COMMUNITY HEALTH AGENTS: THE CHALLENGES OF WORKING IN THE RURAL AREA

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Introduction

Community Health Workers (CHW) are involved in two important Ministry of Health initiatives: The Community Health Worker Programme (CHWP) and the Family Health Strategy (FHS). These programmes have been consolidated within the context of the municipalisation and the de-centralization of primary health care in Brazil.

The CHWP was introduced in 1991 in the north eastern region of the country. Its objective was to improve the capacity of the population to care for their own health with the support of Community Health Agents. A new strategy was adopted in 1994, the Family Health Care Programme (FHCP), with a view to adding human and technological resources to the earlier proposal, so as to improve the access to health services for the community and include more direct professional involvement in family health matters, thus providing better health outcomes vis-à-vis the CHWP (LARA, 2008).

The FHCP was substituted by the Family Health Strategy (FHS) so as to move away from a health care model based on hospital services, medical treatments and cures. The new care model would be centred around the family and primary health care units associated to a network of other services, so as to ensure comprehensive care for individuals and families.

Since 1994, FHS teams have included, as a minimum, a nurse, a doctor, a nursing assistant and four to six CHWs, in addition to the oral healthcare team.

There may also be other professionals involved according to the needs of the population.

Within this context, CHWs are responsible for a particular micro-zone within the geographical area to which their team has been assigned. Their task is to integrate the health team with the population. Some of their responsibilities include registering the micro-zone population and keeping records updated; providing advice in relation to available health services; developing health promotion activities related to disease pre-

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vention and non-aggravation; health screening through home visits, as well as individual and collective educational activities both in people's homes and in the community.

Within the FHS, CHWs represent the link between the community and the health system. One of the requirements of the job is to reside in the community where they work, based on the conception that as part of the community, Community Health Workers are more aware of its needs. In addition, as they share the same social, cultural and linguistic backgrounds, they are in a better position to uphold the rights of the community which is essential for increasing the effectiveness of health education strategies (NUNES et al., 2002).

Nascimento (2008) argues that CHWs are in constant contact with the community. They live in it and belong to it, uniting two very distinct cultural universes - the popular and the scientific - thus facilitating the work of health screening and health promotion.

In this research, the municipality studied had four health units with fully operational teams, as part of the FHS. There were a total of twenty-six Community Health Workers, of whom nine worked in the rural areas of the municipality.

Some of the challenges associated to the know-how and 'knowing how to be' Community Health Workers relate to: their role as "translators" of the scientific world to the popular world; gaining entry and access to the problems of families; the enormous variety of the work, requiring flexibility in working practices; the wide range of Family Health Strategy objectives, sometimes tending toward social assistance and sometimes toward the promotion of health and living standards; people's resistance to suggestions of changes in habits, as well as conflicts and difficulties in the relationship between CHWs and the community, and between CHWs and the health team.

In addition to these challenges, some of the experiences of CHWs in rural areas are unique to their situation. The objective of this study was to identify the challenges of the work of Community Health Workers in the rural areas of the municipality of Jerônimo Monteiro, state of Espírito Santo (ES), Brazil, seeking to discover whether in the course of meeting the demands of the rural population, CHWs create novel ways of carrying out their duties, not stipulated by institutionalized practices.

With regard to land ownership, the municipality of Jerônimo Monteiro is typical of the state of Espírito Santo, where smallholdings managed by families (family-based agriculture) predominate. The urban area of Jerônimo Monteiro is surrounded by smallholdings with dirt roads providing access to the households situated in these rural areas. This is the context in which CHWs experience the challenges of their daily working activities.

Method

We decided on a qualitative approach because it is applicable to the study of the relations, representations, perceptions and opinions which are the product of interpretations human beings make about the way they live, feel, think and construct their artefacts and themselves (MINAYO, 2008).

