The cultural aspects of the practice of Community Health Agents in rural areas*

ASPECTOS CULTURAIS DAS PRÁTICAS DOS AGENTES COMUNITÁRIOS DE SAÚDE EM ÁREAS RURAIS

ASPECTOS CULTURALES DE LAS PRÁCTICAS DE AGENTES COMUNITARIOS DE SALUD EN ÁREAS RURALES

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ABSTRACT

The daily practice of Community Health Agents (CHAs) is permeated with educational interventions aimed at preventive care and health promotion. The sociocultural universe of these professionals can affect the dynamics of their practice within the community, particularly in rural areas, where there is evidence that the population expects to obtain information relative to their health and/or disease by means of cultural rites. Based on a case study, we sought to analyze the influence of the cultural practices of the agents working in a rural area in the interior of the state of Minas Gerais. The analysis revealed the presence of a strong connection between the culture and their activities. Religious beliefs and knowledge developed from the fusion of biomedical information and values based on family tradition regarding the health-disease process have a direct effect on their practices. It is emphasized that they have an important role as facilitators in the practice of health care, with a positive effect stemming from the similarity of their life experiences and inherited cultures with those of the clients, thus making it possible to develop effective interventions.

DESCRIPTORS

Community Health Aides
Health promotion
Culture
Health personnel
Family Health Program
Community health nursing

RESUMO

O cotidiano dos Agentes Comunitários de Saúde (ACS) é permeado de ações educativas direcionadas para os cuidados preventivos e promoção da saúde. O universo sociocultural deles pode influenciar a dinâmica da prática com a comunidade, especificamente nas áreas rurais, onde evidencia-se a expectativa da população em obter resposta aos processos relativos à doença por meio dos ritos culturais. A partir de um estudo de caso, buscou-se analisar a influência das práticas culturais dos agentes de uma área rural do interior de Minas Gerais. A análise revelou a presença de forte ligação da cultura em suas atividades. Crenças religiosas, saberes constituídos da fusão de conhecimentos biomédicos e valores baseados nas tradições familiares sobre o processo saúde-doença influenciam diretamente em suas práticas. Ressalta-se sua importância como facilitador do trabalho na saúde, sendo positiva a semelhança da experiência de vida e culturas herdadas com as dos usuários, dessa forma, torna-se possível o desenvolvimento de suas atividades.

DESCRITORES

Auxiliares de Saúde Comunitária
Promoção da saúde
Cultura
Pessoal de saúde
Programa Saúde da Família
Enfermagem em saúde comunitária

RESUMEN

El cotidiano del Agente Comunitario de Salud (ACS) está impregnado de acciones educativas dirigidas a cuidados preventivos y promoción sanitaria. Su universo sociocultural puede influir en la dinámica de la práctica con la comunidad, específicamente en áreas rurales, donde se evidencia expectativa de la población en obtener respuestas a procesos relativos a la enfermedad mediante supuestos culturales. Mediante un estudio de caso, se buscó analizar la influencia de las prácticas culturales de agentes de área rural del interior de Minas Gerais. El análisis demostró presencia de fuerte vínculo cultural en sus actividades. Creencias religiosas, saberes que fusionan conocimientos biomédicos y valores tradicionales familiares sobre el proceso salud-enfermedad, influyen directamente en sus prácticas. Se resalta su importancia como facilitador del trabajo en salud, viéndose positivamente la semejanza de experiencias de vida y culturales heredadas con las de los pacientes, volviendo posible el desarrollo de sus actividades.

DESCRIPTORES

Auxiliares de Salud Comunitaria
Promoción de la salud
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Personal de salud
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INTRODUCTION

The daily work of Community Health Agents (CHA) comprises educative practices, aimed at specific or general preventive care, and health promotion practices to improve quality of life, focusing on the family and accomplished through home visits. In this context, the agents attempt to make the adaptations necessary for each situation they meet, conciliating personal experiences and alternative practices that are part of their cultural universe. It is perceived that popular knowledge, linked with traditions that are passed from generation to generation, entails social repercussions and enhances adherence to practices in a given environment. These practices have a totalizing meaning and are capable of articulating present and past experiences, valuing each subject's connection with his/her world, values, knowledge and problems[1].

