





## Digital mapping and territorial reorganization in primary care: the experience of residents in public health

*Mapeamento digital e reorganização territorial na atenção primária: experiência de residentes em saúde coletiva*

*Cartografía digital y reorganización territorial en la atención primaria: la experiencia de los residentes en salud pública*

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### Abstract:

**Objective:** to report the experience of resident health professionals in the participatory process of digital mapping and territorial reorganization of the micro-areas of a Family Health Unit. **Methods:** this is an experience report, lived by residents in Public Health, professionals from a Family Health Unit, and the coordination of Primary Health Care. The activities were developed between August and September 2025 and included meetings and collective agreement. The process involved analysis of existing maps and marking of uncovered areas, followed by the digital construction of a new map in MyMaps. **Results:** after discussions about weaknesses, there was a reorganization and redistribution of micro-areas through the digital tool. Comparative analysis identified that the previous map presented limitations such as micro-areas without spatial delimitation, which represented gaps in healthcare coverage and a failure in the strategic performance of the service. With the reorganization, the area of coverage increased with a polygonal delimitation that allowed for subsidies for vulnerability stratification, definition of priorities, and monitoring of actions. **Conclusion:** the territorial reorganization improved Primary Health Care by expanding coverage, reducing gaps, and strengthening bonds. Furthermore, it was evident that participatory territorialization favors equitable access, comprehensive care, and the consolidation of the Family Health Unit as a reference point in the territory.

**Keywords:** Territorialization in Primary Health Care; Public Health Surveillance; Public Health.

### Resumo:

**Objetivo:** relatar a experiência de profissionais de saúde residentes no processo participativo de mapeamento digital e reorganização territorial das microáreas de uma Unidade Básica de Saúde da Família. **Método:** trata-se de um relato de experiência, vivenciado por residentes em Saúde Coletiva, profissionais de uma Unidade Básica de Saúde da Família e a coordenação da Atenção Primária à Saúde. As atividades foram desenvolvidas entre agosto e setembro de 2025 e incluíram reuniões e pactuação coletiva. O processo envolveu análise dos mapas vigentes e marcação de áreas descobertas, seguido da construção digital de um novo mapa no MyMaps. **Resultados:** após as discussões acerca das fragilidades, houve a reorganização e redistribuição das microáreas através da ferramenta digital. Identificou-se por análise comparativa que o mapa anterior apresentava limitações como microáreas sem delimitação espacial, o que representava lacunas na cobertura assistencial e falha na atuação estratégica do serviço. Com a reorganização aumentou-se a área de abrangência com uma delimitação poligonal que permitiu subsídios para estratificação de vulnerabilidades, definição de prioridades e monitoramento de ações. **Conclusão:** a reorganização territorial qualificou a Atenção Primária à Saúde ao ampliar a cobertura, reduzir vazios e fortalecer vínculos. Além disso, evidenciou-se que a territorialização participativa favorece o acesso equitativo, a integralidade do cuidado e a consolidação da Unidade Básica de Saúde da Família como referência no território.

**Palavras-chave:** Territorialização da Atenção Primária; Vigilância em Saúde Pública; Saúde Pública.

### Resumen:

**Objetivo:** relatar la experiencia de los residentes de ciencias de la salud en el proceso participativo de cartografía digital y reorganización territorial de las microáreas de una Unidad Básica de Salud Familiar. **Método:** se trata de un relato de la experiencia vivida por residentes en Salud Pública, profesionales de una Unidad Básica de Salud Familiar y la coordinación de Atención Primaria de Salud. Las actividades se llevaron a cabo entre agosto y septiembre de 2025 e incluyeron reuniones y acuerdos colectivos. El proceso implicó el análisis de los mapas vigentes y el marcado de las áreas sin cubrir, seguido de la construcción digital de un nuevo mapa en MyMaps. **Resultados:** tras los debates sobre las deficiencias, se procedió a la reorganización y redistribución de las microáreas mediante la herramienta digital. Mediante un análisis comparativo se identificó que el mapa anterior presentaba limitaciones, como microáreas sin delimitación espacial, lo que representaba lagunas en la cobertura asistencial y una deficiencia en la actuación estratégica del servicio. Con la reorganización se amplió el área de cobertura mediante una delimitación poligonal que permitió obtener datos para la estratificación de vulnerabilidades, la definición de prioridades y el seguimiento de las acciones. **Conclusión:** la reorganización territorial mejoró la Atención Primaria de Salud al ampliar la cobertura, reducir las lagunas y fortalecer los vínculos. Además, se puso de manifiesto que la territorialización participativa favorece el acceso equitativo, la integralidad de la atención y la consolidación de la Unidad Básica de Salud de la Familia como referencia en el territorio.