The focus of the study was the municipality of Jerônimo Monteiro, located in the south of the state of Espírito Santo, Brazil. This municipality is situated in the Southern

Macro-Administrative Region of Espírito Santo, and in the Micro-Management Region of Polo Cachoeiro, 194 km from the state capital. It encompasses an area of 162.164 km2 and has a population of 10,879 inhabitants (IBGE [Brazilian Institute of Geography and Statistics], 2010).

The study universe comprised the nine CHWs in the rural area who were members of the local health team. The criteria employed for including participants in this study were as follows: being a Community Health Worker, living in the municipality of Jerônimo Monteiro and working in the rural areas. In addition, CHWs had to agree to take part in the study.

There were twenty-six CHWs working for the municipality, of whom five provided services exclusively to rural households, and a further four who worked both in the rural and urban areas. Therefore, the maximum number of potential participants was nine. However, one person declined to take part, thus limiting the actual sample to eight people.

The study made use of interviews and observations.

Marconi and Lakatos (2007) state that an interview is "a meeting between two people, the purpose of which is to obtain from one person, by means of a professional conversation, information regarding a particular subject". Interviews can have many objectives. The purpose of our interviews was to ascertain and classify the action plans of Community Health Workers so as to learn about their behaviour and shed light on the day-to-day nature of their home visits in rural areas.

All interviews were recorded with the permission of interviewees. Observations were conducted directly and recorded in a field log. The field activities log became indispensable to the research. Its purpose was to analyze the procedures carried out by rural CHWs during their home visits.

Interviews with CHWs were pre-arranged, and subsequently conducted and recorded in their respective health units. Similarly, field study appointments were arranged with the help of nurses working at these health units. Two days of home visits were conducted with each CHW.

After the interviews were fully transcribed, they were read through so as to classify them by using units of meaning. Data were subsequently analyzed through the socioanalysis proposed by Lourau (1993). In accordance with Lourau's prescriptions, a partial report of the study was reconstructed, or restituted, to a gathering of the subjects of the study and their health team colleagues. Lourau (1993) argues that "in research, concrete restitution involves both personal and implicit restitution and should be regarded as an actual procedure of research" (p.55). Restitution is part of the scientific process because it involves discussing the outcomes of research with the interested parties so that they can directly intervene in the process.

This study was conducted with the agreement of the municipality's health department and was submitted to the Research Ethics Committee, part of the Health Sciences Centre of the Federal University of Espírito Santo (UFES) and granted approval N. 287/10-CEP/CCS/UFES.

All participants received information on the academic nature of the research and its objectives, and signed the Informed Consent Agreement.

Results

The Community Health Workers of the rural areas of Jerônimo Monteiro, ES

In total, eight rural Community Health Workers took part in the study, of which seven were female, five were white, five married, five catholic and six had completed secondary education. The average age of CHWs was 41 and the average period they had been working as rural CHWs was 8 years.

The characteristics of the CHWs reflect the social reality of the small towns in the inland areas of the state of Espírito Santo, a region settled by European immigrants. The coastal areas of the state were settled very early in the history of Brazil, from 1543 onward, soon after the Portuguese occupation. This was a period marked by the genocide of the indigenous population and the commercial exploitation of important hardwoods - in particular Brazilwood (caesalpinia echinata) - resulting in their depletion. Consequently, coastal areas were given over to sugarcane cultivation with a significant presence of African slaves.

By contrast, the occupation of the inland areas of Espírito Santo only occurred from the 19th century onward, with the settlement of poor European immigrants, in the main Roman Catholic Italians. However, a small number of other Christians, such as Protestants from Pommerania, settled in municipalities like Santa Maria de Jetibá and Santa Leopoldina, along with other Protestants and minorities who arrived from countries such as Poland, Holland and Belgium. It is worth pointing out, particularly in relation to the German settlers, that adaptive changes were so subtle that in these towns, which saw a significant concentration of this population, bilingualism is still prevalent today with the predominance of Pommeranian (a German dialect) as the main means of communication. In these towns, Pommeranian is an essential attribute for the post of rural CHW, given that it is common to hear older residents say, in pidgin Portuguese, that they "do not speak Brazilian". By contrast, despite maintaining their linguistic tradition and customs, the process of acculturation affected the lives of all Italian settlers to such an extent that "they were ready to live a thousand lives" (LARAIA, 2005, p.66).

