Community Health Aides: possibilities and limits to health promotion*

O AGENTE COMUNITÁRIO DE SAÚDE: POSSIBILIDADES E LIMITES PARA A PROMOÇÃO DA SAÚDE

EL AGENTE COMUNITARIO DE SALUD: POSIBILIDADES Y LIMITACIONES PARA LA PROMOCIÓN DE LA SALUD

Luciana Patriota Gusmão Soares dos Santos[1], Lislaine Aparecida Fracolli[2]

ABSTRACT
The objective of this study was to identify the actions performed by community health aides (CHA) and perform an analysis according to the health promotion paradigm. To do this, an exploratory, quantitative study was performed with the CHA's from São Bernardo do Campo, Brazil. Results showed that most HCA's complete the following competencies: team integration with the local population; prevention and monitoring of environmental and sanitary risk; and prevention and monitoring of specific groups and morbidities. However, it was also found that planning and evaluation of health actions and health promotion are competencies that are performed heterogeneously. In conclusion, there is a need to improve CHA competence in health promotion towards the empowerment of the community in addition to improving action between sectors.

KEY WORDS
Community health aides.
Health promotion.
Public health.

RESUMO
A pesquisa teve como objetivo identificar as ações realizadas pelos Agentes Comunitários de Saúde (ACS), analisando-as à luz do paradigma da Promoção da Saúde. Para isto optou-se por uma pesquisa exploratória do tipo quantitativa, com os ACS de São Bernardo do Campo (SP). Como resultado, evidenciou-se que as competências Integração da equipe com a população local, Prevenção e monitoramento de risco ambiental e sanitário, Prevenção e monitoramento a grupos específicos e morbidades são em sua maioria realizadas pelos ACS; enquanto que as competências de Planejamento e avaliação das ações de saúde e Promoção da saúde são realizadas de forma heterogênea no município. Conclui-se pela necessidade de se fortalecer a competência do ACS para a Promoção da Saúde, de forma que esta possa encaminhar para o empowerment da comunidade e para a intersetorialidade.

DESCRITORES
Auxiliares de saúde comunitária.
Promoção da Saúde.
Saúde pública.

RESUMEN
La investigación tuvo como objetivo identificar las acciones realizadas por los Agentes Comunitarios de Salud (ACS), analizándolas a la luz del paradigma de la Promoción de la Salud. Para esto, se optó por una investigación exploratoria del tipo cuantitativo, con los ACS de São Bernardo do Campo, São Paulo, Brasil. Como resultado, se evidenció que las competencias: Integración del equipo con la población local, Prevención y monitoreamiento de riesgo ambiental y sanitario, Prevención y monitoreamiento a grupos específicos y morbilidad, son en su mayoría realizados por los ACS, mientras que las competencias de Planeamiento y evaluación de las acciones de salud y Promoción de la salud son realizadas de forma heterogénea en el municipio. Se concluye en la necesidad de fortalecer la competencia del ACS para la Promoción de la Salud, de forma tal que ésta pueda encaminarse hacia el empowerment de la comunidad y para la intersectorialidad.

DESCRIPTORES
Auxiliares de salud comunitario.
Promoción de la salud.
Salud pública.

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[1] RN. MSc in Collective Health. Community Health Agent Program Nurse in São Bernardo do Campo. São Bernardo do Campo, SP, Brazil. lupatriota@yahoo.com.br [2] RN. MSc. in Special Education. PhD in Nursing. Faculty at Collective Health Nursing Department, University of São Paulo School of Nursing. São Paulo, SP, Brazil. lislaine@usp.br

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INTRODUCTION

The Community Health Aides Program and the competences of this professional for action in the community: focus on the city of São Bernardo do Campo

The Community Health Aides (CHA) was originated from experiences shared at the International Conference of Primary Care in Health, in 1978, in the city of Alma-Ata. This conference had a great repercussion for the implementation of Primary Care programs for specific populations, in several countries[1-2].