**Palabras clave:** Fragilidad; Vigilancia en Salud Pública; Salud Pública.

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## INTRODUCTION

**P**rimarily Health Care (PHC) advocates for the organization of health services based on a territorial foundation and health responsibility, considering not only geographic location but also the social, economic, and environmental particularities that directly influence the health conditions of the population. Thus, the territory is configured as a fundamental determinant of the living conditions of the individuals who inhabit it, and its recognition is essential for comprehensive care, based on situational diagnosis and its specificities<sup>1</sup>.

In this sense, to understand the reality of the territory, territorialization is carried out, which constitutes a dynamic and strategic instrument for organizing health work, performed through the mapping of specific areas to identify risks to the community and families in vulnerable situations. This process involves the identification, delimitation, and organization of the territory, favoring equity in the provision of care and enabling the planning, implementation, and development of effective health actions and strategies adapted to the local reality<sup>2</sup>.

In addition to being a technical resource for territorial analysis, territorialization also represents a process of strengthening the bond between the community and health professionals, as it promotes interaction, recognition of local realities, and understanding of their direct influence on health conditions<sup>1</sup>.

This instrument also allows for the identification of priorities and the allocation of resources in a precise and objective manner. To this end, the use of technological tools is fundamental, as it increases the accuracy and reliability of the data, in addition to optimizing time and favoring real-time monitoring. Digital mapping and georeferencing systems offer a clear and dynamic visualization of the assigned areas and micro-areas of each Community Health Agent (CHA), contributing to the planning of health services by health professionals and the knowledge of the areas covered for users<sup>3</sup>.

Territorialization must be reviewed and updated continuously, since the territory is dynamic, alive, and subject to transformations resulting from social, economic, environmental, and demographic processes. Periodic updating of territorialization and territorial mapping not only ensures greater accuracy in identifying local demands, but also guarantees that health planning is responsive to new realities, maintaining the comprehensiveness, equity, and effectiveness of the care provided to the population<sup>4</sup>.

Due to the dynamism of the territory and its needs, it becomes crucial to carry out the territorial reorganization process of micro-areas periodically, since it constitutes a strategic

process to qualify PHC, as it makes it possible to expand care coverage, reduce health gaps, and strengthen the bond between the team and the community.

In this context, this study aims to report the experience of health professionals in a residency course in the participatory process of digital mapping and territorial reorganization of the micro-areas of a Health Family Unit (FHU).

## **METHODS**

This is a descriptive experience report, with a qualitative approach, developed by residents in Public Health in partnership with professionals from a Family Health Unit and with the coordination of PHC in a municipality in the interior of the state of Ceará, Brazil.

The activities were carried out between August and September 2025, through a participatory process that included planning meetings, workshops for building the territorial map, and collective agreement on the proposed changes. The participants in the process were the Public Health residents, the unit's preceptor nurse, the Community Health Agents (CHAs), the municipal coordination of PHC, and other service professionals.

Initially, the existing territorial maps were analyzed, identifying limitations and possibilities for reorganization. Printed base maps were used as a discussion tool, allowing the CHA and other participants to mark streets, uncovered areas, and points of social and environmental vulnerability.

Subsequently, the final version was built on the MyMaps digital platform, in which each micro-area was represented by a distinct color, facilitating the visualization and definition of the areas of operation of each CHA. This digital version also allowed for better geographical delimitation and agreement on boundaries with neighboring FHU teams, jointly defining the areas of responsibility for each Family Health Team (FHT).

The entire process was guided by criteria of geographical proximity, population density, and social vulnerability, in order to expand healthcare coverage and ensure greater equity in access to the service.

As this is an experience report, there was no need to submit it to the Research Ethics Committee, but the ethical precepts applicable to research and reports in the area of Public Health were observed, ensuring the integrity of the information and respect for the community involved.

## RESULTS

The previous map (Figure 1) prioritizes a linear representation by roads, which, although helpful in understanding the main circulation corridors and facilitating the organization of the CHA's movement in the field, does not clearly define the limits of each micro-area. This leads to overlapping territories, coverage gaps, and difficulties in the equitable allocation of families. Furthermore, its emphasis solely on the road network does not allow for the visualization of the socio-environmental and epidemiological conditions of the territory, restricting its use for the strategic management of PHC.

