Care in the territory: messages produced by community health workers from talking maps

Cuidado no território: mensagens produzidas por agentes comunitários de saúde a partir de mapas falantes

Cuidados en el territorio: mensajes producidos por agentes comunitarios de salud en los mapas parlantes

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REVISA

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RESUMO

Objetivo: descrever as mensagens dos agentes comunitários de saúde sobre cuidado no território. **Método**: estudo descritivo, qualitativo, realizado em três unidades básicas de saúde da cidade de Boa Vista, Roraima, Brasil. O grupo social foi constituído por quinze agentes comunitários de saúde. Os dados foram produzidos com grupos focais a partir de mapas falantes orientado por um roteiro de entrevista semiestruturado. Os achados foram transcritos e analisados segundo o referencial teórico-analítico de Bardin. **Resultados:** as mensagens de cuidado no território foram organizadas em duas categorias: mensagens sobre espiritualidade e religiosidade envolvidas na produção de cuidado no território e mensagens sobre as ações de cuidar realizadas pela unidade básica de saúde no território. **Conclusão:** a espiritualidade e a religiosidade foram descritas a partir da figura das casas das rezadeiras, centro espírita e igrejas presentes no território. As mensagens de cuidado foram decodificadas como escuta de necessidades, apoio emocional, suporte psicológico, atividades em grupos para jovens e dependentes químicos. As ações de cuidar foram descritas em atividades de promoção à saúde e prevenção de agravo por meio das visitas domiciliares, educação em saúde e ações em escolas.
Descritores: Agentes Comunitários de Saúde; Territorialização da Atenção Primária; Território Sociocultural.

ABSTRACT

Objective: to describe the messages of community health agents about care in the territory. **Method:** a descriptive, qualitative study conducted in three basic health units located in the city of Boa Vista, Roraima, Brazil. The social group consisted of fifteen community health agents. The data was produced with focus groups from talking maps guided by a semi-structured interview script. The findings were transcribed and analyzed according to Bardin's theoretical-analytical framework. **Results:** the messages about care in the territory were organized into two categories: messages about spirituality and religiosity involved in the production of care in the territory, and messages about the care actions of the basic health unit carried out in the territory. **Conclusion:** spirituality and religiosity were described from the figure of the houses of the prayers, spiritist centers, and churches present in the territory. The care messages were decoded as listening to needs, emotional support, psychological support, group activities for youth and drug addicts. The care actions were described in health promotion and disease prevention activities through home visits, health education, and actions in schools.
Descriptors: Community Health Workers; Territorialization in Primary Health care; Sociocultural Territory.

RESUMEN

Objetivo: describir los mensajes de los agentes comunitarios de salud sobre el cuidado en el territorio. **Método:** estudio descriptivo, cualitativo realizado en tres unidades básicas de salud de la ciudad de Boa Vista, Roraima, Brasil, con quince agentes comunitarios de salud. Los datos se produjeron con grupos focales a partir de mapas parlantes guiados por un guión de entrevista semiestructurado. Los hallazgos fueron analizados según el marco de Bardin. **Resultados:** los mensajes de cuidados en el territorio fueron organizados en dos categorías: mensajes sobre espiritualidad y religiosidad involucradas en la producción del cuidado en el territorio y mensajes sobre las acciones de cuidado a la unidad básica de salud realizadas en el territorio. **Conclusión:** espiritualidad y religiosidad fueron descritas a partir de la figura de las casas de los rezos, centro espírita e iglesias presentes en el territorio. Sus mensajes de cuidados fueron decodificados como escucha de necesidades, apoyo emocional, apoyo psicológico, actividades grupales para jóvenes y drogodependientes. Las acciones de cuidados se describieron en actividades de promoción de la salud y prevención de enfermedades mediante visitas domiciliarias, educación en salud y acciones en las escuelas.
Descriptores: Agentes Comunitarios de Salud; Territorialización de la Atención Primaria; Territorio Sociocultural.

ORIGINAL

Introduction

From the outset, it is opportune to contextualize that the present investigation is linked to the research project "Tracking of knowledge and managerial, care and educational practices in the context of primary health care (PHC)" registered with the Research Department of the Federal University of Roraima (UFRR). This is the production of scientific knowledge woven by nurses and master's students linked to the Graduate Program in Health Sciences (PROCISA) on care in the territory from the protagonism of the community health agent (CHA).

