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The context of home visits based on communication needs: a perspective from primary care professionals

O contexto das visitas domiciliares a partir das necessidades de comunicação: uma perspectiva dos profissionais da atenção básica

El contexto de las visitas domiciliarias a partir de las necesidades de comunicación: una perspectiva de los profesionales de atención primaria

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Abstract

Introduction: Home visits are a strategy of the Brazilian Unified Health System (SUS) to address changing health needs of the population, bringing challenges, especially when users present communication needs. **Aim:** To characterize the profile and routine of primary care professionals involved in home visits at a health center in a large municipality in the state of São Paulo, as well as to understand their perspective on the communicative needs of users. **Method:** This is a cross-sectional and qualitative study, approved by the Research Ethics Committee of the University of Campinas (no. 6.111.895). The sample included physicians, nurses, nursing technicians/assistants, and community health workers (CHws). Data collection combined a characterization form of the interviewees and semi-structured interviews analyzed through Clinical-Qualitative Content Analysis. **Results:** The professionals involved demonstrated a diversity of experiences during home visits, highlighting the importance of CHWs. Users' communication needs vary in type and origin, and professionals face challenges, adapting strategies to meet them. **Conclusion:**

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Communication should be central in the care process within the context of home visits, integrating interdisciplinary practices, considering social determinants, promoting Health Literacy, and adopting a broadened approach that ensures comprehensive care and user autonomy.

Keywords: Primary Health Care; House Calls; Integrality in Health; Language; Communication Barriers.

Resumo

Introdução: A visita domiciliar é uma estratégia do Sistema Único de Saúde para atender às mudanças nas necessidades de saúde da população brasileira, trazendo desafios, especialmente quando os usuários apresentam necessidades de comunicação. **Objetivo:** Caracterizar o perfil e a rotina dos profissionais da atenção básica envolvidos em visitas domiciliares em um centro de saúde de um município de grande porte do estado de São Paulo, além de compreender sua perspectiva sobre as necessidades comunicativas dos usuários. **Método:** Trata-se de um estudo de caráter transversal e qualitativo, aprovado pelo Comitê de Ética em Pesquisa da Universidade Estadual de Campinas (nº 6.111.895). A amostra incluiu médicos, enfermeiros, técnicos/auxiliares de Enfermagem e agentes comunitários de saúde (ACS). A coleta de dados combinou um formulário de caracterização dos entrevistados e entrevistas semiestruturadas analisadas por meio da Análise de Conteúdo Clínico-Qualitativa. **Resultados:** Os profissionais envolvidos demonstraram uma diversidade de experiências nas visitas domiciliares, destacando a importância dos ACS. As necessidades comunicativas dos usuários variam em tipo e origem, e os profissionais enfrentam dificuldades, adaptando estratégias para atendê-las. **Conclusão:** A comunicação deve ser central no processo de cuidado no contexto da visita domiciliar, integrando práticas interdisciplinares, considerando determinantes sociais, promovendo o Letramento em Saúde e adotando uma abordagem ampliada que garanta a integralidade e a autonomia do usuário.

Palavras-chave: Atenção Primária à Saúde; Visita Domiciliar; Integralidade em Saúde; Linguagem; Barreiras de Comunicação.

Resumen

Introducción: La visita domiciliaria es una estrategia del Sistema Único de Salud de Brasil para responder a los cambios en las necesidades de salud de la población, lo que implica desafíos, especialmente cuando los usuarios presentan necesidades comunicativas. **Objetivo:** Caracterizar el perfil y la rutina de los profesionales de atención primaria involucrados en visitas domiciliarias en un centro de salud de un municipio de gran tamaño del estado de São Paulo, así como comprender su perspectiva sobre las necesidades comunicativas de los usuarios. **Método:** Se trata de un estudio transversal y cualitativo, aprobado por el Comité de Ética en Investigación de la Universidad de Campinas (n.º 6.111.895). La muestra incluyó médicos, enfermeros, técnicos/auxiliares de enfermería y agentes comunitarios de salud (ACS). La recolección de datos combinó un formulario de caracterización de los entrevistados y entrevistas semiestructuradas analizadas mediante Análisis de Contenido Clínico-Cualitativo. **Resultados:** Los profesionales participantes demostraron una diversidad de experiencias en las visitas domiciliarias, destacando la importancia de los ACS. Las necesidades comunicativas de los usuarios varían en tipo y origen, y los profesionales enfrentan dificultades, adaptando estrategias para atenderlas. **Conclusión:** La comunicación debe estar en el centro del proceso de atención en el contexto de la visita domiciliaria, integrando prácticas interdisciplinares, considerando los determinantes sociales, promoviendo la Alfabetización en Salud y adoptando un enfoque ampliado que garantice la integralidad y la autonomía del usuario.

