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Working process of the community health workers in vulnerability areas

Processo de trabalho dos Agentes Comunitários de Saúde em territórios de vulnerabilidade

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Resumo
Introdução: Os Agentes Comunitários de Saúde atuam promovendo a interlocução entre as necessidades de saúde da comunidade e a Estratégia Saúde da Família. Neste contexto, o processo de trabalho destes profissionais encontra-se diretamente relacionado às dimensões do território e suas vulnerabilidades. **Objetivo:** compreender o processo de trabalho dos Agentes Comunitários de Saúde em territórios de vulnerabilidade adscritos à Estratégia Saúde da Família. **Materiais e Métodos:** Trata-se de estudo qualitativo, subsidiado pelo referencial teórico das vulnerabilidades em saúde, realizado com 11 Agentes Comunitários de Saúde, que atuavam em área vulnerável localizada no sertão central cearense, na Região Nordeste do Brasil. Os dados foram coletados por entrevista semiestruturada, contendo sobre o processo de trabalho. **Resultados:** Emergiram três categorias temáticas representativas das dimensões de vulnerabilidade em saúde, que abordam os principais tópicos discutidos pelos participantes: (1) *"Somos o elo entre as pessoas e o posto de saúde"*: a relação do Agente Comunitário de Saúde com a comunidade; (2) *"Você se expõe"*: o Agente Comunitário de Saúde e suas condições de trabalho; 3) *"Cego, surdo e mudo"*: o Agente Comunitário de Saúde frente à violência e ao tráfico de drogas na comunidade. **Conclusão:** O processo de trabalho do Agente Comunitário de Saúde em territórios de vulnerabilidade mostrou-se afetado nas dimensões individual, social e programática.
Palavras-chave: estratégia saúde da família. agentes comunitários de saúde. vulnerabilidade em saúde

Abstract
Introduction: The Community Health Agents act by promoting dialogue between the health needs of the community and the Family Health Strategy. This context, or work process of these professionals, is directly related to the dimensions of the territory and its vulnerabilities. **Objectives:** to understand the work process of Community Health Agents in territories of vulnerability enrolled in the Family Health Strategy. Materials and Methods: This is a qualitative study, supported by the theoretical framework of health vulnerabilities, conducted with 11 Community Health Agents, who worked in a vulnerable area located in the central region of Ceará, northeastern Brazil. Data were collected through semi-structured interviews, containing the work process. **Results:** Three thematic categories emerged representing the dimensions of health vulnerability, which address the main topics discussed by the participants: (1) *"We are the link between people and the health center"*: the relationship of the Community Health Agent with the community (2) *"You expose yourself"*: the Community Health Agent and its working conditions; 3) *"Blind, deaf and dumb"*: the community health agent in the face of violence and drug trafficking in the community. **Conclusion:** The work process of the Community Health Agent in territories of vulnerability was affected in the individual, social and programmatic dimensions.
Keywords: family health strategy. community health workers. health vulnerability.

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Introduction

The Community Health Agents (CHA) work with the health team in the territories attributed to the Family Health Strategy (FHS) as the link between health services and the community[1]. The territory is seen as the result of historical processes and community productions, being a dynamic space marked by human relationships and social, cultural, political-administrative, and economic aspects[2]. This concept of territory seeks to overcome a vision limited to geographical definitions, which gives space a delimitation and a static character[2].

Population groups influence and are influenced by the environment and context in which they are inserted. The production of meanings takes place through collective experiences, and it is contradictory to think of social processes in an interface with health without considering the dimensions of the territory[2]. In this context, CHAs act as social mediators between the needs of the community and health care through bonding, accountability, and respect for the cultural identity of the group[1].

The definitions of vulnerability[3] and territory[2] are intrinsically linked to the social and power relations produced in their interface with the ecosystem and, consequently, influence the forms of health production and promotion undertaken by professionals, as the conditioning and determinants of health act producing differentials of exposure to vulnerability, suffering, and illness.

The performance of community health agents in Primary Health Care (PHC) permeated by health technologies, allows the production of relationships in the worker/user subjective encounter through qualified listening, reception, and bonding, contributing to the identification of needs, enhancing the resoluteness and humanized and comprehensive care for individuals and families[4].