Popular practices can be evidenced in health, as individuals seek disease treatment and prevention forms based on family traditions. There are people who, at the same time or alternately, turn to witchdoctors, use teas, turn to magic, fervently follow a religion, adhering or not to the treatments the physician prescribed. Despite the internalization of care, as current Brazilian health policies recommend, popular practices are still present, and often constitute the population's sole alternative to cure illnesses. Even if there is no scientific proof for popular resources, repeated experiences permit validating their utility, as the set of knowledge and practices is based on empirical experience, experiments and the evaluation of these resources' success or failure[2].

Thus, it is observed that cultural traits interfere in the formation of communities, groups, families and human beings. Moreover, sociocultural relations influence people's behavior in the daily reality and midst they live in, where a wide range of manifestations happen and the process of human life takes form[3].

Community Health Agents, focused on in this study, are marked by particularities that reflect their cultural universe. Their work in the Family Health Strategy (FHS) fundamentally involves the accomplishment of home visits, which contribute to encourage the families' participation in the community health diagnosis, in the planning of health promotion and disease prevention actions, as well as in the definition of priorities for the community. To perform their functions, agents should live in the community they will work in and have finished the basic training course for Community Health Agents and primary education. The core idea in the agent concept is the link between the community and the health system[4].

From a conceptual viewpoint, culture refers to an entanglement of values, standards and conceptions that are considered correct and remain submerged in organizational life. The experience of culture comprises rites, rituals, histories, gestures and artifacts, which are loaded with meanings[5]. The meaning of things emerges in socialization and symbols are shared and interpreted in daily reality. In this respect, it is highlighted that the socialization process allows individuals to internalize values, standards and tendencies that make them socially identifiable[6]. Socialization is part of human beings' individual and social daily reality, permitting individuals' development at the same time as they relate with the environment. Therefore, culture is dynamic and is constantly modified through reflections and successive variations in habits, influenced by other cultures and by the knowledge that emerges in a society.

In health, it is important to highlight the fact that traditional medicine is based on physiopathological principles and allopathic therapy, which emphasizes disease control. Hence, the representations of the health and disease process are reduced to biological characteristics. This Cartesian conception, which goes back to the 16th and 17th centuries and dominates the biomedical model, almost always ignores other determinant factors of individuals[7].

It is fundamental for professionals to understand the sociocultural implications in the health and disease process and expand the focus of actions beyond the biological dimension(8). Not understanding these implications can negatively affect users' effective participation in care.

Indications for the exclusive use of biomedical practices can enhance relations of superiority between health professionals and users and, consequently, the distancing and blocking of intercultural dialogue[8]. After the emergence of the Unified Health System (SUS), a new approach of users, involving care humanization, is gradually occurring. This approach presupposes that health service users are considered holistically, as nobody is a "*whiteboard"* (our italics) to be completed with determinations and prescriptions. It is highlighted that, when seeking health care, users bring their concerns, problems, life histories and values deriving from their life context. Acknowledging users' complexity is fundamental for high-quality health service delivery[7-8].

It is fundamental for professionals to understand the sociocultural implications in the health and disease process and expand the focus of actions beyond the biological dimension[8]. Not understanding these implications can negatively affect users' effective participation in care[9]. In this respect, it is highlighted that the predominant health education practices in the FHS correspond to the traditional and hegemonic model, privileging the disease focus and its prevention form, aiming to change attitudes and behaviors[10]. This conduct tends to enhance professionals and users' distancing, as it adopts top-down information and ignores psychosocial and cultural determinants that guide health and disease behaviors in communities. To complete the gaps present in this type of approach, it is

fundamental to train workers to acknowledge communities' cultural values, articulating popular culture and technical-scientific knowledge.

