DOI: 10.1590/1807-57622016.0512

Territorialization in Primary Health Care: an experience in Medical Education

Larissa Galas Justo[a]

Ana Kalliny de Sousa Severo[b]

Antônio Vladimir Félix-Silva[c]

Lorena Sousa Soares[d]

Fernando Lopes e Silva-Júnior[e]

José Ivo dos Santos Pedrosa[f]

(a,c,d,e,f) Curso de Medicina, Campus Ministro Reis Velloso, Universidade Federal do Piauí. Avenida Capitão Claro, 382. Centro. Parnaíba, PI, Brasil. 64.200-500. larissagjusto@gmail.com; wladyfelix@hotmail.com; lorenacacaux@hotmail.com; fernando.lopes@ufpi.edu.br; jivopedrosa@gmail.com
(b) Curso de Psicologia, Faculdade de Ciências da Saúde do Trairi, Universidade Federal do Rio Grande do Norte. Santa Cruz, RN, Brasil. akssevero@gmail.com

This paper discusses the importance of territorialization for Medical Education based on the analysis of a teaching experience in a medical course. The medical course in this higher education institution is made up of modules, one of which is the primary health care module. It addresses territorialization, with activities linked to five basic health units, recorded in cartographic journals. The experience in one of the units was analyzed using four axes: the participation of community health agents in medical training; learning about equity; the importance of the team-community bond; the role of students, professionals and the community; and learning through territorialization. The analysis of this experience showed the importance of understanding that is sensitive to territory mapping from the ethical-esthetic-political perspective of the devir of the subject group for Primary Health Care and Service, according to the needs of the population.

Keywords: Territorialization. Primary Health Care. Medical Education.

Introduction

There have been a series of changes in the structuring of health policy in Brazil, with the participation of important social and political sectors, that have helped advance the movement for Sanitary Reform[1] and consolidate the Brazilian National Health System (SUS). This system, "like every form of reality, is a result of the conflict involving the different policies of its construction."[2] Consequently, several of the sectors involved with the SUS have an essential driving role in producing changes that cover the field of health practices, such as the field of professional education.

New experiments should offer proposals for the transformation of professional practices, based on critical reflection on health work and the experimentation of alterity with users. These practices need to enable the incorporation of the daily routines of healthcare relationships and sectoral management learning and teaching. Training should go beyond the search for diagnosis of and intervention in the illness process and adapt "to the health needs of people and populations, sectoral management and social control in health, adjusting the development of people's autonomy to the condition of influence in healthcare policy formulation."[3]

In the last few decades, a global movement to restructure medical education has occurred in response to the need to improve and reformulate the training of higher education students in service and the need for changes in the relationship between universities and health services. In the Brazilian context, changes in medical education are required to meet the SUS goals, strengthen health care focused on the health needs of the population, and develop community-oriented education projects[4]. In 2013, the federal government launched the More Doctors Program to fulfill the emergency demand for expanded medical service in the country and promote its adaptation to the health needs of the Brazilian population and primary health care qualification. The federal government has adopted three main areas of focus: increases in the number of openings in medical courses; increases in the number of medical residency openings in several regions of the country; and implementation of a new curriculum based on humanized care training focused on valuing primary health care[5].

We attempted to analyze the importance of territorialization in Primary Health Care in medical education, based on one experience with the inclusion of medical

academicians in the Family Health Strategy (ESF). One of the foundations of the ESF is territorialized Primary Health Care, based on spatially delimited territories according to the model adopted for patient selection[6,7]. A territory, for the purpose of the community health production process, should be considered a living area that is able to produce health; therefore, an epidemiological diagnosis of the area should be carried out to identify the factors and conditions related to the health and disease processes of a certain region[6]. It should be understood as a dynamic area, various aspects of which are in constant change – history, demographics, culture, and epidemiology – and, consequently, it is subject to constant variability of risks and vulnerabilities, characteristics that have an impact on government administration, politics, technology, and society within its physical and intangible boundaries[7].

As medical education planning moves away from the biomedical model and becomes applicable to the reformulation of health systems, knowledge of the territorialization process becomes a tool that is required to help the transition between these learning models occur smoothly and functionally, particularly in the context of Primary Health Care. The medical course of the higher education in the city of Parnaíba has the theoretical-methodological axis of education-service-community and the following areas of professional ability: health care, management, and education[8]. It is a course developed according to the National Curriculum Guidelines for the 2014 Medical Course and the regulations set by the 2010 Medical Education Expansion Working Group. It should be highlighted that the course is organized in modules[8].

