and to what extent hurt the right to full and dignified life. In the field of health, means enlarging the debate about the health-disease process in addition to the biological level, without denying it, but seeking to understand when and how the processes that take place in an unjust social order may trigger conditions or situations that affect health.

Also on this subject, it must be considered that a diversity of knowledge is present in the educational practice of the ACS, more or less anchored in conceptions of health biomedical characteristics, given that this knowledge circulates and is appropriated by many professionals as well as for the people in the population. In times when the lines of CHA respondents presented the contradictions between what the population vocalizes as a necessity (having a doctor) and an expanded concept of health, puts in question the way the various knowledge has been constituted and put themselves in the field of health practices, which also leads them to inquire regarding the role of health information.

In another survey, which examined the production and circulation of knowledge and information by the CHA about dengue fever, the CHA sees themselves, at the same time, as informers and unauthorized personalities.[19] Authorized, by performing as a member of a health professional team, holder of an accumulation of specific knowledge for the resolution of the problems. And unauthorized, for being at the same time a resident of the community where they operate, which leads to the question of loss of autonomy of people who aren't professionals to deal with the issues that affect their health.

In spite of this uncertainty in the work of the CHA, it is he who is, in the words of a CHA, *on the front line*, serving as a bulkhead between the demands of the population's health and responsiveness of services. The work of the CHA-undefined, marked by ambiguity and often made precariousness,[20] partly in the set of answers that the State offers for meeting the health needs of the population, and tends to make persistent contradictions of the Brazilian social order. In this sense, we can say that the change of care model, via educational practices, little happens, is barely visible and has no appreciation of the actual and potential role of the CHA as a popular educator.

## Popular Education in Health as a challenge to the CHA

This contradiction, between the community and work on it, marks the daily lives of the CHA, which seeks ways to build their strengthening within the team, while at the same time, especially in urban areas like Rio de Janeiro, the CHA profession becomes more and more a "profession of passage" [21:243], restricted to women without professional qualification that seek to act near their homes to ensure the care of the children and the home, in a work marked by no demarcation between private and public spheres of production and reproduction of life.[20]

It is evaluated that when the CHA develops a more critical view and expanded on their social reality, this is more due to its experience and practical experience than from a formal training environment.

It is evident that the educational practice of the CHA takes a permeated context of contradictions and ambiguities within which this professional seeks to legitimize themselves, taking on the role of educator of individuals, families and community non-linear or direct, but through negotiations and different laterality. The trend is that, in the context of formation of teams whose social division of labor is well established, at least with regard to the role of doctor, dentist and nurse, the CHA is seen as a low-skill, and therefore low autonomy. The qualification that the CHA does not receive the benefit in carrying out activities that effectively involve the community, and their work is often restricted to bureaucratic activities. The understanding that the work of the CHA signs up as a simple job can be at the root of the low investment in their qualification, what has been the trend to lighter, low-cost training, the example of so-called introductory training [22].

The contradiction between an enlarged health conception and model based on biomedicine permeates the conceptions and modes also act of the population[13], and the CHA understands this as a limiting factor and conflict for the conduct of their activities. This perception, however, doesn't seem to find resonance within the teams, since it appears only as an individual complaint by the CHA. As a result, the development of activities that are guided by the principles of PEH degrades and tends to be undervalued in practice, although it may be in the statements of the teams.

## CONCLUSIONS

The CHA is a professional who acts exclusively on primary health care, and his work as a mediator signals a change of intentionality a biomedical model focused on disease to a strategy focused on creating the link, continuity of care, health promotion and prevention of diseases. As one of the brands of the ambiguity that characterizes his work, conducting health education practices in your daily routine includes characteristics of normative and banking approach, as well as those that are based on the actions of the PEH, in particular the dialog and listening.

As a mediator between the service and the population, and in order to reach the facilitation of access that characterize their work, see, at the same time, as authorized and non-authorized educator. We believe that the legitimacy and strengthening of their role as popular educator goes beyond training or technical preparation, although does not do without these.

It is of fundamental importance that the collective itself and the representations of the CHA engage in a debate that seeks to deepen the reflection around the contradictions rather than deny them or disqualify them as unimportant. And that seeks to also weave current responses to the question: why have CHA in Brazil? To only perpetuate a *modus operandi* based on sanitary control? Or to seek effective, participatory and collective changes in procedures for tackling health issues?

The discussions brought by Popular education and health recognize the role of the CHA as a popular educator and your educational action as one of its main features, besides being an instrument for the expansion of access, the right to health, the recognition of people as subjects and protagonists of their own health.

Recognize that a knowledge important in health is built on the process of social mediation weaves in everyday professional practice of the CHA and involves recast of the insertion of this professional actor, recognizing their right to adequate vocational training, decent working conditions, recognition and social visibility, and their importance as a popular educator in Basic Care.

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