In this context, the work process translates into dynamics and territorial interference in care, as it assumes dimensions that go beyond technique or the use of advanced technologies, given that formal and informal networks (relationship and communication aspects) are in an ethical-political dimension that, due to their complexity, produce daily challenges and tensions, which, in turn, interfere in the processes of management, production, health promotion and care practices[5].

The CHA work process is characterized by risks arising from long distances traveled under adverse weather conditions, complex social situations observed during visits to families, contact with risk areas, unhealthy places, diseases, drug trafficking, and violence[6].

Studies that address the work of CHA in the Northeast region of Brazil focused on the management of their work (hiring and remuneration mechanisms), the devaluation of the worker, working conditions, and training processes[7,8]. However, in public health, studies that discuss the work process of these health professionals and their interface with dimensions of vulnerabilities present in the territory/community and repercussions on the quality of care are still incipient[9].

Understanding the work of the CHA from the perspective of the theoretical framework of vulnerability in health contributes to the apprehension of the expanded concept of the work process in three dimensions: the individual, which relates to intrinsic aspects of the subject and his way of life; the social, which refers to the understanding of health-disease processes as socially determined; and the programmatic one, which refers to how institutions intervene in social reality[3].

To overcome this gap, the question is: *"how do the dimensions of the territory of vulnerability interfere in the work process of CHA in the Brazilian Northeast?"*. By focusing on the

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perspective of professionals who work in community spaces, the dimensions and meanings incorporated into the daily practices and the relationships imbricated in the health-disease process of users can be revealed.

Thus, the objective was to understand the work process of CHA in territories of vulnerability ascribed to the FHS.

Materials e Métodos

Study design and sample

It is exploratory, descriptive research with a qualitative approach. The qualitative approach aimed to investigate a universe of meanings that permeate daily life, experiences, relationships, and social processes from the perspective of the subjects1[10]. Eleven (11) CHA working in a Basic Health Unit (UBS), located in a city in the Sertão Central of the state of Ceará, Brazil, from August to October 2017, participated in the study.

The municipal health network had 19 Basic Health Units where 22 Family Health Teams worked. The unit was chosen because it is located in an area with great territorial extension and population concentration, in a peripheral region, constituting an area of social vulnerability, marked by precarious housing conditions, without basic sanitation, water supply, and unpaved streets, where low-income families predominantly reside and whose main health problems are associated with chronic conditions.

Inclusion and exclusion criteria

The inclusion criteria were: working in an area of vulnerability defined by the municipal health department (based on the territorialization process) and having a minimum professional performance of 1 year in the micro-area (this period allows greater contact with the community and relationship with users). CHA who were away from work activities due to vacations and leave of any kind were excluded.

Procedures

For data collection, we used the semi-structured interview technique. The script was composed of variables of sociodemographic characterization of the participants and triggering questions about the work process. The interviews were audio-recorded, upon signature of the Free and Informed Consent Term, with an average duration of 50 minutes. The confidentiality and anonymity of the participants are guaranteed through the adoption of alphanumeric codes composed of the acronym representing the professional category and the sequential number of the interview. The closing criterion for data collection occurred through theoretical saturation.

The interviews were fully transcribed, organized, and analyzed using the thematic categorical analysis technique (pre-analysis, exploration of the material, and treatment of the results)[10]. The results were presented in thematic categories, citing excerpts from the interviews, representing the individual, social and programmatic dimensions of the theoretical framework of vulnerability in health[3].

The research complied with the ethical precepts recommended in Resolution 466/12 of the National Health Council, having been approved by the Research Ethics Committee under number 2,235,681.

Resultados

Among the 11 study participants, eight were female. The age group ranged from 23 to 60 years (an average of 35 years). Working time ranged from five to 24 years, with an average of 17 years. Regarding marital status, there was one widower, two divorced, two singles, and six married. Six individuals had completed high school, two had incomplete higher education, two had completed elementary school, and one had completed higher education.

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Three thematic categories emerged, representing the dimensions of individual, programmatic and social vulnerability, which condensed the main topics addressed by the participants: (1) *"We are the link between people and the health center"*: the relationship between the Community Health Agent and the community; (2) "*You expose yourself*": the Community Health Agent and their working conditions; (3) *"Blind, deaf and dumb"*: the Community Health Agent facing violence and drug trafficking in the community.

Category 1 – "*We are the link between people and the health center"*: the relationship between the Community Health Agent and the community

In this category, everyday tensions in the work process that constitute vulnerability within the individual scope of the subjective encounter with the other, an intrinsic element of being CHA, were addressed.