Considering Community Health Agents (CHA) as subjects who are part of a community and share its values, standards, life conceptions and beliefs, it is questioned: how do cultural issues influence the daily practices of CHA in a rural area in the interior of the State of Minas Gerais? This inquiry is related to the fact that these agents exert their professional activities in search of conformity between popular beliefs and the technical-scientific recommendations other members of the Family Health Strategy (FHS) use.

OBJECTIVE

To analyze the influence of Community Health Agents' cultural practices in a rural area in the interior of the State of Minas Gerais in their daily work.

METHOD

A qualitative case study was developed in one FHS team and two Community Health Agent Program (CHAP) teams in rural areas of a city in Minas Gerias. This type of approach permits approximating reality, as it works with the universe of meanings, motivations, aspirations, beliefs, values and attitudes, which corresponds to a deeper space of the relations among processes and phenomena[11].

The research subjects were 15 community health agents, three nurses, one physician, three nursing auxiliaries and 11 users living in the teams' coverage area. The users' selection was based on the age criterion (over 18 years). They were chosen through a random draft, using the family registration number. In each selected family, one member of age was drafted who was present at the home. To define the number of subjects, the data saturation criterion was applied[11].

Data were collected through individual interviews based on a semistructured script, addressing cultural aspects of the practices the subjects experienced. Data were collected at a time and place agreed upon with the participants, after the signing of the Informed Consent Term. It is highlighted that approval for the study was obtained from the Institutional Review Board at *Universidade Federal de Minais Gerais*, under Opinion Number ETI 611/07.

For data analysis, the content analysis technique was adopted[12-13]. Data were grouped according to the subjects' reports and categorized in the following phases: pre-analysis, exploration of the material and treatment. In the pre-analysis, data were pre-categorized through vertical and horizontal systemized reading. Then, the data were categorized and interpreted in the light of literature.

The testimonies were coded according to the Community Health Agents' denomination, using the initial *A*, followed by a number, in the order in which they were interviewed (A1, A2, ... A15). The same logic was adopted for the other professionals and users, with the initial *N* for nurses, *NA* for nursing auxiliaries, *P* for physician and *U* for users.

RESULTS

To organize the results, initially, the research subjects' characteristics were considered, followed by thematic categories.

Characterization of research subjects

Concerning the Community Health Agents' socio-demographic profile, the majority was female (73.40%). The predominant age range was between 21 and 29 years (66.70%) and 66.70% were single. As for education, 86.70% had finished secondary education. It should also be highlighted that 66.70% of the CHA under analysis did not have any previous experience in the health area. Work time ranged between 9 months and 9 years; the workday corresponded to 8 hours per day and the remuneration to one minimum wage.

As for the nurses' characteristics, the age range below 30 years was identified and all of them were single. Two of them had a graduate degree. The declared remuneration was R$2,300, in addition to an incentive to work in a rural and unhealthy area. The time of work in the team did not exceed two years and seven months.

The physician was 26 years old, single, only held an undergraduate degree in medicine and had been working on the theme for two months. She declared one year of previous experience in the FHS though. Her remuneration was R$ 5,000, also combined with an incentive to work in a rural and unhealthy area.

Concerning the nursing auxiliaries, women predominated (66.66%); two of them were single (66.66%) and one married (33.33%); the age corresponded to 30, 38 and 40 years. The auxiliaries declared they held a secondary degree and had finished a professional course and the informed salary ranged between R$450 and R$500. Their time of work in the team ranged between one and two years and all of them had previous professional experience.

The group of users was mostly female (81.80%). The minimum age was 26 years and the maximum 73 years, 81.80% were married and 72.70% had not finished primary education. Another aspect that was identified was low remuneration, as more than 50.00% of the informants had no income. As for the time of residency in the community, it should be highlighted that 72.72% of users had been living there before the Family Health Strategy or Community Health Agent Program was implanted in the region.