How does permanent health education constitute a connection involving education-service-community and the areas of competence of medical professionals? We do not intend to address this problem here. Nevertheless, the discussions and results of the experience that will be reported here provide some clues, “recognizing that education is a source of knowledge that contributes to the subjects having greater autonomy in taking care of themselves,”[9] and knowing that “caring for oneself is not produced by knowledge, it has to find fertile existential territory in which to occur.”[9] From this perspective, we think that health education can contribute to the production of new modes of existence based on territorialization.

Among the eight primary health care modules of the course, the Primary Health Care I (APS I) module, included in the curriculum matrix of the first period of the course, introduces the concept and practice of territorialization to medical students in the course. To foster their understanding of the complexity of health processes, the professors start by explaining, through the use of practical and tangible activities, the importance and challenges of the process of territory recognition and selection. This module, which also covers the development of skills related to health care, health management and health education, is addressed in eight of the total of twelve 6-month periods of the course. This paper aimed to discuss the importance of territorialization for medical education based on the analysis of an experience in the medical course.

Methodology: how territorialization was included

The curriculum in the medical course in the city of Parnaíba is divided into two stages, each with different activities and methodologies. The first stage covers the first four years, organized in eight 6-month periods that present levels of coordination of the discipline contents through sequential modules and cross-sectional modules. The APS 1 is one of the cross-sectional modules, placed in the sequence until the eighth period, and it links "the content developed from practices in healthcare networks and recommended in health policies, connecting the individual and collective levels of care; technical-scientific knowledge and tacit and popular knowledge; and targeted, emergency and planned interventions."[8]

The APS I module was developed during the second period of 2015, and it included both theoretical and practical classes focused on learning about the social determinants of health, understanding the theoretical and historical aspects of the emergence of medical practice, recognizing subjects and health practices, and understanding the complexity of community health care. For the development of activities, students were divided into groups of eight to ten participants and inserted in five family health units in the urban area of the municipality. During the training

period, about seven visits were conducted in the territory, with the following purposes: mapping of the areas covered by the health units, based on observations by participants while accompanied by community health agents (ACSs); discussion sessions with ACSs; interviews with nurses and dental surgeons; and home visits. These visits alternated with theoretical classes, and knowledge construction combined them with practical activities and group integration practices. The territory visit activities were recorded in cartographic journals and box of affections.

One of the visited health units is a reference service in the territory characterized in this paper, which includes an old district of the city and a riverside community. The district is considered one of the city's birthplaces. The services offered by this unit include reception, nursing services, medical care, prenatal and child care services, medical dressings, dispensing of medicines, dispensing of condoms and contraceptives, cervical cancer preventive exams, health education groups, immunizations, nebulization, and family planning.

In the territorialization process, this specific group of students and teachers walked the streets of the neighborhood with the ACSs. Some instruments were provided to guide the observations. Besides general aspects of the territory and team identification, the activity was explained in advance using a script with questions to the community, as follows: Who are you? How do you survive? How do you live? What difficulties do you have in the place where you live? What about health? What health problems do you often see in the place where you live? What's good about the place where you live? When you have a health problem, who or what do you look for (include all options)? How do you see the health center and what suggestions do you have for improving the health center work? Other issues that may arise.

In addition, discussion sessions were held with higher-level professional, the primary health care superintendent, the dental surgeon, and the nurse, who was also the basic health unit manager. The areas discussed were the training and level of the professionals, their roles, time of service in the institution, their views regarding the community, activities conducted, methodologies and intervention strategies, and the main challenges and benefits of the service in which they were inserted.

For the construction and synthesis of this analysis, we used cartographic journals and the box of affections produced by this group of students, and we chose to present it in relevant thematic-theoretical axes. The axes were: the participation of ACSs in medical training – a broader look at the territory; learning about equity – the importance of the team-community bond; the role of students, professionals and community – creating subject groups; learning through territorialization– the use of the portfolio, forum and box of affections.

Analytical axes for discussion

The participation of ACSs in medical training – a broader look at the territory

The participation of the ACSs was very important in the reported experience, because it helped insert the students in the communities, create bonds, and demonstrate participative approaches in the work with the communities.