The statements from the CHA demonstrate their conviction of the importance of their work process in the FHS. The recognition of this professional as a bridge of information from the community to the team expands the establishment of bonds and presupposes the figure of an exchanger in this dialogic relationship.

> *I see myself as this actor, the protagonist of this link, of contact between the community and the Family Health Strategy (CHA2).*
>
> *We are the link between people and the health center (CHA5).*
> *I make this bridge. I provide the information to prevent them from making a "lost trip" [...]. I think it's important to keep that bond with people. I always say that if you need something, you can go to my house (CHA3).*
> *We are the pillar, the base because we take all the information from the community to the team (CHA10).*

This communicative process emphasizes the identity of the protagonist's role in the interface between UBS and users.

As a result of the established relationships, contentment with feelings of attachment and gratitude was evidenced, arising from the daily practice of acting in the territory, which goes beyond strictly professional bonds, denoting respect, trust, and exchange of experiences. This subjective and affective encounter with the other is reflected not only in pre-established actions but also in the way they are conducted.

> *For me, there are always ups and downs, but I wouldn't know how to live without being a health worker. We get too attached to families. Thank God, until today, I haven't had any problems with the community (CHA4).*
>
> *I see it more as a way of exchanging experiences and mutual help [...]. It is gratifying to be able to say: "I visited!", I played my role. But I can go further and say: "if you need me, you know where I live, I live there [...] you go there!" (CHA8).*

The CHA performance is not limited to the execution of procedures and the transfer of information as the relational aspects and care are presented as dimensions that stand out in the daily work.

> *Daily, we are a little bit of everything, we end up being a mother, a psychologist, and doing a little bit of everything (CHA8).*

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> *Despite the various tasks and concerns, when I arrive at a house and I feel that the person is happy to see me, wants to clear up any doubts, and receives a cordial treatment, it already makes up for my morning at work (CHA10).*

The community starts to see the CHA as a pillar, looking for it whenever it feels threatened or weakened. Although the need to work 8 hours a day has been established, there is no commitment to this schedule by the community.

> *Being in the community is sometimes not cool because many people think you need to be connected to them 24/7. I'm not saying this is bad, being in the community is essential because I'm a social agent. But the simple fact of being a Community Health Agent and living in the community confuses people. Outside the service, I am a human being like any other (CHA2).*
>
> *Sometimes, the community knocks on our door. It doesn't matter if it's in the morning, afternoon, or evening (CHA9).*
>
> *It turns out that you don't have weekends, you don't have days off, you don't have vacations, if I'm on leave and I don't travel, I don't have any rest (CHA10).*

The community is resistant to dissociating the CHA's personal and professional life, as it assumes that their work in the territory makes contact more flexible in any environment, including home spaces. On the other hand, professionals find it difficult to interrupt the bonds, for fear that this attitude may mischaracterize what they understand by the role of the CHA.

Another negative point that was highlighted by the CHA refers to the recognition of their work. There are difficulties in living with the community, especially when they report situations in which users do not receive them properly during home visits, assuming aggressive postures and underestimating their performance.

> *I experienced a situation in which a user made fun of my work, laughing in my face, saying that it was bullshit for those who have nothing to do. I was so devastated, down, you feel like nothing, my work didn't seem to matter at all (CHA10).*

The fragility of the community's understanding of correctly distinguishing the CHA's attributions makes some users complain and blame the professional when their health needs are not satisfactorily met

There is a dichotomous work process of the CHA, in which there is a lack of recognition from the community about their professional performance, generating a feeling of frustration and helplessness. However, the link and the bond with the users, marked by a dialogic relationship, arouse feelings that counteract the discouragement − typical of the work routine.

Category 2 – "*You expose yourself*": the Community Health Agent and their working conditions

This category describes the activities developed by the CHA in the territory that, by their nature, conditions, or resources, influence the assistance offered and reveal themselves as constitutive elements of programmatic vulnerability.

It is recognized that close contact with users in home and community spaces implies exposure to biological risks, especially from infectious diseases.