Palabras clave: Atención Primaria de Salud; Visita Domiciliaria; Integralidad en Salud; Lenguaje; Barreras de Comunicación.

Introduction

Primary Health Care (PHC) is guided by principles such as accessibility, bonding, care coordination, comprehensiveness, and continuity, and it represents the main gateway for users into the Brazilian Unified Health System (SUS). Its main structure comprises the Basic Health Units (BHUs), located within the territories where users live, and which enable the resolution of most health needs[1].

Among the care tools established for PHC, home visits (HVs) stand out as a response from health systems to demographic changes and evolving health needs—such as the increasing demand for care among older adults and people with chronic or degenerative conditions — as well to ensure access for users who face difficulties reaching health services. Given the need for longitudinal follow-up and comprehensive care, HVs have become a key strategy in health practices[2].

From this perspective, responding to the population's demands and guiding care through a lens of comprehensiveness aligns with the principles of Expanded Clinic. By moving away from a biomedical model and viewing individuals in their uniqueness and wholeness — through teamwork — healthcare embraces multiple viewpoints and considers both the user and their context more effectively[3].

The principles of humanization embedded in public policies[1] reinforce this expanded health paradigm by promoting communication among managers, healthcare professionals, and users as a driver of change and a means of producing health. A humanized approach advocates for the inclusion of diversity in both care and management processes, striving to encompass the multiple dimensions that shape a person's life and health, including communication.

Within this framework, the Universal Declaration of Human Rights[4] establishes communication as a fundamental right, intrinsically linked to opportunities for dialogue and social participation—essential tools for ensuring other human rights and for building a more democratic society.

Therefore, limitations in modes of language for specific populations—such as people with complex communication needs—are also connected to SUS principles, particularly equity and comprehensiveness. These principles aim, respectively, to reduce health inequalities and to address individuals holistically by meeting their full range of needs and coordinating intersectoral actions to promote health and quality of life[5].

From this viewpoint, language, communication, and dialogue are interrelated, yet distinct in their foundational dimensions. Language is understood as a complex discursive activity, materialized in interaction and historically constructed through social use, involving neurological, bodily, and symbolic aspects. Communication refers to the process by which meaning is shared between interlocutors, guided by intentions and contexts that go beyond mere information transmission and require active interpretation. Dialogue, in turn, is the most dynamic and context-sensitive form of this activity, representing the co-construction of meaning between interlocutors through a logic of otherness and mutual understanding[6].

Since communication is a human right, it directly relates to an individual's communicative abilities and their social determinants of health, which include economic, social, ethnic/racial, behavioral, cultural, and psychological factors. Ineffective communication directly affects the health-disease-care process and may become a barrier to accessing healthcare services.

According to Penteado[6], health is intrinsically linked to an individual's capacities for interaction, expression, communication, and action in the world, which underscores the importance of recognizing language as symbolic mediation in health promotion. Promoting health, therefore, also entails fostering individual development and empowerment through and within language and communication.

To uphold PHC principles and maintain a balance between technical and ethical care, communication must take a central role in care practices. It is through communication—via reception and attentive listening—that individuals can be truly understood in their entirety. Addressing communication needs within the health-disease-care process is a shared responsibility of the healthcare team, and professionals must be prepared to strengthen bonds, reinforce relationships, and optimize care delivery[7].

Bertachini[7] emphasizes that communication must not become a barrier between professionals and users. In this light, HVs offer an opportunity not only to get closer to individuals themselves but also to the broader context in which they live.

This promotes the appreciation of the subjectivity of users and the relational dimensions of care. Once inside users' homes, professionals gain new perspectives, often identifying needs that do not surface in health units[8].

