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Articles

Health subjects, territory agents: the community health agent in immigrant Primary Care

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With the intensification and diversification of international migratory flows to Brazil and the need to integrate the immigrant population into essential services, new dynamics are presented in the Primary Health Care. Considering the Bolivian population that uses the services of one Basic Health Unit in São Paulo , this work seeks to understand what the role of the community health agents is, in order to guarantee the principle of universality of the public health services offering access and including the immigrant populations. Through qualitative interviews, examined through content analysis, it was possible to verify that the community health agents appear as essential actors to guarantee the right of access to the health system. Hence, they are responsible for the promotion of health care and they are also the agents of the territory, building up social networks for the holistic care.

Keywords: Migration and health. Primary care. Community health agents.

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Introduction

The Brazilian public health service has a universal character since the implementation and consolidation of the Brazilian National Health System (SUS)[1], constituting a right of the population living in the national territory[2]. In conjunction with the other SUS directives (completeness and fairness), through the principle of universality the immigrant population is ensured access to the services by law through the regulatory conducts of the health system.

However, in a context in which the flow of people is becoming more intensified and diversified, new complexities arise for services. The presence of people from different countries, with different cultural habits and different ways of understanding the health-disease process, leads to different demands for the work of health professionals[3,4]. Considering that the immigrant population should be served and included in the services, it is necessary to reflect on the role of each social actor (incorporated into healthcare providing institutions, civil society, public policy makers, etc.) to ensure this inclusion.

This work stems from a research conducted in the Bom Retiro Basic Health Unit (BHU) on the relations and asymmetries between the access and inclusion of the Bolivian immigrant population to Basic Care services. We decided to analyze this level of health care because it advocates a greater approach between the service and the community of its catchment area. This greater bond is due to the Basic Care (the way Primary Health Care is structured in Brazil) presenting in its mode of operation a continuous monitoring of populational health, proposing a health promotion work[5]. These attributes were postulated by Starfield[5] and guide a form of integral and longitudinal health care provided to the population. The questioning that directed the study was related with the reflection on how this service would work in a context in which the population that needs to be served shows constant mobility in space.

During the research, we observed the need to discuss the role of Community Health Agents (CHAs) for the inclusion of the Bolivian population could be ensured. This observation resulted from the fact that in many of the interviews, both with health professionals and Bolivian users, the CHAs featured as central figures to enable was a bond between BHUs and the Bolivian community.

In the specific case of the Bom Retiro BHU, Bolivian health agents were hired so the immigrant population, which was not being attracted by the services, could be reached. Thus, CHAs may also be considered "strategy-actors" aiming to provide health services to the immigrant population. Accordingly, we sought to understand how the need to hire these CHAs was perceived and the impacts of their work in the community, understanding how this strategy contributed to ensure the inclusion and access of immigrants to health services.

Thus, this article proposes discussing the work of community health agents and its importance in serving immigrant populations, which differ culturally and may face situations of greater vulnerability. Accordingly, we sought to characterize and understand the importance of these subjects in the organization of Basic Care, reflecting on their double condition, being at the same time health promotion actors and subjects participating in the dynamics of the health unit's catchment territory.

Methodological procedures

In order to learn about the work of CHAs in the territory, listening to these subjects was essential. For that purpose, we decided to use qualitative interviews conducted with health professionals and Bolivian users of BHUs in the context of research on the complexity of immigrant Basic Care in São Paulo. In the analysis of the interviews, we sought to understand the participation of Community Health Agents for the health service effectiveness

We conducted interviews with 49 health professionals, including: 4 physicians, 4 nurses, 8 nursing assistants, 2 psychologists, 17 community health agents, 5 administrative assistants, 1 physical education professional, 1 environmental defense agent, 1 psychiatrist, 1 physiotherapist, 1 speech therapist, and 4 pharmacists. These professionals are divided into four health teams that work in the Bom Retiro BHU's catchment area.

In addition, we interviewed 30 Bolivians who lived in the Bom Retiro neighborhood and used the unit's health services. Bolivian immigration to Brazil is increasingly consolidated[6]; therefore, it is necessary to know the different aspects of the inclusion and service in the basic care provided to this population that requires initiatives from public services.