The daily reality of community health agents in rural areas

Concerning activities developed in the Community Health Agents' (CHA) daily work, aspects were evidenced regarding orientations that were transmitted, particularly emphasizing disease control and prevention and health promotion (Chart 1).

Chart 1 – Orientations transmitted by community health agents

Disease control	Health prevention and promotion
Prescriptive actions aimed at medication use;	Vaccination of children.
Obesity control;	Orientation to pregnant women.
Balancing of dietary nutrients, mainly for hypertensive and diabetic patients.	Maternal breastfeeding.
Clarifications about chronic illnesses like hypertension and diabetes.	Care for children under five years of age.
	Need for weight surveillance for children.
	Sexual education for adolescents and young people.
	Care with dengue.
	Care with garbage management and destination.
	Good family relationship.
	Sensitization against drugs, including alcoholism and smoking.
	Need for physical exercise for elderly people.
	Adequate nutrition.

Source: Interviews with Community Health Agents.

The daily work of Community Health Agents (CHA) is marked by actions that focus on prevention and health promotion for the population. These actions take the form of individual and collective practices and cover punctual aspects, such as vaccination and weight control, as well as subjective aspects, related with the sensitization of the community and interpersonal relations. Disease control actions were also mentioned, which are associated with chronic illnesses, nutritional aspects and obesity control.

Special attention is paid to hypertensive and diabetic patients though, concerning care for the disease, identified in the interviewed Community Health Agents' (CHA) reports, who selected this orientation as a priority in their visits, in view of the prevalence of this type of health problem among users in the research scenario. Some authors affirm that this educative action the agents promote represents a translation of the biomedical knowledge the professionals incorporated in their preparation for work. The meaning of the term translation is to take scientific knowledge into the popular universe[14-15].

Self-knowledge and cultural aspects involved in work

The agents' knowledge and life experiences influence daily work. They are part of their own and the community's cultural universe. Experiences are often retransmitted to solve simple health problems or sensitize people so as not to commit mistakes or fall back into previously experienced vices.

> I have always lived in the rural zone and saw the problems there were at the time, where I lived, a region in which people's access to the health center was very difficult. So, many people got ill there, there were health problem. Today, I can advise people in the best possible way, within the limits of what I can tell or then ask them to go to a medical center(A9).

This activity enhances the reduction of distances and the rupture of seemingly impassable barriers. Hence, being a Community Health Agent (CHA) means being a reference for the community; an example to be followed, according to accepted social standards.

> Once, even I felt bad because of drinking too much. I drink today but I am aware that, because of my job, I have to set an example, take something to the personal side (A11).

As for the use of alternative health care measures, the agent reports trusting in these methods and passing them on to people when applicable. The way this practice is accomplished is often detached from professional practice. This evidences the attempt to separate what is considered popular knowledge and life experience from biomedical orientation:

> We actually respect each person's customs to a certain extent. Religion, we don't even comment on those things at the homes. Now, as to medication facts, these things do exert influence. If there's a child here who's got problems and they ask what tea you used to give to your boys. But, that's not the case of an agent, no, it's the case of our life really. We exchange life experiences, I talk about mine, they talk about theirs, talk about child, husband (A15).

Concerning the religious dimension, it was verified that Community Health Agents (CHA) attempt to detach this dimension from the orientations given during the home visits. Religious issues are mainly present at times of social contact though, when agents act without restrictions, encouraging faith to minimize problems.

> Often, we say to put God first: "stick to God!". You stick to him with your faith and I'll do that with mine". We do what is possible to solve problems, but with faith (A12).

> I think community health agents' work is not just there in the books, just in the cards, I think it also involves gaining knowledge from the elderly and respect. Like, for example, a child is ill, then they may believe more in witchdoctors, right? So we teach what is good if he has the flue, but let them do their part, what they believe in. But also reinforce that they should what they are used to, provided that it does no harm. That's because people from small towns do that a lot (A10).

