

Knowledge and practices of community health agents in workers' healthcare^I

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Abstract

Community healthcare agents play a fundamental role in workers' integral care. They collect information about this population's social-demographic profile and identify the productive activities developed at home and in the vicinity, as well as possible labor-related health risk factors. This study contributes to the qualification process of healthcare agents, and is based on the competency model. It was developed in the city of Betim (southeastern Brazil) and used the card collection technique, part of the method Visualization in Participatory Programmes. The study sought to understand the working process of the community healthcare agents, valuing their know-how and perception of the labor-health-sickness relationship. Actions in the competency areas were identified that need to be incorporated into the qualification process of these workers: health promotion/disease prevention and organization of healthcare. The results emphasize the importance of new studies that take into consideration the changes in the agents' working process when developing workers' health actions.

Key words: Occupational Health, Primary Health Care, Competency-Based Education, Community healthcare agent

INTRODUCTION

The definition of *Atenção Primária à Saúde* (APS - Primary Health Care) as the axis that organizes healthcare in the *Sistema Único de Saúde* (SUS – National Health System) through the Pact for Health (Brasil, 2006) has imposed the need of institutional rearrangement and the definition of new attributions and roles for healthcare professionals and social control.

In Workers' Health, these changes are expressed, for example, in the challenge of making the *Rede Nacional de Atenção Integral à Saúde do Trabalhador* (RENAST – National Network for Workers' Integral Care),

which is the main implementation strategy of the policy in the area, organize the actions based on the APS and redefine the role to be played by the *Centros de Referência em Saúde do Trabalhador* (CEREST – Workers’ Health Reference Centers).

In this context, some of the attributions of the *Agentes Comunitários de Saúde* (ACS - Community Healthcare Agents) need to be reviewed with implications for these professionals’ qualification and permanent education processes.

The ACS have become a numerous workforce and have been important players in the reorganization of care in the SUS, since the beginning of the institutionalization of the *Programa de Agentes Comunitários de Saúde* (Pacs – Community Healthcare Agents Program), in 1991. Their work can be considered complex due to the function of “link” between community and team, which is expressed in a double movement: they decode, for the population, “ways of doing” of the official system and provide for the healthcare professionals essential elements to the understanding of the families’ health problems and the population’s needs (Nunes, 2002).

In Workers’ Health, the agents play a fundamental role, especially due to the easy access they have to users in their action territory, which enables them to identify the occupational profile of family members, the productive activities developed at home and in the vicinity, and the risk factors to health and the environment that are related to the productive processes.

The performance of this role requires that the ACS has multiple types of knowledge and skills, which presupposes that this worker needs a solid and permanent education with focus on teamwork.

These requirements regarding performance acquire relevance in light of the changes in the configuration of labor and relations of production, which have resulted in the increase in informal, family and home work (Dias et al., 2008).

It is in this context that the challenge of preparing the ACS for the development of Workers’ Health actions emerges, together with the recognition of the diversity of their daily experiences in facing the problems that involve the labor-health-sickness relations and with the incorporation of this knowledge into the qualification processes. Thus, based on the recognition of concepts and practices used by them in their daily working routine, the present study aims to discuss contents that should compose their permanent education process.

This paper outlines the competency profile of the ACS for the development of Workers’ Health actions. The construction of the profile gives importance to these workers’ know-how, incorporating the workers themselves into the process. The paper also discusses the main difficulties reported by the agents in the implementation of these actions.

Methodology

This is a descriptive-exploratory study of collective construction that aims to define the competency profile of the ACS for the development of Workers’ Health actions.

The dialogic approach to competency was used, according to which competency is the mobilization of personal attributes for the performance of

actions in specific contexts. The action, which belongs to the professional field, and the attributes that underlie it and are mobilized in a specific context form the performance, through which it is possible to infer the competency (Ribeiro; Lima, 2003).

The card collection technique was employed. It is part of the method “*Visualization in Participatory Programmes*” (VIPP) (Unicef, 1993), and it aims to identify, analyze and discuss the tasks developed by the agents and the attributes that are mobilized to perform them. VIPP integrates a set of group techniques used to facilitate the interaction between players and create a process of collective knowledge construction.

The option of the collective construction of the competency profile of the ACS for the development of Workers’ Health actions is based on giving importance to their know-how, the founding principle of the area. In this sense, contributing to the agents’ qualification requires learning and apprehending the knowledge and practices that they mobilize to develop Workers’ Health actions in their work territory.