Thus, one of the singularities of the inland municipalities of the state is that they were significantly influenced by European heritage, with the preservation of traditional customs and strongly affected by their populations' religions. Whilst in the large Brazilian cities - including those in Espírito Santo - there has been an expansion of Neo-Pentecostal forms of Christianity, in the smaller towns inland, marked by European immigration, this does not seem to have occurred. The subjects in the study, similar to most of the population of Jerônimo Monteiro, still conduct their lives as their ancestors did a century ago and - differently from what happens in coastal cities such as Vitória - most CHWs are Catholics. This phenomenon undoubtedly reflects the living experiences of the community, its people's fervent religiosity and the preservation of their Italian cultural heritage which comes to light in their appreciation for Italian food, home-made wine, as well as folkloric dancing and music.

The fact that there are fewer opportunities to access formal education in the smaller inland communities compared to the larger towns affects the educational levels of CHWs, who have a very different profile to the Health Workers in Vitória, where all CHWs have been educated to secondary and sometimes tertiary level. It is clear that the higher the level of education, the more CHWs are able to incorporate new knowledge and provide advice to the families under their care.

In addition, the fact that most CHWs are female reflects the marked presence of women in the health professions, particularly in technical positions. Nevertheless, according to IBGE, women make up 50.7% of the total population of the state. Furthermore, historically women have always sought space in the labour market, given that, traditionally, they are heads of families (IBGE, 2010).

The predominance of female CHWs reflects the growing feminization of the workforce in the health sector, as can be observed in other professions such as nursing. This phenomenon is associated to the role of 'carers' that women have always held in society, where they are responsible for the education and care of children as well as for the care of elderly family members. This gives female CHWs greater credibility and sensibility within the community where they work. Since the implementation of the CHWP, it was expected that the positions of CHW would be mainly filled by women. The underlying conception was that women would improve their social situation by carrying out paid work and that this example would result in an increase in the active involvement of the women in the communities where they lived (LUNARDELO, 2004).

The age of Community Health Workers in the rural areas of Jerônimo Monteiro ranges from 29 to 61 years. Older Community Health Workers tend to know the community better and have stronger links and friendship bonds. However, they may be involved in hostilities and conflicts with other residents. Older professionals may also have their own conceptions of the relationship between health and disease which may be the result of their own or other people's experiences. This may mean that they are more resistant to new theories about health promotion in their communities. On the other hand, younger professionals may not know the community so well and may be less involved. However, they are less likely to be the subject of animosity and to have ingrained views on health issues, making them more open to changes and innovations (FERRAZ e AERTS, 2005).

Findings revealed low staff turnover rates, given that 7 out of 8 interviewees had been working for the FHS for a number of years - between five and fourteen years. The duration of employment is another important element for understanding the role of CHWs, which evolves within their working routine and is dependent on their time in the profession and their links with the community (GAVALOTE et al., 2011).

In relation to digital inclusion, five of the eight interviewees used computers. However, only four CHWs had access to the internet, and only two of these enjoyed this access at their workplace. Most CHWs had experience of other jobs before pursuing this profession. However, only two interviewees had prior experience of working in rural settings.

According to Mendonça et al., (2009), the digital inclusion of CHWs is an aspect of technological progress which can facilitate the acquisition of knowledge via distance

learning. It can also enable the individuals, families and communities they work with to develop and access an information network for promoting knowledge and disseminating public health issues, thus assisting community members to care for their own health. In addition, free technology may be a mechanism for fostering local and regional human development, in particular with regard to health promotion, thus improving the quality of the lives of the people in these communities.

Despite the fact that access to electronic health information can be an important tool for expanding knowledge and an aid to health promotion and disease prevention activities - particularly useful for health educational activities during home visits - it is not part of the daily working practices of CHWs in the rural areas of Jerônimo Monteiro.

