

Territorialization Process and Possibilities for Intervention in Primary Health Care

Processo de Territorialização e Possibilidades de Intervenção na Atenção Primária à Saúde

Proceso de Territorialización y Posibilidades de Intervención en la Atención Primaria de Salud

RESUMO

Objetivo: O estudo tem como objetivo descrever o processo de territorialização em um território em Santa Catarina e analisar as possibilidades de intervenção a partir dos seus resultados. **Método:** Trata-se relato de experiência dos residentes do Programa de Residência Multiprofissional no processo de territorialização. Apresenta as etapas metodológicas da territorialização e as possibilidades a partir dos resultados do processo no município. **Resultados:** Houve a compreensão dos profissionais quanto à realidade do território, suas particularidades e contextos locais, bem como de que maneira as estratégias desenvolvidas pelas equipes de saúde interferem no cotidiano da comunidade. Permitiu ainda o fortalecimento do vínculo entre as equipes e a melhoria da comunicação entre os profissionais, possibilitando a elaboração do planejamento compartilhado. **Conclusão:** A territorialização constitui uma ferramenta para a organização das práticas em saúde, favorecendo o acesso, a participação social e o funcionamento dos serviços de acordo com os princípios do SUS.

DESCRIPTORES: Territorialização da Atenção Primária; Atenção Primária à Saúde; Sistema Único de Saúde.

ABSTRACT

Objective: This study aims to describe the territorialization process in a territory located in Santa Catarina, Brazil, and to analyze the possibilities for intervention based on its results. **Method:** This is an experience report developed by residents of a Multiprofessional Residency Program during the territorialization process. The study presents the methodological stages of territorialization and discusses the possibilities arising from the results obtained in the municipality. **Results:** The process enabled health professionals to better understand the reality of the territory, its specific characteristics, and local contexts, as well as how the strategies developed by health teams influence the community's daily life. It also strengthened the bond among team members and improved communication between professionals, facilitating the development of shared planning. **Conclusion:** Territorialization is an important tool for organizing health practices, promoting access to healthcare, social participation, and the functioning of services in accordance with the principles of the Brazilian Unified Health System

DESCRIPTORS: Territorialization in Primary Health Care; Primary Health Care; Unified Health System.

RESUMEN:

Objetivo: El estudio tiene como objetivo describir el proceso de territorialización en un territorio del Santa Catarina, Brasil, y analizar las posibilidades de intervención a partir de sus resultados. **Método:** Se trata de un relato de experiencia realizado por residentes de un Programa de Residencia Multiprofesional durante el proceso de territorialización. El estudio presenta las etapas metodológicas de la territorialización y las posibilidades derivadas de los resultados obtenidos en el municipio. **Resultados:** El proceso permitió a los profesionales comprender mejor la realidad del territorio, sus particularidades y contextos locales, así como la manera en que las estrategias desarrolladas por los equipos de salud influyen en la vida cotidiana de la comunidad. También favoreció el fortalecimiento de los vínculos entre los equipos y la mejora de la comunicación entre los profesionales, posibilitando la elaboración de una planificación compartida. **Conclusión:** La territorialización constituye una herramienta fundamental para la organización de las prácticas de salud, favoreciendo el acceso a los servicios, la participación social y el funcionamiento de los servicios de acuerdo con los principios del Sistema Único de Salud

DESCRIPTORES: Territorialización de la Atención Primaria; Atención Primaria de Salud; Sistema Único de Salud.

RECEIVED: 06/22/2026 APPROVED: 08/26/2026

How to cite this article: Bottamedi D, Filipi JF. Territorialization Process and Possibilities for Intervention in Primary Health Care. *Saúde Coletiva* (Brazilian Edition) [Internet]. 2026 [cited year month day];18 (113):20902-20913. Available from: DOI: 10.36489/saudecoletiva.2026v18i113p20902-20913

ID Daiane Bottamedi

Master's Degree in Public Health – Graduate Program in Public Health, Federal University of Santa Catarina (UFSC). Florianópolis, Santa Catarina, Brazil.

ORCID: <https://orcid.org/0000-0002-4651-8847>

Corresponding Author:

Email: dai.bottamedi@gmail.com

Address: Rua Bernardo Groh, nº 93 – Bairro 1º de Maio. Brusque – SC, Brasil CEP: 88353-51

ID Jaqueline Fuchter Filipi

Specialist in the Multidisciplinary Residency Program in Primary Care and Family Health. University of Vale do Itajaí (UNIVALI). Itajaí, Santa Catarina, Brazil.