The last report of the Alma-Ata Conference stated that the primary health care would be the main means so that all populations in the world could achieve an acceptable standard of health in a near future. The reference to the use of the CHA appears, in this report, at the elaboration of actions and competences that should compose the primary health care, as the first level of organization of the health system[1-2].

In 1979, in Brazil, 400 community aides started to act in the state of Maranhão with the support of UNICEF and, in 1987, a similar program with health aides was implemented in the state of Ceará, and named Health Aides Program. This program constituted the first official initiative to implement health aides as a government strategy, in the state area[3]. Positive evaluations regarding the implementation of this Program contributed to its maintenance and broadening in the state of Ceará and to the proposition, by the National Health Department, in 1991, of the National Program of Community Health Aides for the entire Brazilian territory, which was renamed in the next year to the Community Health Aides Program (CHAP)[3].

The last report of the Alma-Ata Conference stated that the primary health care would be the main means so that all populations in the world could achieve an acceptable standard of health in a near future.

At first, the CHAP was elaborated with the proposal of extending the coverage of health services, aimed at reducing infant and mother mortality rates, mainly in the North and Northeast regions. It was established to act, mainly, in areas that most needed it, introducing to the health practices a focus on the family, not on the individual, as well as the intervention in integrated health to the community in a broadened approach of health, in other words, not centered exclusively in the doctor's figure[4].

Supported on the laws that regulate the exercise of the CHA activities, the Health Department proposed a set of actions for this worker and also designed a professional profile. This proposition listed a group of actions that concentrate activities in the health promotion, either through the prevention of diseases, the mobilization of resources and social practices of life promotion and citizenship or through the instruction of individuals, groups and populations, with characteristics of popular education in health and the monitoring of families[5].

Based on the analysis of this proposition, which considered the singularities and specificities of the work, the Health Department built five broad competences that compose the current profile of the CHA. Each competence expresses a dimension of the reality of the CHA's work and represents a structuring axis of its practice[5]. The defined competences of the CHA are:

1) Integration of the health team to the subject population: provided with this competence the CHA is expected to be able to develop actions aimed at the integration between the health team and the subject population, considering the characteristics and purposes of the work with individuals and social groups.

2) Planning and evaluation of the health actions: in which the CHA is expected to be able to perform, together with his team, planning and evaluation activities for the health actions in the scope of the Health Unit's subjection.

3) Health Promotion: developing health promotion actions in team aimed at improving the life quality of the population, the social administration of the public health policies and the exercise of the society control over the health sector.

4) Prevention and monitoring of environmental and sanitary risk: developing prevention and monitoring actions aimed at situations of environmental and sanitary risk for the population, according to the action plan of the team.

5) Prevention and monitoring to specific groups and morbidity: developing prevention and monitoring actions aimed at specific groups and prevailing diseases, as defined by the action plan of the team and the Public Health protocols.

The analysis of the profile of competences designed for the CHA shows the great potential of this health worker in order to invest in the actions of health promotion and individual and community empowerment. Contributing, thus, so that it is possible to design a CHA role that aims at the community area, instead of reinforcing health actions in the *healing* scope for this worker, which must be executed by properly qualified professionals[6].

In 1997, the City Health Department of São Bernardo do Campo (SBC) proposed the inclusion of the CHA as strategy for a new care model in the city. Initially, the Project *Community Health Aides Program of São Bernardo do Campo* had its own guidelines and was proposed in order to prioritize the coverage extension of the health basic actions in the areas with the worst life conditions. In the same year, 201 CHA were hired for the pilot project, which had three constitutive stages: the implementation, the supervision and the evaluation[7]. At the implementation stage of the CHAP in SBC, the purposes and actions of the CHA

were established, as well as the guidelines and rules of the processes of recruiting, selection and qualification of this worker. The stage of supervision involved a partnership with the School of Medicine of the ABC which introduces medicine academics to work on the qualification and supervision of the CHA. It was defined that each CHA would take care of 150 to 200 families and the work would be initiated after the registration of the family, which would receive the CHA's visit once a month. In face of the success of this proposal, the CHAP was extended to other regions of the city and SBC became the first city of the region of Grande São Paulo to introduce this care strategy. For this purpose, it provided all the necessary money for maintaining the CHAP for one year and only after that received the incentive of the National Health Department. In 2000, the city hired the first nurses to act in the direct supervision of the CHA, in the place of the medicine academics[7]. The stage of evaluation of the CHAP in SBC was carried out in an unsystematic way, based mainly on the opinion of the professionals, the assisted dwellers and some indicators of mortality and morbidity.