Entering the home allows professionals to access a person's world and uniqueness more intimately, gaining insight into their living conditions, home environment, work, and relationships[9]. Through active listening, the potential of home visits is greatly enhanced, as user-professional communication strengthens bonds, builds trust, and reinforces the health-disease-care process by including the individual and their family. Through the construction of dialogue, it becomes possible to understand the other—and to be understood[10].

In this context, professionals often work with individuals affected by sequelae, degenerative diseases, or other limiting health conditions that may impair language. Thus, the user's narrative becomes crucial for the construction of care. However, those who are unable to tell their story due to specific communication needs are often left unheard, which directly impacts their access to adequate care[11].

Therefore, the objectives of this study are to characterize the profile and routine of PHC professionals involved in home visits at a health center (HC) in a large municipality in the state of São Paulo, and to understand their perspectives regarding the communication needs of the users they serve.

Materials and Methods

This is a cross-sectional, qualitative study approved by the Research Ethics Committee (CEP) of the Faculty of Medical Sciences at the University of Campinas (UNICAMP), under protocol number 6.111.895.

The study was conducted at a health center (HC) in the municipality of Campinas, São Paulo. The site was chosen due to its relevance to the research, as it serves a population assigned to the unit with the highest socioeconomic vulnerability in the region and, consequently, greater reliance on the Unified Health System (SUS).

To ensure the feasibility of the research, a pilot study was conducted with individuals who met similar inclusion and exclusion criteria as those for the final sample, but who were not part of the selected HC team. Based on the pilot, necessary adjustments were identified and implemented to refine the questionnaire and prepare for interviews with the study participants.

Inclusion criteria included professionals — physicians, nurses, nursing technicians, and community health workers — who participated in home visits conducted by the Family Health Strategy (FHS) teams at the selected HC. Exclusion criteria included professionals not permanently assigned to the teams, such as residents, and those who did not complete the research instruments.

The HC is organized into four FHS teams, and participants included physicians, nurses, nursing technicians and/or assistants, and community health workers (CHWs), as these are the professionals involved in home visits at the selected unit.

All 24 interviewees were presented with the Informed Consent Form (ICF) for review and signature prior to the data collection process.

Data collection initially involved the administration of a questionnaire with questions aimed at characterizing the participating professionals (age, gender, profession, years since graduation, and time working in primary care, at the health center, and in home visits).

Following the questionnaire, a semi-structured interview was conducted, guided by the following questions:

1) Who are the users served during home visits by your team?
2) Do you perceive any communication difficulties among users during home visits? If so, what are these difficulties?
3) What strategies are used during home visits to facilitate communication with users?
4) What is the importance of communication in the context of home visits?

The interview was chosen as the main data collection method to capture a broad range of experiences and perspectives on the topic, valuing and highlighting the uniqueness of each participant, shaped by their individual life experiences, personality, and biography[12].

All interviews were audio-recorded and fully transcribed for analysis. The qualitative data was processed using the Clinical-Qualitative Content Analysis method, a systematic approach designed to provide clarity to researchers and ensure quality. This technique aims to stimulate reflection and

promote intervention among health professionals based on the lived experiences of the interviewees[13].

Results

A total of 24 professionals from the health center were interviewed: nine Community Health Workers (CHWs), five nursing technicians and/or assistants, five nurses, and five physicians. The following presents the characteristics of the interviewees in each professional category based on questionnaire data, including information related to the home visits they conducted.

Regarding average age (Table 1), CHWs had a mean age of 41 years (range: 33 to 54). Nurses had an average age of 36 years (range: 28 to 41). CHWs also reported the longest average time since graduation and the longest duration working in primary care and conducting home visits—an average of 16.5 years (range: 9 to 22). Nursing technicians/assistants had the longest tenure at the health center, with an average of 16 years (range: 1 month to 22 years). Physicians had the shortest average length of experience in both primary care and home visits—nine months and six months, respectively.