Bom Retiro was chosen because of its historical recognition as an immigrant neighborhood in São Paulo, currently being the place of residence of a large number of immigrant Bolivian population[7]. According to the São Paulo municipal government, 2010 Census demographic data indicate that the neighborhood had 33,832 inhabitants[8]. In addition, the neighborhood hosted 30.3% of the Bolivian immigrants that lived in São Paulo[9]. According to data provided by the manager responsible for the Bom Retiro BHU, among the population living in the catchment area, 15,137 people are registered and served by the BHU, being estimated that about 5,000 are of Bolivian origin.

This study required approval from the Research Ethics Committee through processes no. 34589614.1.0000.5404 and 34589614.1.3001.0086, in addition to consent from the subjects for the interviews to be recorded. The interviews were transcribed, as spoken, and analyzed from the perspective of content analysis, in which there is the possibility of understanding the meanings and significances of the words said[10].

The interviews were analyzed after an initial selection of excerpts showing the role of the health agents. This selection was based on a thematic analysis, seeking the meanings of the discourse content[10] in order to understand how the health agent was represented by the health professionals and Bolivian immigrants. Interview contents were then analyzed in relation to bibliographic references referring to issues of the organization of Basic Care, the work of community health agents, and the prospects for the use of health services by the immigrant population.

Health Promoting Subjects

To understand the role of CHAs in Primary Health Services, which in Brazil is also known as Basic Care, we considered important to readdress the consolidation of the work of these professionals in the Brazilian territory. Accordingly, we aim to discuss

the importance of these activities for health care in Primary Care services for the population.

Since it came to be understood as the axis organizing health care, the basic care network entered the institutional rearrangement of the SUS, and new roles had to be defined for health professionals who would work in it[11]. Implemented through Basic Health Units (BHUs), Basic Care initiated its work with the Family Health Program (FHP), created in 1994, which in its principle aimed to cover small municipalities, focusing on areas showing greater social vulnerability. Since 2006, the FHP has become a national Basic Health strategy, having been redefined to Family Health Strategy (FHS) and definitely as a work focusing on the family and territory, based on health promotion and care and disease prevention activities[12].

Thus, with the objective of promoting health and the guarantee of improvement in the quality of life for subjects, the FHS gives great emphasis to the subjects' autonomy in their health care, their family's health care, and their community's health care[13]. In order to work in a transversal manner, the health professionals were separated into teams – Family Health Team (FHT) – composed of an interdisciplinary work group[13]. Providing for Home Visits (HV) as central instrument in the teams' work, a new mode of care is introduced, which in addition to providing care to families through longitudinal care also works as a device to diagnose the local reality, enabling the proposition of initiatives based on it[12].

CHAs register families for use of the services during the home visits[14]. Therefore, they are the first ones that become aware of the reality of these families, establishing a close contact with the unit's users and enabling the recognition of their health problems. Hence, they observe issues related to infectious and contagious diseases and social and environmental problems that affect the health of the population, such as domestic violence and poor basic sanitation[15].

In addition to home visits, CHAs are responsible for participating in educational groups, for dengue surveillance activities, for registration of minimum income individuals, for active search of absentees, for community service, in addition to often performing administrative activities when necessary, even if they are not among their initial assignments[15].

CHAs become important connections between the population that use the unit and health teams, because in addition to frequently meeting the community in home visits, CHAs must live in the same catchment area of the BHU. As a result, in addition to living in the same locality of users of the unit, they belong to the same community. Thus, trust relationships are established and strengthened, and the CHAs even become the voice of the community within the BHU[15].

Therefore, the importance of CHAs for Basic Care services extends beyond the limits of their assigned and expected tasks. They become "agents of meetings, language interpreters, mediators of borders, inventors and/or guarantors of access routes to one another, or the catalyst figure of one of the territories"[16] (p. 2934).

Due to this double belonging, to the health team and to the community, Jardim and Lancman[17] argued that CHAs have a dual role, being at the same time agents and subjects. However, an even more complex function may be assigned to these professionals, because, beyond being health promotion agents and community subjects, they are health promoting subjects and territory transforming agents.