Three ACSs of this health unit welcomed the students and gave them a map that they had made according to the region where they worked. Two of these agents had worked as ACS in the unit for more than 15 years, and the other had been there for more than 17 years.

At the beginning of the discussion, the ACSs listed the permanent members of the health team of that health unit, mentioning the physician, nurse, dental surgeon, social worker, and group of community agents, which was the largest and consisted of people who lived in the neighborhood. After this introduction, the three ACSs showed all the micro areas that constituted the territory covered by the unit.

As the ACSs described the micro areas, the cultural and historical riches of the neighborhood were revealed, as well as the heterogeneity of its population, it’s very rich and very poor areas, and infrastructure problems, among others. In addition, they explained how health agents, among health professionals and community members, handled local problems. This process also revealed that the complexity and characteristics of the territory are almost exclusively the knowledge of the ACSs. In

interviews with the higher-level professionals of the unit about the territory and its resources, they showed poor knowledge of community experiences.

As stated in the National Primary Health Care Policy (PNAB), the ACSs have to work with micro areas, defined as “family selection with defined geography”[10]. Each ACS of the UBS was responsible for one of the micro areas in the covered region; most of them lived in the area to which they were assigned, including the member of the team in charge of the riverside community. Although they were divided up in this way, even though there were only three agents from a much larger team present at the initial meeting, all ACSs were aware of the main characteristics and nuances of the selected zones.

Regarding the work of the Family Health Strategy, addressing social issues in health should include existing resources in the territory, so teams and general practitioners need to understand communities: the way they live, their challenges, and the resources that can be used in health production. In a discussion about community-based education, Haddad explains that the student: [...] should learn at an early age that the patient or the user of health services is the subject, and not the object, of the professional action. For this reason, it is necessary to change from a technique-centered practice to actions in places where life (and health and disease) happens.[4]

This highlights the fact that this integration was only made possible by the participation of the ACSs, since they participate actively in the production of population health, in terms of production of the clinic and health care and actions of health promotion and education[11]. Thus, the participation of the ACSs is essential in current medical training, in order to pull down the hegemonic biomedical paradigm, which is based on knowledge of diseases and vertical actions within the community. This insertion in the territory enables the development of; ways of learning and interventions that consider the knowledge of people; broadened practice in the territory, where essential for the ESF; and a strengthened relationship among education-service-community.

Learning about equity – the importance of the team-community bond

In the visits during the program, we realized that care and deconstruction of prejudices in specific groups are essential to effectively guarantee the universal right to health, especially when approaching and creating a link with riverside populations, *quilombola* populations and sex workers.

One of the places visited by the students attracted their curiosity: a bar that probably had drug dealing and also offered sex workers – including children and adolescents. The ACSs explained that they occasionally distributed condoms and other methods to prevent conception and sexually transmitted infections, but with care and kindness, so as not to break the trust relationship between the users of this place and the ACSs.

This case started a discussion about addressing the most vulnerable users in the region. The ACSs agreed on one point: They cannot show the impact caused by some social situations. In these cases, their approach is cautious, since more energetic attitudes of accusation and abrupt intervention can cause irreversible loss of confidence among the covered population.

The UBS referral for extreme social situations is the social assistance reference center in a nearby neighborhood. However, the ACSs are reticent about the intervention of social workers. They describe the method as more energetic and likely to cause irreparable loss of user confidence in agents who report the situations. Although they are obliged to report complications, the ACSs seek to do that in a way that does not impact the image of the health team.

Another highlight was a place that used to be a waste disposal area, but has been cleaned and occupied by local residents, becoming an inhabited place with a garden that is grown by the community. It has a large commercial area that supplies grocery products and a landscaping shop. This area has an old village of fishermen; according to the local population, they are descendants of *quilombolas* who migrated long ago from the State of Ceará. They were a rather reserved group, at first, and did

not go to schools or use other public services offered to the community. One of the strategies used by the health team to approach the village was to have a member of the village as part of the group of the ACSs. Now, the ACSs have established a link with this village, which is already inserted in public services, including education and health. There are doubts as to whether this small community is descended from *quilombolas*, despite the origins described.

Finally, the agents described the riverside community, which has its own agent, who lives in the area. Although small and remote, it has great historical value for Parnaíba. It is the site of old *Testa Branca* village, historically referred to as the beginning of the city.