ORCID: <https://orcid.org/0009-0009-7392-5809>

INTRODUCTION

The concept of space is related to the natural heritage found in a defined region. Understanding space as a set of fixed elements and flows brings together materiality and the life that animates it ⁽¹⁾. Active elements are interconnected through actions and redefinitions as they undergo changes.

Territory is constituted by space and humanity's appropriation of it. It is a delimited space, produced by society, comprising a sum of spatial elements, geographic features, social actors, relationships, and variable power dynamics ⁽²⁾. This concept involves perceiving people's way of life and power relations—both among themselves and with their environment—which form constant interactions and meanings that construct the territory's identity, alongside an understanding of territoriality. It is closely linked to the way people use and organize themselves within space, thereby attributing meaning to the place ⁽³⁾. It is, therefore, a dynamic, socially constructed space considered an area of action and responsibility ⁽⁴⁾.

Within the context of the SUS, the distribution of territory incorporates its multiple dimensions, enables the creation of bonds and identities, and facilitates the development of health practices and the creation of spaces for communication and education ⁽⁵⁾.

Territorialization is an important tool in the Primary Health Care

(PHC) work process. It can be understood as a process of appropriating space or, in its own terminology, the creation of territories ⁽⁶⁾. It serves as an organizational tool for work processes and health practices, while also redirecting health professionals' focus toward the reality of their practice ⁽⁷⁾. Through this process, strictly geographical concepts are expanded and interact with political, social, and productive contexts. Territorialization makes it possible to assess social, epidemiological, and demographic characteristics and, furthermore, is necessary to appropriately influence the health status of the registered population ⁽⁸⁾, directing attention to the various elements that comprise and shape the health-disease process.

Therefore, the territorialization process is an indispensable part of organizing PHC services, as it enables the identification of the population under their care and facilitates planning aimed at providing longitudinal care ⁽⁹⁾. The Family Health System (ESF) operates through the territorial delineation of service users, the work carried out by multidisciplinary and interdisciplinary teams, and the knowledge of the families receiving care, and the bond between staff members and the families they serve ⁽¹⁰⁾.

Through territorialization, it is possible to assess the social, epidemiological, and demographic characteristics of a population; furthermore, it is necessary to appropriately address

the health status of the enrolled population. However, for this to happen, it is necessary to register all families, since through this assessment it is possible to: identify the population's risk factors and health determinants; develop, together with the community, action plans aimed at addressing the determinants and conditioning factors of the health/disease process; provide comprehensive care to the community, whether at home or at the Family Health Program (ESF), as well as follow up with individuals who have received care at referral hospitals or outpatient clinics; and develop educational practices aimed at finding ways to address health problems ⁽⁸⁾.

There is a wide variety of approaches and methodological proposals that inform the formulation of policies, the organization, and the evaluation of health systems, leading to the subsequent development of projects and strategic reorientations to address problems and meet community needs based on geographic, demographic, epidemiological, and social factors ⁽¹¹⁾. In this regard, the overall objective of this article is to describe and analyze the territorialization process in a specific area of the municipality of Brusque, Santa Catarina, and to examine the possibilities for intervention based on the results.

METHODOLOGY

This is a descriptive study based on an account of experience. It employs a

qualitative approach, as this allows for the interpretation of the experience, relating it to the principles of health and its fields⁽¹²⁾. It describes the experience of residents in the Multiprofessional Residency Program in Primary Care and Family Health during the pilot project of the territorialization process carried out in a municipality in the Médio Vale do Itajaí region of Santa Catarina in 2018.

To achieve the proposed objectives, the territorialization process followed a methodological framework organized into four stages: planning, implementation, analysis, and finalization. The instruments used during the implementation of territorialization consisted of mapping, image production, and semi-structured interviews⁽³⁾. Additionally, collection of epidemiological data previously gathered by family health teams (eSF).

The findings were derived from an analysis of the results in conjunction with the scientific literature. In summary, the information was collected throughout the process through firsthand experience, discussions, and reports. The final outcome of the territorialization process raised hypotheses and identified possibilities for intervention.

The municipality, located in the Itajaí Valley region of the state of Santa Catarina, covers an area of 283.223 km² and has an estimated population of 128,818 inhabitants⁽¹³⁾. In the health sector, the municipality comprises 31 Family Health Strategies (ESF), distributed across 23 basic health units (UBS) and subdivided into five regional health districts to improve the organization and operation of services.