In a context of building new territorialities, in which distinct populational groups show, create, and recreate their characteristics and peculiarities in space, there is an intense volatility in the formation of ties with the territory. This fluidity makes it hard to maintain a bond between the health unit and the population served by it. Thus, it is observed that in participating actively in this dynamics, CHAs become health promoting subjects and facilitate the bonds of trust necessary for the continuity of health care.

Territory Transforming Agents

One of the main guiding axis for implementation of the FHS is territorialization, which guides the forms of intervention in the catchment area of each FHT, resulting in autonomy of the units with respect to their strategies[15]. Territorialization defines the target public of the services, defining their area of work and the population that will be covered by their care[18].

However, in addition to the administrative territory, in which the FHT will work, the process of territorialization of services may become a problem, since the social and populational dynamics are constantly changing and a prior delimitation could restrict this fluidity[19]. On the other hand, the unit's very condition of proximity to the population, resulting from territorialization, really enables the Basic Care practice. Considering the criticism towards using the concept of health territorialization, CHAs themselves end up being the professionals that most merge with the community and bring significance to the conceptualization of territorialities that are built in space.

Since the territory results from actions of the subjects included in it and marked by power relations, the territoriality will reflect "the multidimensionality of the territorial 'experience lived' by the members of a collectivity"[20] (p. 158), that is, the relationships that are formed and transformed in the territory. The territorialities are formed in the territory's everyday life; "it is the 'lived face of the acted face' of power"[20] (p. 161-2).

The Bom Retiro BHU is situated in a location known to be a territory of immigrants[7], due to its very history, characterized by roughness in the space[21], resulting in immigrant flows from different times being represented in the constitution and landscape of the neighborhood. At times called "ethnic enclaves"[22], the immigrant territories are constituted voluntarily representing the creation of social networks[23], which facilitate the coming of new immigrants and assist them in settling in the country of destination.

The importance of the territory is also featured in the interviews with health professionals of the BHU, as shown in the following excerpt:

> [...] The Bom Retiro neighborhood has a peculiarity [...] It brings together the immigrants of the world. Because here you will find everything, there are African, [...], Japanese, Chinese, Latin American people, [...], from all continents. So the small, mini world that Bom Retiro is [...] It is a concentration of ethnicities and cultures. (Interview with health professional)

Thus, the territorial dynamics should be understood, since the CHAs share not only the space of health care, but also the space of daily living, in a context in which

new territorialities are built based on the presence of people coming from different social and cultural contexts. This is one of the main differentials of the practice of the CHAs. They are also territory agents, that is, they participate in the territorialities that are constituted in the unit's catchment area; their life spaces are the same as those of BHU users[17].

CHAs partake in experiences, building bonds with the population, which is essential for the continuous monitoring of health. Therefore, they know who the subjects who inhabit the territory are and, often, partake in the difficulties faced by them, since they are also part of the territorial dynamics. Hence, they have differentiated conditions to provide humanized care to the population, which, when immigrant, is often "hidden" due to various reasons, such as the conditions in which they live in the country of destination, their documents, their work in precarious conditions[24].

Subjects that Promote Immigrant Basic Care

The presence of Bolivian immigrants in São Paulo is observed since the late 1950s, arising from bilateral agreements between the two countries[25]. During the 1980s, the flow intensifies as a result of their inclusion in the textile industry centered in central neighborhoods of the city of São Paulo[24-26].

Bom Retiro, a neighborhood that was composed of the presence of international immigrants since the late 19th century[27], also became one of the localities where the Bolivian population gathered, and where there are many of the city's sewing workshops, a branch of business that employs many of those that come to Brazil as a country of destination[24,27]. Since the Bom Retiro BHU operates in a pre-determined territory, immigrants there must be included and provided care in the available health care services.

The organization of services is precisely what will favor the access of the Bolivian population to health care, since there are no administrative barriers[28]. However, as mentioned by several professionals during the field work in the BHU, the health team's first contact with the Bolivian population showed different hampering factors, which corroborates what had already been found by other studies[28,29]. One of the obstacles can be understood by the legal condition under which many Bolivians are, often undocumented in the country, making them vulnerable to precarious work situations, non-supported by the Brazilian labor laws[30-32]. This context favors the condition of poverty, social exclusion, stigmatization and vulnerability of many Bolivians who live in São Paulo[32].