Only four of the interviewees knew how to use the internet at a basic level. Two respondents claimed only to have access to the internet in their workplaces. Nevertheless, it is worth stressing that digital inclusion in the Family Health Units of Jerônimo Monteiro is a recent phenomenon, given that computers and internet access in the workplace have only been available to family health teams since 2011.

The daily routine of rural Community Health Workers

This research points to some of challenges relating to the know-how and the 'knowing how to be' of Community Health Workers, particularly for those who work in rural settings. After all, some of the experiences of these professionals are specific to their situation.

With regard to the work of CHWs in rural areas, one of the main challenges is accessing households, which are generally located in remote places and sometimes are almost inaccessible.

> "I go to work on a motorbike, but the bike cannot go everywhere. At some point I have to stop and walk and I often have to walk a lot. Some of the places I go to are really difficult to get to, sometimes I am still out by lunchtime, very far from home. Then I have lunch at the place I am visiting" (Subject 2).

Some of the paths to reach a few of the households in the middle of coffee plantations are just small trails surrounded by scrubland and woods and they are fenced off by barbed wire. To conduct their home visits, CHWs have no option but to go through scrub or woodland:

> "There are no roads to reach some of the houses. We have to go through the middle of the woods and go through fences. I think it's dangerous because there may be snakes or other animals in the middle of the woods" (Subject 2).

The urban area of Jerônimo Monteiro is set in a valley surrounded by smallholdings crisscrossed by dirt roads. In some of the more hilly parts of the municipality

these roads are almost impassable. With regard to the difficulty of access, subjects 2 and 3 stated:

> "The greatest challenges for me are the highest parts of my allocated area. Because in the lowlands I can go round on a motorbike and if it doesn't rain, everything is fine. But I can't use my motorbike in the highlands. You can only reach them on horseback and I don't like riding horses. At the beginning I used to go on horseback. I would go up and when I reached the last house, so that I wouldn't have to turn back, I used to go down a track... But if you looked down, it was almost a cliff and there was only enough space for the horse. And what if something were to happen and it (the horse) stepped out (of the track)? One of my colleagues had an accident up there. Nowadays, I don't go anymore, it's a choice I'm making. I don't go on horseback anymore. I'll go as far as my motorbike can go and then I continue on foot, because I don't like riding horses, I think it's dangerous to ride up there when it's raining, it's very slippery, then you are there on your horse and the horse slips. That's not fun; it's not easy at all. The bike doesn't even do half of the area. It takes me to the first house and then I do the rest on foot" (Subject 2).
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> "[...] I would always work on Sundays and my husband used to come, in case something happened, he was there. Then, when we arrived up there, it started raining really heavily. It rained lots; I had to forget the other houses because it was getting late. We walked down, because it was too slippery for the horse, and there were places where even I could not manage (to go through)" (Subject 3).

In this sort of terrain, horses were more than a means of transportation. For a long time, they were a unique "protagonist", present in all work settings. The man-horse relationship is a binary connection and this human/horse machine stands out in rural settings in a way that is unimaginable in large urban centres:

> "Today I can use my motorbike, when it's not raining. But I used to do it (home visit) on horseback and on foot" (Subject 5).
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> "I now work in the lowlands, but before I used to work in an area you could only reach on horseback. I used to leave home at six in the morning and get back at six in the evening. I used to go on horseback and when I came home, my body would be hurting and the first time I went I ended up having a temperature for three days, because I was not used to riding [...]" (Subject 3).

However, with more modern means of transport available, horses have become less popular and are no longer the main form of locomotion in rural areas, not even for CHWs. Despite being part of a neo-globalized system which makes everyone equal, it seems that CHWs manage to draw on ethnicity and tradition, reflected in their use of

horses. This means of transportation, which today is obsolete in urban areas and only used as a last resort, is able to withstand the worst weather conditions.

Therefore, the possibility of returning to the use of the binary horse-man machine as a 'natural analyzer' is still alive in these communities. Natural analyzers are phenomena which are part of the routine of institutional organizations and which occur spontaneously due to the historical, social, libidinal and natural life of these organizations. They are the result of self-determination and their degree of freedom (BAREMBLITT, 2002).

