

## Identity of community health agents: composing emerging rationalities

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We analyze the identity of the community health agent based on the gender category, in dialogue with the categories: public and private/domestic space, and popular and scientific knowledge. We note that this profession is undervalued not because it is almost entirely occupied by women, but because it is seen as feminine work, and this condition is historically marked by gender inequality, associating women with family care and domestic tasks and, therefore, with subordination. This profession reflects hegemonic gender positions in society and the definition of its identity occurs in the daily routine with the healthcare team and the community, full of conflicts and affections, and also in the daily practices, characterized by hierarchies. At the same time, it carries the possibility of an emancipatory social and political horizon, defined in the creation of a community work that is organized to comply with the principle of integrality.

Keywords: Patriarchy. Gender system. Production relations. Integrality. Health work.

## Introduction

The *Programa Saúde da Família* (PSF – Family Health Program) was created as a strategy to overcome the model of care provision that focuses on disease and on individualized medical assistance. The Program, which was subsequently converted into Strategy, so as to emphasize the broad spectrum of activities and responsibilities, is targeted at the organization and strengthening of Primary Care in Brazil. As its action should be continuous, and not merely prompt and programmatic, it has, in its precepts, the marks of the innovative project of the *Sistema Único de Saúde* (SUS – Brazilian National Healthcare System), and it is supported by its doctrinaire principles: universality, integrality and equity.

According to Paim (2003, p.568), model of care or model of assistance “[...] is a certain way of combining techniques and technologies to solve problems and meet individual and collective healthcare needs. It is a rationale, a rationality, a kind of ‘logic’ that guides action”<sup>1</sup>.

Alves (2004, p.41) argues that the central issue of the principle of integrality is that it “incisively confronts hegemonic rationalities in the system – such as the reductionism and fragmentation of the practices, the objectification of the subjects and the focus on disease and on curative intervention”. According to Mattos (2004, p.1412), “perhaps it is useful not to consider integrality as synonymous with access to all the levels of the system”, as the possibility of increased understanding of healthcare needs would be lost. The thesis defended by this author is based on an elementary principle of primary care, which is the encounter between healthcare professionals and people – a daily encounter that is loaded with subjectivities. The author suggests that the construction of healthcare interventions should occur through a dialogic and negotiated process between professionals and service users, taking into account different aspects that are found in the moments of healthcare practice and that

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<sup>1</sup> All the quotations have been translated into English for the purposes of this paper.

constitute subjective dimensions of these subjects: knowledge (formal and empiric), experiences of suffering, expectations, desires and fears.

Thus, there is, in the *Estratégia Saúde da Família* (ESF – Family Health Strategy), two logics: one represented by a set of techniques, norms and procedures or by the medicalization of disease, supported by normative and instrumental rationality, where the biologicist and programmatic models operate; another one represented by relational strategies, forms of care, daily assistance, solidarity practices, where the models of prevention and promotion of health and public health operate.

Ferreira et al. (2009) argue that this rationality is located on a *folded* territory, in the sense given by Deleuze: it enables innovations in care management, putting users on the center of care and management, but, at the same time, this rationality is not recognized in its technical capacity, in its legitimacy, as it is placed on the frontier with the hegemonic rationality encompassed by the technical–scientific perspective of the dominant paradigms of modernity. The notion of *fold* is quite interesting, as it moves away from the idea of opposition and contradiction between rationalities or territorialities, and emphasizes their simultaneous co–existence within reality: “The fold shows a scenario that is different from the one that opposed interior/exterior” (Deleuze apud Oliveira, 2005, p.59). This place of co–existence is neither passive nor pacific; rather, it is characterized by a tense co–existence, as the difference between these rationalities involves power relations that have been historically constituted since the 17<sup>th</sup> century.

The issue of rationalities has been discussed by Boaventura Sousa Santos. When Santos (2011) approaches the dominant and emerging paradigms of modernity, he analyzes them based on two great pillars: regulation and emancipation. The pillar of social regulation is constituted by: the State principle, “which consists of the vertical political obligation between citizens and State” (Santos, 2001, p.50); the market principle, which consists of the horizontal political obligation, individualistic and antagonistic, among market partners; and the community principle, which consists of the political and horizontal obligation that is characterized by solidarity among community members and among associations. The pillar of emancipation consists of

the three logics of rationality: the esthetic–expressive rationality of the arts and literature; the instrumental–cognitive rationality of science and technology; and the moral–practical rationality of ethics and the law. The balance that is desired between regulation and emancipation would be obtained by the harmonious development of each one of the pillars and of the dynamic relations among them.

