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Collective care strategies for the elderly promoted by basic health unit teams

Estratégias coletivas de cuidar promovidas por equipes da unidade básica de saúde a idosos

Estrategias colectivas del cuidar promovidas por equipos de la unidad básica de salud para ancianos

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ABSTRACT

Objective: To find out about the collective care strategies promoted by the minimum teams of Basic Health Units with elderly people. **Methods:** This is an exploratory study with a qualitative approach, carried out in five basic health units located in the municipality of Boa Vista, capital of the state of Roraima. Twenty professionals working in the Family Health Strategy were included. The data was produced through semi-structured interviews, from May 2021 to April 2022. The analysis was guided by Laurence Bardin's framework and the findings were organized into two thematic frameworks. **Results:** Within the scope of health promotion for the elderly people, two thematic dimensions were identified, namely: group activities and health education. In the first thematic unit, collective care strategies were related to group activities for hypertensive and diabetic elderly people, physical activity groups, dance groups and collective activities on commemorative dates. The second thematic unit presented the lecture as the centrality of health education, mediated by the following themes: Chronic Non-Communicable Diseases, use of medications, and Sexually Transmitted Infections. **Conclusion:** Learning about the collective care strategies promoted by teams of the basic health units has brought to light the need to rethink the practices of group activities and health education carried out in the health services. In fact, collective strategies that value health over illness and dialogical currents capable of strengthening the autonomy and the emancipation of the elderly people should be considered.

Descriptors: Health Strategies; Health Promotion; Primary Health Care; Elderly.

RESUMO

***Objetivo**: Conhecer as estratégias coletivas de cuidar promovidas pelas equipes mínimas de Unidades Básica de Saúde com pessoas idosas. **Métodos**: Estudo exploratório com abordagem qualitativa, realizado em cinco unidades básicas de saúde situadas do município de Boa Vista, capital do estado de Roraima. Foram incluídos 20 profissionais atuantes na Estratégia Saúde da Família. Os dados foram produzidos por meio de entrevistas semiestruturadas no período de maio de 2021 a abril de 2022. A análise foi orientada pelo referencial de Laurence Bardin e os achados organizados em dois quadros temáticos. **Resultados**: No âmbito da promoção da saúde à pessoa idosa, foram conhecidas duas dimensões temáticas, a saber: atividades em grupo e educação em saúde. Na primeira unidade temática, as estratégias coletivas de cuidar estiveram relacionas com atividades*

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em grupo de pessoas idosas hipertensas e diabéticas, grupos de atividades físicas, grupos de dança e atividades coletivas em datas comemorativas. A segunda unidade temática apresentou a palestra como centralidade da educação em saúde, mediada pelos seguintes temas: Doenças Crônicas Não Transmissíveis, uso de medicações, e Infecções Sexualmente Transmissíveis. ***Conclusão****: Conhecer as estratégias coletivas de cuidar promovidas por equipes da unidade básica de saúde trouxe à tona a necessidade de repensar as práticas das atividades em grupo e da educação em saúde protagonizadas nos serviços de saúde. Com efeito, devem ser consideradas estratégias coletivas que valorizem a saúde em detrimento da doença e correntes dialógicas capazes de fortalecer a autonomia e emancipação da pessoa idosa.*

Descritores*: Estratégias de Saúde; Promoção da Saúde; Atenção Primária à Saúde; Idoso.*

RESUMEN

Objetivo: *Conocer las estrategias colectivas del cuidar promovidas por equipos mínimos de Unidades Básicas de Salud con ancianos.* ***Métodos:*** *Estudio exploratório, cualitativo, realizado en cinco unidades básicas de salud ubicadas en el municipio de Boa Vista, capital del estado de Roraima. Fueron incluidos veinte profesionales actuantes en la Estrategia Salud de la Familia. Los datos fueron producidos por medio de entrevistas semiestructuradas en el período de mayo de 2021 hasta abril de 2022. El análisis fue orientado por el referencial de Bardin y los hallazgos ordenados en dos cuadros temáticos.* ***Resultados:*** *En el ámbito de la promoción de la salud de la persona mayor fueron conocidas dos dimensiones temáticas: actividades en equipo y educación en salud. En la primera unidad temática, las estrategias colectivas del cuidar estuvieron relacionadas com actividades en grupo de personas mayores hipertensas y diabéticas, equipos de actividades físicas, equipos de baile y actividades colectivas en fechas conmemorativas. La segunda unidad presentó la conferencia como centralidad de la educación en salud, mediada por los siguientes temas: Enfermedad Crónica no Transmisible, uso de medicaciones, e infecciones Sexualmente Transmisibles.* ***Conclusión:*** *Conocer las estrategias colectivas del cuidar promovidas por equipos de la unidad básica de salud trajo a la luz la necesidad de repensar las prácticas de las actividades en equipo y de la educación en salud protagonizada en los servicios de salud. De hecho, deben ser consideradas estrategias colectivas que valoren la salud en detrimento de la enfermedad y corrientes dialógicas capaces de fortalecer la autonomía y emancipación del anciano.*