The purpose of this study is to contribute to the evaluation of the CHAP in SBC, using the actions developed by the CHA as the axis of its analysis. It aimed to describe the way the CHA, who integrate the CHAP, have been executing the actions expected by the National Health Department and which are described as expected abilities in the five competences designed by this Health Department for this worker. The guiding question is to identify in which *perspective* these CHA are executing these actions, to verify whether it is a perspective of health recovery and, therefore reproducing the care model centered in the doctor, in the hospital, in the pathology, in other words, through a biologicist view of the health-disease process; or if they are acting in the perspective of health promotion, aimed at developing practices based on a social view of the health-disease process, which is centered in the health needs of the community where they work and live, operating, from this point, interventions to promote the emancipation and autonomy of the individuals and the community, aimed at a better life qualify, collectively built.

Health Promotion and the practice of the Community Health Aides

Health Promotion represents one of the possibilities of intervention regarding the health sector, in the individual or collective perspective, which (re)introduces a broad conception of the health-disease process and its determinants, reflecting a reaction to the increasing medicalization of the social life[8]. Health Promotion strategies take place through public policies and favorable conditions to the health development, as well as the reinforcement of the capability of the individuals and communities.

The Ottawa Charter, which is considered a document of basic and fundamental reference of the health promotion ideas, defines Health Promotion as *the process of qualification of the community to act in the improvement of its health and life quality, including a greater participation of it in the control of this process* and proposes five central strategies of action: the elaboration and implementation of healthy public policies; the establishment of favorable environments to health; the reinforcement of the community action; the development of personal abilities and the reorientation of the health services and systems[9].

As the Ottawa Charter is considered a reference of promotion ideas to the world, the Declaration of Bogota is the term of references to the Latin America, bringing into discussion its fundamental principles: the overcoming of the difficulties of economical, environmental, social, political and cultural character; new alternatives to fight simultaneously the illnesses caused by the underdevelopment and the poverty and those derives from the urbanization and industrialization; democracy in the social relations; conquest of the equality and development of the human beings and societies[8].

The Health Promotion works through concrete and effective community actions in the development of the priorities, in the decision making, in the definition of strategies and their implementation, aimed at the improvement of the health conditions. The center of this process is the improvement of the communities, and their development, in the perspective of the Health Promotion, takes place through the intervention over the human resources and matters existing in them, aimed at intensifying the self-help and social support, to develop flexible systems of reinforcement of the popular participation towards the health themes. This intervention requires total and continuous access to information, to the opportunities of learning regarding the health matter, as well as the appropriate financial support[9].

As the National Health Department proposes the reorganization of the Basic Care according to the Family Health Strategy (FHS) and the CHAP, and thus, incorporates the CHA in the work of the health team, there is the possibility that this worker may execute actions to promote the strengthening of the community and broaden its capability to face health problems. The discussion of the potentialities of this new worker in the Basic Care indicates that his community dimension assumes a great importance and this is the aspect that may help change the focus to the reorganization of the health care[6].

In face of the exposed context, this study aims to describe, as it follows, the actions performed by the CHA in the CHAP of SBC, a city in São Paulo, based on the competences and abilities proposed by the National Health Department, and analyze them in light of the paradigm of the health promotion.

