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The work of the community health worker from the perspective of popular health education: possibilities and challenges

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Abstract *This article addresses the possibilities and challenges in the performance of the community health worker (CHW) from the perspective of the National Policy of Popular Health Education. It is based on the analysis of findings from a research-intervention carried out at a Family Health Center in a small city in the southern region of Brazil. The data analyzed was produced in meetings with the research team, in activities with the CHWs (individual interviews and workshops), and in feedback sessions with the team regarding the intervention. Among the results, the intertwined role of the CHW within the team was emphasized. In situating themselves between technical and popular forms of knowledge, the work of the CHW potentializes the actions of the Popular Health Education program, as it points to the need for training, agreement of the developed practices, and professional valorization. From these findings we were able to approach and understand the results in terms of the National Policy of Popular Health Education. Based on the analyses, we recommend the establishment of practices associated with the broader concept of health sustained in holistic teamwork that valorizes the knowledge/action of CHW and of the community, inspired in the guiding principles of PNEP-SUS.*

Key words *Health education, Community Health Workers, Health promotion, Primary care, Unified Health System*

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Introduction

The healthcare model implemented in Brazil during the last two and a half decades has aimed at the decentralization of assistance and invested in strengthening basic care (*Atenção Básica,* or AB). The National Basic Care Policy, issued by decree No. 2488/2011[1], establishes the following principles and guidelines for AB: the exercise of democratic and participatory practices of care and management, teamwork, aimed at populations in the defined territories and comprising the individual in their singularity and sociocultural inclusion, in search of holistic, integrated care[2]. For these principles and guidelines to materialize, the insertion of the health teams and the everyday practices of support need to respect the local culture and the popular knowledge that gives meaning to the way that people experience their health-sickness process.

It is no accident that the Family Health Strategy (ESF) takes the Program of Community health workers, created in 1991, as its basis[3]. The ESF presents itself as the main strategy for the consolidation and expansion of the AB, to establish the organization of action in the territory, in a close relationship between the team and the users of the health system. Among the main work characteristics of the AB are educative actions that intervene in the health-sickness process of the population, in the development of individual and collective autonomy, and in the search for quality of life by the users[2]. The focus of production in health, thus, faces the differences and singularities of the communities served that demand specialized teamwork.

The community health worker (CHW) plays the role of mediator between the technical and popular forms of knowledge, and between the healthcare staff and the community. At the same time that he is part of the healthcare staff, he is also part of the community; at the same time that their practice is for the community, it is also of the community; at the same time they feed on technical-scientific knowledge, they are also absorbed in the local culture of health. One of the inherent potentials of the work of the CHW is in the possibility of transcending the existing dichotomy between technical knowledge and the knowledge of the populace, moving towards the construction of discourses that promote broadened understanding and experiences of the concept of health[4]. In this way, they stand out as a broker of emancipatory actions and practices in health.

According to the data of the Department of Primary Care of the Ministry of Health (MS), in June of 2015, Brazil counted 332,289 CHWs accredited by the MS, covering an estimated population of 128,804,351[5].

The present article is the fruit of reflections produced from the analysis of the findings of a research-intervention developed alongside a health unit of a small municipality in the southern region of Brazil. From the results established regarding the possibilities and challenges of CHW performance raised by this research-intervention, we will analyze here the powerful convergence of the problematics of everyday work realities with the precepts of Popular Health Education aiming at the materialization of genuine Collective Health[6].

Popular health education as a strategy of operationalization of the broader concept in health

Popular Health Education (EPS), inspired by the Popular Education movement created by Paulo Freire, considers the following in addressing question relative to health,: 1) the concrete possibilities of the life context of subjects that facilitate or complicate the occurrence of transformation in their way of living, and 2) that it will be necessary to act upon these possibilities, in order for the changes to materialize[7]. The act of education, thus, occurs in the identification, discussion, and intervention of "social issues in a given community that traverse the social practices and conceptions of health/sickness"[6].

