Abstract

**Background:** To report the experiences during the practical experiences in the territory assigned to a basic health unit provided by the module of Integral Health Care I.

**Methods:** Case studies resulting from a process of critical reflections about practical experiences by medical students in a basic health unit from August to December 2015.

**Results:** Through the module of Integral Health Care I, students were allowed to recognize the assigned area of a family health team, as well as to develop the territorialization process and to classify the demographic, epidemiological, socioeconomic and environmental profile in that place; in addition to perform other activities as a singular therapeutic project and intervention project.

**Conclusion:** The activities developed motivated the students to be able to apply the concepts of family and community medicine in primary health care, in addition to bringing them closer to the reality of this work process.

**Keywords**

Integral Health Care; Family Health Strategy; Physician-Patient Relationship; Basic Health Unit.

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Introduction

Primary Health Care (PHC) governed by the principles of the Brazilian Unified Health System (SUS) give emphasis to the autonomy of individuals in the individual and collective spheres through integral care and the work of family health teams (FHT), which shows the way of the care model. [1] These teams, made up of at least one physician, one nurse, one nursing technician and Community Health Agents (CHA), are organized to ensure the efficacy of their objectives by working in an interdisciplinary way in a territory attached. They are responsible for the continuity in health care actions and are capable to produce favorable results for the assisted populations. [2]

With that, meet given territory and the individuals in it allows the establishment of reliable demands attached to the real situations of health and illness and to give answers to the analyzed needs. [2] In this sense, in the current conjuncture of the health-disease process, territorialization, considered to be the a feature of the Family Health Strategy (FHS), proves to be a useful tool for identifying vulnerable individuals and families. [3] It acts according to the guidelines recommended by the PHC, on the topic of risk monitoring, in the expectation of ensuring the effectiveness of actions to promote and protect health, to minimize the incidence of diseases and to avoid exposure of the population. [2]

The meaning of territorialization transcends the delimitation of the geographical space, since it allows the interpretation of the conditions and situations of life and health of the assigned population as a methodological tool within the service network offered by the State in a universal way, as established by the Constitution of the Federative Republic of Brazil in 1988. [4-5]

In consequence, the precepts of the geographic mapping process are based on the recognition of barriers and accessibility within an area of coverage and has as its role to perform epidemiological, socio-environmental and demographic profile of that location. [3] It should be noted that the health agents are of extremely importance in this complex work, given that their knowledge often crosses the specificity of their main field of activity. They are proactive concerning their interaction with the community and contribute to collective well-being through reception and health surveillance; and integrate the territory and its needs with the available resources in the respective basic health unit (BHU).

So, this is how territorialization is inserted in the FHS work process. It has a significant applicability in the field of health, as it promotes the inclusion of the individual in the social environment through the design of projects that promote the development of a locality, articulating the inherent instruments to geography to public policies. Although the health care model proposed by the FHT has not yet been fully met, this process promotes the principles of universality, equity and completeness of the bond and humanization to remain in force and respect the singularity of the individual. [2]

Thus, a family and community doctor has a prominent role when he comes to this issue, because when considering the current scenario of the health system, he must diligently meet the challenges to ensure the essential attributes of PHC that relate to the use of the service as a source of care in situations of first contact or return. It is important to ensure continued attention to offer users services ranging from the biopsychosocial character of the health-disease process to actions of health promotion, prevention, cure and rehabilitation of diseases through the context of PHC. [6]

Moreover, the bond that he is able to develop ensures greater certainty in solving problems, since, generally, this doctor is present for many years and knows the family, the inhabitants of the territory, the present diseases, and the lifestyle of the individuals and the epidemiological characteristics of the area.

It is worth mentioning that they are still important actors in the territorialization process, because
recognizing the area to which it is subjected gives them greater property and safety to carry out interventions and allows them a recognition and identification of the particularities of the people who live there. [6]

These perceptions, at the time of medical graduation, reply to various emblems and conclude needs that cross disciplinary barriers. In addition, the medical student learns from the beginning about the curriculum guidelines of medical graduation to understand the medical competencies that involve approaches of the health-disease process of the individual and of the population in its multiple aspects of determination, intercession, promotion of integrity and humanization of care through continuous medical practice and integrated with diverse instances of health and bonding, always considering the context of the patient’s life. [7]

It is perceived that integral health care is present in all areas of medicine, since it aims at the holistic observance of the human being and contributes to its greater access in the health system, being based on the follow-up and implementation of the precepts of the SUS.