METHOD

This is an exploratory study with quantitative focus. The question was the need to know the way the CHA's work is

being organized in a large city, which counts on several social and health resources. The main focus of the study is the quantitative description of the performed actions, based on the competences and abilities defined for this health worker. The study took place in the city of SBC, which is located in the Southeast sub-region of the metropolitan region of São Paulo. This city has 407.1 Km^2 of area and, in 2004, it had around 758,430 inhabitants. The Index of Social Responsibility of São Paulo in the period between 1997-2000 (which considers wealth, education and longevity) classifies SBC in the group 1, the group of cities in the Center of Development[7]. Concerning the health care, in 2005, SBC had 02 hospitals, 05 general emergency units, 30 Basic Health Units (BHU), among other services. Concerning CHAP and FHS teams, the city had 15 CHAP teams distributed in 13 neighborhoods of the city, which covered 33% of the population. There were also 16 FHS teams, distributed in 3 BHU, which covered around 8% of the city population. The data collection of this study was carried out through the application of a formulary that aimed to identify the executed actions and the frequency that these actions were executed by the CHA. The data collection formulary was build based on the instrument used in the study CIPESC[11] and the competences/abilities of the CHA. It was a closed instrument, with multiple choice alternatives and presented a list of 60 actions, articulated according to the competence in which these actions were inserted[7].

Therefore, the competence *Integration of the Team with the Local Population* listed actions such as: instructing individuals, families and social groups regarding the workflows, routines and actions developed in the Basic Care area; executing actions for data collection and registration of information regarding the work; participating in team meetings; expressing opinions at the team meetings; bringing the needs of the community, which they consider relevant, to be discussed with the health team; using the home visits as basis for the development of their actions as CHA, among others. The competence *Planning and Evaluation* listed actions such as: making an institutional, social and demographic mapping of the micro-area; analyzing the social and environmental risks to the health of the population; registering the families in their micro-area; consolidating and analyzing the registration data; executing actions that allow the population to learn information regarding the performed socio-epidemiological surveys; elaborating an action plan to act in the community together with their team, among others. The competence *Health Promotion* comprehended the following actions: identifying the relation between health problems and life conditions; identifying potentially health promoting situations and habits; organizing discussion groups; implementing processes of reflection with the individuals, social groups and collectivities; performing educational activities; instructing the population regarding the self-care; giving instructions regarding preventive measures of domestic accidents; proposing intersectorial actions; establishing articulations with nurseries and schools; mobilizing the population to participate in committees and other institutions. The competence *Prevention and Monitoring of Environmental and Sanitary Risk* has the following actions: identifying environmental and sanitary conditions that constitute a risk to the community; identifying diseases related to the environmental and sanitary local problems in the micro-area; instructing individuals and groups regarding measures of reduction and prevention of environmental and sanitary risks. At last, the competence *Prevention and Monitoring to Specific Groups* presents the following list: identifying individuals and groups that demand special care and communicating the team; instructing families and groups to identify signs that indicate health problems; instructing pregnant women and mothers regarding the baby care; encouraging individuals and groups to participate in networks for the prevention of family violence; instructing individuals and families regarding measures for the control of transmissible and non-transmissible diseases.

The procedures involved in the operationalization of the data collection comprehend: the presentation of the study project to the Health Department of SBC; the presentation of the study project to the CHAP team and meeting with the CHA who accepted to participate in the study. In this meeting, the participants received the multiple choice formulary, which was completed and returned to the researcher. The study was answered by 241 CHA who worked in the CHAP of SBC in 2005, which covered, at that time, all CHA in action. The work was approved by the ethics committee in research of the EEUSP and respected the conditions of secrecy and voluntary compliance of the CHA to the study. Data were collected in the period between April and May of 2005 and organized at a database in the software SPSS. The analysis was based on the simple frequency of the occurrences, organized through the frequency in which they occurred.

RESULTS AND DISCUSSION

Concerning the competence **Integration of the Team to the Local Population**, the results demonstrated that most of the CHA develop actions of integration of the team to the population living in the region covered by the CHAP. The results showed that 83% of the CHA mentioned they use the home visits as basis for the development of their actions. Inside this competence, the most developed actions are: *instructing the community about the functioning of the BHU, activities and campaigns* and *instructing the community regarding the actions developed in the several health services*. Among the actions pointed as rarely performed, the one that stands out is *expressing opinions in the team meetings*, in which 39% of the CHA answered that they rarely do it.