The EPS problematizes the naturalization of compulsory health interventions, imbued with a morality, with the aim of transmitting biomedical knowledge considered indispensable for health. The broader concept of health encompassed by the EPS takes into account peoples' common knowledge about the experience of illness and healing. The production of health occurs by means of the production of life; hence, the point of departure for the educative process happens with discussions, participatory diagnosis, assemblies, and manifestations of folk culture[8].

The National Policy of Popular Education, anchored in the ethical principles that enhance human relations generated in the act of educating, is geared toward the establishment of educative processes and emancipatory social work. It positions itself in favor of the "promotion of autonomy of people, of horizontality between popular and technico-scientific knowledge, of

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the cultivation of critical consciousness, of participatory citizenship, of respect for the different types of life," with the intention of transcending "social inequality and all forms of discrimination, violence, and oppression"[5].

Decree 2.761/2013 established the National Policy of Popular Health Education within the framework of the Unified Health System (PNEP-SUS). In its 3rd Article, the PNEP-SUS states the following guiding principles: I – dialogue; II – affection; III – problematization; IV – shared knowledge construction; V – emancipation; and VI – commitment to the construction of the democratic and popular project[9].

Starting with this contextualization, we present reflections on the possibilities and challenges of the process of the CHW's work and their interface with the guiding principles of the PNEP-SUS.

Outline of a methodological path

The research-intervention

The reflections expressed here are associated with the results of a research-intervention produced through following the work processes of a Family Health Unit. The research-intervention is associated with the modality of participatory research[10,11]. Basing itself in the ethical-aesthetic paradigm, the research-intervention is characterized by the following: a process of denaturalization of the object it seeks to know and of the subject/object dichotomy; recreation of the field of investigation; involvement of the researcher in the singularizing of the accompanied experiences and, thus, in a social and political engagement with the reality in which they work[12]. These preconditions are connected to the premise that to research is to intervene[11,12], to the degree that the combination of knowledge and action produces other realities, sparking new questions and new subjectivities[12].

The research group was comprised of three psychologists, teachers in the Psychology program, and two interns in psychology. Inspired by institutional analysis[13], the researchers formulated the analysis of the demand production, the diagnostic formulation, the planning of interventions, and the feedback sessions and work evaluations carried out together with the team[14].

The research took place in an ESF of a municipality of approximately 25,000 residents in the southern region of Brazil. The ESF team was comprised of one doctor, one dentist, one nurse, three nursing technicians, eight CHWS, two receptionists, and one cleaning assistant. Temporarily, one nursing intern and two psychology interns (members of the research group) comprised part of the team.

The production of the demand began with the activity of members of the ESF team, in particular the CHWs. The issues experienced in the quotidian life of the ESF were addressed to the psychology interns in search of spaces for listening and reflecting upon the inherent practices of the work being done.

The outline of the elaboration of the research is created through contact and mixing with the ESF team. Initially, the research team meets with leadership and afterwards with all the members of the service team to analyze the demand. The production of diagnosis and of strategies of intervention were engendered in the meetings with the ESF team – in listening to the questions of the team members; in the ethical-political involvement of the researchers in favor of establishing health-promoting practices[15,16] anchored in the principles of collective health[6]; and in the exercise of other relations between subject and object, theory and practice – in order to affirm the interventionist character of knowledge, "all knowledge is action"[14]. Understanding that these premises are mutually produced by the researcher and the researched, in rapprochement with the field of study, secures the inseparability of theory and practice.

For the elaboration of intervention strategies, we took into account the production of analyzers, or in other words the "occurrences, in the sense of that which produces ruptures, that catalyzes flux, that produces analysis, that decomposes"[12]. Among the analyzers, questions associated with the work of the CHW gained emphasis in meetings with the team. Situated *among* the outside and inside of the health service, the questions involving the quotidian activities of the CHW were proven to be complex, to the degree that they would translate concepts and ways of acting regarding health that were present in the work of the rest of the team. The execution of a task together with the CHWs was prioritized by the team in the definition of an intervention's proposal and contract.

Hence, the participants of the workshops were eight CHWs, age 24 to 51. There were seven women and one man, the majority of whom possessed high school diplomas, and had on average five years of professional experience. For the outlining and operationalization of the intervention, group interviews and workshops were carried out with the CHW agents.