The work of rural CHWs in Jerônimo Monteiro is influenced by the dry and the wet seasons. Between the months of November and March, when rainy days are more common, and during the sporadic rains which occur throughout the year, reaching the rural homes of health service users is even more challenging than usual. In this period, due to the lack of paving, rural roads are almost impassable.

> "There's only one problem: when it rains. Then it's terrible, because reaching rural homes is a nightmare. Sometimes you cannot use cars, or anything else. There are a few places that, when it is really raining, we can only reach on foot. It has happened many times and it is still happening today. There are three homes which are impossible to reach" (Subject 3).
> "My main challenge is transport. When it rains (in rural areas) it's a problem" (Subject 6).

Although horses are not the main means of transport for CHWs, it is during the rainy season that they become important for locomotion. Thus, the binary connection - the human/horse machine - is recovered. It is used as a means of overcoming inclement weather conditions. For many residents of the rural areas of Jerônimo Monteiro, during the rainy season, "health" arrives on horseback:

> "The other problem is flooding, because with the rain, there is no road and we have to go on horseback and sometimes, even horses can't get there, because there is no road and then we have to walk" (Subject 5).

It is worth pointing out here that due to the significant demographic dispersion in the rural zone, CHWs spend a long time travelling, often on foot, as Subject 5 describes:

> "My main challenge is the distance I have to cover between houses. Sometimes I walk 40, 50 minutes, sometimes one hour, to go from one house to the next. [...] another factor is that people live far from the unit (Family Health Unit - FHU). I live at the beginning of my allocated area, which is 20km away from the unit, just imagine the people who are further away than me" (Subject 5).

During the dry season, motorbikes are the main means of transportation used by CHWs for home visits, followed by cars and bicycles. For some CHWs in the rural areas

of Jerônimo Monteiro, along with horses, bicycles have for many years been the main form of locomotion. Subjects 1 and 3 stated:

> "Motorbike. That's now, because I've used a bicycle for four years. At the beginning I used a bicycle" (Subject 1).
> "At the beginning I only went (on home visits) by bicycle. But now I have a hernia, my back can no longer take it, my legs can't take it. If I use a bicycle my head explodes with pain because my back hurts from top to bottom, then my head hurts too, and I can't bear it. But when I started, I only used a bicycle. I cycled to my home visits for three years" (Subject 3).

CHWs working in the rural areas have no choice regarding the various forms of transport they use. Often, given the specificities of the rural areas, these are the only solutions CHWs find to carry out their duties. For CHWs unaware of bureaucratic restrictions and the possibility of threats, targets can only be met by using viable alternatives such as substituting a car by a motorcycle, giving up the motorcycle for a bicycle, swapping the bicycle for a horse or even going on foot.

Both domestic and wild animals are common in rural areas and they often make the work of CHWs difficult. According to the interviewees, bulls and dogs are the animals that cause most problems, both in the course of their travel and during home visits:

> "[...] I was scared off many times by dogs and bulls" (Subject 1).
> "[...] the worst was being bitten by dogs [...] I arrived on my motorbike, I stopped and put my foot down and they came towards me barking, and then bit me [...]" (Subject 7).

To avoid being attacked by dogs some CHWs adopt a specific strategy: they become "friends" with the dogs. Friendship? That's right, they establish an emotional bond with the animal so as not to be caught out and attacked. During a home visit a CHW tenderly stroked the head of a dog and stated:

> "As well as winning over the residents, we also need to be friends with their dogs, you know? Most rural homes have a guard dog to protect the house and its residents and, as well as doing our jobs, we also need to be friendly with the dogs. We even have to know their names, so that when we arrive for a home visit, we don't run the risk of having the dogs running towards us and biting (us)" (Subject 5).

Family-run smallholdings are the most prevalent type of property in the rural areas of Jerônimo Monteiro (family-based agriculture). The main crops cultivated are coffee and orange, in addition to pig and cattle-rearing. Maize, rice and beans are also farmed on a smaller-scale, mainly for family consumption.