Tabela 1. Média e desvio padrão de idade, tempo de formação, atuação na atenção básica, no centro de saúde e nas visitas domiciliares por categoria profissional

Variáveis	Grupos							
	ACS (n=9)		Técnicos (n=5)		Enfermeiros (n=5)		Médicos (n=5)	
	Média (anos)	Desvio Padrão	Média (anos)	Desvio Padrão	Média (anos)	Desvio Padrão	Média (anos)	Desvio Padrão
Idade	41	10	37	13	36	14	38	8
Tempo de formação	16,5	5,5	14	10	5,5	5,4	10,8	11,5
Tempo de atuação na AB	16,5	5,5	8	10	10,5	8	9 meses	17
Tempo de atuação no CS	15	6,3	16	31	6	30	1	607
Tempo de atuação nas VD	16,5	5,5	7	8	7	7,4	3 meses	2

Legenda: ACS - agente comunitário de saúde, AB - atenção básica, CS - centro de saúde, VD - visita domiciliar.

As for gender (Table 2), the majority of CHWs (88.9%), nursing technicians/assistants (100%), and nurses (100%) were female. Among physicians, most were male (60%).

Tabela 2. Caracterização dos entrevistados quanto ao gênero

Grupo	Gênero	
	Feminino	Masculino
ACS (n=9)	88,9% (n=8)	11,1% (n=1)
Técnicos (n=5)	100% (n=5)	0
Enfermeiros (n=5)	100% (n=5)	0
Médicos (n=5)	40% (n=2)	60% (n=3)

Legenda: ACS - agente comunitário de saúde.

With respect to home visit routines (Table 3), CHWs performed them most frequently, averaging 2.5 visits per week. CHWs and nursing technicians/assistants made the highest number of visits per day, averaging four. Physicians had the longest average visit duration — approximately 45 minutes.

Tabela 3. Caracterização das visitas domiciliares quanto à frequência, tempo médio de duração e quantidade por dia, por categoria profissional

Variáveis/Grupos	ACS (n=9)	Técnicos (n=5)	Enfermeiros (n=5)	Médicos (n=5)
Frequência (por semana)	2,5	1,2	1	1
Tempo médio de duração	30 minutos	40 minutos	30 minutos	45 minutos
Quantidade por dia	4	4	3	3

Legenda: ACS - agente comunitário de saúde.

Based on Clinical-Qualitative Content Analysis, four thematic categories were identified based on recurrence and relevance in participants' responses:1. Characteristics of users served during home visits; 2. Users' communication needs; 3. Communication strategies; 4. The importance of communication in the context of home visits.

To attribute quotes from the interviews, the following abbreviations are used: TEC for nursing technicians/assistants, NUR for nurses, DOC for physicians, and CHW as the standard abbreviation for Community Health Workers. For context, each quote is accompanied by the participant's gender, age, and time working with home visits.

Characteristics of users served during home visits

When asked about the profile of users receiving home visits, the most frequent response (n=16) was that they are bedridden and/or unable to attend the health center due to various conditions such as reduced mobility, recent hospital discharge, visual impairment, accidents, postpartum status, stroke sequelae, or requiring special care (e.g., cancer treatment):

> *"Usually, the patients we visit are those who can't come to the health center. So, the bedridden, homebound, or those temporarily unable to come in—if someone had an accident or surgery and can't get here."* (NUR3, female, 35, involved in home visits for 4 months)

> *"Patients who cannot get to the health center, who have difficulty moving around, are bedridden, or were recently discharged from the hospital."* (TEC2, female, 29, involved in home visits for 6 years)

> *"Primarily patients with mobility issues—elderly, bedridden, post-stroke, amputees, or diabetic patients with comorbidities, visually impaired people, or patients undergoing special care such as cancer treatment."* (DOC2, male, 34, involved in home visits for 6 months)

The second most frequent response (n=8) referred to age, highlighting that most users receiving home visits are older adults:

> *"In general, most of the users are elderly."* (TEC1, female, 47, involved in home visits for 3 months)

> *"We serve a lot of elderly people — grandparents and even their grandchildren. My team sees mostly elderly people."* (CHW7, female, 49, involved in home visits for 21 years)

Six professionals described the users as having more complex health needs, including aphasia, stroke, cognitive impairments, chronic illness sequelae, and patients in palliative care:

> *"They are the most vulnerable—bedridden, with more complex illnesses."* (DOC5, female, 56, involved in home visits for 4 months)

> *"Most are elderly with chronic diseases, but we've also started seeing children in palliative care and adolescents with conditions like obesity."* (NUR3, female, 35, involved in home visits for 4 months)

Another common response (n=5) cited mental health issues such as schizophrenia and depression:

> *"[...] sometimes a mental health condition like severe schizophrenia or depression."* (DOC1, male, 32, involved in home visits for 4 months)

> *"Also, patients with mental health challenges who find it hard to leave home."* (CHW9, female, 37, involved in home visits for 9 years)

Four professionals mentioned socioeconomic vulnerability as a reason for not attending the health center:

> *"Some patients can't come due to financial or family reasons, so we continue care at home to prevent worsening conditions."* (NUR4, female, 37, involved in home visits for 8 months)

Three professionals cited poor adherence to treatment as a common characteristic:

> *"Sometimes it's a patient who struggles with treatment adherence or a pregnant woman who has missed many appointments."* (NUR1, female, 38, involved in home visits for 4 years)

Users' communication needs

When asked about communication difficulties, only one respondent reported that users had no issues:

> *INT: "Have you ever noticed communication difficulties in users during visits?" RESP: "No."* (CHW8, female, 54, involved in home visits for 22 years)

Four respondents acknowledged communication needs but did not specify the nature, attributing them to health conditions:

> *"[...] communication difficulties can definitely exist for a variety of reasons."* (DOC1, male, 32, involved in home visits for 4 months)

Thirteen participants stated users had difficulty understanding information:

> *"Yes, I notice difficulty understanding the therapeutic plan."* (DOC2, male, 34, involved in home visits for 6 months)

> *"[...] there are communication disorders, often due to age, and they don't fully understand."* (CHW2, female, 33, involved in home visits for 9 years)

Thirteen professionals also cited difficulties in users expressing themselves:

> *"[...] they have trouble speaking and expressing themselves."* (TEC1, female, 47, involved in home visits for 3 months)

> *"Elderly and bedridden patients often don't communicate at all—we speak with caregivers instead."* (DOC4, female, 30, involved in home visits for 4 months)

Six participants associated low literacy with communication challenges:

> *"Many can't read or write. Some are illiterate or barely able to sign their name. Even young people haven't finished elementary school."* (CHW7, female, 49, involved in home visits for 21 years)

Communication strategies

When asked about communication strategies for users with complex needs, 19 of 24 cited the use of intermediaries, such as family members or caregivers:

> *"Often the patient can't provide information, so we ask the family for feedback."* (TEC3, female, 48, involved in home visits for 2 months)

Thirteen professionals mentioned using multimodal strategies—written notes, gestures, visual aids, etc.:

> *"For medications, we organize boxes labeled by days."* (TEC1, female, 47, involved in home visits for 3 months)

> *"We try deduction—like nodding for yes or no — trial and error."* (NUR4, female, 37, involved in home visits for 8 months)

Eight participants highlighted teamwork as a strategy, particularly collaboration with CHWs:

> *"We discuss cases in team meetings to identify barriers and plan actions."* (TEC4, female, 55, involved in home visits for 28 years)

> *"CHWs help a lot—they know the families better and understand their needs."* (NUR5, female, 41, involved in home visits for 13 years)

Eight professionals also reported adjusting their speech—simplifying vocabulary, repeating information, speaking louder or more slowly:

> *"[...] repeat information and explain in detail if the person doesn't understand."* (CHW1, male, 53, involved in home visits for 21 years)

> *"We use simple language so they can follow our instructions."* (TEC4, female, 55, involved in home visits for 28 years)

Importance of communication in home visits

All respondents emphasized the fundamental role of communication. Thirteen related it to the care process itself:

> *"It's important to hear directly from the patient, not just the family, to understand what they feel and think."* (CHW6, female, 43, involved in home visits for 16 years)

> *"It's through conversation that we understand their needs and respond accordingly."* (CHW5, female, 44, involved in home visits for 11 years)

> *"Communication is the foundation of the health professional–patient bond. There is no care without it."* (DOC1, male, 32, involved in home visits for 4 months)

Eleven participants highlighted communication as essential for treatment effectiveness:

> *"[...] without clear communication, we can't ensure effective treatment."* (DOC5, female, 56, involved in home visits for 4 months)

> *"I need to understand whether the person is improving and whether they understand my instructions."* (NUR1, female, 38, involved in home visits for 4 years)

> *"Communication is everything—it drives treatment and care. Everything must be made as clear as possible."* (TEC3, female, 48, involved in home visits for 2 months)

Discussion

This study has limitations related to its small and specific sample, as it was conducted in a single health center in a large city, within an area of high socioeconomic vulnerability, and involved only 24 healthcare professionals. This geographic and demographic restriction may compromise the generalizability of the findings to other contexts, such as health units in areas with different socioeconomic or organizational characteristics. Furthermore, as a cross-sectional and qualitative study, the results reflect a specific moment in time and are based on the subjective perceptions of the participants, making it difficult to extrapolate the findings to other settings or to identify trends over time.