First, each CHW responded to a semi-structured interview that contained questions regarding socio-demographic data, pertaining to their professional trajectory as a CHW and their understanding and contextualization of their work in the area of health. This material was recorded and transcribed in its entirety. Afterwards, five workshops with each group were held, with an approximate duration of an hour and a half, registered in a logbook.

In the first meeting, the group contract was made with a mapping of the expectations of the CHW in relation to the workshops and the difficulties encountered in their everyday work. The theme of the second workshop, chosen by the CHW, reflected on the duties of the CHW according to their perceptions and by Decree No. 1,886/1997, which specifies the tasks of the CHW. In the third meeting, the CHW agents talked about personal experiences charged with violence and suffering that had a negative influence on their relationships with the community and with the technical team. In the fourth meeting, the importance of collective work in order to face these violent experiences was discussed. In the closing workshop, all of the themes developed in the process of the research-intervention were discussed. With the CHW, it was elaborated and agreed upon what would be presented as feedback in the meeting with the ESF team.

Various techniques were utilized in the meetings such as: storytelling, rounds of conversation, and dramatizations, among others, connected to the discussion themes. The triggering theme of each workshop was identified in the interview with the CHWs, in the evaluation of each workshop, and in the meetings of the team. Each week, in the meetings with the group of CHWs and the research groups, participants evaluated the planned and executed intervention, the results, and the analysis of implications produced[14] with an aim to guide the planning of the next meeting.

In this sense, the quotidian situations presented by the CHWs were taken as complex social events determined by a heterogeneity of factors and relations[17]. The reading of the issues expressed in the everyday work of the AB was done from a historical and political perspective. Thus, the challenge was to place both the implications of the group with the practices produced under analysis, in order to advance instituting movements to the naturalized questions.

The results produced with the CHW group expressed: little time for initial work training; difficulties with concretely conceptualizing their practices; professional devaluation, as much on the part of the ESF as by the population; and difficulties in separating the quotidian aspects of their work from their personal life as someone belonging to the community. Elements such as these can generate psychic suffering in the worker[18].

The production and analysis of the data were engendered during the intervention, denoting a process of collective construction anchored in workshops and the review of the literature on the theme being addressed. The synthesis of discussions and results elaborated in the workshops with the CHW were shared with all of the team, aiming to establish processes of self-analysis and self-management in the work process of the ESF team.

The research project was approved with report number 188.1/2011 by the Ethics Committee on Research with Human Subjects (CEPSH) of UNIJUÍ. The research met the requirements for the ethical aspects of research according to resolutions No. 196/96, 2012 version, and No.251 of August 5, 1997, of the Ministry of Health, and by the ethical position of the professional psychologist, meeting the resolution of the Federal Council of Psychology.

Research-intervention as a trigger of reflections on the EPS

The work done with the CHWs generated concerns and worries among the research group. Among them were some related to the PNEP-SUS. Therefore, for the purpose of this article, we focus on the recovery of the material in the logbooks, the conversations, and the scenes arising from this research-intervention that raised questions about the possibilities and challenges of the professional practice of the CHW in the perspective of the EPS, with emphasis on the guiding principles of the PNEP-SUS. The reflections produced by us are presented in the following section as a result of a mobilization to face these realities.

The performance of the CHW in the PNAP-SUS: (im)possibilities and challenges

The membership and participation of the CHW in the group activities was massive, denoting the need and valorization of a space for speaking and listening. For its part, the support for workshop space demanded moments of team problematization. Even with a scheduled day and time, there was an overlap of activities that inter-

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fered with the workshop. In discussing the issue within the team, the *inter(connected)* professional space occupied by the CHW was clarified: resident and worker, popular knowledge and technical knowledge.

This space sometimes mirrored the difficulties of the team to address the peculiarities of the work of the CHWs. As both resident and worker in the area serviced, in certain moments the other professionals did not see the CHW as an "inside" member of the team. In comments by other members of the team, their place was relegated to "walking the street" or even "running around the street," associated with the idea of someone about whom "nobody knows for certain where they are" (daily logbook, November 2011). Thus, even impacted by other issues, such as the difficulty of controlling the work schedule, "outside" is their place. Hence, perhaps this accounts for the strangeness for the whole team, and even for the CHWs, of the occupation of a space "inside" with the workshops. The problematizations and tensions produced by the *inter(connected)* space become an analyzer of the work of the CHWs.