According to the Community Health Agents, beliefs and popular customs related to the use of teas and medicinal herbs contribute to community health. These prac-

tices may be conciliated with medication therapies and other biomedical prescriptions:

> In my area we are having an episode of diarrhea and vomiting and there's a lady who works with false hens-and-chickens and sorrel. She teaches us, we pass it on to the people and, often, they don't even need to come here to the center, the problem's solved. So these are experiences of older people, things of the land, which you can plan, you may have it at home and it solves the problem (A9).

Cultural values and rooted in the community and in Community Health Agents' (CHA) knowledge. Habits are part of each person's way of life and shared daily among all people. This context is part of the identity the Community Health Agents construct. They deal with cultural issues differently though, as they do not ignore technical knowledge and respect the local culture, conciliating both in their activities.

The two sides of the same coin

This category refers to the other FHS and CHAP professionals' perception of the agents' work. According to some nurses, Community Health Agents are seen as a reference for the community, which the users can turn to, at first, to seek information, complain and solve problems.

> The CHA is the key piece of the FHS. I see that, without him, I think the service really does not work, we don't know the community because, it's when the health agent acts that we are able to, we see the community through the agent's eyes, right? (N1).

Concerning relational aspects, the fact that the Community Health Agents (CHA) live and act in the same territory as the community is considered a facilitator. Moreover, personal characteristics influence their receptiveness by the community, reinforcing the bond and relation of trust, fundamental for any health professional's work:

> The family learns to like the CHA, to trust that agent who's communicative, who opens up, who likes to participate in other people's lives, who shows to the other people that that family is important to him and that he likes to be there (N2).

On the opposite, one of the interviewees appointed the fact that the CHA's being very close to the community also exerts a negative influence on their activities, alleging that living close to the community entails a greater proneness to conflicts with inhabitants.

> But he's there, that's also complicated, because anything that happens there, any problem he may have with the neighbor, already messes up the professional side. Sometimes I think that's complicated! Because these are the two sides of the same coin. (N1)

As for the cultural aspects, according to the nurses, people's values and customs are respected, but the agents also encourage the maintenance of some habits that are not adequate.

> The agent himself has his cultural aspects, he doesn't give that up when he's visiting. *You've got high blood pressure, have some tea*. So, he's got this cultural perception, which he doesn't give up, he does this even blindly. And he also respects people's cultural perception (N2).

It is also observed that, in daily practices, popular knowledge is mixed with scientific knowledge. In this respect, it is highlighted that popular knowledge crosses generations and is part of the population's cultural universe. Hence, in disease prevention and health promotion practices, popular knowledge should be taken into account, contributing to good social contact and to the establishment of adequate care forms.

The medical professional's perspective on the cultural elements that permeate Community Health Agents' activities should also be underlined. For the interviewed physician, although the agent and user believe and use habits deriving from popular culture, they seek medical help if they do not reach the expected results. Difficulties to modify these habits are mentioned though, especially among agents living in interior cities and who cultivate ancient customs:

> There are families that are completely closed off, that do not want anyone from the outside to get close and find out, the doors are really closed! And it's difficult to change cultural habits, it's difficult to tell people to use sunblock; to clean the house without seeming intrusive. And that is opposed to what people are accustomed to in their daily life! So, health professionals try to change habits but have to respect individualities (P1).

As for the nursing auxiliaries' perception, they highlighted the population's lack of knowledge about the Community Health Agents' activities and about the functioning of the Family Health Strategy and the Community Health Agent Program, attributing some difficulties in their daily practices to this lack of knowledge:

> The community itself makes it difficult because, sometimes, we work with patients who do not accept the FHP or the CHAP's functioning (NA1).