Descriptores: *Estrategias de Salud; Promoción de la Salud; Atención Primeria de Salud; Anciano.*

INTRODUCTION

The increase in the length and quality of life is one of the greatest developments of humanity, even if it is not an equal and fair reality in the world. Reaching old age is a goal for all countries, even the poorest. Thus, it's a big challenge, because it's not enough to grow old and prolong life if it's not of good quality. With the increase in life expectancy, discussions are emerging that analyze the elderly person as a person who has rights and needs to be cared for in his or her multidimensional needs[1].

Given the increase in life expectancy, it is predicted that by 2050 there will be 2 billion elderly people in the world. These statistics suggest that there will be approximately 33 million elderly people in Brazil by the end of 2023. With this in mind, the World Health Organization (*Organização Mundial da Saúde – OMS*) predicts that the proportion of the world's population over the age of 60 will double[2,3].

Demographic and epidemiological transitions provide an opportunity to reflect on public health policies aimed at healthy ageing. Thus, these transitions are also capable of taking into account multiple interrelated factors that invariably require the application of strategies for caring for the elderly with a focus on health promotion[4].

Health promotion is defined as a collection of methods for enhancing public health, guided by technologies aimed at promoting equity and improving quality of life, while reducing vulnerabilities and health risks that arise from social, economic, political, cultural, and environmental determinants. Thus, from the point of view of care, health promotion becomes a health production strategy that respects the specificities and potentialities in the construction of therapeutic projects, through qualified listening to users, in order to shift attention from illness to the reception of stories and living conditions[5].

From this perspective, the collective care strategies produced in the field of health promotion for the elderly, especially those carried out within the Family Health Strategy (*Estratégia Saúde da Família – ESF*), need to consider human rights, fundamental freedoms, biological, political, cultural, psychological, emotional, spiritual, social, economic and historical dimensions of being[6].

In contemporary times, it is possible to recognize the limitations of ruptures with biomedical modes of care for the elderly. In addition, there are obstacles that interfere with accessibility to basic health services, which requires ESF teams to provide continuing health education (*educação permanente em saúde – EPS*) in order to overcome barriers and offer quality care to the elderly in a variety of situations in the health-disease process[7].

EPS can be understood as a work-learning process, in other words, it takes place in people's daily lives and in the social context of health services. This is why it is in the nature of the EPS to invite professionals to come together and exchange knowledge and experiences. In this sense, the ESF presents itself as a vigorous place for bringing collectives together since the work involves acting in the dynamics of the complexity and diversity of people's daily lives, especially the elderly[8].

In this way, the ESF teams have increasingly focused on the social determinants and conditions of health in order to produce comprehensive practices and expand territorial care, particularly for the elderly, their families and communities. Exploring the reality of the areas assigned to the Basic Health Unit (*Unidade Básica de Saúde – UBS*) allows for greater knowledge of the collective context in which the elderly are inserted, and can work to expand health promotion and strengthen care support for these situations[9].

In fact, health promotion aimed at the elderly is a fundamental objective of the ESF. This is because the connection established between the team and the elderly person, their caregivers, family members and the community allow them to track the lifestyles and needs of people experiencing ageing in order to provide healthy environments. By means of the micro-regional situational diagnosis, it is possible to implement appropriate health planning for collective care activities that attend to the needs of the elderly located in the UBS's area of coverage[9,10].

Thus, promoting health involves sharing information, clarifying ideas, getting to know life situations, communicating with the elderly, being able to touch them, listen to them, comfort them, etc. In this way, and as an area of interest for this research, the production of collective strategies emphasizes care as health promotion.