As the trajectory of modernity gradually identified with the trajectory of capitalism, the regulation pillar was strengthened at the expense of the emancipatory pillar, generating unbalances within them. In the emancipation pillar, the rationality of science and technology was developed to the detriment of the others and colonized them. The hypertrophy of this rationality caused the transformation of positivistic science into hegemonic epistemology. In the regulation pillar, there was the hypertrophy of the market pillar to the detriment of the State, and of both to the detriment of the community.

According to Santos, “the principle of community and the esthetic–expressive rationality are the most unfinished representations of Western modernity” (Santos, 2001, p.73) and, due to this, they would be the principles that could collaborate with the construction of a new emancipatory pillar. The principle of community is “the best one to establish a positive dialectic with the pillar of emancipation” (Santos, 2001, p.75) and, according to the author, it consists of fundamental dimensions: participation and solidarity. These dimensions have been only partially colonized by modern science and they continue to be a non–specialized and undifferentiated competence in the community.

Therefore, these principles would be the bases of the emerging epistemologies, and it is possible to analyze them as the center of the rationality proposed in the integrality principle of the SUS, which proposes the overcoming of the hegemonic logic of the healthcare system – curative, individualistic, fragmented, positivistic, biologicist – through the proposition of another logic or rationality. However, this overcoming could not be performed by the agents of the hegemonic rationality – healthcare professionals – whose praxis is organized by the dominant paradigms. It was necessary to incorporate, literally, the community, whose praxis has not been

colonized by the dominant paradigms and, for this very reason, contains the emerging paradigms, creating the possibility of transformation. Its agents are the *Agentes Comunitários de Saúde* (ACS – Community Health Agents).

In the healthcare teams, structured so as to operationalize the objectives of the ESF, the community health agents act as the ‘link’ between the community and the technical family health team. Originally, the ACS’ action in the SUS network used to occur by means of the *Programa de Agentes Comunitários de Saúde* (PACS – Community Health Agents Program), instituted by the Ministry of Health in 1991. However, this professional’s action in the history of public health in Brazil has some peculiar characteristics, such as the fact that, although the PACS was created in 1991, it was only six years later that the ACS’ assignments were defined, with the publication of Directive no. 1.886/1997 (Brasil, 1997)<sup>2</sup>; subsequently, with Decree no. 3.189/1999 (Brasil, 1999), the guidelines for the exercise of the ACS activity were established. The regulation of the profession occurred later on, in 2002, with the promulgation of Law nº 10.507 (Brasil, 2002).

Therefore, although the ESF is viewed, in different scenarios and debates, as the model that is capable of fulfilling the SUS proposal, guaranteeing universality of access, moving the focus away from hospital-centered care, and electing the family and its social space as the basic nucleus of approach in healthcare, the effective fulfillment of this policy still meets basic operational difficulties, such as uncertainties around the professional consolidation of an important actor of the family health team: the community agents.

In addition, there are the different forms of selection and hiring of these professionals that exist in the Brazilian cities, which configure a unique profile of professionals, depending on the city. Concerning this, a significant aspect that characterizes the majority, if not all, the healthcare teams of the country, is the fact that the majority of the ACS are women.

This aspect was the object of attention and reflection on the part of the team that developed an extension project involving the theme of permanent health

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<sup>2</sup> Revoked by Directive nº 2.488/2011 (Brasil, 2011).

education with PSF teams of a small city located in *Zona da Mata*, State of Minas Gerais (Southeastern Brazil). During the execution of this project, we realized that, in the healthcare teams with which we worked, all the ACS were women. In a further evaluation, we found that, among the fifteen teams existing in the city, of 84 professionals, 93% were women. These findings are corroborated by other studies that show that, in Brazil, women predominate in the profile of the workforce in the health area and in the ESF (Silva et al., 2010; Fernandes et al., 2009; Rocha et al., 2009).