> *I see that the risk is more the issue of contagion of the disease, which you have all the time (CHA10).*

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> *Contact with diseases. I had to take care of a patient with tuberculosis [...] so, being there (at home), taking care of a person whose care is no longer good, because you arrive at the house, it is not ventilated, the space is closed and then you expose yourself (CHA2).*

Unhealthy conditions were evidenced in the development of work activities, marked by precariousness in the basic sanitation and garbage collection system and adverse climatic and geographical conditions, which implied exposure to environmental risks.

> *First, because there is no basic sanitation, so [...] all sewage goes to the street [...] second thing is the issue of garbage [...] the risks in terms of distance, once I lost, it was winter, and then I took a different path (CHA2).*

The context exposed by the CHA is accentuated by the lack of support and individual and collective protection measures.

Concerning supplies and work instruments, the lack of resources and materials during home visits results in occupational risks, as equipment and minimum conditions are not offered for the execution of work activities, compromising the personal safety of the assistance provided.

> *At the moment we don't have many supplies, we feel a little without resources (CHA3).*

> *Work structure is lacking. In my case, I still have my scale, but there are health agents who don't, so how will that child weigh? (CHA10).*

> *They do not have the necessary instruments and Personal Protective Equipment, they lack scales, uniforms, masks, and gloves. They always say they are providing [...] we don't have any support (CHA9).*

This aspect shows that the influence of structural and organizational factors compromises the execution of the CHA's work process and, consequently, the quality of care provided.

Category 3 – *"Blind, deaf and dumb"*: the Community Health Agent facing violence and drug trafficking in the community.

In this category, the local context was outlined where the CHA work process took place in relationships, norms, and rules present in the territory, indicative of vulnerability in the social sphere.

Usually, health workers work in closed, safe, and secure physical environments. However, the UBS is a place of support and supervision of the work activities, as much of their work process is developed in community spaces.

Respondents recognize in their areas of expertise that there are recurring cases of violence associated with drug trafficking. As a result of the widespread expansion of trafficking in communities, the CHA points out that easier access to illicit substances, linked to the absence and/or fragility of strategies to combat violence, favors the involvement of children and adolescents with trafficking and consumption of illegal substances.

> *People smoked on the railways, so on the comings and goings you saw it naturally [...] (CHA2).*

> *Teenagers are using drugs and selling drugs. The guardianship council does not resolve anything (CHA4).*

> *There was the issue of the "boca de fumo" (the place where drugs are sold), you*

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could see that the teenagers were already involved (with drug trafficking) (CHA7).

The contact with places where illicit substances are bought and sold popularly referred to as “bocas de fumo” (the place where drugs are sold), and the constant conflicts between rival factions and with the police result in feelings of fear and insecurity in the interviewees.

I experience too much in my area the issue of licit and illicit drugs (CHA8).

It's horrible to work in the area, I'm scared to death. I leave the house to work with my legs, I don't know if I'll come back with them, because the traffic is predominant in the area. You are in a house, an unknown person arrives, you already think you are going to kill someone, you look, suspect, and retreat (CHA4).

In my area there is a “boca de fumo” (the place where drugs are sold) [...] it is certainly a risk, another gang may appear at the time and even the police invade. We are subject to living together, risking our lives (CHA9).

The police take a long time to arrive, and they only come here when they kill one (CHA1).

This context experienced by CHA in communities comes from the process of naturalization of violence in the social environment, which is structured as a central dimension of community dynamics, which adapts and subordinates the daily life of the population to the practices of organized crime.

Furthermore, the implementation of public security actions after police incidents, to the detriment of the preventive approach, conditions the population to maintain a state of alert. Thus, the insertion of the CHA in the network of relationships, daily practices, and community spaces in a territory of vulnerability is marked by risk situations, which compromise the performance and quality of life of this professional.

The interviewees' speeches show a dichotomy between living and working in the area covered by the UBS. As a member of the community, the CHA can move easily in community spaces, however, this position favors constant contact with risk situations that would need to be reported to the family health team for planning and implementing intervention strategies.

However, these circumstances that generate feelings of insecurity and fear are conflicting for the professional, who tends to assume a passive posture in favor of preserving their safety and integrity, considering the ease of access that the community has to personal and family information.

I was born and raised within the community. Everyone knows me and my family [...] I had to act naturally, for me they were selling vegetables (CHA9).

We have to be blind, deaf, and dumb if we don't want to die if we don't want the family to die (CHA4).

When I was weighing the children, the guy came to buy drugs, I didn't look, I pretended I wasn't seeing (ACS7).