Based on the presented facts, it is evident that research on health promotion is crucial to the field of Collective Health. This is due to the significant proportion of research that highlights health education as a care strategy implemented by UBS teams for the elderly. In this way, the intent of this study is based on the concept of health education as a dialogical instrument of knowledge, as well as an incentive for autonomy, popular participation and the leading role of individuals in their own care[11].

Thus, as previously mentioned, the following objective of this study emerges: to learn about the collective care strategies for the elderly promoted by the teams at the basic health unit.

METHODS

This is an exploratory study with a qualitative approach. In this type of study, the researcher analyzes the customs experienced by the groups, the feelings among the collectivities, life habits and beliefs valued by each person in their context. Achieving quality requires an in-depth approach, analyzing the interviewees closely and considering the meanings of the social actors[12].

The study was conducted in the municipality of Boa Vista, the capital of the state of Roraima, from May 2021 to April 2022. The municipality of Boa Vista is located in the extreme north of Brazil and is geographically delimited by with two countries, British Guiana and Venezuela. The territorial area is 223,644.530 km², of which 229.30 km² is urbanized. Regarding the population, the last census identified 636,707 people living in the city, which represents a population density of 2.85 inhabitants per km² (*Instituto Brasileiro de Geografia e Estatística – IBGE*)[13].

It should be noted that the State of Roraima has been experiencing a continuous process of population growth for at least five years, a fact explained by the Venezuelan migration process. It is estimated that almost 32,000 Venezuelans live in Boa Vista. Thus, projections by local authorities and humanitarian agencies indicate that 1,500 Venezuelans are homeless in the capital (*Fundo das Nações Unidas para Infância – UNICEF*)[14].

In the city of Boa Vista, five UBS were randomly selected from a total of 34 in the primary health care network. Each zone of the municipality's urban area was represented by one unit, namely: north, south, central, east and west. After the random draw, the following criteria were used to select the UBS: it must have at least one ESF team, with each professional category agreeing to participate in the study. However, when this criterion was not met, the zone was re-drawn and the inclusion criteria listed in the study were reapplied.

In terms of regional conditions, it can be said that the Boa Vista metropolitan area has a multi-territorial reality, where urban and rural areas coexist – with settlements, private properties, park areas and institutional areas of the armed forces. In general terms, it can be affirmed that most of the neighborhoods in this area arose from irregular land occupations. These occupations took place precisely in places of socio-environmental risk by people from the lower social classes, who currently live west zone places, with inferior infrastructure to that observed in the east, center, north and south zones[15].

With these socio-spatial characterizations, the participant group in this study was composed of health professionals working in the ESF's minimum teams in the UBSs in these municipal areas. These participants were selected according to the following inclusion criteria: one general doctor or specialist in family health or family and community doctor, one general nurse or specialist in family health, one nursing assistant or technician and one community health worker (*agente comunitário de saúde – ACS*), making a total of 20 participants. In addition, all professionals should have been working in the unit for at least six months, given that this period allows professionals to have a concrete view of their work area. The exclusion criteria for participants in this study were: incomplete ESF teams, UBS that exclusively treat COVID-19 cases, professionals on vacation or leave, and refusal to participate in the study.

During the first half of 2021, data were collected through semi-structured interviews using an MP3 player voice recorder in the following order: a doctor, a nurse, a nursing assistant or technician, and an ACS from the ESF teams of each selected UBS.

It is important to emphasize that the semi-structured interview is a tool used in the qualitative work process. It involves a two-way conversation, mediated by an interviewer, with the objective of constructing relevant information about the object of investigation. In this way, the interviewer guides the questions objectively, allowing the interviewee to reflect freely and in depth on the most relevant aspects, thus promoting a discussion between norms, rules and practices[12].

In this study, the semi-structured interview script presented two central questions on the themes: meanings about health promotion and collective health promotion strategies with elderly people treated at the UBS.

The data was processed using Laurence Bardin's framework, which divides content analysis into three chronological areas: pre-analysis, data processing and interpretation[16]. After the three chronological moments of content analysis in the transcribed interviews, the recording units (*unidades de registros – URs*) were presented in descriptive form and their illustrative statements were represented in two thematic tables.