This scenario motivated us to reflect on the team based on a gender perspective, in which this concept does not refer to men or women, but to the relationship between sexes. Thus, gender is not linked to sex, but to a social construction. According to Weeks (2000, p.56), “[...] gender is not simply an analytical category; it is, as the feministic intellectuals have increasingly argued, a power relation”. This author also argues that power relations act through complex and, many times, contradictory mechanisms, and produce domination and oppositions. To the historian Joan Scott, the definition of gender lies on two propositions: “gender is an element that constitutes social relations founded on the differences that are noticed between sexes, and gender is a primary form of giving meaning to power relations” (Scott, 1995, p.86).

Therefore, we aim to reflect on the aspects that favor and strengthen the presence of women in this space. Furthermore, we reflect on how the identities of the community health agents are constructed, and how the hierarchic and power relations that permeate this profession are related to this identity. In short, for the purposes of this study, this professional group interests us, as it is on this group that the possibility of fulfilling the project of integrality of healthcare lies.

### **Do gender issues permeate the profession of community health agent?**

In the Enlightenment’s conception of subject, the woman was seen as not being a ‘subject’, that is, she was considered an inferior being not endowed with reason, an irrational being (Hall, 2001) – to such an extent that this subject was described as

male. This thought pervaded the modern world, creating and strengthening the opposition between 'male' and 'female'. This opposition is expressed in different dimensions of the social tissue, such as task division in the labor market (social division of labor), in which the private space is reserved for women (the home, for example), and the public space is reserved for men. Such opposition is an epistemological and political condition of the origin of inequalities, materialized, for example, in salary differences, which persist to this day.

The inequalities between men and women and the overvaluation of the former compared to the latter can be better explained through the studies conducted by the historian Joan Scott.

According to Scott's (1995) proposition, using gender as a historical analysis category implies performing an analysis in two integrated levels: gender as an element that constitutes social relations, based on the differences perceived between the two sexes; and gender as a basic way of representing power relations, in which dominant representations are introduced in a natural and unquestionable way. Thus, the concept of gender is used in the understanding of how the social environment determines the constructed differences, and it should be emphasized that the characteristics attributed to one sex and to the other are characterized as power relations, as women are designated to subordinate positions. The concept of gender refers to the way in which inequalities operate between sexes and organize the power relations; thus, it refers to dominations.

To Kofes and Piscitelli (1997), adopting gender as a category of analysis implies saying that experiences are marked by gender, and it also implies showing how gender operates, how this operation marks experiences, as well as what is expressed in them. This orientation aims to warn of the difficulty in moving away from a descriptive perspective and heading towards an analytical perspective. Remaining in a descriptive perspective would mean to be limited to the indication that the work in the area of health allocates men and women differently, that is, men would 'naturally' be in administration and management positions and in some medical specialties that have higher technical 'prestige'; while women would 'naturally' be in the majority of the

positions related to provision of care and in other medical specialties with higher social 'prestige'. These analyses are important as they give visibility to the frames of symbolic stratification in the social, political and economic scopes. However, as they focus on description and quantification, they contribute to establish the social roles, or even the sexist stereotyping, much more reifying than problematizing.

Thus, it is not enough to show that the ACS profession is eminently performed by women, confirming the opposition between male world and female world, which happens even in the working space. The ACS image, associated with the act of caring, guiding, ensuring the physical and social wellbeing of the entire family, although it is contained in the law that creates the profession and defines its assignments, is the factor that ultimately undervalues the profession, because it is seen as a feminine profession.

According to Hall (2001), the subject is constituted in the world, that is, there is no interaction between the 'self' and society, thus receiving interferences from the environment; rather, we 'construct' ourselves in the plurality of relations, which involves identifications, contradictions, differences and other relational dynamics in the social tissue of subjectivities. In light of this statement, it is possible to say that it is during the home visits, during the professional practice of the health agents, that this identity is gradually constructed and modified. It is in these spaces, in which there are exchange of knowledge, exchange of experiences, and the direct contact with the community, that relations are established and bonds are formed and strengthened (or weakened), producing the plurality of the ACS identities.