The users acknowledge the conciliation of popular and biomedical practices the agents perform, assuming the use of drugs to improve their health condition, despite the maintenance of religious practices:

> The CHA says like, *blessing is good, but you need the medicine, right?* So it's no use for you to bless and not take the medicine, it's the same thing as praying and not taking the medicine! So, they say, encourage that blessing is good! (U8).

Knowing the viewpoint of professionals who share daily work with Community Health Agents (CHA) showed its relevance, as it allowed us to identify singularities in their actions, as well as the direct relation between cultural issues and health practices in the community.

DISCUSSION

Based on the Community Health Agents' socio-demographic profile, it is observed that their function represents an employment opportunity in the communities. Their lack of previous experience in health services is in line with their age, the family's socioeconomic situation, the priorities of marital life and the limitations characteristic of these subjects' life stories[16]. The remuneration agents are offered is qualified as low and similar to that of the large majority of the population they monitor. It is highlighted that their wages remain fair below those of other team members, in line with data in a study accomplished in Porto Alegre, which clearly reveal Community Health Agents' little professional valuation[17].

The presence of CHA in family health care programs has shown the relevance of these social actors in collective health practices, mainly regarding social mobilization actions to prevent illnesses and promote health.

Health promotion represents a change strategy in techno-care models, signaling the construction of other possibilities for new knowledge and activities that broaden the community's training process to act in order to improve their own quality of life and health[18]. Thus, the goal is develop community empowerment in the health-disease process. Health promotion is accomplished through concrete and effective community actions in the development of priorities, in decision making and in the definition of strategies to improve health conditions[19]. Community Health Agents are incorporated in this strategy to promote a true integration among health professionals and the community.

Despite the theoretical premises that guide health promotion actions, in practice, the care mode Family Health offers is still directed at the biological dimension and at medical knowledge, identifying the disease in the body and delivering care through therapeutic resources[20]. The range of the interprofessional structure can be evidenced through, covering care forms that go beyond the exclusive focus on the disease. The expansion of the care focus is observed in the CHA's daily practices in the rural area under analysis, even if it is empirically put in practice.

In this perspective, it could be evidenced that the CHA's work is characterized by routines, predominantly related with home visits, although other activities are part of their daily reality. Among these activities, participation in operating groups, planning, team decisions, help with welcoming at health units and updates in family registers stand out. Also, the incorporation of distinguished activities is underlines, including administrative and decision making actions.

All Community Health Agents mention home visits in the description of their daily work, which are fundamental in the interaction with families, in view of the construction of trust and friendship bonds, the observation of relatives' habits, information exchange and transmission of orientations about health care. Agents frequently serve as the communication channel that transfers information between the health team and the family. Appointment making in the city or beyond (with specialists) is perceived as a CHA activity in rural areas, which derives from the fact that they are close to people and recognize the demands for primary health care or forwarding to another service. Thus, it is observed that the CHA have accomplished activities that go beyond their attributions and competences.

In other studies, the main activities Community Health Agents perform coincide with the present research findings, appointing home visits, health education related to hygiene, vaccination, care delivery to children, pregnant and puerperal women and elderly people. Administrative work in the context of the health units is also observed[21].

Concerning the CHA's preventive care practices, those aimed at disease control stand out, which may be related to their previous preparation to work in this area. It is highlighted that disease prevention is linked with a biological and behavioral view of the health-disease process[22].

As to the strategies used for health promotion and disease prevention, educative material is adopted, which is rich in preventive and health promotion information. Training within and outside the team and information transmitted in daily work were also mentioned. Information aimed at disease control and care is more specific for professionals who deal with treatment, control and rehabilitation, i.e. physicians and nurses.

The Community Health Agents consider their orientations relevant in health practices, revealing that they have positively influenced the population's health conditions. The success of the orientations and educative practices the CHA appoint grants meaning to their work and raises their self-esteem and social acknowledgement, contributing to the consolidation of their social identity[5]. Despite the relevance of their actions, some of the CHA admit that there is a lack of knowledge in certain areas and assume their limitations, indicating the need for training and courses to support their improvement. Their understanding of community problems facilitates and derives from previously established relations and experiences in the community. The Community Health Agents know daily forms of living, of signifying life and how families behave, and they use these forms to put in practice their work.