The study was carried out in Betim, a municipality in the metropolitan region of Belo Horizonte (southeastern Brazil). The city was selected because of its complex productive profile, as it is the locus of diverse large, medium and small-sized productive activities, and because of the integrated work experience between CEREST and the primary health care network. Healthcare units with the exclusive presence of the Community Healthcare Agents Program (Pacs) were selected, due to the predominance of this model in the studied municipality. Other criteria used for the selection of the studied units were: a) larger coverage of the population enrolled in the Pacs; b) degree of previous articulation with the regional CEREST; and c) previous development of Workers’ Health actions, among them, the mapping of the productive activities and the reporting of labor-related health problems.

Based on the above-mentioned criteria, two primary healthcare units were chosen. The criterion of larger period working with Pacs was utilized for the selection of the 20 ACS who participated in the study. The group was constituted by female agents. Their minimum level of schooling was complete primary education, their mean age, 44.4 years, and their mean time in the function, 8.3 years.

The competency profile was built based on three workshops. In the first one, the ACS were invited to explain their understanding about the labor-health-sickness relations and to report the actions they developed that were considered as “Workers’ Health actions”. Cards were distributed to the agents so that they could write the performed actions. Then, these cards were stuck to a panel so as to allow the recognition of the described activities. The discussion of the activities registered on the panel allowed to regroup them according to their nature and the way in which they are performed. The ACS’ reports were registered by two relaters and the discussions were recorded. The registers, complemented by the transcriptions of the recordings, were systematized in an analysis matrix that was used to identify the meaning nuclei, as proposed by Bardin (1998). The

results of the analysis enabled the construction of the performance profile of the ACS.

In the second workshop, in which the ACS should validate the performances, they were requested to indicate the degree of agreement or disagreement with each performance expressed in the statements, which had been previously organized, using the Likert scale (Malhotra, 1996). The items that obtained total or partial degree of agreement were considered valid. After the agents' evaluation of the items described in the panels, the items marked in the scale as below 3 were discussed (no opinion; partial or total disagreement). The suggestions of changes in the form and language employed in the description of the performances were incorporated and validated by the agents.

The third workshop had the participation of professionals involved in the line of care of the user-worker: managers, doctors and a social worker of the *unidades básicas de saúde* (UBS – primary health care units) and of CEREST Betim, nurses who coordinated the Pacs and representatives of the ACS who had participated in the first and second workshops, totaling 19 professionals. In this workshop, the ACS' competency profile was discussed and validated using the same Likert scale.

The participants in the workshops had previously signed a consent document, in compliance with Resolution 196/96.

RESULTS

The description of the actions reported by the ACS and characterized by them as belonging to the field of Workers' Health is similar to those described in notebook 5 of Primary Health Care:

to report to the healthcare team the existence of workers in risk situation, work at an early age and workers who had labor-related accidents or diseases; to inform the family and worker about the day in which and the place where they can seek assistance and plan and participate in Workers' Health educational activities (Brasil, 2001, p.16).

It is interesting to observe that the ACS have incorporated these actions into their daily practice in their action territory, even though they have not received prescriptions or specific preparation for it.

The identification of the developed actions and of the attributes that were mobilized for their execution allowed to define the performances, which were organized in two areas of competency: health promotion/disease prevention and organization of healthcare.

The discussions about the actions developed in the field of health promotion and disease prevention allowed to apprehend the performances described in Chart 1, presented below.

Chart 1: Competency profile of the Community Healthcare Agents for the development of Workers' Health actions

Competency area: Health Promotion and Disease Prevention
Performances
In her home visit the agent observes, identifies and registers people's work and the working situations of all the family members, recognizing work as an important factor in health promotion and disease prevention in different age groups and genders.
She carefully observes the home space and the vicinity, searching for the productive activities that are developed in the territory, and identifies the possible related risk factors that might be exposing the worker, the family or the community.
She explains to the worker in an ethical way about the risks to which he can be exposed, listening attentively to the value he gives to what he does, to the precautions and/or measures he takes to preserve his work/job and to the knowledge he already has about occupational diseases.
She tries to raise the worker's awareness concerning the recognition of the importance of his work as health producer and potential disease producer.
Exploring the leadership she has in her catchment area and the knowledge she has due to the survey and register of information on labor-related diseases and/or accidents, she participates in the planning of collective mobilizations in the community, connected with workers' health.
Based on the systematization, in the primary healthcare unit, of the data collected through the register of occupations and risks/problems to workers' health, she participates in discussion groups and educational practices for users with specific labor-related diseases.