Most of the CHA mentioned their daily efforts to *execute the actions proposed by the team* (46%), and this may indicate that the CHA develop, primarily, the actions requested by the health team, without making their percep-

tion of the community's needs explicit to the team. Some CHA (12%) stated to *take the community's needs into discussion with the health team* on a daily basis and 9.5 % of the CHA stated they rarely do it. Therefore, it is possible to observe that this pro-active action of the CHA is not an agreement between the health teams yet.

The discussion of this competence, **Integration of the Team to the Local Population**, indicates the historical recognition of the CHA as a link between the community and the health service, however, this worker cannot constitute an isolated link, he must promote a true integration with the health professionals and the community[12-13]. Being a link not only means to be present in the chain, but also to interact with it. Therefore, the great challenge of the CHA is to integrate his *community* side, associated to the fact that he shares the social, cultural and linguistic contexts with the social group subject to his health team, to his *health professional* side, which shares with the health team the biomedical model of intervention[13]. By analyzing the data it is possible to identify the difficulty of the CHA to make collocations regarding his recognition of the health needs at the team meetings. This fact suggests that the expected integration (community/health team) is more effective in the scope of reproduction of the biomedical model in the interior of the community, rather than in the *contamination* of the knowledge and practices of the health team to the health needs of the community.

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In the analysis of the competence **Planning and Evaluation,** it was observed that 46.5% of the CHA mentioned they daily perform the action *encouraging the population to participate in activities at their own community* and 36.5% mentioned they *identify and analyze the environmental risks in their micro-area of action*, also daily. The frequency rarely was the answer of over 40% of the CHA regarding the execution of the actions *instructing about the resources of the territory of his micro-area* and *establishing actions to solve the health problems in his micro-area of action, according to the criteria established by the local population*. Most of the CHA mentioned they do not analyze social risks, but they analyze environmental risks. This may be related to the fact that the CHA is not prepared to identify and intervene in social questions, since he generally receives trainings aimed at facing problems such as dengue or other epidemic diseases. The qualification for the CHA's work is still made in a non-structured and fragmented way, and most of the times insufficient to develop the necessary competences for the appropriate performance of his role in the community[13]. More than half of the CHA mentioned they do not *establish actions to solve health problems based on the criteria established by the team and/or local population*, and stated they rarely *evaluate and reprogram these actions*. The results indicate that the health team seems to be disregarding the importance of involving the community in prioritizing and facing the health problems, not recognizing the importance of the CHA's presence in the development of this partnership. The team also needs to be encouraged to evaluate the actions they execute aimed at re(qualifying) the actions they develop.

The analysis of the competence **Planning and Evaluation** indicated that the actions integrating it are not performed in order to make the community and the subjected geo-social space as the action location to the health team. It is possible to observe that the initiatives to evaluate the actions are almost inexistent. It is believed that, in the city in question, the CHA have differentiated lines of actions among the teams, since the action *encouraging the community to participate in the local committees or health conferences and others* appears polarized, in other words, half of the CHA states they rarely do it and the other half says they do it on a daily basis, even though, in general, most of the CHA mentions they *encourage the popular participation in their own community*.

In the practice, it is possible to perceive that many CHA avoid the contact with groups that have some sort of political involvement (and they include committees and conferences in this list) and, therefore, they feel more supported to instruct the population about the actions performed in their own neighborhood and in the biological-individual body. A great part of the CHA mentions they *do not provide information to the community and the program regarding the social resources of their micro-area*, possibly because there is not an appropriate printing for this registration or a specific request, which shows a practice that is distant from the recognition of the intersectoriality.

Concerning the competence **Health Promotion**, the results showed that the frequencies in which the actions of this competence occurred polarize between daily and rarely, indicating different behaviors in the different teams.