Since this is an experience report that does not involve human subjects as research participants, the manuscript was not submitted for review by a Research Ethics Committee, in accordance with CNS Resolution No. 510/2016.

RESULTS

The territorialization process described here took place as a pilot project in two Family Health Strategy (ESF) units in the municipality of Brusque. The project was conceived by management, preceptors, and residents to raise awareness among ESF teams regarding the continuous nature of the work process, as well as to identify the potential and needs of the territories at the local level.

The territorialization process began following a meeting between management, ESF and NASF teams, and residents. Initially, the teams were briefed on territorialization, and the objectives, methodology, and deadlines were explained. With assistance from management and in support of the urban development sector, updated maps of all municipal territories were provided, and residents and NASF teams were divided into working groups to support the ESF teams.

The tools used during the territorialization process included a demographic survey, mapping and image production, and semi-structured interviews⁽³⁾, as well as the analysis of epidemiological data previously collected by the family health teams (ESF). Mapping and image production were carried out using photoethnography, based on a guiding script, in order to assess aspects social, environmental, and health aspects based on the images produced, documenting elements such as: An overview of the territory; Built sociocultural spaces frequented by people; Workplaces; Residential spaces; Urban infrastructure; Natural spaces; People/social integration; Aspects of people and nutrition; Risk factors for health problems; local practices that demonstrate the population's potential. The photos were organized into folders on the desktop, created for storage and to facilitate access by all those involved. Following the on-site process, the

team met to mark the map with the locations identified during the mapping and photoethnography process. Stickers were added representatively to each point, and the maps were created using distinct colors to differentiate between micro-areas. The epidemiological and demographic data collected by the eSF teams were used to map the population profile of the territories. The data were requested individually from the Community Health Agents (ACS); in micro-areas that had not been identified or where data were incomplete, home visits were conducted to update records and collect information, and the data were subsequently compiled into a single document. Finally, contact was made with some residents of the territory to gain insight into the population's perspective, understand their impressions of the locality, and deepen our understanding of the territory's nuances.

Once these steps were completed, a meeting was held between the participants and management to present and discuss the results of the pilot project, which spurred the project's advancement throughout the entire municipality. Subsequently, the collected data were analyzed, and based on this analysis, smart maps were created, which highlight epidemiological data, demographic data, social infrastructure, areas of vulnerability, living conditions, and health status. As expected, the analysis revealed both strengths and weaknesses in the organization and development of the territorialization process.

Of particular note is the use of this methodology as a pedagogical strategy for the educational and professional development of those involved, especially the residents. It helped reframe the territory based on the subjects' life contexts and the territory's specific characteristics, thereby enhancing the possibilities for intervention. It also improved communication

and strengthened the bond between the NASF and ESF teams. There is a clear perception of the different conceptions of territory and territorialization among the professionals in the network, as reflected in the conceptual vision, organization, and development expressed in the practical implementation of this work process. Ultimately, this has opened the possibility for the joint development of strategic planning.

One of the challenges encountered was re-registering families in the uncovered areas, highlighting the importance of community health workers in identifying the local epidemiological profile. We identified a lack of knowledge regarding the demographic, epidemiological, and social characteristics of the Family Health Program (ESF) territories, a lack of infrastructure and human resources, an excess population per ESF, and a lack of local health councils and community participation. Based on these analyses and observations, we were able to outline the territorial profiles and identities, and the interviews facilitated closer rapport between the professionals and the interviewees.

DISCUSSION

The new PNAB Ordinance No. 2436, dated September 21, 2017, establishes revised guidelines for the organization of Primary Care within the SUS, redirecting the population assigned to Primary Care (eAB) and Family Health (eSF) teams from

2,000 to 3,500 people, located within its territory⁽⁹⁾. There is a need to periodically review these boundaries; however, there is no set timeframe for doing so⁽⁶⁾. Given the municipality's growth in recent years and the need for management to realign and reallocate territorial boundaries at the municipal level, it is important to identify areas with the highest pop-

ulation growth, as well as those with the greatest need for health resources and potential hiring of personnel.

The territorialization process was resumed in response to a request from the municipality's Primary Care administration, following the identification of both quantitative and qualitative imbalances in territorial distribution. Given that the last quantitative review at the municipal level was conducted in 2012, it became apparent at that time that there was a need to identify and redistribute areas with populations exceeding 3,500 people, as well as to ensure adequate coverage of the most vulnerable areas by Community Health Agents (ACS) already working in those territories, and to justify—based on data collected during the process—the establishment of new Family Health Strategy teams and the hiring of additional ACS for the identified vulnerable areas that remain uncovered. Regarding territorialization, the theoretical propositions are positive and broad; they embody a vision of democratic construction, with strategies oriented toward living conditions and health, and ownership grounded in accountability and sharing. However, in practice, territorialization is often reduced to the service's appropriation of space, with a view toward a standardized service delivery model regulated by available resources⁽⁶⁾.