They already do things to be able to

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see what I'm seeing, so when the comment comes it's risky to death. It's sad to see and not be able to take action [...], but I go blind, deaf, and mute to pass and stay alive (CHA6).

Contradictorily, the CHA seeks to be seen by the traffickers as professionals who integrate and develop their work process in the community, and, at the same time, they fear that there is, on the part of the public security agencies, some type of retaliation resulting from the association between being in the place and be part of the traffic. In this way, this medium conditions the professional to adopt an invisibility posture to "not see" the actions of organized crime present in the community and "not be seen" by the police.

There were three "bocas" that I entered [...] I felt intimidated, there was too much! I was afraid the police would arrive, I don't know, and not, believe me, think I was involved (ACS10).

All have already been arrested. I imagined that the police would associate and think that I was involved (ACS1).

We had to map the "boca de fumo" (the place where drugs are sold) to identify areas of risk and consumption [...] if I say who they are and where they are, who will take care of me? How would that expose me? (CHA2).

In some places you can't get in, you know what people are saying. I just listened and kept to myself, because there are situations where I have to think about my integrity (ACS6).

As these are complex situations, professionals tend not to interfere or go unnoticed in certain community spaces. Personal security overlaps with the feasibility/notification of collective problems − consequently, trafficking, drug consumption, and violence, as public health problems, continue to be made invisible.

Discussão

The central role of the CHA in the FHS is outlined in the way professionals report the community needs to the team of professionals for interventions with users[11]. These workers, because they live in the area of activity, know and live with the reality of their environment, share and interact with the values, culture, and language used among residents, and use communication to increase the bond, "translate" complaints and doubts, and pass on information to the FHS team[12].

Professionals identify with their communities for having shared values, customs, language, and for playing a leadership role in improving community conditions, through political, educational, and preventive actions[13]. This immersion of the CHA in the reality of the community and the approach to the users' health needs allows the agent to interpret them and help them more cohesively in the team's work process[14].

However, these professionals are affected by physical and mental exhaustion, as they are requested during periods outside their working hours, at night, in cases that residents consider urgent, on weekends, and even on vacation[15]. This wear and tear associated with the lack of professional recognition generates dissatisfaction with the job, contributes to the goals of the work process not being achieved, and makes the CHA feel unmotivated, negatively influencing their work process, the health of the community, and workers' health[16,17].

The CHA workplace is the community itself and differs from common places, where there is a physical structure,

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in which the professional has his safety protected. This specificity of the CHA to integrate into the community and to follow up more actively with the families can expose them to risk situations and the particularities present in the territory[14].

The working conditions of CHA, because they are often unhealthy, present health risks. These professionals are exposed to risks and geographic barriers; bad weather resulting from climatic variations, such as heat, cold, and humidity; work pathologies; situations of physical, moral, and symbolic violence; and local effects of drug trafficking[18]. Also noteworthy are odors from sewers and ditches, poor sanitary conditions in the environment, inhalation of dust and smoke, and contact with infectious diseases[13].

The role of the CHA is marked by exposure to workloads of mechanical, biological, chemical, physiological, and psychological origins. The professional's interaction with these loads impacts health, which translates into daily life and generates processes of physical and mental exhaustion[6].

The Ministry of Health established the need for the municipalities to make essential supplies available (uniform, identification badge, PHC information system sheets, scale, stopwatch, thermometer, measuring tape, and educational material) for the performance of CHA tasks; when not supplied, they compromise the work process and guarantee that the needs of the local population are met[7].

The provision of equipment for the daily protection of workers is essential to reduce the occurrence of adverse events to professional health[19]. The unavailability of supplies and equipment in PHC is one of the main points that affect health planning, as structural and organizational factors associated with the managerial and financing dimension influence the performance and quality of care at this level of care[20].

It is important to point out that these expressions of precariousness at work experienced by CHA can be seen as signs of the weakening of PHC and the Unified Health System (SUS) and are articulated with the advance of administrative, political, and economic reforms of a neoliberal nature [21,22] that has increasingly weakened rights and social protection systems.

This scenario marked by hypercapitalism and economic adjustments guided by neoliberalism has reinforced and increased social inequalities which negatively impact health and ways of livingv[23]. Given this context, violence has been configured as one among many other dimensions through which inequality is expressed, affecting the daily life and health of individuals and communities[24].