Thus, the themes discussed above are part of the content of the Comprehensive Health Care modules of a Brazilian university, whose purpose is to prepare medical students to be capable to carry out changes in the quality of life of the population and contribute with the improvement, when it is possible, of health indicators in the territory.

In this context, this study aims to report the experiences during practices in the territory assigned to a BHU, provided by the module of Integral Health Care I.

Methods
It is a descriptive study of case studies type, the result of a process of critical reflections on practical experiences in a BHU in the period between August and December 2015. It is understood that an account of experience is more than one simple description; it is actually a record of a number of relevant situations experienced. This increases the possibility of additional discussions in the area that can examine the ideals presented and contribute to the construction of self-knowledge.

There was carried out through the discoveries about the theme that was initiated through the module of Integral Attention to Health I (AIH I), offered to the first series of the undergraduate medical course of a Private Higher Education Institution (IES), located in the municipality of Natal, Rio Grande do Norte, in accordance with the National Curricular Guidelines for Graduation in Medicine [7].

The AIH I module enables the medical student to act in the promotion of primary care for individual and collective health and is focused on teaching about the principles and fundamentals of Brazilian SUS, with emphasis on family and community assessment, as well as knowledge about the Therapeutic Singular Project (PTS) and Intervention Project (PI). Also included in the agenda is the explanation about the Health Care Networks (RAS) and the organization of services, concepts on epidemiology, social and cultural determinants of the health-disease process, health surveillance, concepts and principles of family approach, as well as the process of territorialization.

In the referred IES, the module has a workload of 240 hours divided into theoretical and practical-theoretical classes in the university, as well as practical experiences in BHU of the territory agreed. It makes the student able to apply SUS guidelines in the teamwork process so that he can intervene in an interdisciplinary way in the problems of the community, making it possible to develop proactivity in the process of changes in the health problems of the student’s community; to identify vulnerabilities and situations of risk; to recognize health indicators and to excel in good relationships and mutual respect with patients, colleagues, teachers and employees.
Results and Discussion

The AIH I module, in part of its practical workload, places students in a BHU so that, from an early age, they can begin to deal with the reality of the Brazilian public health system and prepare to work in that environment. Students follow a schedule in which each week they come into contact with different types of situations sensitive to PHC. In addition, going to the unit, along with the process of territorialization, serve as guiding axes for the medical student to realize if the population of the region is truly being accordingly fully and resolutely fulfilled, as recommended by the country’s public health policies.

As part of the process, it is of utmost importance to explore each topic and focus on what is regarded as a positive impact factor for medical training. The following will be described experiences of practical experiences more meaningful to the teaching-learning process while graduate student in medicine.

The beginning of everything: characterization of the basic health unit, the territory and the work process

To receive the mission to characterize the BHU located in a municipality of the metropolitan region of Natal, state of Rio Grande do Norte, Brazil, was a significant experience, since the theoretical classes provided a more critical view of what a BHU was about and how Presented the functions. Remembering the principles and guidelines of SUS was necessary to observe how this application was given in the context of individual and collective care.

Consequently, because the unit is located in a very populous neighborhood, of about thirty thousand people, and there is a notable proportion of elderly people and a low family income among those who live there, it is doubtless difficult to faithfully contemplate the problems of this population, which requires differentiated attention.

The unit has a good physical structure, with ramp at the entrance that guarantees full accessibility to those who move by means of wheelchairs. It has a pharmacy that distributes medicines for the treatment of hypertension, for example, since it is a problem that most people in the neighborhood have.

In addition, the existence of a bathroom for employees, a pantry, two doctors’ office and a dental, a vaccination room, one for blood collection, a dressing and a medical records make up the scenario and collaborate with the proper functioning and systematization of the attendances made on that place. It was also checked a schedule at the reception, considered a positive factor, since patients are informed about the activities that take place throughout the week.

In the BHU a reproductive planning orientation to avoid the occurrence of unwanted pregnancies is carried out, as well as to prevent the spread of sexually transmitted infections. Follow-up actions are carried out to monitor the child’s growth and development, in which there is notably a special attention focused on the health of people with a lower age range, from the first days of life, through a careful educational accompaniment, concomitantly guiding parents about the breastfeeding, feeding, hygiene, vaccination and comprehensive care.

It is highlighted as fragile aspects of BHU a greater demand of people seeking attention than the installed capacity for the supply, which prevents them from receiving an immediate service, which makes a risk assessment as an essential tool. [2]

There is no room for the patient to receive an initial care, what configures a lack of structural planning.