This choice is due to the daily experiences of the authors in directing theoretical and practical discussions of an interdisciplinary nature involving encounters, welcoming, tensions, desires, approximations, distances and the CHA's own performance in the production of care in the field of primary care (PC) in the far north of Brazil. In fact, PC is considered the preferred gateway of contact with users, and the place of dialogue of the care networks.[1] It is from the health needs located in it that the organization and functions of the health network are reinforced.[2]

Therefore, the Basic Health Units (BHU) are understood as the main health service at the primary level, where care is offered that contemplates the needs of the population of their territory, either by the Family Health Strategy (FHS) or by the dispositions of Primary Care teams. Thus, the FHS has the role of reorganizing the work process of PC with ways to solve the individual and collective health situation in the specificities and dynamics of the territory and the population enrolled.[3]

Thus, thinking about emerging perspectives of care in the territory requires a rescue of what was once present in it beyond its geographical representation. It is a passage in motion resulting from time over generations capable of modeling and (re)constructing care practices. In this perspective, the CHA, because they belong to the territory, is considered the fundamental social actor in bringing the population closer to the FHS. Here, considered as an object of knowledge, the CHA is understood as a professional who has greater bond establishment and the ability to identify the necessary demands of the population enrolled in the UBS.[4]

In fact, because he lives in the place where he works, he knows the territory and has the possibility of approaching the families that make up the place.[5] It should also be emphasized that because it is not a profession legitimized by the biomedical model, it can contribute or affect its "transit" within some spaces and social scenarios present in the territory.[6]

In view of the contextualizations posed, the following guiding question of this investigation arises: Which messages of care from the territory emerge from talking maps produced by CHA? Based on this question, the following objective is aligned: to describe the messages of the CHAs about care in the territory.

Method

This is a descriptive study with a qualitative approach, carried out in basic health services located in the municipality of Boa Vista, capital of the state of Roraima. It is noteworthy that the city is located in a border state, with the neighboring countries of Guyana and Venezuela.

At the time of the study, the city has 34 UBS, of which 03 were selected by convenience considering the relationship of bond established between researcher-investigative scenario, namely: 01 located in the south zone and 02 located in the west zone. The territories that constitute the BHU selected for the study refer to sociocultural differences. In this sense, the presence of Venezuelan migrants residing in the territory is highlighted, as well as intergenerational populations that maintain the permanence of knowledge and practices in health in the place where they live.

The social group of this study consisted of 15 CHAs, working in the family health teams (FHT) at the BHU in the city of Boa Vista. The selection of these participants followed the following inclusion criteria: CHA working in PC and member of the FHS for at least two years, having direct contact with the community and being responsible for a microarea. Regarding the exclusion criteria: CHA in exclusively administrative work, CHA on leave from work activities for health reasons, vacations, absent at the time of the invitation and social production of the data. In all, there were eight refusals to participate in the study.

The data were produced in person in focus groups by a nursing student who was previously oriented about the collection technique. For this, the strategy of production of talking maps was used, which consists of the graphic representation of situations or problems of a given reality by the individuals who experience them.[7] Therefore, the talking maps are the representative and symbolic expression of the daily perceptions in a given territory, which enables the understanding of the places of prominence and relevance for the individuals who live and act in it.[8]

From the technical point of view, the production of the data was divided into two moments. Initially, the CHAs were invited in person at the UBS of capacity, through the responsible board and the nurses of the FHS. After the acceptance and presentation of the objectives, a date and time were scheduled according to the availability of the researcher and the participants. Secondarily, a maximum of 04 participants was stipulated for the creation of each speaking map, where the CHAs were free in the composition of the groups, opting as a distribution criterion the proximity of their microareas and the territorial limits for each map.

The production of the talking maps took place from January to May 2022 in the meeting room located in each BHU. The use of the talking maps served as a technical resource for detachment of meanings about the care messages produced in the territory and followed the following steps: induction, creation and presentation of the speaking maps. The induction enabled the CHAs to understand the strategy, which is based on their knowledge and experience of the micro-areas covered by the BHU in which they operate. At this stage, the participants were organized into groups and accessed the terms that induced the study: "Territory" and "Care".

Regarding the creation, the CHAs were free as to the form of production of the speaking maps, which included drawings and/or collages. For this, they had access to the following materials: cardboard, colored pens, pencils, erasers, magazines, brochures, scissors and glue. After the creation, the participants were invited to present the talking maps guided by questions present in the semi-structured interview script.

The script contained questions related to the territory of the CHA's activities and the care experiences lived by them. The participants were free to choose a representative of each group to present the speaking maps, or collective participation, respecting the speaking time of each CHA. All presentations were recorded with the aid of a smartphone recorder and had the approximate duration of three hours and fifty minutes of audio in MP3 Player format.

The findings were transcribed, returned to the participants and later analyzed according to the theoretical framework of content provided in Bardin, which systematizes the analysis in three chronological poles: pre-analysis, exploration of the material and treatment of the data obtained, and finally, interpretation.9 After these analytical poles, the territorial descriptions were organized in a table that contains the themes identified directly from the data.

It should be noted that the present study was submitted to the Research Ethics Committee and approved with the opinion number 4,701,055. The anonymities of the participants were maintained based on the abbreviation "CHA" referring to "Community Health Agent", followed by increasing ordinal numbering, according to the disposition of the groups producing the speaking maps. Finally, the entire study design met the consolidated criteria for qualitative research reports.