The results support existing literature in the field of health, particularly the predominance of women among health professionals. Women represent 70% of the healthcare workforce, and since 2000, their presence in higher-paying professions has increased—reflecting progress in the fight for fair compensation and professional equity[14].

Among the professional categories interviewed, only the medical group had a male majority. While the proportion of female physicians is increasing, gender inequality in specialized medical roles and income remains evident. This reflects a broader trend in gender distribution across professions—men tend to occupy higher-paid roles such as physicians, pharmacists, and dentists, while lower-paid professions, like nursing, are predominantly held by women[15].

Another important finding was the high turnover of professionals at the health center, as evidenced by short tenure at the facility. This raises concerns about both the quality and continuity of care. A high number of newly hired staff suggests instability in the healthcare workforce, which can affect provider–patient relationships and the effectiveness of systems that rely on building strong bonds[16].

One major consequence of staff turnover is the lack of continuity in care. Users may struggle to adapt to different professionals with each visit, weakening mutual trust and communication and potentially compromising adherence to treatment. Since home care relies on professionals' proximity to users' social and family contexts, frequent staff changes hinder rapport and impact the effectiveness of home visits[16].

Additionally, training and integrating new professionals requires time and resources—including onboarding, theoretical and practical training, and adjustment periods. As each team is responsible for planning, scheduling, and organizing home visits, team composition changes can disrupt workflow and service delivery.

Among all professional groups, community health workers (CHWs) had the longest tenure in primary care and in home visits, and the second-longest time working at the health center. In several interviews, they were described as key figures in establishing user relationships—an essential aspect of their role[17,18].

CHWs often serve as the first point of contact between users and the health center, responsible for registering and monitoring population health indicators. Their frequent interactions and proximity to the community foster trust and enable a deeper understanding of users' individual needs, which may contribute to better health outcomes through a more comprehensive view that includes social, economic, and cultural factors[17,18].

As the main health contact within the community and the professionals conducting the most home visits, CHWs play a vital role in forming bonds with families. These connections, built through active listening, foster shared care and support horizontal health education efforts[17].

Regarding home visit organization, visit duration is determined by each team based on available time and the number of users to be seen, as well as the prioritization of cases[16]. The average duration found in this study was 30–45 minutes, which is like other studies reporting a stay of 45–55 minutes in the family's home[19], though this may vary—especially for CHWs.

Time spent on home visits varies among physicians, nurses, nursing technicians, and CHWs, reflecting different roles in healthcare delivery. Physicians reported the longest visit duration, which may relate to the need for detailed assessments and diagnoses—particularly crucial in managing complex medical conditions[19].

CHWs conducted the highest number of visits per week, with user needs and procedures varying greatly. This diversity likely contributed to shorter average visit durations compared to other professionals.

Sakata et al.[8] reported that visit duration is frequently discussed by teams and perceived as a limiting factor for the effectiveness of home visits. They describe two types of time: **chronological time** (actual time spent on each visit and how it fits with other responsibilities) and **emotional time** (relational engagement and the use of soft technologies for holistic family care). While chronological time was seen as a constraint, emotional time was identified as a positive factor for promoting user-centered care.

Despite time constraints, sensitive and effective communication remains essential. Professionals can still provide meaningful care through structured dialogue and time management strategies, ensuring mutual understanding even within shorter visits[7].

The user profiles identified in this study align with the Ministry of Health's 2020 guidelines[16], which prioritize home visits for bedridden individuals or those with limited mobility due to age, complex health needs, or socioeconomic/family issues. Home visits serve as a tool to guarantee the constitutional right to health.

It is important to note that user profiles in this study also reflect the local population served by the health center, marked by socioeconomic vulnerability. Thus, home visits respond to specific needs and potential benefits in such contexts[16].