Participants were informed about the objectives, methodology, risks and benefits, as well as the confidentiality of the information produced. They then signed the voice recording authorization form and the free and informed consent form (*Termo de Consentimento Lire e Esclarecido – TCLE*). These strategies aim to maintain anonymity by using the identifying word "participant" followed by an ordinal number related to the interview number.

The study was submitted to the Research Ethics Committee of the Federal University of Roraima. It complied with the standards required by resolutions No. 466/2012 and 510/2016 of the National Health Council, where it obtained the "approved" certificate with the number 4.054.281.

RESULTS

The qualitative representation of the data was organized into two thematic tables. A total of 157 URs were obtained spontaneously, related to the collective health promotion care strategies developed by ESF professionals with the elderly. From that total, 55 URs were related to the thematic unit "Group Activities", and 102 URs to the thematic unit "Health Education". These two analytical pillars were homogeneous and had no discrepancies in terms of the content of the different professionals and the UBSs in which they work.

In the first thematic unit, there were 31 URs related to group activities carried out with hypertensive and diabetic elderly people, 11 URs related to physical activity groups with elderly people, 08 URs contextualized with a dance group for the elderly and, finally, 05 URs characterized collective activities for the elderly on commemorative dates. All this can be highlighted in thematic Chart 1.

Thematic Chart 1 – Statements related to group activities produced by the ESF team in promoting the health of the elderly. Boa Vista, Roraima, 2021.

GROUP ACTIVITY	ILLUSTRATIVE TESTIMONIALS
Monitoring group for elderly people with hypertension and diabetes.	[...] we also have a group for the elderly with hypertension and diabetes. (Participant 3). [...] We do the hypertensive and diabetic groups [...] (Participant 4). [...] group activities with the elderly [...] involving varied topics, sometimes hypertension and diabetes [...]. (Participant 8). We monitor and guide the groups, the comorbidities that most affect this class, which are hypertension and diabetes." (Participant 10). [...] We carry out group activities with elderly people with hypertension and diabetes [...] (Participant 14).
Physical activity group.	[...]we used to do exercises with them [elderly people], some dynamic activities, very nice." (Participant 1). [...] we do physical activity groups. Huh? With them [elderly people], to encourage them (Participant 2). [...] group activities with the elderly [...] involving different topics, sometimes hypertension and diabetes [...]. (Participant 8). [...] group activities for interaction, movement and physical stimulation [...] (Participant 15). [...] I used to teach them [elderly people] some exercises to do at home or here in the unit. (Participant 17).
Dance activity group	We always do dance activities with them [elderly people] [...] (Participant 2). Before the pandemic, we also did a lot of dance activities with groups of elderly people, on specific dates [...]. (Participant 3). [...] dance groups with senior citizens [...] (Participant 7). [...]We get the elderly to dance [...] (Participant 16). [...] we used to do dance activities with them [elderly people] [...] (Participant 19).
Collective activities with the elderly on commemorative dates.	[...] we always did activities with them [elderly people] at the June festival [...]." (Participant 1). We also do a lot of activities on specific dates [...] (Participant 5). Everything that includes a commemorative date for the elderly, I believe is health promotion and we do it with them." (Participant 13). [...] we used to do Christmas parties, but with the pandemic we've been doing simpler events [...]." (Participant 17). [...]There were activities, interaction, birthday bingos with the elderly [...] (Participant 18).

Source: Authors.

In the second thematic unit, 102 URs were found with the identifying word lecture to mean health education. From this total, it was possible to identify 56 URs linked to Chronic Non-Communicable Diseases (*Doenças Crônicas Não Transmissíveis – DCNT*), 37 URs to care in the use of medication and, finally, 09 URs on Sexually Transmitted Infections (*Infecções Sexualmente Transmissíveis – IST*). These findings can be seen in thematic Chart 2.

Thematic Chart 2 – Statements about health education activities produced by the ESF team aimed at the elderly. Boa Vista, Roraima, 2021.