Coffee is one of the main agricultural products in the municipality of Jerônimo Monteiro. Harvest time lasts between two and three months, usually starting at the end

of April or the beginning of May and sometimes continuing to the end of July. During this period, people in the rural communities frequently leave home very early, sometimes before sunrise, spend the day working in the coffee fields and only return at sunset. This routine is important to ensure that the crop is harvested at the right time. However, it affects the work of CHWs, because during this period home visits are hardly ever successful.

In relation to home visits during the coffee harvest season, Subject 6 states:

> "In June, I went there (to the rural area) 18 times. That's because it was during the coffee harvest and they were working even on Saturdays up to 5pm, there's no electricity there. I can't go after 5pm because, if I do, I am scared of coming back" (Subject 6).

Most families living in the rural areas of Jerônimo Monteiro work in agriculture and related activities, which provides their sustenance. Therefore, even outside harvesting times, family members, including some women, are out working in the fields in the area. This forces CHWs to innovate and find different ways of complying with their objectives.

> "In my rural area, access is somewhat difficult. I either go on Saturday or Sundays, or I go in the evening, because if I go during the day, I won't find anyone. If I go in the morning, I might find 3 or 4 (residents), the others are out in the fields, they are working. And my children, the ones I have to weigh, I can only find some of them on Saturdays, because their mothers are working, so I only find them on Saturdays. That's the reason I swap: I stay at home on Fridays and go to work on Saturdays and Sundays. That's how it's got to be; otherwise I can't meet my targets for this area" (Subject 6).
> "During the coffee harvest, sometimes I go up and I go right into the coffee fields for a visit. There are even places where I have to arrive there before sunrise, because if I go at other times I will not find anyone at home. And we have to do this so we can do our jobs, isn't that so?" (Subject 5).

The working routines of rural service users often force CHWs to conduct their visits outside the home, in places which would be unimaginable in an urban setting. In relation to these "special" visits, Subject 1 states:

> "There are days I find no one at home, but if they (rural service users) are working nearby, sometimes I carry out my visits there and then. Today, for example, he was in the animal enclosure looking after the cows and I had to go and do my visit there" (Subject 1).

This Community Health Worker team is obviously unaware of the precepts of Institutional Analysis, after all, they have never heard of Lourau (1993), the proponent of Socioanalysis. They are also not familiar with the founding principles of the institutionalist movement. Nevertheless, once the rainy season comes, they provide us with a

significant and concrete example of "functionality". According to Baremblitt (2002), "[...] functionality is the movement of productive-desirous-revolutionary processes of any type of materiality and essence [...] which generates difference, invention and metamorphosis" (p. 153).

Within a wider perspective, functionality, marked by the inventiveness and creativity of rural CHWs, can be conceived as Immanence. Baremblitt (2002) leads us to reflect that for some philosophers, amongst whom the most significant is Spinoza (2011), this term means the state of being within. It is in opposition to transcendence. In Institutionalism it expresses the non-separation of economic, political and cultural processes (that is, broadly speaking social processes), as well as natural and desirous processes. These are all inherent and intrinsic, and can only be separated for semantic or educational purposes.

Despite the challenges of their working routine, all the subjects in this study reported that they liked being CHWs in the rural areas and saw their profession as having an important role within the Family Health Units. In relation to enjoying being rural CHWs, Subjects 1, 6 and 3 stated:

> "I feel very good. I first started because I needed a job, [...] it was to work, but after a year or two, I started to like this profession and nothing would make me leave it now. People can say whatever they like, but I will always be proud of being a Community Worker" (Subject 1).
> "Without the information I bring and without my visits, how would the nurses and the nursing assistants know what is happening out there (in the rural area)? I think that 90% of the work of the Family Health Programme is due to us. That's what I think. I say this because everything revolves around us. We are the ones that monitor people with high blood pressure and see people with diabetes. The Family Health Programme (FHP) puts a lot of faith in us. Without CHWs, the FHP could not exist. If they stop having CHWs, there is no FHP" (Subject 6).
> "I like my profession. [...] I would not like to be anything else. There is only one problem: when it rains it's bad, because the access to rural households is terrible. Sometimes you cannot use cars, or anything else. There are some places that, when it is really raining, we can only get to if we walk [...]. There was a time it rained so much that even walking was difficult. Even horses, there were places the horses got stuck. These are the difficulties" (Subject 3).