The religious dimension is also present in the CHA's testimonies, which give meaning to the beliefs and manifestations of faith. In this perspective, the welcoming practice stands out as a relevant factor, in addition to religious practices, in view of its contribution to help people to elaborate the experience of suffering[7].

The Community Health Agents have customs and beliefs and share them with users, so as to complement biomedical prescriptions with a view to guaranteeing pa-

tients' improvement. Some studies attribute this attitude to the agents' technical shortages[20]. It is believed that a relation exists between low level of technical training and the strong influence of in-rooted cultural values in their daily reality, as they have more arguments and explanations for these values than for biomedical orientations. In a study about the appropriations of popular knowledge, it was observed that the users believe that unconventional health care practices can offer positive responses to illnesses and suffering and represent the first conducts adopted before seeking medical help at the health service[7]. Besides, trust is vested in natural practices like *medicine from the woods* as, coming from nature, they are beneficial and, even if they do not result in cure, they will probably not cause any harm[8]. In this respect, it is highlighted that people's identity and the things they use in leisure, work and the satisfaction of basic needs, like a type of food they consume for example, are interrelated[20]. The meanings these practices produce position the subjects and give sense to existence and to what one is.

From the perspective of FHS professionals, the agents' work is relevant and loaded with expectations, which are based on aspects related to initiative, knowledge dissemination, professional posture, incorporation of values, among others[23].

The proximity with the community makes the relationship between agent and user increasingly easy. The community starts to contact the FHS and CHAP not only in case of illness or need for medical care. Thus, the Community Health Agents' functions is not only restricted to care delivery to physical, but also to mental health, and mainly to the promotion of wellbeing[21].

CONCLUSION

The Community Health Agents' knowledge and life experiences influence their work and point towards new health care production possibilities. Their cultural universe and the community they belong to mark their daily practices, conciliating scientific with popular knowledge.

The presence of Community Health Agents in the Family Health Strategy has positively affected the care delivered, as these professionals are members of communities. Thus, the shared experiences and the inherited culture influence their daily activities, permitting the development of health promotion and disease prevention actions. It should be highlighted that the health practices the Community Health Agents (CHA) develop in the communities gain relevance to put in practice public health policies in Brazil, making room for new possibilities to attend to the population's actual needs, in view of the conciliation between customs and beliefs and other therapies needed for patient care. It is fundamental to incorporate scientific into popular knowledge, as the later surpasses generations and is part of culture.

REFERENCES

1. Boehs AE, Monticelli M, Wosny AM, Heidemann IBS, Grisotti MA. Interface necessária entre enfermagem, educação em saúde e o conceito de cultura. Texto Contexto Enferm. 2007;16(2):307-14.

2. Cavalcante AM. A cura que vem do povo. Psychiatr On Line Brasil [Internet]. 2001 [citado 2010 fev. 21];6(3). Disponível em: http://www.polbr.med.br/ano01/mour0101.php

3. Penna CMM. Realidade e imaginário no processo de viver de moradores em um distrito brasileiro. Texto Contexto Enferm. 2007;16(1):80-8.

4. Brasil. Lei n. 11.350, de 5 de outubro de 2006. Regulamenta o § 5o do art. 198 da Constituição, dispõe sobre o aproveitamento de pessoal amparado pelo parágrafo único do art. 2º da Emenda Constitucional n. 51, de 14 de fevereiro de 2006, e dá outras providências [Internet]. Brasília; 2006 [citado 2010 fev. 21]. Disponível em: http://www.planalto.gov.br/ccivil_03/_ato2004-2006/2006/lei/l11350.htm

5. Brito MJM, Gazzinelli MFC, Melo MCOL. Os estágios identitários da enfermeira-gerente: uma abordagem piagetiana. Texto Contexto Enferm. 2006;15(2):1-15

6. Dubar C. Trajetórias sociais e formas identitárias: alguns esclarecimentos conceituais e metodológicos. Educ Soc. 1998;19(62):13-30.