Nevertheless, the female condition pervades the exercise of their job when the ACS assume several postures due to the operationalization of their work, which occurs in transit across the neighborhood, and enables them to be mothers, friends, listeners, sisters-in-law, at the same time that they are 'healthcare professionals'. Working in the same neighborhood where they live and having to establish a relationship that is formal and, at the same time, intimate with people/users is the condition that induces such performances. Thus, the rationality that the principle of integrality carries needed to incorporate this 'new element' (ACS) and the potentialities that it signals as a

possibility to strengthen the elements community and emancipation. However, changing paradigms involves power relations and this is not performed outside the game of forces of history. The relation between the dominant rationality (vertical, curative, individualistic, scientific) and the emerging rationality (horizontal, community-based, subjective, preventive, characterized by solidarity) happens, in this case, through the dichotomies that converge to the undervaluation of the work of the ACS. When it is integrated into the ESF team, the work of the ACS is maintained, at least, as an appendix. This work conducts to integrality, but it does not carry its rationality into the assistance because it remains on the margin. In this scenario, the ACS assumes a place of frontier, cited by Anzaldúa (2005) as the place that is configured as having knowledge and not having knowledge, translated here as 'biomedical knowledge' and 'popular knowledge'. As this dichotomy is organized by gender, it does not have enough political power to oxygenate the dominant rationality. Thus, integrality is not fulfilled: it remains imprisoned, like a *fold*, a place of difference.

### **The interrelation between scientific knowledge and popular knowledge**

Generally speaking, the community health agent is usually characterized as the link between the healthcare team and the community. However, the professional profile she assumes is different from that of the other professionals, which ultimately hierarchizes the relations within the healthcare teams, and the ACS becomes subordinated to the other professional categories. One founding element of such hierarchy is the dichotomy that exists between biomedical/scientific knowledge and popular knowledge which, in turn, defines the very hierarchies that exist between those types of knowledge and which not only values the former to the detriment of the latter, but also creates polarities and oppositions.

In this context, the social discourses, which, according to Foucault (1999), are power devices that result from diverse control systems and restrictive practices, are elements that also reinforce the delimitation of hierarchical spaces among professionals. In the case of the health agents, these discourses value scientific knowledge and generate the hierarchization of relations. The discursive practice constructs power relations, which are viewed as truths, influencing the production of subjectivities. Thus, the discourse is seen as a force, a truth that is supported by scientific discourse. Therefore, when there is the incorporation of the norm based on the internalization of the discourses, power is established.

Thus, it is possible to notice the fragility of this professional compared to the other members of the healthcare team (professionals with university and/or technical level), because they do not master biomedical knowledge so efficiently, as they do not have a specific education, or even, because they do not need technical education to work as a health agent, unlike doctors, nurses or nursing technicians. This condition becomes even more critical when their salary is compared to that of the other professionals of the team. In light of these factors, this professional feels placed in an inferior and fragile condition in relation to the other members of the healthcare team, and this undervaluation is performed, mainly, through the principle of the sexist technical-scientific knowledge.

As for the importance of the educational function of the ACS, this is the professional who is closest to users – for example, when she performs home visits – and, due to this, the experiences and the constant exchange of information are important means for the construction of collective knowledge in the area of health. Based on this exchange, the enhancement of popular and scientific knowledge also occurs in an educational process, in which one type of knowledge is not excluded by the other. Thus, the ACS play the role of mediators between scientific and popular knowledge, constructing this knowledge in a collective and participant way, together with the community. In this process, the ACS perform a work of health education and, at the same time, the affective relations with the community are strengthened and enhanced.

Valla et al. (2006) argue that the ACS' work is similar to the work of church priests in their daily and community-based practices, which are close to the perspective of Popular Education. It is interesting to notice that, instead of understanding the ACS' work or of relating it to the work of healthcare professionals and their hegemonic practices, the authors compare it to a different logic of receptiveness and hearing.

Being available to hear allows them to give proper attention to the patients' needs. Thus, as discussed by Silva et al. (2004), the ACS would not only represent links with the population, in the sense of being a communication vehicle; they would also represent bonds when the predominant relation is based on respect and dialog. By means of the extended hearing, the contents of knowledge are constructed and reconstructed according to daily situations.