The performances required to the development of actions in the field of organization of healthcare can be seen in Chart 2.

Chart 2: Competency profile of the Community Healthcare Agents for the development of Workers' Health actions.

Competency area: Organization of Healthcare
Performances
She includes workers' health activities in her healthcare actions agenda (for example, in the home visits, in the planning of educational groups, etc), based on her amplified understanding of health, which encompasses quality of life, food, housing, work and leisure and on her understanding that the formal or informal worker is a user of SUS.
She acts as a link between the community and the primary healthcare units, by means of the precise register and provision of relevant information to the team, recognizing their role in the prevention of labor-related health problems.
She registers the information about labor-related diseases and accidents in instruments adjusted to this end and ensures the provision of this information to the team, understanding the importance of registering the information about labor-related problems so that they become priority of action in the UBS.
She tries to establish a relation between family members' complaints from her action area and the developed productive activities. Respecting the ethical principles, she includes in her reports to the UBS coordination information on findings connected with workers' health that is relevant to the organization of

the user care plan.

She discusses with the team, whenever possible, the possibilities of improving the access, reception and quick referral based on the knowledge of the user-worker's needs and difficulties; among them, the employer's frequent resistance to liberate the worker to attend medical consultations in the healthcare services.

The health promotion and disease prevention actions can be summarized as follows: a) mapping the productive activities developed in the unit's catchment area, including home work; b) identifying labor-related risk factors to health and the environment; c) explaining about problem prevention measures and worker's protection; and d) participating in social mobilization actions.

In the area of organization of healthcare, the following actions were identified: a) identifying and monitoring the care provided for users who had labor-related accidents or diseases; b) identifying and analyzing the population's problems and needs that are possibly related to labor; and c) reporting on these problems to the healthcare teams.

The knowledge and skills required to the development of these actions, as well as the difficulties and problems identified to fulfill them, will be discussed in the next section.

DISCUSSION

The profile of the ACS that participated in this study has similarities to that of other studies found in the literature, regarding gender, age and level of schooling (Martins, 2006; Ferraz, Aertz, 2005).

The predominance of women playing the role of Community Healthcare Agent has been correlated with the traditional role of caregiver that the woman performs in society (Ferraz, Aertz, 2005). The possibility of becoming an ACS represented, to many of these women, the entrance into the job market and the remuneration of activities that, many times, they already developed as volunteers in the community (Silva, 2001).

The period of service in the Pacs, 8.3 years on average, signals low rotation of this worker in the activity and constitutes an important factor in the agent's qualification process, which is constructed in her daily working practices (Ferraz, Aertz, 2005).

It is worth mentioning that the ACS that participated in the study had not received any specific qualification on the theme "Workers' Health". However, their technical education with focus on the amplified concept of health and the experience acquired in the development of their daily practices with the community facilitated the recognition of labor as determining the health-sickness process.

- **Competency profile required of the ACS for the development of Workers' Health actions**

Concerning the list of health promotion and disease prevention actions to be developed by the ACS, those referring to the field of Workers' Health are restricted due to diverse factors, such as: lack of information on the workers' morbidity and mortality profile; prioritization of the development of actions directed at groups defined by national guidelines, such as hypertension and diabetes control, maternal and child care; persistence of the assistance model centered on the individual medical consultation to the detriment of collective actions; among others.

Among the suggestions to facilitate the development of these actions, the ACS highlighted the importance of identifying the occupation of all the members of the families enrolled at the primary healthcare units and the recognition of the productive activities developed in the action territory, with emphasis on home work.

In the working routine of the ACS, filling in the item "occupation" in the family enrolment card, called card A (Brasil, 1998), enables the characterization of the population's occupational profile. The identification of the productive activities that are present in the territory should be included in the situational diagnosis, performed by the APS teams in the stage of recognition of the territory for team implementation. It should be updated periodically.