The collected data indicated that the daily frequency was mentioned by over 70% of the CHA for the performance of the actions *instructing the individuals regarding the self-care and measures of health prevention* and *encouraging the individuals and the community to reflect about their health and disease conditions*.

Most of the CHA mentioned they *identify the relation between the social problems and life conditions* and rarely *execute actions together with other departments existing in the city*. Regarding this last action, around 47% of the CHA mentioned they do not make any proposal of action for this partnership. It is also observed that 25% state they daily *use appropriate information and communication resources to the local reality* whereas 28.6% state they rarely do it.

Concerning the participation in health committees, it was observed that the CHA rarely participate in local health committees, possibly because they are not encouraged to do so or because they are not sure about their contribution. The community performance of the CHA should be encouraged so that he would be able to act in a broader way in the social determinants of health. In face of the exposed results, it is possible to infer that the actions aimed at an intersectorial approach in the competence of the health promotion are not performed by most of the CHA.

A great heterogeneity of actions is observed among the CHA in terms of the execution of health promotion actions and the importance attributed to an intersectorial action proposal. Most of the CHA have a good interpersonal relationship with the community and with the individuals living in this community, thus, instructing the individuals and the community about the self-care really seems to be their *favorite* action. Being requested to contact other services or to establish partnerships with other sectors of society constitute actions that are not easily executed by the CHA. This difficulty is reinforced by the organization of the health teams in the CHAP, since it tends to centralize the actions in the nurse and, therefore, inhibits spontaneous intersectoriality initiatives of the CHA, which is proved by the reduced number of educational activities for groups performed by them.

In the competence P**revention and Monitoring of Environmental and Sanitary Risk**, it is possible to observe that most of the CHA perform the actions *identifying the environmental and sanitary conditions that may cause risks to the health of the community* and *instructing the population about the occurrence of risk situations in their micro-area of action* on a daily basis.

The action *instructing the community about the care related to hospital environment* was mentioned as rarely performed by most of the CHA. Based on the provided data, it is possible to observe that the CHA find it easier to identify and instruct the community regarding sanitary and environmental questions, since they have this autonomy and they are encouraged to develop these instructions in the community. Another important question to remember is that the CHA have been often used in the campaigns to prevent dengue, among other projects that involve the environment.

The data analysis showed that the actions that integrate the competence **Prevention and Monitoring of Environmental and Sanitary Risk** are mostly related to the instruction of the individuals regarding the care involving the environment. The CHA feel comfortable performing the actions comprehended by this competence, however, it is necessary to say that, by attributing to the CHA the responsibility of *every environmental action* to be developed in the community (cleaning water tanks, fighting dengue, among others), there is the qualification process of this worker as the direct implication, which may generally assume characteristics of inadequacy, since the CHA receives several fragmented micro-trainings, provided by different sectors of the society, outside the work context of the health team, and often unarticulated from the environmental and sanitary problems of his micro-area.

In the competence **Prevention and Monitoring to Specific Groups and Morbidities**, the answers indicate that the actions composing this competence are frequently executed by the CHA. The fact that stands out is that over 60% of the CHA mentioned they daily perform the actions: *instructing the community regarding the signs that indicate health problems*; *identifying a health problem in individuals or groups* and *sending them to the BHU for care*.

The CHA answered they rarely *encourage individuals, families and groups to participate in local social programs involving instructions and prevention of intra and inter-family violence*; and stated they rarely *take medication to the population* and *schedule or reschedule appointments for the community*. The actions *instruction to the family of pregnant women about the care related to the postpartum* and *instructing the family of pregnant women about the care related to the childbirth* are frequent in the practice of the CHA.

In the competence **Prevention and Monitoring to Specific Groups and Morbidities,** the expected actions are mostly related to instructions to the individuals and/or groups about chronic or transmissible aggravations and they are often performed by the CHA. This worker seems to prioritize the development of actions aimed at the instruction of the community regarding the clinical signs that indicate health problems. Another action that has been often developed in this competence is the one that concerns the care to pregnant women and children. Nevertheless, instructions related to facing morbidities such as inter and intra-family violence are not often executed.