**Figure 1.** Previous map of the micro-area, developed from a participatory process with residents in Public Health, the FHU team, CHA, and the PHC coordination. Crato, Ceará, August and September 2025.



The new map (Figure 2), by using the polygonal delimitation of micro-areas, clearly identifies the territorial boundaries of each CHA, avoiding overlapping areas and ensuring greater accuracy in coverage. Furthermore, it facilitates the visualization of the territory as a whole, enabling more robust analyses of socio-environmental conditions, the distribution of health problems, and factors of vulnerability.



and families in situations of greater socioeconomic fragility. This involvement reinforced the value of their role as a link between the community and the health service.

The PHC coordination also played a strategic role in conducting the process, ensuring technical and institutional support so that the reorganization was agreed upon and effective. The coordination with managers and professionals on the team allowed for the construction of an updated base map, initially prepared on paper and consolidated in a digital version using the MyMaps tool, which facilitated the visualization of the territory and the equitable distribution of micro-areas.

One of the distinguishing features of the experience was the production of two versions of the final map: one for display in the unit, allowing users to visualize the coverage area of the FHU and better understand the territorial organization, and another aimed at internal use by the teams, in which the points of greatest social and environmental vulnerability can be highlighted. This strategy contributed both to transparency with the community and to more targeted planning of health actions.

The reorganization also enabled an important methodological change: while previously the micro-areas were delimited only by streets, now the CHA could take over closed areas, which brought greater rationality and proximity between the registered households and the FHU. This adaptation expanded coverage, ensured greater comprehensiveness in care, and reinforced the principles of equity by prioritizing populations in situations of greater risk and vulnerability.

Despite the advances, the process also highlighted challenges. The re-registration of families demands a great effort on the part of the CHA, who face difficulties in including new users in the system, especially in areas of urban expansion or recent occupations. Another recurring obstacle was the resistance of some families to accepting the change of CHA, since the bond built over the years proved to be a very important factor in adherence to care. This situation required the team to develop strategies of welcoming, listening, and negotiation, in order to minimize friction and preserve the users' trust in the service.

## **DISCUSSION**

There are difficulties and limitations, but also potential in the processes of territorialization in health. Territory should not be understood only as a physical space, but as a lived space, permeated by social and economic relations that directly impact how health services are provided<sup>5</sup>. From this perspective, the distribution of territory should take into

account not only material dimensions such as the FHU, equipment and human resources, but also immaterial ones, including power relations, living conditions and cultural practices.

A study also showed weaknesses resulting from territorialization with imprecise delimitations, with a negative impact on the health of the resident population. Among them: the lack of knowledge about adverse social conditions and barriers to access, which compromise the effectiveness of health actions in the territory<sup>6</sup>.

For planning, the new map provides subsidies for risk stratification and priority definition by allowing managers and health teams to recognize the specificities of each micro-area. It also contributes to the organization and monitoring of health surveillance actions, since events can be specialized within the polygonal boundaries, facilitating decision-making.

Another positive aspect is that the polygonal format strengthens the territorial management of PHC, by enabling the integration of different dimensions of care, such as socioeconomic, environmental, and epidemiological conditions. In this way, it becomes a strategic tool not only for the routine of the CHA, but also for intersectoral planning and the evaluation of public health policies.

The social aspects and daily life of the population are essential for health planning, as disregarding sociocultural variables and local dynamics can generate weaknesses and limit the effectiveness of actions<sup>5</sup>. In this context, understanding the history, culture, and potential of the territory allows the health team to get closer to the reality of the community, going beyond the geographical and political space and favoring more effective and sustainable interventions<sup>7</sup>.

The health unit should be considered as a basis in light of the guidelines and orientations of the Ministry of Health itself, which, in 2006, through the Secretariat of Health Care and the Department of Primary Care, published the "Manual of Physical Structure of Basic Health Units: Family Health", in which it provides guidance on the physical structure of the FHU, including aspects related to location<sup>8</sup>.

It highlights the importance of the FHU being located in a way that facilitates access for the population, considering aspects such as proximity to residential areas and integration with the surrounding community. In addition, it also emphasizes the need for adequate planning to ensure that the location of the unit meets the health needs of the assigned population, ensuring that the unit is accessible to all users<sup>8</sup>.