The identification and characterization of the productive activities developed at home are carried out by the ACS during the home visits. To achieve this, the ACS should have instruments, technical support and permanent qualification. In the state of Minas Gerais, the State Coordination of Workers' Health of the State Department of Health has created an enrolment card of productive home activities that includes the identification of possible risks to health deriving from their development. This information will subsidize the teams in the planning and development of surveillance and assistance actions directed at this group of workers.

A recurrent remark or complaint of the ACS is the non incorporation, in a systematic way, of the information about the productive activities developed at home and in the vicinity into the planning of health actions directed at workers' healthcare.

An explanation to this finding is the emphasis on the development of prescribed basic programs, such as: the control of hypertension, diabetes, tuberculosis, among others, failing to consider the role of labor in the determination of the health-sickness process.

The results of the study also allowed to identify, as an important difficulty to be overcome in the permanent education processes of the ACS, the optimization of the register of the occupations of the members of the families. To achieve this, it is fundamental that the ACS understands the concept of worker in the SUS perspective. According to the *Política Nacional de Saúde do Trabalhador* (PNST – Workers' Health National Policy), to the SUS, workers are

all men and women who perform activities for their own support and/or the support of their dependents, whatever the form of insertion in the job market, in

the formal and informal sectors of the economy (Brasil, 2004).

On the other hand, the *Classificação Brasileira de Ocupação* (CBO – Brazilian Occupation Classification) defines occupation as “the activity performed by the citizen in a job or other type of labor relation, such as autonomous work”¹, which is distinct from and independent of the citizen’s profession (Brasil, 2009).

The ACS’ difficulty in recognizing the informal sector worker is reflected on the manual of the *sistema de informação da atenção básica* (SIAB – primary care information system), which instructs the professionals to register in the space “specific assistance for labor-related accident”, present on card D, only the assistances in which the medical examination report that is present on the back of the CAT (*comunicação de acidente de trabalho* - labor-related accident report) is filled in (Brasil, 1998). It is important to note that this instruction contradicts the universality principle, as it does not include as labor-related accident the occurrences with workers who are not covered by the *Seguro de Acidente do Trabalho* (SAT – Labor-Related Accident Insurance) of the Social Security.

Thus, the ACS and a significant part of the SUS professionals need to be instructed, so as to incorporate the encompassing concept of worker described in the PNST for the adequate performance of their activities. This change implies overcoming historical cultural barriers that associate the worker with formal labor registered on the employment book.

The ACS also expressed the difficulty in distinguishing profession from occupation, which hinders filling in this item on card A. In this sense, it is important that these concepts are clear both to the agent and to the interviewed family member. The ACS should be prepared to identify the workers and the different working situations developed in their action territory.

Another relevant issue in the agents’ practices refers to the development of the risk perception skill, which, according to Wiedmann (1993), is:

the skill to interpret a situation of potential damage to the health or life of a person, or of third parties, based on previous experiences and their extrapolation to a future moment. This skill ranges from a vague opinion to a firm conviction (Wiedmann, 1993, p.3).

It was observed that the perception that the ACS have of labor-related risks is connected with the identification of danger. Guilherme (2008) differentiates the concepts of risk and danger. The author defines that risk “is the probability and the intensity of damage resulting from exposure to some danger”. The same author defines danger as an agent (physical, chemical or biological) or an action that may cause damage. According to

¹ All the quotations have been translated into English for the purposes of this paper.

the Houaiss dictionary (2009), danger is a situation or event in which damage can occur.

To the development of Workers' Health actions in the APS, the ACS should be capable of identifying danger situations that are present in the productive activities that are potential generators of damages and problems to the health of workers and of the community, particularly those that are performed at home.

The discussions with the ACS revealed that the development of productive activities at home is frequent and many times represents the alternative the family found to ensure their support. These activities are generally developed in a rudimentary and improvised way, without knowledge of the risks and protection/prevention measures to the workers.

Home work can be considered as paid activity performed at the dwelling space of the person who performs it. This activity can assume the form of employment for wages or be autonomous, and the worker can perform the entire productive process or some of its stages (Neves, Pedrosa, 2007).

The identification of different situations of risk to health that are related to the development of productive activities allows the agent to take this information to be incorporated into the planning of health actions, to contribute to the orientation on the adoption of prevention and protection measures concerning accidents and/or labor-related diseases, and to refer, whenever necessary, the user-worker to the primary healthcare unit that is responsible for his follow-up.