The problem of violence in Brazil has historical roots marked by social inequalities[25]. The country ranks first in the world when considering the number of years lost due to this violence, which is directly related to the illegal drug market[25,26].

In the peripheries and favelas, organized drug trafficking has become the main factor in the increase in violence. This context has been reshaping the relationships between the community and health devices as the negative effects on the neighborhood, associated with the hostile and unstable environment, result in social segregation and marginalization, hindering access to public health services[26,27]. Thus, it is possible to affirm that urban violence constitutes a limiting element for the conduction of actions and the effectiveness of the FHS as a pillar of PHC[28].

In the routine of the FHS, the main limitations are insecurity and fear in the performance of care; difficulties in accessing the territory, especially to households in risk areas; and the planning

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of work processes, especially in carrying out visits and home care, during which these professionals become vulnerable to situations of violence due trafficking, disputes over power, shootings, robberies, personal intimidation, and murders[27].

The work process of CHA in vulnerable territories is limited by the fact that they do not assiduously frequent the households located in the assigned areas, where trafficking and violence predominate[27].

In a context marked by the existence of social codes and values, in which disputed force fields regulate daily life in the territory, the CHA needs to transit daily within these dynamics, which makes these professionals - although they have individual communication skills and relational bonds with residents, including those involved in illicit activities – face limitations during attempts to negotiate and produce health that is expressed in the territory, bluntly compromising the assistance to users[9].

The condition of a worker at the UBS makes it possible to expand relational boundaries beyond those arising from the professional field which, associated with their experiences of being a resident of the neighborhood, express greater legitimacy, credibility, and trust. However, in living with people involved in trafficking, in which the condition of CHA and affective and/or normative attachment are not considered, relationships are permeated by ambiguities, translated into “keeping in touch” and “being distant”[9].

These limits, considered impassable, are revealed in specific situations in daily work, in the form of the professional's fear of suffering retaliation[9]. Thus, the subordination of health professionals to the networks of relationships established by criminal organizations, as well as behaviors of personal intimidation, results in difficulty in acting in the territory, especially in preventing health teams from carrying out work in areas under the domain of traffic[26].

In vulnerable territories, the CHA has great potential to identify numerous problem situations that can be intervened by specific bodies and which, therefore, would need to be reported to the public authorities. However, in cases of drug trafficking in the community, these professionals are in the midst of the conflict between criminal organizations and security agencies [26].

This aspect is revealed as a conditioning factor for the work, as some professionals fail to report suspected cases of child abuse or neglect for fear of retaliation as a result of determinations of drug trafficking leaders concerning non-intrusion in community affairs[26].

Underreporting of diseases within the scope of public policies can be analyzed in addition to issues related to the lack of training of professionals, management, and/or the unsatisfactory performance of competent organs or backup services reported by the study[29]. In vulnerable territories, this gains a new dimension and new meaning in everyday practice as a result of local social regulations and orders, which prevent CHA from reporting to competent organs and/or giving visibility to complex issues due to the lack of protection, support, and safety.

Conclusão

The analysis of the Community Health Agent's work process, under the prism of a theoretical framework, made it possible to identify that the performance in vulnerable territories is affected by the individual, social and programmatic dimensions.

At the individual level, this action is permeated by dichotomous relationships and feelings, arising from interactions with the community, translated into the identity of being the link between the population and health devices, in the position of dialogic exchange of health needs, the establishment of bonds and satisfaction in service to users,

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as well as affected by the lack of recognition, and the inability of residents to dissociate the figure of the agent as a member of the community and worker in the area assigned to the Family Health Strategy.

From the programmatic perspective, it is evident that the performance of the Community Health Agent is precarious, due to the working and sanitary conditions of the territory, which expose them to several occupational risks that, are associated with deficits in supplies and the absence of individual and collective protection measures, compromise the safety and development of work activities.

Regarding the social dimension, assisting in vulnerable areas marked by violence and criminality implies adopting a protective posture, in the face of relationships and codes present in the territory and in living with adverse situations in which one cannot intervene, due to personal and family safety.

The results presented contribute to filling gaps in the field of collective health regarding the work process of the Community Health Agent and its interface with dimensions of vulnerabilities present in the territory/community. However, limitations include the reduced sample associated with the locoregionalization of data and the intentionality in the selection of participants.

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