The difficulty in access to the riverside population was due to infrastructure problems. The small size of this community allowed quick and direct recognition of all the descriptors already mentioned by the ACSs in previous meetings: a riverside family-based community, made up especially of fishermen who used the nearby river. One of the surprises was the garbage collection situation in the place, which did not exist because of access was difficult access. For this reason, they burned the garbage, since it was the only option for material disposal.

The school evasion rate is high in the region; school teachers are often absent and seem discouraged, according to one of the agents who accompanied the group. For this reason, children often go to school to receive a meal and spend a short time there. The agents also reported that local youths tend to migrate to more urban areas at the end of their teenage years, and they do not come back. Therefore, the population of this community has more children and older adults than young adults.

Due to the distance between the community and the health unit, and the unavailability of free time for ACS monitoring, the students were not able to visit the community. However, learning more about it was one of the most interesting moments in the territorialization process, because of the reality shock and the ideas discussed by the students about intervention projects to be conducted in that place.

It is noteworthy that the ACSs reported to the students the violent interventions of the state. In modernity, a hegemonic model of health intervention is established,

characterized by actions of control over the life and bodies of the people, especially of the vulnerable population. Home health care is also based on this same perspective, with actions that seek to control the population[12].

To change this situation, it is important to strengthen, in the medical training curriculum, the discussion about the heterogeneities of the Brazilian people, the adequacy of interventions in face of these differences, and assuming equity as a guideline for care; and to insert into health professional training discussions about opposing actions that attempt to control the poorest population and inequality in access to health services and assets. The SUS "has implemented policies to promote equity aiming to reduce vulnerabilities to which certain populations are exposed, and which result from social determinants of health."[13]

Building equitable care systems also involves the adoption of an ethical attitude of respect and acceptance of differences, producing health based on the specific needs of the population. Therefore, it is necessary to seek knowledge that supports the recognition of community history, cultural specificities and social reproduction systems of individuals and populations[14].

The role of students, professionals, and community – creating subject groups

In the report based on the box of affections, one of the students in the group mentioned the song *Clube da Esquina II*, by Milton Nascimento, Lô Borges, and Márcio Borges, that says "Because they called themselves men/They also called themselves dreams/And dreams do not get old." She referred to a time without dreams, a time of sadness, when she felt lost. Along with other students, she sang a song that speaks of dreams that do not get old. The students talked about the reasons that led them to study medicine and their family traditions, but they explained that they did not understand them. In their contact with the poor population and the history of SUS, they found dreams that did not get old, they felt like they were playing an active role in the construction of another reality of rights to health. Their souls, along with the soul of the SUS, were intensified and had meaning.

This was because they found in the territory stories they had not imagined, that had not been broadcast by media vehicles. As one student reported, they only knew medicine centered on the doctor-patient relationship and the SUS service for those who could not pay. They did not know that they could produce other collective stories in health production.

In one of the remote micro areas far from the health unit, there was a health facility that had been abandoned for a decade. The residents and ACSs united to clean and organize the place, sharing expenses and acting on their own, without the support of the Municipal Department of Health (SMS). Today, the community has assumed control of this health facility, clearing it out and keeping it for the visits by the health team.

While this involvement of the community and engagement of health professionals working for it are certainly honorable and an example of interest in the proper functioning of the ESF, a sensitive issue observed by the students during the module was precisely the lack of a link between municipal management and health unit management. The more initiative and autonomy the team members showed, the less priority their demands received; one of the ACSs told the students that the fact that the UBS solves some of its problems on its own seems to be a justification for this situation.

In order to be able to operate in the region without broader SMS support, the ACSs do not like to advertise their events. They don't want the credit for their independent actions to mask the fact that success is largely the result of efforts from the local team, and not of the municipal programs and budget. Activities that used to be conducted by the family health support center (NASF), which were discontinued after it was closed, still remain. These include "Capotherapy," which takes place every Sunday with elderly people at a neighborhood school, involving physical activities that simulate capoeira, and a walking group organized by the community.

The students reported that getting in contact with people's expressions about their lifestyles mobilized them and made them feel like they were part of the system's construction and these lifestyles. In this way, methods of learning and caring are

mobilized to produce community care with the people, and with the students working on their existential territories to “be” in the community and in the university.