As for the health promotion and disease prevention actions, it is important to observe the role played by the ACS, particularly in the development of educational actions.

The skill of listening to the users was highlighted by the ACS as being relevant to perform educational actions. In this sense, the explanation about the possible risks to health and the environment related to their work and the possible protection measures has, as point of departure, the worker's perception about his work. This requires of the agent qualified listening and the capacity to mobilize knowledge, skills and attitudes to guide the worker adequately.

The listening attitude presupposes the professional's capacity to provide a "space so that the user can express what he knows, thinks and feels in relation to his health situation, as well as to respond to the user's real expectations, doubts and needs" (Filgueira, Deslandes, 1999, p.124).

Ceccim (2004) argues that it is necessary to change the education process of the healthcare workers. They have been educated as if they already had innate skills, such as the capacity to perform qualified listening.

The agents demand qualification and supervision to instruct workers in labor-related risks and protection measures, as they frequently use their own knowledge extracted from common sense and from their previous experiences. Silva (2001) mentioned in her study the lack of instruments, technologies and knowledge for the diverse dimensions that are expected from the agent's work. The author reiterates the use, by the ACS, of knowledge "borrowed" from the team's professionals, like doctors and nurses.

The posture of “agent and educator” assumed by the ACS is close to Freire’s (1997) conceptualization about education as communication, dialog. According to the author, communication implies reciprocity and does not admit a passive subject. He argues that the dialog should be capable of reducing the distance between the technician’s significant expression and the workers’ perception of the meaning. In his words:

The verbal expression of one of the subjects must be perceived within a significant framework that is common to the other subject. If there is no agreement concerning the signs, as expression of the signified object, there cannot be understanding between the subjects, which hinders communication (Freire, 1977, p. 67). É 1997 ou 1977?

In the ACS’ discourses, it was possible to notice their understanding that the educational action is not reduced to the act of knowledge transmission; rather, it implies communication, dialog.

Besides the actions directed at the families in home visits, the agents also develop works with groups and the community. Some of them, classified in this study as belonging to the promotion and prevention field, are forms of participation in projects of collective and social mobilization. The agents have been important allies in the planning and development of social mobilization projects, in large part due to their acceptance in the community, which facilitates the awareness-raising and adherence of the population. In addition to this role, the importance of their perceptions is also observed, as well as the value of the information collected about the population’s health conditions, which many times represents the direction for the planning of this type of action.

Social mobilization is something that “occurs when a group of people, a community, decides and acts with a common objective, seeking, on a daily basis, to achieve the results that are desired by all” (Toro, Werneck, 2004, p.11). The authors also mention that to mobilize “is to summon wills to act in search of a common purpose, under an interpretation and a meaning that are also shared”.

In the Workers’ Health field, social mobilization is an important action tool, as it requires the action of different players, like the workers themselves, companies, healthcare professionals, among others, and, at the same time, it demands the establishment of different levels of connection and responsibility of these players in the process.

In the field of organization of healthcare, it was observed that the ACS develop actions to monitor the care provided for the user-worker, including the identification of needs and problems deriving from the labor-health-sickness relations, reports provided for the healthcare teams and the monitoring of healthcare actions.

To the field of Workers’ Health, it is essential that the ACS recognizes that the user is a worker and, based on this recognition, identifies these users’ demands and needs. This implies, among other things, that the agents

incorporate into their practices the amplified concept of health, as defined in the Organic Law of Health 8080:

health has, as determinant and conditioning factors, among others, food, housing, basic sanitation, the environment, work, income, education, transportation, leisure and access to essential goods and services (Brasil, 1990).

Among the difficulties observed in the agents' testimonials about the development of their work, we can highlight their feeling of frustration and weakness deriving from the tension between the population's demand and what the institutions can offer to meet this demand. Campos (1997) explains that this occurs when the value of use and utility of the service is considered equivalent to the social needs.

This fact was aggravated by the implementation of the Pacs in large cities, which shed light on a new logic of social needs coming from issues like unemployment, violence, drug use, among others. In this sense, the APS teams have been dealing, more and more, with other social/health needs, in addition to those that have already been incorporated into the services, like the control of hypertension, diabetes and maternal and child care (Furlan, 2008).