Regarding the families’ medical records, they are organized in drawers divided by each CHA of the FHS. It would be essential to have computerization of these documents to make their use more accessible. The vaccination room totally moldy is one of the weaknesses, since the children treated there may end up developing some respiratory problem.
The second stage of the experience was to explore part of the neighborhood, a process that composes the territorialization. For it, the best way to succeed was to follow a health agent, who provided an explanation of the general characteristics of the neighborhood. He was responsible for 160 families, or approximately 600 people. There are about eight houses that he visits per day and he has been working in the neighborhood for ten years. He said that in his micro area there were many diabetics, hypertensive and many people had problems related to intense pain in the belly due to water improperly treated.

It was observed that there were many vacant lots in the vicinity, as well as open sewers, rubbish and garbage dumps. It is known that excess trash is attractive to ruderal animals such as cockroaches, rats, flies and mosquitoes, which proliferate in dirty and abandoned environments and can transmit diseases such as dengue, cholera, dysentery and leishmaniasis.

Many building materials and metallurgical trades, as well as churches and day care centers integrate the neighborhood panorama and are classified as social facilities. When visiting some households, she showed the files that follow the actions and results of the activities carried out by the FHS. Through these records, information about family registration, housing and sanitation conditions, health situation, literacy, occupation, age, among others are collected with the purpose of recognizing the reality and the family profile.

This process referred to the need for family risk stratification as an instrument for the prioritization of home visits. As there was already a basis about this subject, it was possible to recall the concepts of the Rabbit Family Risk Scale, which divides the families visited in strata of risk. On this scale, social, clinical, and environmental factors are taken into account. Through it, one can analyze the specificities of each family, which makes possible an analogy between them and the planning of intervention in each community, to direct and optimize the services of the FHS teams to the most vulnerable groups. [8]

In making intertextuality with the Brazilian SUS, it is understood that the territorialization makes it possible to define the favored population, the delimitation of a territory of comprehensiveness and the survey of data of this place, effecting the full knowledge and control over the area.

It was possible with this whole process to realize how important it is to revere the people and caution with words, not to take full ownership of the lives of families so as not to cause embarrassment or invasion of privacy. The link must be built over time, because the first visit is observation rather than intervention. Above all, it is necessary to know how to respect cultural and moral differences and to clearly inform the reason for the visit.

Medical-patient relationship in practice

Humanization in medical practice is of major importance, because the doctor should always seek to focus more on the individual and less on the disease. The doctor-patient relationship involves such factors such as trust, respect, responsibility, and time. This relationship should not be limited to the objectivity of hard technologies, since anamnesis is necessary, especially in the initial approach and needs to overcome, through professional empathy, negative situations that patients have experienced and, for some reason, of credibility to doctors. [9]

The doctor should be able to face the circumstances of adversity and provide the patient with physical and mental well-being. Also, creating a pleasant environment for the reception of a patient is a function of the doctor, which will ensure an efficient anamnesis, bringing solace to the impasse faced.

Through the opportunity to have this knowledge acquired in the theoretical classes of the subject, the practical experience provided the experience of witnessing if doctors really care about cultivating
this relationship, considering the favorable points that can result from it.

As a result, it was within the BHU, that there was a greater contact with the general practitioner, through the follow-up of consultations during a whole morning, which took place in a very optimistic way, since it was perceived that, in an insightful way, it allied its technical bases to the care of the attached individuals and incorporated the invaluable concepts of the doctor-patient relationship.

The professional used a lot of education and gentleness to explain the conducts in a simple and accessible way, listening to them and doing the summary. Additionally, he was aware of their financial situation and did not prescribe expensive or over-priced medicines. A key factor that drew attention was the safety in prescribing and writing the recipes, as well as the interest of their part in carefully observing each complaint brought, which classified the services as effective and caused in the patients a trustworthiness and empathy with the professional.

It is worth mentioning that in cases of urgency and emergency, the doctor referred the patient to a specialist, rather than trying to make possible causes and consequences of diseases outside his area of performance. Usually this would be for the Emergency Unit (UPA), located in the same municipality.

This experience, in addition to having been the opportunity to consolidate knowledge, has further developed the desire to be at the front position of certain obstacles of the health system with simple actions such as those reported. The theoretical load of acquired knowledge was essential to evaluate if in practice the conducts are carried out in the same way that they are wished. Daily care cannot be treated lazily because it is routine, since each person has a history and requires total resilience when it comes to action.