Therefore, taking advantage of this opportunity, residents and preceptors, with the support of the AB administration, met to explore the concepts in greater depth and bring territorialization into alignment with the literature and the principles of the SUS, highlighting aspects that need to be taken into consideration—beyond merely quantitative factors.

Territorialization is one of the basic principles of primary care work. This task, however, takes on at least three different and complementary meanings: defining the boundaries

of the services' areas of operation; recognizing the environment, population, and social dynamics present in these areas; and establishing horizontal relationships with other adjacent services and vertical relationships with referral centers⁽⁴⁾. It is included in the National Primary Care Policy (PNAB) as a tool for the work process⁽⁹⁾. It should be a continuous process that is part of professionals' daily routines; however, our experience showed that this is not the case. Due to a lack of interest and high turnover among professionals, as well as a shortage of human resources, there are even times when its importance seems to be taken for granted. For this reason, adoption of this process ends up being enforced through mandatory registration⁽⁶⁾. This weakens and limits the effectiveness of this tool. Other aspects are noted by other professionals during home visits and shared during case discussions, which broaden the understanding of the territory from the perspective of other professionals.

View the territory as a starting point, not as a criterion to be used to define limitations⁽⁶⁾. Understand that distinguishing the actual living conditions of population groups makes it possible to identify health problems and propose appropriate interventions. To understand personal practices and actions in daily life, one must identify how life unfolds starting at the most local level⁽⁴⁾. Therefore, it is important to recognize the practices of the territory from the perspective of the population itself, as well as through historical and personal accounts. One must also consider local history, which helps shed light on the health situations and living contexts of the current population by looking back at the past—including the occupation and appropriation of the territory, social participation, living circumstances, economic status, and people's integration into pro-

ductive processes⁽⁴⁾. The population is subject to contextual factors that must be acknowledged in order to address their underlying determinants; it is essential to listen to their historical accounts, descriptions of living conditions, concerns, motivations, feelings, and aspirations. Therefore, understanding, engaging with, and involving them as active participants becomes fundamental.

After acknowledging reality, the goal is to define the scope of possible actions to be undertaken. Based on the results obtained through territorialization, among the possible interventions is rethinking the reorganization of micro-areas, based on territorial reality and taking into account specific characteristics, without limiting territorialization to epidemiological data. This is because one of the problems encountered in the planning and management of primary health care services is the consolidation of their boundaries; however, it is not feasible to conceive of fixed boundaries in dynamic and fluid territories⁽⁶⁾. These should be used as pillars for the organization of care, not as limiting factors; nor should territorialization be reduced to this single intervention.

Furthermore, by (re)familiarizing ourselves with the territory, we can approach territorial planning in accordance with actual local needs and potential. From this perspective, theory and practice, reflection and action come together as integrated elements of planning⁽⁶⁾. To assess and adapt health services and interventions, it is essential to consider epidemiological and sociodemographic data on the population, as well as the most common health problems they face and the occupational and housing risks to which they are exposed, along with an understanding of the range of existing services and the population's access to them.

Currently, health care extends across the territory in an intersectoral

and expanded manner; to achieve this, it requires people to participate in defining and resolving local issues and leveraging local potential. It is through this empowerment that we can design interventions, involving the population in the processes and encouraging the sharing of decisions and responsibilities⁽⁴⁾. As seen, health issues extend beyond this sector to engage with other sectors when developing action plans; therefore, strengthening community participation, giving a voice to local stakeholders, and working alongside the community become key strategies for effective care.

Another possibility arising from the results obtained is to explore public, community, and social spaces and to forge partnerships with various entities, thereby fostering environments grounded in the principles of health promotion. Furthermore, ongoing awareness-raising among health professionals is essential for the continuity of this process, as the local context—and the interactions and relationships intrinsic to it—are in a state of constant transition and transformation.

CONCLUSION

It is concluded that understanding and identifying the social relationships, determinants, and social determination present in these territories are fundamental to PHC work process. It is important to recognize that the territorialization process is an integral part of the daily work of PHC, with a focus on the demands and needs specific to the territory.