These questions point to the importance of the qualification of the professionals who act in APS so that they can perform the analysis of the territory, which consists in the collection and systematization of demographic, epidemiological, socio-economic, political-cultural and sanitary data (Monken; Barcellos, 2005). These data will provide knowledge about the population's health situation and life conditions, so as to elect the priority problems and to identify necessary devices to the development of intersector and interinstitutional interventions, thus contributing to the development of more effective actions.

Many times, the fact that the population's demands identified by the ACS are not met is interpreted by the community as deriving from the lack of effectiveness of their work, resulting in the lack of recognition of the actions developed by the agents (Jardim, Lancman, 2009).

It is interesting to observe that the ACS attribute the difficulties found to transform the community's demands into effective actions in the scope of surveillance and assistance to the difficulty in recognizing that the problems deriving from the labor-health-sickness relation are a public health issue. Thus, they are not prioritized by the APS teams.

In this sense, the agents call the attention to the need of amplifying the visibility of labor-related problems by means of the register of data on labor-related diseases and accidents contained in directive 2472 (Brasil, 2010). As an example, they draw an analogy with the actions to combat dengue, which is understood as a priority by the government and the healthcare teams. The ACS mentioned that the fact that they register with quality and quantity data about labor-related problems in a certain territory may contribute to the understanding of the issue as a public health problem.

The ACS' demand for qualification and technical support, manifested in connection with the improvement in the registers of labor-related diseases and problems, also emerges in relation to the identification of work situations developed at home and their related dangers.

In the area of organization of healthcare, the ACS explains to the user the path to be taken within the network, informing him about the flow towards integral care. The home visits of the ACS, besides allowing to monitor the user in the line of care of SUS, favor the identification and the overcoming of obstacles so as to obtain agile and effective assistance.

Among the limitations to the access to care, the ACS mentioned that the workers, particularly men, rarely go to the primary care units, which is explained by cultural factors and also by the restrictions imposed by the service's working hours, often incompatible with the user's work.

A recent ethnographic study about the relationship between men and healthcare in the APS strengthens these findings and points to the creation of alternative working hours to assist workers as one of the facilitating strategies. However, other factors that were mentioned were the inexistence of programs directed at men's health and the professionals' incapacity for recognizing men as users in the services (Couto et al, 2010).

Finally, the knowledge about the agent's action in Workers' Health for the construction of the competency profile revealed the discrepancy that exists between what is prescribed and what their real work is. Although the SUS defines health promotion as the focus of the ACS' action, they continue to face "old problems"; among them, the control of malnutrition, maternal and child mortality and the cure of tuberculosis. In addition, there are the diverse demands and problems that follow the urbanization process, like the emergence of slums, lack of basic sanitation, unemployment, the increase in pollution and the unequal distribution of health risks deriving from productive processes installed on the peripheries, which transform the way of getting sick and dying of workers and of the neighboring population.

Thus, it is necessary to conduct more detailed studies on the changes that have been occurring in the ACS' working process in view of the wide diversity of problems, needs and demands that are present in their action territory, so as to contribute to improve the processes of professional qualification and valorization of these players who are so important to the development of integral care in the SUS.

FINAL REMARKS

The results of the study show that the Workers' Health actions developed by the ACS in their catchment area can be characterized as not far reaching and not very institutionalized, depending to a great extent on personal initiatives. It was observed that the agent does not have previous specific preparation to deal with the issues involved in the labor-health-sickness relation, which makes her resort to common sense and/or to the knowledge acquired in previous experiences with other users or even with family members to decide how she will solve the problems. It is necessary that the qualification

and permanent education processes of the ACS incorporate these issues, allowing the development of effective workers' care actions.

The study revealed that among the difficulties faced by the ACS in the development of their work are those deriving from the ambiguity of the place they occupy in the SUS, sometimes representing the community, sometimes the healthcare team.

Another important issue is the fact that the agent's work is not valued by the healthcare teams, as they have difficulties in incorporating the information collected by them into the planning and execution of the healthcare actions directed at users and their families.

The full participation of the ACS in the development of care provided for workers requires, besides investments in permanent education, the revision of the healthcare teams' working processes.

COLLABORATORS

Thais Lacerda e Silva was responsible for reviewing the literature, designing the methodology, carrying out the fieldwork and writing the paper. Elizabeth Costa Dias participated in the design of the methodology, in the fieldwork and collaborated in the writing of the paper. Eliana Cláudia Ribeiro collaborated in the design of the methodology, in the fieldwork and revised the paper.

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