Integration with the team, apart from a view of "team and CHWs," may be related to the guiding principles of the PNEP-SUS. In particular, this is a difficulty in operationalizing the *commitment to the construction of a democratic and popular project,* by which is meant "a reaffirmation of the commitment to the construction of a just, solidary, democratic, egalitarian, sovereign, and culturally diverse society"[9]. For this, it requires pursuing the creation of health practices "that have popular subjects, their groups and movements that historically were silenced and marginalized, as protagonists"[9]. The non-opening of spaces on the part of the ESF team contributed to the CHW not feeling like part of the team, perceiving their activity as unqualified, hence weakened.

As a professional that belongs to the health team, the CHW introduces the conditions to promote individualized care in relation to the health of people by conducting household visits and using an accessible language. In the everyday work of the health professionals, they are capable of establishing a *dialogue of intimacy*[9] with the population. In weaving relationships of empathy and reciprocity, with "an expansion of dialogue in the relations of care and in the educative actions by the incorporation of exchanges of emotion and sensibility"[9], the role of mediator in health actions falls to the CHW. In taking on the role of mediation and articulation between the health team and the community, the CHW establishes themselves as a pivotal element of the health actions[19-22].

In the quotidian work of the studied ESF, the follow-up work of the CHW involves technical actions linked to health guidelines, marked by a network of affection and closeness created by the established link[23], as can be seen in the following transcript:

…I accompanied the mother since the pregnancy and today I see that they respect me. When I arrive at their homes, they are glad and I feel good around them. It is as if we were genuinely family. I truly like the children. We watch over them as if they were our own kids, you know? To know them since pregnancy and today they are all going to school already. (CHW L)

The closeness of relations and affections established are associated with the opening of *dialogue* and the creation of practices of *intimacy* with one another – two of the six guiding principles of the PNEP-SUS[9]. As is told in the statements of the CHW, these experiences of exchange with the families assisted, mingled with different types of knowledge (as much for the family as for the CHW), contribute to the holistic development of the children[24] in this community.

It can be observed, however, that the perspective of the community about the function served by the CHW in everyday work is sometimes associated with the checking of signs and symptoms linked to a biomedical understanding of health. This is a demand that, while strengthening the diverse dimensions of the CHWs' work, shows an ingrained understanding of their duties as curative, as noted by Stoltz, David and Borstein[8] and related by an CHW:

The technicians could teach us to measure blood pressure because many people ask us to do this […] *When they make a house-call, they can do it. But we can't and try and explain this to them, but not everyone understands.* (CHW L.)

In associating themselves in a primary sense with a biomedical understanding of health, the CHW does not visualize the efficacy of their encounters with the population, except through medical devices, associating them with the frustrating situations of their work. In this way the demands of the population and the actual duties delegated to their work practice are indicated as difficulties for the organization and realization of CHW activities[25], as expressed in the passages that follow:

Maybe they could make better use of us, don't you think? Enough people complain because we cannot use a blood pressure device, or something

of that sort, which would at least be something… useful, but useful for them also… (CHW M.)

Sure, there are many times when people ask us to do some technical work, you know? Of course it's not part of our role, but this could be a good thing, if we could have had technical training. (CHW L.)

Even bearing in mind which duties are theirs, the fact of not possessing "*a technical training*" like the other ESF professionals is viewed by the CHW as a flaw, at the same time that they believe if they were carrying out "concrete" actions they would be "more useful" to the population[25]. The devaluing of the health actions performed by the CHW causes a weakening in the promotional and preventative health actions. As a counterpoint, it activates the principle of the PNEP-SUS that refers to *problematization*[9], in that it falls to the health teams and other professionals to cultivate dialogical relationships in the approach to constructing health practices rooted in the critical reading and analysis of reality. The recognition and reinforcement of the actions performed by the CHWs as engines of health actions[21] make them fundamental for the realization of practices guided by the EPS.