The health workers interviewed reported that because of this context there was a great apprehension on the part of the owners of sewing workshops as to letting the health team enter the facility so they could register the families who lived there, because besides being a place of work, it was is also considered as the residence of many Bolivian immigrants. Their mistrust as to receiving the BHU team was based on fear of some form of inspection that could negatively affect their stay in the country.

In addition, as a result of the immigrants' unawareness as to the operation of Brazilian services and the health professionals' difficulties as to providing humanized care to this population, despite the access to services was recognized in law, their

effective inclusion was still a goal to be achieved. Furthermore, the linguistic and cultural differences also hindered interaction with the health unit, interfering with the understanding of the health and disease process, which is culturally determined[33].

Traditional Andean populations, for example, have an intense relationship with nature, called *Pachamama*, characterizing their medicinal rites by their holistic and cosmocentric vision. They understand that the state of health is defined as the regulation of the balance, which comprises the health of individuals, of their community, and of their environment. From this perspective, diseases develop as a result of a break in the natural or social order[34]. It is necessary, therefore, to be aware and consider the distinct world views so health care may indeed be provided in an integral manner.

Accordingly, it was necessary to devise strategies so the Bolivian population present in the BHU's catchment area could be provided the health care services. Thus, in 2001, through decisions of the unit management in conjunction with other professionals, two Bolivian Community Health Agents were hired aiming to break the barrier of first contact.

Then they began the work of visiting workshops to raise awareness as to the operation of BHUs and to the importance of ongoing health monitoring for the population through the new Bolivian CHAs. Hiring these professionals proved highly important not only for home visits, but also in the everyday routine of BHUs, and whenever there was some difficulty as to understanding their language during consultations and there was no companion that spoke Portuguese, they were requested for the role of interpreters. This fact was also found in other similar studies, which repor,t that professionals seek strategies so they may somehow communicate with international immigrant users[35].

Other activities were also carried out, such as the health teams' participation in typical Bolivian fairs and festivals, with campaigns for measuring blood pressure and capillary blood glucose. In addition, as of the Bolivian community agents was also a broadcaster in Bolivian community radios, an effective health communication work was conducted using this communication medium. The Bolivian population, knowing the Bom Retiro BHU and recognizing their rights, went on to take ownership of the space and of the services supplied by the health unit, which was facilitated by the presence of the Bolivian CHAs.

Through the accounts recorded during the interviews with health professionals, we could perceive how the Bolivian CHAs' work was necessary so the BHU service was provided. The CHAs mediated the establishment of a trust relationship between the health team and the Bolivian population they need to serve in their territory. The following interview excerpt shows the report concerning how these professionals were hired and the reason they were needed:

> When the "Bolivian community agents were hired", at that time we had an important need because we "didn't have much contact with the Bolivian population", you know, we wouldn't be received in the workshops. I think today the "community is already quite included", you know, in the service. This hiring was a policy of the municipal department of health at the time, I think 2001, and "there was a demand for that" in fact, yeah, because of that access,

> to have professionals who were Bolivians and could have a little more of that understanding, help a little with that language too, doing a little more of this prevention work. (Interview with the health professional)

Some accounts from professionals of other sectors of the BHU show a significant recognition of the work carried out by the CHAs, observing an improvement resulting from their practice:

> They were afraid of contact with us, because Brazilians are a little fidgety, and they are more coy. But they are getting along well with us, the health agents are doing a very nice job, like, to have the connection, they are creating the connection. (Interview with the health professional)

This account shows the health team's perception of a vulnerability of the Bolivian population, as "fear" was often used to refer to their reserved attitude. The health professionals perceive that they are people who are in an unfavorable social condition and that humanized care is necessary so they can overcome this situation.

In statements of other professionals there is the perception about the importance of the active search carried out by the CHAs, as, without them, the free demand for service would be more scarce, and the service would occur with greater difficulty:

> No, they wouldn't come without the health agents, they have the main role in everything. Here it really works because the health agents they go there, they talk with them, they treat everyone the same way, there isn't, like, inequality because they're from another country, another ethnicity. The service does exist, the principles of the SUS are really being applied to them. (Interview with the health professional)

It should be noted the importance given to these professionals by the other actors of the work collective. Without cooperation and collaboration in the workplace, it is known that the activity of a sector can be greatly impaired. Because, in their absence, there is a need for additional efforts by those who work, generating dissatisfaction and frustration[36].