HEALTH EDUCATION	ILLUSTRATIVE TESTIMONIALS
Lectures: DCNT.	[...]we used the Silver Hair structure [a municipal program to promote healthy habits in the elderly] with lectures on SAH [...] the lectures themselves. (Participant 3). [...] lectures, the diabetes care itself, everything that includes the elderly in this. I think it's health promotion that we do with them [elderly people]. (Participant 5). [...]for the elderly, we give lectures about the most common comorbidities, which are hypertension, diabetes, obesity [...]. (Participant 10). [...]gives some kind of lecture trying to advise about diabetes, about weight gain [...]. (Participant 13). [...]by giving a lecture [...] the elderly person raises their hand, so you can advise them about high blood pressure [...]. (Participant 20).
Lecture: Care in the use of medication.	[...]the team provides orientation and gives lectures to see if the elderly person is correctly taking their medication. (Participant 4). [...] talk about medication care during lectures [...]. (Participant 5). It was a lecture about the use and care of medicines [...]. (Participant 8). [...] clarification in lectures about the continuous use of medication for their [elderly people's] chronic illnesses [...]. (Participant 10). [...] giving lectures about topics, giving guidance on how to take medication, how to take treatment [...]. (Participant 12).
Lecture: IST.	[...] lectures in order to educate, to clarify about IST, and, therefore, to promote health. (Participant 2). [...] lectures, explaining how to prevent sexually transmitted diseases [...]. (Participant 11). [...] giving talks to this group of elderly people, this patient needs to know about the risks of sexual infections at this stage of life [...]. (Participant 14). [...] meets at the unit, in the town square with them [elderly people] and talks about ISTs too [...]. (Participant 17). [...] we talk about HIV [...] we separate the men from the women to talk about the preventive, about how long it needs to be done [...] talking about the importance of disease prevention, for both women and men. (Participant 19).

Source: Authors.

DISCUSSION

The nature of health promotion involved (re)understanding the collective care strategies promoted with the elderly by the ESF team in the context of the UBS, considering two fundamental elements: activities with groups of elderly people and health education. It should be emphasized that this content variety was presented uniformly in the testimonies of the participants selected in this study, despite their professional category.

As mentioned in the first thematic framework, health promotion was considered to be a powerful care strategy based on group activities[17]. In this study, considering the healthcare promotion activities developed with groups of elderly people, UBS professionals focused on collective activities to monitor and control DNCTs, with an emphasis on systemic arterial hypertension and diabetes. By contrast, there were health promotion strategies to promote the life of the elderly, through physical activity groups, dances and highlighting commemorative dates.

It is considered possible and useful to work on DCNT control in group activities for the elderly. However, when we think about health promotion, it is necessary to break away from the problematic strategies present in group activities. These strategies are characterized by focusing strictly on diseases and not on the needs of the elderly and their daily lives, regardless of whether a problem exists or not.

The focus of the discussion is on hypertensive and diabetic groups, which are mostly conducted through the vertical transmission of knowledge. This process of guidance on DCNTs is based on a banking model, which produces evidence of the elderly blamed for the negative results of the guidance. In this sense, there is an urgent need for discussion groups as a way of encouraging the active participation of individuals in the construction of knowledge, decision-making, empowerment of the elderly and respect for their rights[18].

This reality reveals the fragility of collective care for the elderly population, aimed at solving the signs and symptoms of their illnesses. In other words, it denies that care must respond to the needs of the elderly in their singularities, modifiable factors, cultural, psychological, social and economic dimensions of human being[19,20].

However, it is essential to (re)understand the unique context of elderly people's lives, from the perspective of integrality and social determinants. To achieve this goal, the ESF team professionals must comprehend the health-disease process from a biopsychosocial and spiritual perspective. These attitudes aim to promote the autonomy of elderly individuals and establish collaborative spaces for care with family members, caregivers, and the community[21].

This is because in the aging process, elderly people are surrounded by doubts and changes that can make their aging process even more difficult. It's about idealizing, planning and implementing group activities with the elderly. In this way, it is possible to look beyond the disease and reduce insecurities and fears about the transformations of ageing. It is necessary to strengthen perceptions of the elderly, body and mind, anchored in meaningful representations of experience, longevity, natural processes, periods of illness and decline, in order to develop holistic ways of promoting care within groups[22].

Based on this consideration, the aim is to break with the stereotype created and legitimized by our society, which treats the elderly as incapable and fragile. It is, therefore, appropriate to reflect on the fight against etharism in health practices, marked by behaviors and attitudes that are tendentious and end up contributing to a pejorative perception of the elderly and their aging process[23].