In this sense, the discussion necessarily turns to the appropriation of the broader concept of health by the entire team, and the creation of practices that valorize health knowledge linked to the territory and to the life context of the people and of the community as a whole. From the perspective of the EPS, the health actions are considered in a non-vertical way, basing them in practices that contemplate more than health *for* the people and thinking about their composition *with* the people[6]. Thus they are taking on the project of a *shared construction of knowledge* in a collective way, in accordance with the guiding principles of PNEP-SUS[9].

The understanding of the constraints towards the equalization of a healthy life is associated with issues linked to factors such as a healthy diet, reduction of stress, physical activity, and the presence of spirituality, as indicated in the expansion of the concept of health proposed by Czeresnia e Freitas[15]. The lines that follow illustrate these concepts:

Health has to be something like this… a person feels good in every way. She has to have … harmony within the household, right? Have peace… I think that spirituality is an essential. […] where there is no belief… we can see that there.. it's destructive, isn't it.. health is not only… medication… it is the whole process of well-being of the family, isn't it… that sometimes the family… someone in the family is sick, but in itself the family is well, right… (CHW L.)

Not getting stressed out, having a normal life, you know, to whatever degree possible. (CHW G.)

For me it is the well-being of people, that they have some physical activity, a healthy diet… (CHW R.)

The CHWs reveal a keen understanding of the broader concept of health that transcends an exclusive focus on illness and of interventions that solely prioritize the medical path[16]. Based on these understandings of health, we may conclude that these CHWs, in their quotidian practices, are capable of reflecting and creating dialogues[9] and health practices together with the population that move towards the deconstruction of a concept of health limited to biomedical knowledge and a curative perspective. From there, they can promote emancipatory practices[9] together with the population in joint responsibility regarding the process of health-sickness-care.

While the understanding and production of health actions associated with the enlarged concept of health was considered an advance, integration with the team and support in carrying out teamwork was one of the difficulties faced by the CHWs. One of the difficulties for professional practice was the lack of moments of exchange in the team that would make discussion and instrumentalization of work possible, so they could effectively craft resolutions to the health problems that foster the exchange of knowledge together with the population[8]. This is not a verticalized movement imposing these forms of knowledge, but an enrichment of the possibilities for confrontation of the situations lived through by the population.

There are families that have problems with adolescent children…. They don't know how to explain many things about sexuality and they come ask me. I'll say a few things, but we have to work on some subjects as a team, like we have done when the other nurse was still here. And afterwards I got everyone together to talk, explain a lot of things. (CHW M.)

We have to know how to do everything, even teach a young married woman how to have relations with her husband. And to him we have to say that he needs to have patience and be caring. If we were prepared for this it would be better. (CHW M.)

I'm there every day… I see the physiognomy of the person, take note of it, you know, and from there when I see there is really some sickness, I ask the person to see a doctor, we take precautions and

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if necessary, we find, sometimes you have to even do the work of a psychologist (laughs). (CHW L.)

… since we listen to them, they vent about things. We give advice about nutrition or other things, check the vaccine card... They comment about everything. (CHW R.)

Given the diversity of demands associated with the work of the CHW, support beginning with the welcome, listening, and backing of the team are fundamental for the realization of health actions that consider the *commitment to the construction of a democratic and popular project*[9]. To attend to these needs, a longer time is needed to hear people and their demands, which can only be accessed through interaction, through the establishment of links and relations of trust. To this end, the materialization of the general goal of PNEP-SUS of implementing Popular Health Education in the context of SUS, contributing with population participation, participatory management, social control, attention, training, and educative health practices[9] becomes a challenge to be faced. Without support from the health team the CHW perceives themselves as not knowing know how to utilize the knowledge/resources of the community, and the good relationship established with the user ends up being threatened. The population, in many cases, comes to see itself not as a participant, a protagonist of their health-sickness-care process, but as always complaining, dissatisfied and resistant to preventive measures and promotion of health, preferring medication and welfare benefits.

Look, we try, like when we form a health group, we always try something new for people. Read, research, look for a dynamic, to bring the people to participate in the health group because we want the people to participate, because it's not about coming here to the unit and just take, take, take and don't participate in the extra things. (CHW C.)