According to Lopes (2009), in order to transform work that is tiring into work that is balanced, it is crucial to have flexibility, so that it affords workers more freedom within the working environment, enabling them to identify the factors which give them pleasure.

Work enjoyment and personal satisfaction are associated to the potential for creativity. They are linked to the ability to innovate and actively participate in decision-making. In addition, work must be valued and recognized (LOPES, 2009).

Restituting the study to rural Community Health Workers: does it all add up?

According to socioanalytic theory, restitution requires debating and bringing to light factors which often remain obscure. These are the factors which are usually silenced, spoken about only in corridors, cafés or in the intimacy of couples. These "things" are institutional "talk" which cannot be "heard" publicly. There is often an aspect of indiscretion in the concept of restitution and even the risk of falling into accusations which are purely recriminatory. Researchers must be very careful when managing this technique. The best way to counter these risks is applying the techniques to themselves, in order to combat indiscretions, revanchist accusations, disenfranchising reports or spurious and thoughtless accusations. That is, they must state "things" and not denounce others (L0URAU, 1993).

In socioanalysis, if restitution is to be truly constructive, it must follow certain rules, including, of course, those essential to discretion, as well as technical rules regarding the right time for restitution. It is somewhat similar to daily life, when we choose what to say about what we think (and when). We never really say all we think, regardless of the situation. Restituting scientific knowledge to the subjects one works with is a relatively recent concept ignored by researchers for a long time. The first field sociologists were not concerned in restituting the results of research to the studied population, or even concerned in discussing the importance a specific population had for scientific production (LOURAU, 1993).

The restitution of the material of this research occurred in a meeting at the beginning of March 2012, in a room at the Pastoral Centre of Jerônimo Monteiro's Catholic Church. This space is frequently used by the municipality's family health teams for meetings. Five of the CHWs who participated in the study were present. The other three participants justified their absence on the day of the meeting by declaring involvement in a vaccination campaign.

The CHWs received information on research data through a slide presentation using a multi-media device. It included all information relevant to the study, such as objectives, methodology and results, including photographs taken during the observation work conducted at home visits to the rural areas, as well as the statements made by the subjects of the study. During this meeting, CHWs were entirely free to intervene and express their opinions.

The information provided was well-accepted and despite heated manifestations during the presentation, which mainly involved the recounting of experiences during the presentation, there were no requests of alterations to the text. Restitution is not a charitable act or a friendly gesture; it is an intrinsic part of research. Feedback is just as important as the data contained in articles in scientific or specialized periodicals or books. It forces us to think of research beyond the boundaries of the final draft. That is, to think beyond its transformation into a cultural commodity serving the researcher and the academic world (LOURAU, 1993).

Within a socioanalytic perspective, research continues after the final drafting of a text. It is sometimes an endless task. If the studied population is restituted with the results,

it may be able to appropriate part of the status of the researcher, a sort of "collective--researcher", but without the need for diplomas or years of further education. This act may lead to new restitutions, both for the potential "ex-researcher" and the more immediate social or global present. This is, in fact, the socialization of research (BAREMBLITT, 2002).

Final considerations

In the urban areas of small municipalities, reaching a household for a home visit may not seem to be a problem for CHWs. However, in rural areas, simply getting to households is often a challenge, given that rural hamlets and isolated homes are far from each other, and in some places roads are inaccessible, due to the rugged landscape of the locality. In the rainy season, reaching rural households becomes an even greater challenge. During this period, rural roads are virtually impassable, due to the lack of paving.