Results

With regard to the descriptions of the CHAs' messages about care in the territory, two categories derived from the data emerged, namely: "messages about spirituality and religiosity involved in the production of care in the territory" and "messages about the actions of caring for the BHU carried out in the territory".

Specifically, in the first category, messages are evidenced in the statements of the CHAs about spirituality and religiosity described as care in the territory. The messages describe the prayer center, the spiritist center and the churches as devices that offer personal care, listening to needs, emotional and psychological support to the community. In addition, the promotion of group activities was highlighted, with emphasis on alcoholics anonymous and young people. These messages can be evidenced in the following illustrative statements:

> *When spirituality is worked, health behavior is worked, the emotional side (CHA 2).*
> *[...] there is the service offered at the Spiritist Center of Psychology [...] that works on the emotional and spiritual side (CHA 3).*
> *[...] makes the youth group [the evangelical church], which helps in spirituality, in prayer [...] (CHA 4).*
> *[...] it takes some of the word [the evangelical church] to the person who really needs to listen (CHA 5).*
> *[...] there are many sisters from the church who come here and leave those little notes with Bible verses for the patients of the UBS (CHA 9).*

> *[...] has the prayer as a reference. We also use it as our own personal care (CHA 10).*
> *[...] place of prayer [the church] that several people will ask for help from the Lord Jesus [...] (CHA 12).*
> *[...] there are the church groups that are Alcoholics Anonymous and smoking, they do this group support [...] (CHA 13).*

The second category presents as messages of care, produced by the CHAs in the territory, the realization of home visits, education and guidance in health and actions in schools. In addition, it is (re)recognized the registration, monitoring of people's needs, especially the elderly, pregnant and postpartum women, children, diabetics, hypertensive patients, cases of tuberculosis, dengue and diarrhea. All this can be evidenced in the illustrative testimonies provided below:

> *[...] make periodic visits; accompany pregnant women; young children; monitor cases of diarrhea, in this case, diphtheria indicator (CHA 1).*
> *[...] do health actions in schools [...] vaccinated children inside the same school [...] care more is guidance, registration [...] (CHA 3).*
> *[...] there are diabetics, hypertensive patients, where there are people who need greater attention, in relation to my work, my care [...] to do this close monitoring, especially when they are cases of tuberculosis and older people [...] (CHA 6).*
> *Visiting people and seeing their needs, what they need [...] registers families, visits pregnant women, puerperal women, babies and provides health guidance to people (CHA 7).*
> *[...] performs actions in schools, bringing health education to children (CHA 08).*
> *[...] He lectures, he gives orientations. We are always in these units [schools] campaigning and helping children about dengue (CHA 11).*
> *[...] lectures to students [...]. It brings education and health to them there in the schools. In addition, we do several actions here at the post. Hypertensive, diabetic, pregnant woman (CHA 14).*
> *[...] Our care more is guidance, registration [...] (CHA 15).*

Discussion

The discussions on care go through two thematic axes: the spirituality-religiosity dyad and the technical actions produced by the UBS in the territory. In this perspective, the messages coming from the talking maps produced by the CHAs start from their relations with a territory organized by static care devices.

In the first category, religion and spirituality are reinforced in the descriptions of the messages of care by the CHA, considering the territories they operate. Scientific evidence points out that spirituality is linked to the search for the compression of life and all the aspects that permeate it, as well as the relations with the transcendent, while religion is considered a system, with beliefs, practices and other symbolic designations that bring the subject closer to the sacred.[10]

In other words, spirituality and religiosity can interfere in the orientations of health professionals, as well as in the performance of examinations or procedures, with deviation of the conducts for a faith-centered search for healing.[11] By understanding these dimensions it is possible to ensure satisfactory results in the health and quality of life of users, seeking to understand the various

signs of spirituality and aspects of life that are linked to religion within the practices produced by the UBS.[12]

In the messages described by the CHA, it is possible to identify churches, prayer and the Spiritist Center as producers of care actions that meet the needs of the community. The actions linked to the churches are described as assistential, aimed at different groups. Among these groups, those of drug addicts stand out. In this domain, the performance of therapeutic communities with drug addicts and users is common, contributing to the treatment process through religious methods.[13] Other actions are focused on prayers, listening to needs and emotional support. The performance of these activities contributes not only to overcoming addictions, but also to coping with and accepting clinical diagnoses.[14]

Therefore, these activities that involve not only sick and dependent people, but also those who perform functions that go beyond the religious, moving towards the subjective dimensions of life, contribute to the production of healthy territories and were described as care in the micro-areas in which the CHAs work.