These activities, however, are also made difficult by the great number of families served for the fulfillment of pre-established targets, as told by one participant:

I have 285 families, you know? Impossible, there's no way…, but I'm happy. (CHW L)

In the view of CHWs, they receive little follow-up and aid from the municipal service network, as well as from their own work team. The shortage of mobile technology for recording data, communication with the team, and computerization of data that would confer an optimization of the follow-up process for families, comprises an area of difficulty in the work process[26]. This isolation results in weakening important characteristics of the duties linked to EPS, as noted by Bornstein et al.[8], such as assuming a position of leadership in the community, the capacity to communicate with people, and to stimulate the joint responsibility of users. When prompted to suggest improvements in the work of the ESF, a feeling of helplessness and insecurity can be observed, illustrated in the passages that follow:

I think that we have to speak with one voice. The fact that everyone speaks the same language, like where everyone works on the same thing, this is not to load things off onto the shoulders of another… I'm just not the right person to say this. (CHW M)

Qualifying and training us, that would be the first thing, wouldn't it? Putting more professionals out there and decreasing our areas, reducing our population – we can give more attention to those that we have. (CHW M)

Final considerations

As indicated by the CHWs themselves in some hints about how to confront the problematic situations, it falls to all the AB professionals to make a commitment to the construction of a democratic and popular project in health work.

The interventions[28] carried out highlight ongoing processes, permeated by questioning, meetings, and disagreements occurring in the everyday work of the CHW. The relations established in the "intertwined" pair of research team and community, the singularity and specificity of its knowledge, are facilitating factors in the EPS process. In this sense, the CHW can be seen as a pivotal individual in the actions of the AB, a "catalyst of citizens," in initiating *dialogues,* relations of *affection, problematization,* and *emancipation* in closeness with people, in the *shared construction of knowledge*[9] using and valorizing the existing resources, reducing distances in order to deliver information into the everyday life of people, permitting the free expression and valorization of the subject in the construction of their reality. In this sense, the CHW is contributing to the *commitment to the construction of a democratic and popular project*[9].

If we look at advances in the educative process in health – influenced by the search for universality, equity, and wholeness – we see that there is still a need to break with concepts rooted in a biomedical heritage that fragment and verticalize the work processes. They create separations in the relations between the work teams and with

users, as expertise is invested, in some cases, in a single knowledge/space, and errors are accentuated by the lack of training. This is one of the challenges found in teamwork together with the CHW.

In everyday encounters with distinct situations and subjective particularities, the CHWs have need of effective support of a work team and management to avoid the weakening of their actions or, on the other hand, as a defense against crystallization/hardening. In spite of recognition of the importance of this worker, there is still little investment in their training. There is little inclusion or listening to the CHW in the team, with little recognition of their participation. Consequently, in a general way there is a reduction in their critical process and engagement with the practice of leadership in the community.

From the perspective of permanent education, the qualification of work and the support of the healthcare team, in relation to duties, were considered important points for the strengthening of the CHW's performance, as noted by Vasconcelos[28]. In some cases, the feeling of not belonging to the healthcare team, and being regarded as someone in the community, reinforced the prioritization of actions linked to technical knowledge in detriment to popular knowledge, thus weakening the role of the CHW as a subject of the EPS.

In the Health Teams, the CHW is the professional that occupies the prominent position in performance in health from the perspective of Popular Education. As someone who is part of the community, the CHW knows and experiences the needs of the residents, while as a member of the health team (but not always), their role is recognized and legitimated by the other professionals of the ESF in which they operate[23,29]. The EPS, for its part, legitimates the place of the CHW in the health teams and, furthermore, recognizes their protagonism.

In the EPS perspective, it is the function of the CHW to assist the families of their community, offering information, intervening in educative processes, enabling access to the health unit, carrying out actions of lesser complexity, and facilitating the entrance of the professional into peoples' homes, among other things. They are also given the role of incentivizing community participation and the development of local organization[8].