With this in mind, the EPS, involving ESF professionals, must also highlight issues capable of placing at the center of care strategies, not only clinical contents and protocols for the care of the illness process, but also social, political, economic and cultural reflections present in life and in the aging process[7].

Based on this concept, groups, especially those that value dimensions of life, are considered promotional care strategies that benefit older people. These strategies encourage active participation, communication, critical-reflective thinking and social integration with other elderly people who face similar difficulties and experience different realities. This experience is a rich exchange of knowledge that influences collective health in a positive way. At the same time, it should be noted that group activities empower the interprofessional and multi-professional team, allowing the development of effective, problem-solving strategies aimed at integrality and the connection with the community[24].

In group activities, each individual, whether a professional or an elderly person, becomes an author in the construction of knowledge. It is therefore necessary to encourage autonomy and independence in the health process among elderly people, strengthening their self-care and increasing social interaction. These groups provide opportunities for well-being, dialogue, bonding, moments of leisure and health education, providing healthy and active ageing, favoring the elderly on a biopsychosocial and spiritual level[25].

Furthermore, there has been a rise in the level of trust that the elderly people have in basic health units. Through group activities, it is possible to bring up complex issues in a more dynamic way, providing rich interaction between everyone and breaking the idea that only health professionals have knowledge. In other words, creating existential spaces of freedom for the elderly to share their experiences and popular knowledge. In this sense, elderly people feel safer when they can clarify their doubts and exchange knowledge about their needs, which contributes to the promotion of health and quality of life in this population[26].

The significance of the UBS multi-professional team in supporting elderly groups should be emphasized. This can enrich practices and build effective health promotion interventions that transcend the limits of the health service. In this sense, the team is fundamental in creating groups for physical activities, dance and meetings on commemorative dates, adding knowledge and health practices in the existential spaces of the elderly.

The second thematic table emphasizes the preference of health professionals for educational lectures regarding health education as a collective care strategy promoted by the minimum ESF teams with the elderly. Thus, it should be emphasized that the vast majority of this type of strategy is carried out in the unit and on special dates for the elderly.

The scientific evidence indicates that the ACS was involved in inviting the elderly to attend a meeting with professionals who provide guidance on a pre-established topic in a vertical manner. Such educational actions denote an old representation of health education, based on traditional, technical methods and reduced to simply passing on information[“27].

This way of working in health education often concentrates knowledge in the health professional and leaves a lot of misunderstandings among the elderly. As a result, many elderly people seek assistance at primary care units for activities such as blood pressure checks, blood glucose tests, and preventive tests.

Thus, two statements in the thematic table refer strictly to biomedical lectures, covering DCNTs, proper medication use for controlling them, and ISTs. The discussion of such characterizations can be based on the curative approach, and health professionals have developed reductionist health education that centers on the disease and values technical procedures. In this way, this is mainly done through one-way lectures that are not very attractive to the elderly.

In addition, and based on a debate about the effectiveness of the impact of this model of health education carried out by primary care professionals, there is a difficulty in critically self-analyzing actions and blaming patients for their own health conditions[28]. However, it is important to note that the issue of sexually transmitted infections (IST) can be seen as a counterpoint. This demonstrates that the ESF understands the new relationships and experiences of the elderly population, who were previously socially perceived as asexual[29].

We need to think in more comprehensive terms, based on a territorial logic, where the practices of health education in the concept of promotion are closer to the community, getting closer to their worlds and the elderly's ways of life. Through education in response to spontaneous requests and complaints, presenting current issues applied to the context of the elderly[30], health is worked based on the realities.

Considering these points, it can be concluded that health education is a versatile strategy because it is constantly evolving to effectively reach the elderly population. It has been shown that health education for the elderly has great value. Therefore, it allows scientific and popular knowledge to be shared, valuing the knowledge and understanding how elderly people feel about themselves, the world and others, realities and the health-disease process[31].

It is therefore essential to emphasize the need to incorporate theoretical and pedagogical perspectives of a dialogical nature into health education practices, as a way of empowering the participation and emancipation of the elderly person in meetings with primary care professionals. Dialogic educational activities with the elderly, based on Freire's theoretical framework, promote a space for interaction that stimulates awareness of self-care, generating greater autonomy and improving quality of life[18].