Users with severe mental health conditions are also eligible for home visits. These visits enable more comprehensive assessments by considering family and socioeconomic contexts, which can influence treatment adherence and help prevent complications or relapses[20].

For users with mobility challenges or who are unable to reach health units, home visits provide a critical mechanism to ensure continuous access to healthcare, helping to "reduce the risk of disease and other harms and ensure universal and equal access to actions and services for promotion, protection, and recovery"[21].

In addition to access challenges, difficulty adhering to treatment plans emerged as a recurring theme. Bertolozzi et al.[22] argue that the less users understand their own health process, the more passive they become in accepting treatment. Education—an important determinant of health—must therefore be considered through the lens of Health Literacy (HL), enabling users to access, understand, and apply health information to engage in self-care[23].

A study with 350 older adults found direct relationships between HL and both age and education level: the older the individual, the lower the HL; the more years of schooling, the higher the HL[24]. Since age and education were highlighted by professionals, home visits may serve as a strategy to tailor HL interventions through direct instruction, clarification of doubts, and reinforcement of

care plans. By understanding specific barriers to adherence, professionals can develop more effective strategies to support user participation in care.

In addition to literacy issues, the population's vulnerability—as cited by interviewees—underscores the need to consider the Social Determinants of Health (SDH). By acknowledging factors such as income, resource access, and social support, the home visit setting can foster deeper understanding and reduce health disparities[5].

As Santos et al.[25] note, healthcare cannot be separated from other social sectors. Low education levels were among the barriers to effective communication during home visits. Socioeconomic fragility often limits educational opportunities, impairing HL and reducing user engagement with the healthcare system[26]. As Passamai et al.[27] suggest, people with limited HL often report that health professionals use inaccessible terms, speak too quickly, or provide insufficient information.

Interviewees often framed users' socioeconomic vulnerability as a communication challenge, particularly in terms of comprehension. However, the focus of their responses often placed responsibility on the user for communication breakdowns rather than on their own communicative practices. This perspective risks blaming users for their limitations instead of encouraging professionals to reflect on their own roles in ensuring effective communication and care.

In the field of public health—where the goal is to empower communities to participate in their own health processes—health professionals must move away from a strictly biomedical model. Recognizing the multiple dimensions of health requires adapting communication strategies to promote understanding and meaningful engagement.

By addressing mental health needs, treatment adherence, complex health conditions, socioeconomic vulnerability, and aging, a focus on SDH within home visits supports the right to health, promotes equity in access, and contributes to a more comprehensive and person-centered approach to care. In striving for comprehensive care—a core principle of SUS—language must be embraced as symbolic mediation that enables joint efforts to improve quality of life[5,6].

Interview analysis revealed a heterogeneous understanding of users' communication difficulties. While only one participant denied any challenges, others recognized a range of complex issues affecting communication. Some professionals struggled to identify specific communication barriers, but the dichotomy between comprehension and expression emerged as a central theme. Some cited difficulty in understanding therapeutic guidance, while others highlighted challenges in user expression—suggesting a shift toward unidirectional communication[11].

Since communication is an interactive, shared process of verbal and non-verbal meaning-making, breakdowns in expression or reception compromise its effectiveness. Professionals must validate user understanding and tailor language accordingly. Active listening is essential for uncovering underlying needs, often hidden beneath the surface complaints, and initiating meaningful care.

Professional–user interactions during home visits are not merely exchanges of clinical data but are spaces where subjectivity is expressed, shaped, and shared[28]. Understanding this complexity—and the central role of communication—is vital for humanized and effective care. Language is not simply a clinical tool but a way of affirming individuality, fostering autonomy, and supporting the user amid vulnerability.

Acknowledging the user's role in their own care invites more horizontal relationships and challenges hierarchical dynamics[7]. In this context, vulnerability should not signal limitation, but rather call for a more inclusive, empathetic approach where communication serves as a bridge for mutual understanding and shared care.

Home visits offer a unique opportunity to engage with users' everyday environments, which contain valuable insights into their lives. Health professionals can directly assess users' SDH and real-life contexts, enabling more effective care planning that aligns with their circumstances and support networks[16].

Understanding users and their contexts is crucial for designing appropriate communication strategies and therapeutic interventions. Entering users' homes allows professionals to tailor their approach to individual needs and circumstances[10]. Communication strategies must be adapted to ensure truly dialogical processes.