Under this approach, the CHW comes to be seen, potentially, as an educator to the degree that their actions turn to the promotion of health education actions. The realization of the CHW's work as educator points to two challenges that can be confronted in the everyday life of the AB: the appropriation and establishment of practices associated with the wider concept of health, as well the integrated work of the entire Health Team from this perspective. Thus the training of health professionals guided by the principles of Popular Education becomes fundamental as a method[30].

For changes possible in this context, some fundamental ones are the implementation of the guiding principles proposed by the PNEP-SUS and the recognition of the place occupied by the CHW. Just as the potentialities for the creation of closer relations with the users of the SUS, in order to establish practices links to an expanded concept of health and the strengthening of a model of healthcare that privileges strategies for promotion and prevention. Thus, necessary elements are: 1) strategies of permanent education in health associated with EPS that value local and cultural knowledge, that makes possible a transformative vision for the community in such a way as to guarantee the collective construction of quality health for all, based on popular participation, and 2) the encouragement of discussion about the work process among the different subjective involved in the production of health – health professionals, managers, and users.

The challenge of the AB is in promoting horizontal relationships anchored in ethical principles, to the degree that those who teach also learn, and that the production of health occurs within this relation of immersed exchanges in life. This is to agree with Gomes e Merhy[30], in that the greatest challenge to all is make health education more than just an occasional offer of services, and into something "interconnected" in its practices, effectively constructing popular participation in the quotidian life of health services.

Collaboration

RC Maciazeki-Gomes participated in the development of the project, fieldwork, analysis of data, composition, and revision of the article. CD Souza and L Baggio participated in the fieldwork, analysis of data, composition, and revision of the article. F Wachs participated in the revision of the article.

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References

1. Brasil. Ministério da Saúde (MS). Portaria n.º 2.488, de 21 de outubro de 2011. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes e normas para a organização da Atenção Básica, para a Estratégia de Saúde da Família (ESF) e o Programa de Agentes Comunitários de Saúde (PACS). *Diário Oficial da União* 2011; 22 out.
2. Brasil. Ministério da Saúde (MS). Secretaria de Atenção à Saúde. Departamento de Atenção Básica. *Política Nacional de Atenção Básica*. Brasília: MS; 2012.
3. Girade HA. Assim nasceu o programa de Saúde da Família no Brasil. In: Brasil. Ministério da Saúde (MS). *Memórias da saúde da família no Brasil*. Brasília: MS; 2010. p. 20-25.
4. Pinto RM, Silva SB, Soriano R. Community Health Workers in Brazil's Unified Health System: A framework of their praxis and contributions to patient health behaviors. *Soc Sci Med* 2012; 74(6):940-947.
5. Brasil. Ministério da Saúde (MS). Secretaria de Gestão Estratégica e Participativa. *Política Nacional de Educação em Saúde. Comitê Nacional de Educação Popular em Saúde*. Brasília: MS; 2012.
6. Simão CRP, Zurba MC, Nunes ASB. Educação Popular em Saúde: o círculo de cultura como ferramenta de promoção de participação popular no SUS. In: Zurba MC, organizadora. *Psicologia e Saúde Coletiva.* Florianópolis: Tribo da Ilha; 2011. p. 75-102.
7. Freire P. *Pedagogia do Oprimido*. Rio de Janeiro: Paz e Terra; 1977.
8. Bornstein VJ, Lopes MR, David HMSL. Educação popular na formação do agente comunitário de saúde. In: *II Caderno de educação popular em saúde*. Brasília: Ministério da Saúde; 2014. p. 151-156
9. Brasil. Ministério da Saúde (MS). Portaria 2.761, de 19 de novembro de 2013. Institui a Política Nacional de Educação Popular em Saúde no âmbito do Sistema Único de Saúde (PNEPS-SUS). *Diário Oficial da União* 2013; 19 nov.
10. Maciazeki-Gomes RC. Pesquisa e intervenção: Traçados de um caminho em composição. In: Borges JL, Winter L, Souza D, organizadores. *Pesquisa em Psicologia: Pressupostos Teóricos e Metodológicos*. Três de Maio: Ed. Setrem; 2013.
11. Passos E, Kastrup V, Escóssia L. *Pistas do método da cartografia: pesquisa-intervenção e produção de subjetividade*. Porto Alegre: Sulina; 2009.
12. Paulon SM, Romagnoli RC. Pesquisa-intervenção e cartografia: melindres e meandros metodológicos. *Estud. pesqui. psicol.* 2010; 10(1):85-102
13. Passos E, Barros RB. A Construção do Plano da Clínica e o Conceito de Transdisciplinaridade. *Psicologia Teoria e Pesquisa* 2000; 16(1):71-79.
14. Baremblitt G. *Compêndio de Análise Institucional e outras correntes: teoria e prática*. Belo Horizonte: Instituto Félix Guattari; 2002.
15. Czeresnia D, Freitas CM, organizadores. *Promoção da Saúde: conceitos, reflexões, tendências*. Rio de Janeiro: Ed. Fiocruz; 2009.
16. Zurba MC. Contribuições da Psicologia Social para o Psicólogo na Saúde Coletiva. *Psicologia & Sociedade* 2011; 23(n. esp.):5-11.
17. Rocha ML, Aguiar KF. Pesquisa-Intervenção e a Produção de Novas Análises. *Psicologia Ciência e Profissão* 2003; 23(4):64-73.