The importance of the knowledge of the CHAs about the territory and community dynamics allows not only the spatial delimitation of micro-areas, but also the identification of families in situations of greater vulnerability and areas with difficult access. The involvement

of CHAs in the construction of processes reinforces their strategic role as intermediaries between the community and health services<sup>9</sup>.

The articulation between managers, health professionals and CHAs was also addressed in a recent study<sup>10</sup>. It was observed that this integration makes it possible to build updated base maps, which can later be digitized to facilitate visualization and equitable management of micro-areas. This alignment between local knowledge and technological tools indicates that the integration between the knowledge of CHAs and institutional planning generates greater precision in the identification of areas of risk and vulnerability, as in the case of the present study, strengthening the capacity of PHC to respond to the needs of the population and improving the process of organizing care.

Experiences reported in different Brazilian regions demonstrate that the adoption of digital maps and geospatial tools contributes to the identification of higher-risk areas and to the qualification of health team planning<sup>7,11-12</sup>. Thus, in this territorialization process, the use of technologies, such as georeferencing, Geographic Information Systems (GIS), and digital platforms, has proven fundamental to increasing the accuracy of family registration and visualizing local vulnerabilities.

Among the most prominent advantages of using these technologies are the possibility of spatial risk stratification, dynamic monitoring of health indicators, and the identification of gaps in PHC population coverage. Studies show that geoprocessing provides support for the more efficient allocation of resources and for strengthening health surveillance strategies, especially in vulnerable territories<sup>12-13</sup>.

Experience reports also show that easily accessible tools, such as Google Maps, have been incorporated into the territorialization process, contributing to virtual mapping and the continuing education of teams<sup>4,14</sup>. These strategies are configured as low-cost solutions that expand the analytical capacity of services and support the daily work of the CHA. At the same time, soft technologies, associated with communication practices and participatory mapping, complement the use of hard technologies, reaffirming territorialization as a collective and dynamic process<sup>15</sup>.

This expansion of FHU coverage can have positive impacts on the inclusion of families in the health care network. In a study carried out in several states of Brazil, an inverse relationship was identified between Hospitalization rates for Ambulatory Care-Sensitive Conditions (ACSC) and the increase in coverage of the Family Health Strategy (FHS), pointing to the improvement in the effectiveness of health actions and the reduction of inequalities in access to services<sup>16</sup>.

By understanding the problems and potentialities of the territory and representing them spatially, health professionals have tools that make it possible to organize the work process and act more efficiently in the face of the population's needs. In this sense, effective territorialization and geoprocessing products constitute an essential basis for planning actions and policies in health<sup>17</sup>.

The experience also demonstrated the relevance of technological mapping tools as instruments of territorial management, allowing for greater precision in delimitation and greater flexibility for future updates. In addition, the importance of aligning the organization of the territory with the guidelines of PHC was observed, favoring access to the service, continuity of care, and strengthening the bonds between the team and the community.

The redistribution of micro-areas enabled a fairer balance between the workload of the CHAs and the number of families served, reduced overlaps and gaps in care, and expanded the potential of the FHU to respond to the needs of the population. Territorialization, when conducted in a participatory manner and supported by technological tools, constitutes a pillar for care management, consolidating PHC as the preferred entry point to the Brazilian Unified Health System (*Sistema Único de Saúde - SUS*).

## CONCLUSION

The territorial reorganization of micro-areas proved essential to improve PHC, expanding care coverage, reducing gaps, and strengthening the bond between the team and the community. Based on the geographical proximity between the PHC unit and households, the redistribution favored user access and highlighted the importance of recognizing population specificities in the organization of PHC.

The active participation of the CHAs and the support of the coordination were fundamental to the legitimacy of the process, while the use of digital tools, such as MyMaps, proved to be a strategic resource to support territorial planning and local health management.

Despite challenges, such as the re-registration of families and the resistance of some users to the change of community health agent, the experience showed that territorialization, when carried out in a participatory and continuous manner, contributes to equitable access, comprehensive care, and the consolidation of the primary health care unit as a central reference in the territory.

Limitations of the study include those inherent to the methodological design adopted, since it is a descriptive account of an experience, which restricts the generalization of the findings to other contexts and realities. Furthermore, the territorial reorganization process was

predominantly based on the perception and technical knowledge of the professionals involved, especially residents, community health agents, service professionals, and managers, not including the direct participation of the user population in the planning and execution of the actions. In turn, it highlights the importance of territorialization as a mode of care coordination.

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