The ACS' experience of this place of *fold* is emphasized by Ferreira et al. (2009). The authors show that the ACS work is expressed in contradictory feelings as, at the same time that they are qualified due to their popular knowledge, affection and bonds with the community, they are proud because they belong to the PSF, as the biomedical knowledge they receive during training enables them to differentiate their knowledge from popular knowledge. The authors also analyze that the biomedical knowledge and practice, which inform the ACS' way of acting, reproduce the hegemonic model, as this knowledge is constituted within the dominant paradigm, which is specific of the healthcare professions.

Therefore, while the community is included in an order that strengthens the emancipatory pillar, operating it based on the popular knowledge that it has and guaranteeing basic rights (like that of health), the healthcare team, on the other hand, strengthens the hegemonic practice of healthcare, in which the rationality of science and technology is the favored knowledge. This situation produces a tension that is projected on the subject that is on the center of this dynamic - the community health agent.

**Oppositions between the spaces: public and private/domestic**

Another dichotomy that permeates the constitution of the ACS profession refers to the oppositions between public and private/domestic. According to Pateman (1993, p.24), “this is a dichotomy that reflects the order of sexual division in the natural condition, and it is also a political difference”. In addition, Pateman (1993) argues that the private sphere – female (natural) – and the public sphere – male (civil) – are opposed; however, one only acquires meaning based on the other.

According to Okin (2008), what is fundamental to this dichotomy is the sexual division of labor, in which men are seen as responsible for the economic and political sphere (public sphere), while women are seen as responsible for occupations referring to the private sphere (associated with the domestic dimension, the female universe), being inappropriate for the public sphere.

In the work performed by the ACS, many elements and their characteristics are positively qualified by the feminine dimension: care provision, attention, hearing, understanding the community, the interrelation with neighbors, acquaintances and relatives, patience with conversations, with banal events, with the daily routine. Social reproduction in the sense of family unit is appropriated and re-signified as the ACS’ public work, similar to the one performed by the primary teacher at the end of the 19<sup>th</sup> century and in the first decades of the 20<sup>th</sup> century. Psychological qualities such as affection and patience are necessary, and these qualities are inherent in the female nature, as the superior cognitive faculties would be given to scientists, busy with scientific knowledge, which is hard in its logic and technical rationality. In the case of the ACS, the feminine essentiality continues, and, instead of their maternal, biological nature, it is their social nature of daily care; mothering is shifted from the educational to the social and community dimension: the person that takes care of everybody.

In this perspective, it is considered that there is, in the ACS profession, a power game, a political game, and we state this based on the thought of Laqueur (2001). Therefore, it is possible to say that this profession is undervalued not because it is occupied almost entirely by women, but, rather, because it is a job that is seen as feminine, associated with the domestic dimension, and this differentiation is caused by

gender inequality. This factor ultimately draws women into this profession, which seems to be feminized. This is a historically constructed condition of gender inequality, associating women with family and domestic care and with the condition of subordination.

In this sense, Scott (1995) argues that gender is the element that constitutes the social relations that are founded on the differences perceived between sexes, and mentions four elements/axes that are interrelated: the symbolic aspect, the normative aspect, the institutions and organizations, and subjective identity. All these axes contribute, in some way, to the decoding and understanding of the differences that exist between sexes.

In brief, we can say that, in the work of the health agents, the symbolic aspect involves the referent of the woman who provides care and protects, and these references are hegemonic representations of the female dimension. The normative axis would lie in the definition of the profession of caregiver in the area of health, organized by the procedures and knowledge defined by medical science – positivistic –, as well as by good practices and by patterns of dedication to work. Institutions and organizations refer both to the formal and informal socialization of these ACS, which places them as having the vocation for this work, and also to the knowledge/power relations of the healthcare units, which organize, classify and hierarchize the daily practices. These axes, articulated with one another, function as discourses of truth, so that symbols can organize forms of thinking about sex differences. Regarding the aspect of subjective identity, Scott (1995) argues that it is necessary to analyze how it is constructed throughout the professionals' life trajectory and that gender identity results from tensions produced during this trajectory. Scott also mentions that none of these four elements can operate separately, as one is necessarily a reflex of the others.

Thus, although the ACS work allows the emancipation of these subjects through the access of women to labor and to action in the public space, the condition of wage workers (gender and class) maintains them imprisoned in the female universe – both symbolic and of practices –, illustrating the subtleties and strategies that ensure social

reproductions and reaffirm the places of men and women in society; moreover, they enable the reproduction of gender inequalities in different spaces.