In addition, the world has sought to invest in education and health, which has a direct impact on increasing life expectancy and the quality of life demanded by the current changes in the epidemiological and demographic scenario. The discussion about collective care strategies for the elderly has been promoted from the point of view of health promotion in order to value autonomy, independence in Basic Activities of Daily Living (*Atividades Básicas da Vida Diária – ABVD*) and Instrumental Activities of Daily Living (*Atividades Instrumentais da Vida Diária – AIVD*), and the adoption of healthy habits for active and favorable aging. The aim is to promote health education through a dialogic approach, covering a range of topics related to aging and not only focused on the disease[31].

When providing health education to the elderly, primary care professionals must understand their reality to determine the most appropriate pedagogical strategy for their context and territory. Each dialogic strategy has a positive effect on health education, which is strengthened by the bond, dialog, trust and therapeutic relationship with the elderly[32].

It therefore becomes necessary to improve the way topics are approached with this target audience. There is an urgent need to innovate the lecture method and the presentation of topics, using playful, participatory, practical, dialogic and welcoming strategies. It's not just a matter of providing information, but of exchanging knowledge and lives in a real space for the collective expression of experiences based on the demands, needs and desires of the elderly.

These expressions open windows for the elderly to share their real needs and deficiencies on a particular subject, respecting and welcoming other visions of the world and care. In this way, inclusive approaches to health education enable horizontal sharing of experiences, promote self-care and the exercise of autonomy, and contribute to comprehensive care aimed at healthy and active ageing[33].

These concepts raise investigative concerns regarding the provision of culturally appropriate care in the Roraima region, which includes the unique ethnic and cultural needs of indigenous elderly and elderly Venezuelan migrants[34,35]. From a social analytical point of view, this meaning highlights investigative problems related to the daily contact between these elderly people and health professionals in primary care.

In this sense, how can we explain, for example, the health promotion strategies implemented in primary care for migrant and indigenous elderly people? How can we explain the coexistence of such different cultural manifestations in a single territory? Are health professionals prepared to deal with this multiplicity of perspectives in the process of producing care aimed at healthy ageing?

Taking these issues as a reference point in the production of collective promotional care strategies as a basis for emerging studies seems to be a promising route that will benefit ways of caring for the elderly in the context of the extreme north of Brazil.

Thus, in this context, a methodological limitation of this study must be considered: the pandemic context that has led some UBS to exclusively care for symptomatic COVID-19 patients, and therefore limited their collective activities, especially with elderly groups.

FINAL CONSIDERATIONS

The ESF focuses on health promotion for the elderly. Thus, it can be concluded that health professionals implement group activities and health education as collective care strategies in the context of the UBS in the municipality of Boa Vista.

Regarding group activities, the focus is on elderly diabetics and hypertensive patients. In addition, group strategies such as dance, physical exercise and collective activities on festive dates have been recognized as extremely powerful in the field of health promotion for the elderly.

Regarding health education, the lecture was recognized as a collective strategy to promote health among the elderly. However, these activities were guided by speeches about diseases and the ways to treat them. An important strategy for promoting health is being reduced to monologues, where the health professional from the UBS is seen as the owner of knowledge, disregarding the knowledge of the elderly in the collective-educational proposal.

The inferences of this study suggest the need for further research into the care strategies employed by ESF teams for the elderly, particularly in the extreme north of Brazil where there are diverse ethnic and cultural groups. Thus, we believe that it is essential to transcend the limits of professionals' work in the UBS in order to reach the spaces experienced by the elderly and to improve healthcare strategies for this population. In addition, we understand the difficulty in establishing exclusive lines of care for the elderly, based on the real context of life and the technical-scientific-existential knowledge that affects the specificities of health promotion within the Collective Health field.

CONFLICTS OF INTEREST AND ACKNOWLEDGEMENTS

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CONTRIBUTIONS

Letícia Pacheco Silva contributed to the preparation and design of the study, data acquisition, analysis, interpretation, writing and revision of the manuscript. **Natália Carvalho Barbosa de Sousa** and **Thais Renata Muniz** contributed to writing and revising the manuscript. **Paulo Sérgio da Silva** contributed to the analysis, data interpretation and final revision of the manuscript. All the authors have approved the final version to be published and are responsible for its content, accuracy and integrity.

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