Although caregiver support was often cited as a communication strategy, it is essential to recognize communication not only as central to the home visit, but also as a constitutive element of the subject[28]. Health promotion requires that users—and

their communication—become protagonists in the care process[7].

Inspired by Paulo Freire's principles[29], "respect for the autonomy and dignity of every person is an imperative, not a favor we may or may not grant each other." While caregivers play a vital role in supporting care[16], the user's autonomy must be preserved—even in contexts of dependency—through communication that upholds their integrity: "no one is the subject of another's autonomy"[29].

Caregivers can be powerful allies in co-constructing the care process and in supporting users to express needs, understand information, and participate in decision-making. Effective communication is thus co-created, fostering equality and respect[30].

Teamwork also emerged as a key facilitator of communication. Interprofessional collaboration during home visits provides users with a holistic perspective of care, considering both needs and context[9]. Recognizing that care occurs within social and family environments reinforces the importance of collective approaches. Interdisciplinarity enriches communication strategies and broadens understanding of user demands.

Among the multiprofessional team, CHW was highlighted as a key communication actor, bridging the Family Health Strategy and the local community. Their involvement strengthens social bonds and supports comprehensive, horizontal care[7].

Communication, within the context of comprehensive care, highlights the deep interconnection between users, how they communicate, and the care they receive. Communication is not just a means of transmitting information but a constitutive part of the subject—and thus, of care itself[6]. Recognizing how users express, understand, and interact is essential for promoting individualized, integrative approaches[5].

Communication is a multifaceted expression of the individual, shaped by emotional, social, and cultural factors that directly influence care. Limiting a person's communicative potential violates not only the principles of SUS but also fundamental human rights[4].

Communication goes beyond treatment effectiveness—it shapes therapeutic relationships and supports the user's overall well-being[7]. Moving away from biomedical care means acknowledging that empathy, understanding, and sensitivity in communication are fundamental to user experience[16].

Trust, built through effective communication, enhances treatment adherence, user satisfaction, and the perceived quality of care. Communication thus transcends clinical outcomes, deeply influencing quality of life[7].

Ultimately, communication is the essential tool for establishing partnerships between health teams and users. It enables individualized, collaborative care and empowers the user to become an active participant in their own well-being[28]. In this view, communication is not part of care — it is the only way care can truly occur.

Final Considerations

The professionals involved in home visits demonstrated a wide range of experiences, and the central role of Community Health Workers (CHWs) stood out. This professional group had the longest tenure in terms of training, experience in primary care, and participation in home visits, functioning as a crucial link between the community and the healthcare team and playing a key role in building the bonds essential for effective care.

The average duration of home visits ranged from 30 minutes for CHWs to 45 minutes for physicians. CHWs and nursing technicians/assistants reported conducting the highest number of visits per week and per day, with an average of 2.5 days and four visits per day for CHWs, and 1.2 days and four visits per day for technicians/assistants.

According to the professionals' reports, the profiles of users served during home visits revealed a variety of needs, including socioeconomic challenges, poor adherence to treatment plans, complex health conditions, advanced age, and specific mental health demands. It became clear that home care is essential to ensuring continued access to health services, especially for those facing mobility difficulties or other limitations that prevent them from reaching healthcare facilities.

Users' communication needs were identified as a key factor in the success of home visits. However, some participants associated communication primarily with treatment effectiveness, rather than recognizing it as a foundational element of the care process. Communication barriers, such as users' lack of understanding of therapeutic plans, were highlighted as significant challenges. Furthermore, the socioeconomic vulnerability of the population directly impacted communication, emphasizing

the need for a sensitive and adaptive approach that takes Health Literacy into account.

The collected data indicates the importance of adopting targeted strategies to improve communication within healthcare teams. These include implementing regular training focused on health literacy, strengthening the role of CHWs as communication facilitators, and promoting personalized approaches that acknowledge the uniqueness of each user.

This study paves the way for future reflection and highlights areas for further research, such as understanding communication needs in different cultural contexts, developing strategies to support and enhance home visits, and examining the impact of communication on users' adherence to treatment.

Focusing on communication in the context of home visits is not only an immediate need but also an opportunity to promote equity in access to healthcare services and strengthen the bonds between professionals and users—ultimately improving the practice of care.

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