### **Association of the neighborhood as a domestic space and working place**

Concerning the domestic/neighborhood dichotomy, it is extremely relevant to highlight the daily routine of the work, mainly the home visits, as it is in the neighborhood in which they live that their relations are established and strengthened, because it is there that their affective bonds are situated, and even their conflicts. This space is, at the same time, public, as it is the neighborhood, the street, the community, and private, as it is an area of recognition of their daily routine, which enables free circulation during working hours. Although they have the family as their unit of care and the home visit as their monitoring tactic, the work cannot be characterized as 'invasion' of privacy, as users are talking to someone who is part of their personal relations.

The singularity of the obligation of living in the neighborhood to exercise the profession puts the ACS in a certain 'comfort zone'. Therefore, it is an environment that they already know, where the relations, in the majority of times, are already constituted.

They are women with an average level of schooling, who find, in this activity, an opportunity to work in their own neighborhood, with people they know – many times, they are their own relatives. These characteristics facilitate the management of domestic tasks, as a space of double shift for women; furthermore, they remain in the 'comfort zone' that is the community. These elements are also mentioned by Barbosa et al. (2012), who argue that the advantage of working as an ACS is being near home, being able to reconcile the assignments of paid work with the care that she provides for her home and children. In fact, this is one of the main arguments presented by the ACS for staying in the job, which is almost always poorly paid and precarious.

Thus, although they are working outside their homes, this 'outside' refers to the surroundings, to their children's school, to their own relatives. To many of them,

the PSF is their first paid job. The choice is based on the profile of the job and on the perceptions of female 'nature' or women's 'culture', which enable many of them to project themselves as being adequate to the job proposed by the ESF.

Thus, as women are associated with the domestic environment, the transit of this professional into the homes is facilitated because of their relations, which have already been established in the neighborhood. This allows them to enter users' homes and approach matters that belong to the families' intimacy. It is in the family space, a domestic space that is related to the private dimension, that the health agents gradually construct their social networks and assume diverse identities. At the same time that they introduce themselves as acquaintances, there is some distancing so that they can perform their jobs as health agents.

### **Final remarks**

The profession of community health agent reproduces social inequalities that are historical, and the fact that it is associated with a 'women's' practice, related to the domestic dimension, operates gender inequalities, associating women with care (provided for the other individual, the family, the domestic space) and with the condition of subordination. The analytical category of gender enables to introduce the power relation 'riddled' with inequality to explain the complexity of the principle of integrality and of the impacts of the ACS' work as subjects that belong to a gender/class. According to the hegemonic perspective, as they are women, they would be more adequate for having solidarity relations, and as they have a cultural and social capital, due to class belonging, this subjectivity would be appropriated by the SUS to 'solve' the principle of integrality.

However, integrality, as the expression of an emerging rationality, is undervalued by the hegemonic technical and scientific rationality; thus, both gender belonging and class belonging are rejected by the technical and scientific knowledge in the area of health. This is expressed in the very difficulty in incorporating this principle into the operationalization of the ESF. As the compliance with the principle of integrality does not question the hegemonic medical-scientific discourse and remains

in the *fold* of the ACS, the dichotomies are rebuilt and, with them, the dominant rationality. What maintains the gender dimension are not the women – or men – who work as community agents, but the power relation that engenders the dynamics and the meaning of the community agents' work in the ESF in order to comply with the principle of integrality.

Therefore, the Community Health Agent has been idealized as a subjectivity that integrates subject/practice or as an expressed practice, which creates possibilities of a democratizing action of healthcare through decentralization and incorporation of: subjectivities, culture, popular knowledge, horizontalities, affections. However, as this professional is placed on the frontier and is treated as an expression of gender dichotomies, she is configured as a subjectivity that rebuilds unequal relations in the capillary scope of daily relations. In these relations, the practice and knowledge of common sense are disqualified by the point of view of medical discourse; affectivity and solidarity are considered dispensable and irrelevant aspects. In short, in the way in which the ACS's subjectivity is engendered, the hegemony of the curative perspective of healthcare is reconstructed.

### **Collaborators**

The authors worked together in all the stages of the manuscript production.

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