7. Siqueira KM, Barbosa MA, Brasil VV, Oliveira LMC, Andraus LMS. Crenças populares referentes a saúde: apropriação de saberes-sócios culturais. Texto Contexto Enferm. 2006; 15(1):68-73.

8. Kreutz I, Gaiva MAP, Azevedo RCS. Determinantes sócio-culturais e históricos das práticas populares de prevenção e cura de doenças de um grupo cultural. Texto Contexto Enferm. 2006; 15(1):89-97.

9. Monticelli M, Elsen I. A cultura como obstáculo: percepções da enfermagem no cuidado às famílias em alojamento conjunto. Texto Contexto Enferm. 2006;15(1):26-34.

10. Alves VS. O modelo de educação em saúde para o Programa Saúde da Família: pela integralidade da atenção e reorientação do modelo assistencial. Interface Comun, Saúde Educ. 2005;9(16):39-52.

11. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 8ª ed. São Paulo: Hucitec; 2004.

12. Bardin L. Análise de conteúdo. São Paulo: Martins Fontes; 2009.

13. Rocha D, Deusdará B. Análise de conteúdo e análise do discurso: aproximações e afastamentos na (re)construção de uma trajetória. Alea Estudos Neolatinos [Internet]. 2005 [citado 2010 fev. 21];7(2):305-22. Disponível em: http://www.scielo.br/pdf/alea/v7n2/a10v7n2.pdf

14. Levy FM, Matos PES, Tomita NE. Programa de Agentes Comunitários de Saúde: a percepção de usuários e trabalhadores da saúde. Cad Saúde Pública. 2004;20(1):197-203.

15. Nunes MO, Trad LB, Almeida BA, Homem CR, Melo MCIC. Agente Comunitário de Saúde: construção da identidade desse personagem híbrido e polifônico. Cad Saúde Pública. 2002;18(6):1639-46.

16. Bachilli RG, Scavassa AJ, Spiri WC. A identidade do agente comunitário de saúde: uma abordagem fenomenológica. Ciênc Saúde Coletiva. 2008;13(1):51-60.

17. Ferraz L, Aerts DRGC. O cotidiano de trabalho do Agente Comunitário de Saúde no PSF em Porto Alegre. Ciênc Saúde Coletiva. 2005;10(2):347-55.

18. Santos LPGS, Fracoli LA. Community Health Aides: possibilities and limits to health promotion. Rev Esc Enferm USP [Internet]. 2010 [cited 2010 May 14];44(1):76-83. Available from: http://www.scielo.br/pdf/reeusp/v44n1/en_a11v44n1.pdf

19. Silva KL, Sena RR, Grillo MJC, Horta NC, Prado PMC. Promoção da saúde como decisão política para a formação do enfermeiro. Rev Esc Enferm USP. 2007;41(n.esp):826-9.

20. Silva JA, Dalmaso ASW. Agente Comunitário de Saúde: o ser, o saber, o fazer. Rio de Janeiro: FIOCRUZ; 2002.

21. Pedrosa JIS, Teles JBM. Consenso e diferenças em equipes do Programa Saúde da Família. Rev Saúde Pública. 2001;35(3):303-11.

22. Westphal MF. O movimento cidades/municípios saudáveis: um compromisso com a qualidade de vida. Ciênc Saúde Coletiva. 2000;5(1):39-52.

23. Martines WRV, Chaves EC. Vulnerabilidade e sofrimento no trabalho do Agente Comunitário de Saúde no Programa de Saúde da Família. Rev Esc Enferm USP. 2007; 41(3):426-33.

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