18. Mota CM, Dosea GS, Nunes PS. Avaliação da presença da Síndrome de Burnout em agentes comunitários de Saúde no município de Aracaju, Sergipe, Brasil. *Cien Saude Colet* 2014; 19(12):4719-4726.
19. Stotzs E, David H, Borstein V. O agente comunitário de saúde como mediador:uma reflexão na perspectiva da educação popular em saúde. *Rev APS* 2009; 12(4):487-497.
20. Costa S, Carvalho E. Agente Comunitário de Saúde: agenciadores de encontros entre territórios. *Cien Saude Colet* 2012; 17(11):2931-2940.
21. Costa SM, Araújo FF, Martins LV, Nobre LLR, Araújo FM, Rodrigues CAQ. Agente Comunitário de Saúde: elemento nuclear das ações em saúde. *Cien Saude Colet* 2013; 18(7):2147-2156.
22. Roman LA, Raffo JE, Meghea CI. Maternal Perceptions of Help from Home Visits by Nurse-Community Health Worker Teams. *Am J Public Health* 2012; 102(4):643-645.
23. Bornstein VJ, Stotz EN. Concepções que integram a formação e o processo de trabalho dos agentes comunitários de saúde: uma revisão da literatura. *Cien Saude Colet* 2008; 13(1):259-268.
24. Afulani PA, Awoonor-Williams JK, Opoku EC, Asunka J. Using community health workers in community-based growth promotion: what stakeholders think. *Health Educ Res* 2012; 27(6):1005-1017.
25. Maciazeki-Gomes RC, Baggio L, Souza CD, Mayer GVL, Schwerz DR, Roedel LBT, Huber LC. Agentes comunitários de saúde: trabalho real x trabalho ideal. In: *Anais do III Congresso Brasileiro de Psicologia da Saúde*; 2012; Santa Maria. p. 370-381.
26. Braun R, Catalani C, Wimbush J, Israelski D. Community Health Workers and Mobile Technology: A Systematic Review of the Literature. *PLoS ONE* 2013; 8(6):e65772.
27. Sade C, Barros LMR, Melo JJM, Passos E. O uso da entrevista na pesquisa-intervenção participativa em saúde mental: o dispositivo GAM como entrevista coletiva. *Cien Saude Colet* 2013; 18(10):2813-2824.
28. Vasconcelos EM. Educação popular: de uma prática alternativa a uma estratégia de gestão participativa das políticas de saúde. *Physis* 2004; 14(1):67-83.
29. Cardoso AS, Nascimento MC. Comunicação no Programa Saúde da Família: o agente de saúde como elo integrador entre a equipe e a comunidade. *Cien Saude Colet* 2010; 15(Supl. 1):1509-1520.
30. Gomes LB, Merhy EE. Compreendendo a Educação Popular em Saúde: um estudo na literatura brasileira. *Cad Saude Publica* 2011; 27(Supl. 1):7-18.

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