Learning through territorialization – use of the portfolio, forum and box of affections

The last evaluation activities of the students in this module included the development of a portfolio describing the territorialization experience in detail, its impact, and the creation of a forum for the module outcomes, to be conducted by all medical course groups involved in primary health care activities.

Considering that the medical course in question prioritizes active methodologies for the construction of collaborative learning,[15] the portfolio was adopted to encourage intense participation of the students in the production of knowledge that will benefit them in their training. Instead of focusing on a summative and individual assessment, this methodology ensures a collective, consensual and reflexive evaluation, driving student criticality, and consolidating the social awareness of all participants. This process reflects the identity of the students and allows a formative evaluation guided by reflection and self-assessment[15].

The other evaluation activity was not related to individual reflection. It was developed with the groups from the primary health care modules, at several levels: groups were arranged by health units within the same module of different modules (in this case, APS I and APS III). Based on these principles, the professors from the APS modules planned a forum that would encompass all APS participants, from students and teachers to health professionals involved in primary health care in the municipality.

The forum was not implemented in all possible ways, due to difficulties in the development of planning and evaluation strategies for university education in an effective partnership with the network of services[4]. The great potential of this event will only be realized when all the modules can participate in its implementation, so that the work conducted by the students in primary health care will continue in symbiosis,

from APS I to APS VIII, with the participation of APS internship groups, the workers and the community.

In addition to the forum and group integration practices, such as group discussions and culture circles, used in training activities, and the use of the portfolio, we also used the box of affections. It is a tool developed by each student in a workshop with the teachers of another module, Basic Psychosocial Processes of Health; the tool was enhanced after the students' visit to the territory in the APS I module, generating integration between the modules. The use of this box of affections[16] aimed to establish a connection with the experience based on objects of impact related to the activity of territorialization and the sensations and thoughts associated with the experience that helped in looking at the potentialities of the territory, generating the desire to record the experience in journals and systematize the portfolio. The box acted as an important tool that enabled discussions on different points of view, reconciling the demands and needs of both parties, "without forgetting the fact that the main objective is to meet the needs of the user"[4].

Final considerations

The specific objectives of the APS I module include learning about social health determinants, understanding the theoretical and historical aspects of the emergence of medical practice, recognizing health subjects and practices, and understanding the complexity of community health and care. The module also includes study of the research elements of basic health care and the health situation in Brazil, including the health care model, regionalization, and health care municipalization at different levels of care and health systems[8].

These activities were performed concomitantly with the practical activity of territorialization conducted by the students to fulfill the module requirements. Guided by the teachers and staff members of the health care units located in the neighborhoods, especially the ACSs, the students were able to actively set the learning content, producing knowledge beyond the walls of the classroom. Students and

teachers noticed a greater level of sensitivity in the learning process as a result of using active methodologies and being exposed to the impact of the community on the social determinants and multifactorial characteristics of health.

Due to the effectiveness of this teaching model, the method will be improved and will remain in the APS I module, which is responsible for introducing new medical students to the complexity of the health service through the various facets of what, at first, seems to be a simple and small portion of a map.

Despite its challenges, the experience was considered positive by the students and teachers, as they learned from the activities of the module, which took place in a reference unit in the city of Parnaíba. Although its physical structure is not the most modern or suitable, according to the ESF guidelines – after all, it exists in an environment that was initially built as a home, and not as a UBS – it is a place organized by the professionals in charge and the community. The team is punctual and organized, and is able to plan their actions according to national health calendars and adapt them to the characteristics of the population they cover, according to the demands and needs observed.

In addition to the imaginary production of a reference unit, we highlight the positive outcome of segmented groups in education (teachers and students), service (community agents and other professionals), and community (social participation), and the focus on the ethical-aesthetic-political perspective on what is common to these multiple groups, the community *porvir*[16] and *devir* of the subject group[17], as devices that make us experiment, problematize and narrate the experience of territorialization.

Collaborators

Larissa Galas Justo, Ana Kalliny de Sousa Severo, and Antônio Vladimir Félix-Silva worked on the conception and writing of the intellectual content of the reported experience. Lorena Sousa Soares, Fernando Lopes e Silva-Júnior, and José Ivo dos Santos Pedrosa worked on the critical review of the intellectual content of the reported experience, as well as on the approval of the final version to be published.

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Translated by Silmara de Oliveira