Facing health problems that have a social interface is not a frequently performed action by the CHA and it indicates the difficulties found by this worker to deal with these situations, which should be the main object of his work. It is also possible to consider that the CHA's reality of intervention is complex, in which the universe of problems circulates among demands of mental health, odontological care, physiotherapy and rehabilitation, from patients in bed and their caregivers up to those resulting from urban and family violence, and the environment (such as trash, rats, floods), and in face of this, the CHA's mission must be reviewed with him and by him[14].

FINAL CONSIDERATIONS

Health promotion is a field in expansion, with a great potential, given the demands resulting from the decentralization recommended by the Unique Health System (UHS), which favor the development of a city health movement and the strengthening of the popular participation and the social control in health matters[6].

The proposals CHAP/FHS are based on an insertion in local level, in which the technicians know the population in a broad way and have information that allow to recognize life conditions and identify the impact over the health-disease process. In these proposals, the territory assumes a differentiated dimension, constituting the place where it is necessary to face the market logic, the supremacy of the competitiveness and the globalization, since it aims to unify rather than to unite, not respecting the historical and real conditions of everyone involved.

Based on this study it is possible to identify that the CHA's work has potential to contribute to the development of involvement processes of local leaderships in the discussion and facing of the health problems and their social determinants, present in their territory. Therefore, it is important to highlight the need to build health actions for the CHA that characterize a specific work, well based, which explores the community center of this worker, instead of designing a *jack of all trades* profile for him or treating him as a *low cost resource for the expansion of the health services coverage*. It is necessary to review the actions that the CHA has assumed lately, so that he does not become a *health pseudo professional* that will little contribute to the change of the complaint-conduct, biomedical and excluding model, which prevails in the health sector.

Nevertheless, it is important to remember that it is not acceptable to assign to the CHA the hard and complex role of the *propelling spring of the UHS consolidation*, since in the practice this consolidation depends on a set of technical, political and social factors and the involvement of different actors, including the CHA, who certainly have a fundamental role[12] .

This study indicated two great challenges for the CHA's work, the first one is to encourage him to develop community actions centered in the perspective of local territory appreciation, exploring the potentialities of the supportive life experience as basis for the strengthening of the citizenship identity.

The CHA's second challenge would be to prioritize the development of intersectorial actions. The concept of intersectoriality emerged as a perspective of integrated solution for the problems experienced by the population, and the necessary changes include the approach of the people in charge for different institutions aimed at reading the needs of the collective[15].

In this logic, the school is not limited to teaching. The health service is not limited to the care of occurrences or preventive actions. The gymnasium is not limited to offer its space and equipment. Each service offered at a certain community composes a network of social actions. This network must articulate in order to identify the problems and designate integrated solutions[15] .

Supported by an intersectorial practice, the CHA would have more technological options to respond to the needs of the population he cares for, and he could, thus, broaden his actions over the problems whose determination is not only biological, but built in the interface between the biological body and the social body. However, it is necessary to remember that the strengthening of the intersectorial action comes up against favorable political conditions, because it is fundamental to review the role of the institutions that promote public policies, aimed at the promotion of equality and the integrality in the care to the citizen.

Finally, promoting health is making policies. It means to accept the huge challenge of triggering a broad process that includes the articulation of partnerships, intersectorial performances and popular participation to optimize the available resources and guarantee its application in policies that respond more effectively and integrally to the needs of the society[15].

The authors expect that the questions raised in this study may become the object of future studies, since the actions developed by the CHA do not correspond to the expectations of the team, the government, the community and his own expectations yet.

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Correspondence addressed to: Luciana Patriota Gusmão S. dos Santos
Rua das Flores, 55 - Ap. 93 - Vila São João
CEP 09726-310 - São Bernardo do Campo, SP, Brazil