When the rainy season arrives, marked by torrential storms, Community Health Workers could simply have remained in their units, alluding to the difficulties in reaching rural homes which are very dispersed and sometimes located in areas of difficult access.

Our experiences of the urban FHS in Vitória, the capital of the state, reveal that at the smallest sign of a change in the weather or rumours that drug-traffickers are blocking a specific health zone, Community Health Workers return to their Family Health Unit base.

Unaware of bureaucracy or even risks of different kinds, the objectives of their rural work become paramount for CHWs. These workers reveal the highest degree of self-analysis and self-management, by finding viable alternatives such as substituting their car with a motorcycle, giving up the motorcycle for a bicycle, swapping the bicycle for a horse or even going on foot.

In face of the challenges of their day-to-day working routines and the need to comply with their institutional commitments, rural CHWs based in Jerônimo Monteiro innovate and seek different ways to carry out their work.

It seems that the Community Health Workers in the rural areas of the municipality of Jerônimo Monteiro are driven by a desire to produce, an essential and immanently productive desire which is generated by (and generates) the process of invention, metamorphosis and creation (BAREMBLITT, 2002).

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COMMUNITY HEALTH AGENTS: THE CHALLENGES OF WORKING IN THE RURAL AREA

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Abstract: The purpose of this qualitative study is to identify the challenges Community Health Workers (CHW) face in the rural areas of Jerônimo Monteiro - ES and assess whether in the course of meeting the demands of rural health service users, CHWs seek different ways of carrying out their activities, over and above institutionalized practice. The study material was collected through interviews and observation, following an Institutional Analysis perspective. The extension of the Family Health Unit (FHU), its large demographic dispersion, the fact that homes are distant and difficult to access, forms of locomotion, animals, and home visits during the coffee harvest constituted the main challenges of the daily work of CHWs in rural areas. Given these challenges and the need to fulfil with their assigned activities, CHWs working in the rural areas of Jerônimo Monteiro innovate and seek different ways to develop their practice.

Keywords: Community Health Workers; Family Health; Rural Health; Small Cities; Environment.

Resumo: Estudo de abordagem qualitativa objetivando conhecer os desafios do trabalho dos Agentes Comunitários de Saúde na zona rural de Jerônimo Monteiro – ES e identificar se estes ACS, no atendimento das demandas dos usuários rurais, além de suas atividades instituídas, buscam formas diferenciadas de produzir a sua prática. A produção do material do estudo se deu através de entrevistas e da observação. A Análise Institucional norteou a análise deste estudo. O extenso território de abrangência das USF, a grande dispersão demográfica, os acessos distantes e difíceis aos domicílios, as formas de locomoção, os animais e as visitas domiciliares no período da colheita do café foram os principais desafios do cotidiano laboral do ACS rural. Diante destes desafios e na obrigação de cumprir as ações instituídas, os ACS rurais de Jerônimo Monteiro inovam e buscam formas diferenciadas de produzir a sua prática.

***Palavras-chave*:** Agentes Comunitários de Saúde; Saúde da Família; Saúde da População Rural; Cidades Pequenas; Meio Ambiente.

Resumen: Este estudio cualitativo busca identificar los retos de la labor de los trabajadores de salud comunitarios en las zonas rurales Jerônimo Monteiro - ES e identificar si estos ACS, para satisfacer las demandas de los usuarios rurales y sus actividades instituyó, buscando diferentes maneras de producir su práctica. La producción del material de estudio se recogió a través de entrevistas y observación. El Análisis Institucional guiado el análisis de este estudio. La amplia cobertura de la USF territorio, la gran dispersión demográfica, la distante y difícil de acceder a viviendas, formas de locomoción, los animales y las visitas domiciliarias durante la cosecha de café fueron los principales desafíos de la labor diaria de la campo ACS. Ante estos retos y la obligación de cumplir con las medidas impuestas, la ACS rural Jerônimo Monteiro innovar y buscar diferentes maneras de producir su práctica.

***Palabras clave*:** Agentes Comunitarios de Salud; Salud de la família; Salud Rural; Ciudades Pequeñas; Ambiente.