Regarding what was found in the accounts of the Bolivians, it is perceived the importance of having Bolivians working in the BHU, so they can feel represented, originating relationships of trust. In the interviews we found accounts that recognize the need to have someone they trust who can provide assistance at the time of health care service. Moreover, they understand the importance of the work carried out by the Bolivian CHAs.

> You see, for us it is not difficult to understand you, for us it is difficult to speak. We need to have a person, but that person that actually helps [...]. "We need to have a person who does this work", with patience, because it needs patience, [...]. If we already get nervous trying to talk [...] (Interview with Bolivian user)

> [Having the Bolivian CHA] helps eh, to tell us the test results, because if there's some problem we go as soon as possible to the clinic. It's good that "they know us" [...] (Interview with Bolivian user)

The interview with the Bolivian CHA shows how he understands his work and the importance of his role for the Bolivian population living in this territory and how his community recognizes him:

> With the radio work that we do, I have this appreciation, this "respect", not only from my community, especially from Paraguayans, Peruvians, Argentines, but also from Koreans, Greeks, so this is rewarding to me. "It's very rewarding", because, in the weekend, "when I'm walking on the street", I, the human being, person, not the health agent, then there comes that hug, "there comes that thank you". My children are very happy to see that, witness that, they say: "Gosh, dad, how did you get so much affection, so much respect from them?". (Interview with the professional)

In this excerpt, the issue of double belonging is clearly shown. Being a subject of health promotion and at the same time belonging to the territory of work becomes an essential strategy for the principles of the Basic Care. Basic Care, as detailed by Starfield[5], would be the gateway to the health services, having as central characteristic the longitudinality of the service, proposing widespread, accessible, integrated and continued care; in addition to being centered on the individual and not on the disease, supplying a service aimed at the family and the community, without restrictions as to age, sex, or ethnicity groups[5].

The work carried out by the CHAs leads to a closeness between people of the catchment area and of the BHU; with this, bond relationships are established and complete care is enabled. These bonds prove even more necessary when it comes to a situation in which the population shows characteristics of greater vulnerability and social exclusion, as often is the case of the immigrant population. Not to mention that the social affirmation of the work practice, by the population served, gives the CHAs a feeling of a job well done, as it grants them symbolic recognition, so important for the construction of their own mental health[37].

Final considerations

The decentralization of the SUS and the changes in its directives enabled discussing a continuous monitoring in health care, conducting health promotion and not only the treatment of diseases. However, for this process to happen, it was necessary to discuss how health professionals would work. The requirement of having health agents that belong to the catchment area of the BHU in which they work leads to bond networks being strengthened and ongoing care being enabled. However, establishing bonds requires awareness as to otherness, and culture and language have undeniable importance in this process.

In the case studied, Bolivian agents contribute to minimize the barrier of language and cultural differences. Thus, these health agents and social actors contribute so a broader view of the concept of health – which involves the whole context of the person's life – is discussed, and that cultural differences are respected.

In a certain way, the presence of Bolivian community agents favors the inclusion of the Bolivian population in the services. These agents are characterized both as fundamental social actors for mediation between health units and immigrant populations and as a strategy for this population to reach the services. Because of them, the Bolivian population that lives in the territory of the Bom Retiro BHU has the possibility of inclusion in the services, overcoming barriers to access that are placed socially.

Even though this presentation has limitations for being an analysis of only one Basic Health Unit, based on what has been presented it is possible to perceive that using the SUS is also a strategy to stay in the country of destination for these immigrants. The health agents' work is one of the strategies developed to create bonds in a context of intense transitoriness, especially the hiring of foreign CHAs, such as the Bolivians. However, how to strengthen such bonds of trust if the connection with the territory is still much recent? How to expand this inclusion to other immigrants who are not Bolivians? Therefore, it is suggested here the need for more reflections on the migratory processes and their relations with the health services, since this issue is increasingly considered in light of the new characteristics of the populational flows.

Contributions of the authors

All authors participated actively in all stages of preparation of the manuscript.

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