Through the territorialization process, professionals' understanding of the territory's reality—including its specific characteristics and local contexts—was broadened, as was their understanding of how the strategies developed by health teams impact the community's daily life. Addition-

ally, a strengthening of the bond between the NASF and ESF teams was observed, along with improved communication among professionals and greater opportunities for joint strategic planning.

Based on this process, a previous lack of knowledge regarding the demographic, epidemiological, and social characteristics of the ESF territory was identified, along with limitations related to infrastructure, insufficient human resources, an excess population per team, and the absence of local health councils and community participation. It became evident that knowledge of the population's actual living conditions enables the identification of health problems and the development of intervention proposals tailored to the territory's needs.

The results also pointed to the possibility of reorganizing micro-areas based on territorial realities, taking into account their specific characteristics and moving beyond the limitations of territorialization focused solely on epidemiological data. In this way, it became possible to identify collective and individual needs, recognize the territory's strengths and vulnerabilities, prioritize demands, and support the development of action plans aligned with local realities.

It is concluded that territorialization should be implemented in the work processes of PHC teams and constantly updated in light of the dynamics and transformations of the territory. Finally, the experience reported here reinforces the importance of territorialization as an essential planning and management tool within the PHC framework, contributing to the organization of surveillance activities and to the strengthening of the principles and guidelines of the SUS.

REFERENCES

1. Santos M. A natureza do espaço: técnica e tempo, razão e emoção. 4ed, São Paulo, SP: Edusp, Ed. da Univ. de São Paulo; 2009.
2. Godim GMM, Monken M. Território e Territorialização. In: Godim GMM, Christófar MAC, Miyashiro GM (org). Técnico de vigilância em saúde: contexto e identidade. Rio de Janeiro: EPSJV; 2017. p. 21–44.
3. Monken M, Peiter P, Barcellos C, Rojas LBI, Navarro M, Godim GMM et al. O território na saúde construindo referências para análises em saúde e ambiente. In: Miranda AC, Barcellos C, Moreira JC, Monken M (org). Território, ambiente e saúde. Rio de Janeiro: Editora FIOCRUZ; 2008, p.23–41.
4. Monken M, Barcellos C. O território na promoção e vigilância em saúde. In: Fonseca AF, Corbo AMD (org). O território e o processo saúde-doença. Rio de Janeiro: EPSJV/FIOCRUZ; 2007. p. 177–224.
5. Melo CMM, Santos HS, Christófar MAC, Santos MM. Trabalho. In: Godim GMM, Christófar MAC, Miyashiro GM (org). Técnico de vigilância em saúde: contexto e identidade. Rio de Janeiro: EPSJV; 2017. p. 81–104.
6. Faria RM. A territorialização da atenção primária à saúde no Sistema Único de Saúde e a construção de uma perspectiva de adequação dos serviços aos perfis do território urbano. Hygeia - Revista Brasileira de Geografia Médica e da Saúde [serial on internet] 2013 [cited 2018 out 15]; 9(16):121–30 available from: <https://doi.org/10.14393/Hygeia919501>.
7. Monken M, Barcellos C. Vigilância em saúde e território utilizado: possibilidades teóricas e metodológicas. Cad Saúde Pública. junho de 2005;21(3):898–906.
8. Brasil. Saúde da Família: uma estratégia para a reorientação do modelo assistencial. Brasília: Ministério da Saúde; 1997.
9. Brasil M da S. Portaria no 2.436, de 21 de setembro de 2017 [serial on internet]. 21, 2017 set [cited 2018 set 12]. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt2436_22_09_2017.html.
10. Costa EMA da, Carbone MH. Saúde da família: uma abordagem multidisciplinar. 2. ed., rev.ampl. Rio de Janeiro: Rubio; 2009.
11. Rouquayrol MZ. Epidemiologia e saúde. 6o ed. Rio de Janeiro: Medsi Editora Médica e Científica Ltda; 2003.
12. Minayo MCS. A utilização do método qualitativo para a avaliação de programas de saúde. In: Campos RO, Furtado JP, Passos E, Benevides R (org). Pesquisa avaliativa em saúde mental - desenho participativo e efeitos da narratividade. Campinas: HUCITEC; 2008. p. 27–37.
13. IBGE. Cidades e Estados [Internet]. 2018 [citado 22 de agosto de 2018]. Disponível em: <https://cidades.ibge.gov.br/brasil/sc/brusque/panorama>.

Funding

None.

Conflict of Interest Statement and Data Availability Statement

Conflict of interest: the authors declare that there is no conflict of interest.

Data availability: the data supporting the findings of this study are available upon request from the corresponding author.