It is also interesting to highlight that the CHAs emphasize the prayers as reference elements for thinking about health care. In simplicity, there is a complexity of a care in which they are requested in the territories, especially for activities that involve blessing children, when they are affected by diseases or malaise of the bodies, the so-called "looked", being a practice carried out mainly by older women, a generational care passed from grandmother / mother to daughter / granddaughter.[15]

It should be said that the production of the speaking maps potentiated the description and evocation of messages capable of valuing the use of popular practice that occurred in the territories, aggregating the knowledge that remains or is born in these places and that is found in the daily life of life. Subsequently, the CHAs described the Spiritist centers as powerful places of psychological support and development of community activities. The Spiritist Houses have a wide range of activities for the general population, in order to alleviate physical ailments and provide spiritual help. Among these activities is the support and welcoming, the energization, application of passes and, mainly, the spiritual surgeries.[16,17]

In the second category, technical messages of care emerged as content, distinct in variety and with exclusive emphasis on the participation of the CHA. Among the messages exposed, actions developed by them in the community are described, which involves registration, monitoring, family monitoring, home visits and health education.

These practices are commonly developed by the CHA, with the main emphasis on the registration of families and home visits in their micro-areas of responsibility. It is through the visits that the CHAs are able to identify, promote and intervene in situations of vulnerability or illness. In this study, the CHAs describe periodic visits. However, they can vary from one to two times a month, depending on the needs or situation of each territory.[18,19]

In addition, home visits may follow some criteria that define this frequency, including the presence of pregnant women, the elderly, children, and people with chronic diseases or some motor difficulty that makes it impossible to mobilize to health services.19 These criteria are described by the CHAs when

they report the follow-up of these social groups and cases with tuberculosis, in addition to the concern to monitor occurrences of diarrhea and dengue.

In addition to follow-up, they perform health education, which may involve basic questions about the importance of performing the Pap smear for women, prenatal care, warning signs during pregnancy, guidance on breastfeeding and presence in childcare consultations for children under five years of age, as well as lifestyle changes and self-care for patients with chronic non-communicable diseases.[20-22]

It should be said that the occupation with school actions is one of the attributions of the FHS professionals, in which it must be organized and planned together with the educational devices present in the territory.[23] In this scenario, the CHA presents itself as an integrating actor of the FHS with the schools, collaborating for the effectiveness of the actions to be developed, through warnings to the families regarding the educational activities to be implemented.

In this sense, educational skills were perceived in the field of domain of the CHA, especially with close proximity in schools to strengthen health promotion activities, either voluntarily, through invitations to actions, or through the actions provided for in the School Health Program.[24,25]

Having said that, the discussions presented reveal that the proximity of the CHAs with the population enrolled in the territory locates (in)formal devices for the production of health care. They were able to make emerge from the talking maps a complex singular network of care existing in the territory that articulates directly with actions of a more technical and biomedical nature operated by the UBS.

Despite the limitations of this study, the analytical process should be considered strictly content, which allowed the imagery dimension present in the talking maps not to appear in this investigation. In this perspective, techniques of analysis of fixed images, as a way to complement qualitative research, need to be incorporated to expand the understanding of the findings beyond the thematic description.

In terms of implications for future research, it is also considered that studies, which cover the perspective of FHS professionals in the territory, are central to the formulation of strategies, programs and public policies for sustainable locoregional emancipation, especially respecting the singularities in the territories in which the CHAs work.

Finally, it is believed that the contribution of this manuscript focuses on strengthening the figure of the CHA as a central element in the recognition of needs and forms of care operationalized in the territory. Its place is very special in the scope of PC, especially because it mobilizes expanded dimensions of health care when it brings together people's daily lives with the practices produced at the BHU.

Conclusion

This study raised conclusive descriptions about care messages present in the territory covered by the BHU through the production of the CHA's speaking maps in two central aspects: spirituality and religiosity in the production of health care and care actions carried out by the BHU in the territory.

With regard to spirituality and religiosity, they were represented by the houses of the praying women, spiritist center and churches. These devices refer to alternative practices, essentially present in the places where the CHAs live and which produce care described as listening to needs, emotional support, psychological support, group activities, especially for young people and drug addicts.

Other messages of care described include the programmatic actions of the UBS in its coverage territories. The main descriptions underline the role of the CHA in the production of health promotion and disease prevention activities essentially through home visits, health education and actions in schools. In addition, it is (re)recognized the registration, monitoring of people's needs, with emphasis on the elderly, pregnant women, puerperal women, children, diabetics, hypertensive patients, cases of tuberculosis, dengue and diarrhea.

We expect that this research will contribute to future inquiries regarding the aspects that involve care and territory in the scope of collective health, especially involving professionals who make up the PC, managers and users of the Unified Health System. Thus, it is believed that this research contributes to the understanding of the diversity of practices and actions existing in the territories and of the populations that use and strengthen this articulated network of (in)formal health care.

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