Programming actions in the basic health unit: pre-natal accompanying

Still in the BHU, because of the reproductive planning is carried out, as a result, prenatal care is also performed, which should be started as soon as the pregnancy is confirmed. Throughout the gestation there are performed laboratory tests that aim to identify and treat changes and diseases that can bring harm to the health of the mother or the child. This is of extreme value, as a woman's health has an intrinsic relationship with that of her child. [10]

In the follow-up of prenatal care by the nurse it was noticed that he provided the women with guidelines about healthy eating, physical exercise and the importance of avoiding alcohol, smoking and other drugs. He also carried out the monitoring of patient weight, blood pressure measurement and some questions about: contraceptive use, the beginning of sexual intercourse, how the vitamin intake was, its pathological history and when the last preventive was performed, besides performing the maneuvers of Leopold and to make auscultation of the fetal heartbeats with the use of sonar.

Highlights, in this sense, the Stork Network, instrument that guarantees women the right to plan reproductively and guarantee the child a safe birth with growth and development and has assisted some services related to PHC, one of the entrance doors of individuals in the health care system. [11] The networks have been used to administer a number of policies, whose resources are often insufficient or non-existent problems of greater complexity and integrate the services and demands for benefits and by increasing citizen participation. [12]

Construction of a unique therapeutic project as a tool for integral attention to health

Subsequently, in order to participate even more in the proposals advocated by PHC, there was an initiative to develop a Unique Therapeutic Project (PTS), a tool that directs the primary care teams in the definition of their actions and guarantees actions in ac-
cordance with the context of each person or family. It is divided into four stages: diagnosis, goal setting, division of responsibilities and reassessment. It arises from the tie created with the individual or family. It is emphasized that psychic vulnerabilities are also part of the construction of PTS. [13]

This project was aimed at a family that was classified as vulnerable, with risk two in the Rabbit Scale. A 69-year-old woman stands out as a patient index. Initially important information was collected about her and her family for a deeper understanding of her health problems. She reported taking medications to control hypertension, which she acquired at the popular drugstore, was a former alcoholic, ex-smoker, and sedentary.

The abovementioned patient stated that two years ago she had begun to have difficulty walking due to pains associated with weakness in her lower limbs. From then on her activities began to be limited, she progressed with gradual loss of her functionality and she needed help to walk. A genogram was developed to understand the dynamics of the family structure, to explore the most prevalent diseases and the types of relationships existing among the members in order to reflect on her main problems. Another tool designed was the ecomap, which, unlike the genogram, does not work for generations, but is capable of providing an insight into the relationships that exist between the family core and the environment, the social facilities that the family enjoys, the types of recreational activities that this core has and the intensity of these ties.

The objectives and strategies defined for the index patient were to promote the reduction of her blood pressure and the obesity level and to identify needs that could be met through education about medication and feeding and orientation of change in her lifestyle.

It is understood that PTS is a way of comprehending the integral attention and humanization of SUS users through interdisciplinary teamwork as a fundamental focus for its achievement. [13] These perspectives are based on routine practices developed in the BHU, since there are many users with different demands, which allows constant exchange of knowledge of the population with health professionals and seeks to ensure greater autonomy of the patient.

The intervention project as a tool for academic integration with the community

The experiences also enabled the planning and development of an intervention project in the neighborhood. The visit to a municipal school and the conversation with the pedagogical coordinator revealed the existence of the children's need to learn about certain subjects. So topics such as body care, instructions about sexually transmitted infections and nutrition guidelines were cited and considered of extreme relevance to be approached.

Recognizing the structure of the school, it was perceived that it was well organized and comfortable, because it had room for collective activities, spaces directed to reading with good conditions and air conditioned, dining room where children lined up by class to receive meals and secretariat in good condition. After getting to recognize the whole school, it was decided to hold a schoolchild directed at the parents of students from six to nine years old, to guide them on how to improve their children's diet in order to promote healthy eating habits.

After planning, the implementation day arrived. During approximately ninety minutes of explanations and dynamics, relevant considerations were stressed such as the possibility of the child evolving with great nutritional deficiency when poorly fed in childhood, which is more likely to develop some diseases. Slides with topics, images and videos were used to approach children's development. There was also an alert about the high amount of sodium and sugar present in common foods that are consumed by them.
Later, a dynamic was performed to evaluate the perception of parents and children present in the room about foods that should be consumed constantly, in moderation and those that should be avoided. The result was very positive, since there was participation and interaction of all present with frequent questions to clarify doubts.

The activities were closed with a debate about the importance of parents in the eating habits of their children, because children are a reflection of what they perceive in their parents; as a result, the example in these cases is always vital.

This plan of action, built with the purpose of guiding parents has certainly allowed the medical student to develop in order to improve empathy for others, allowing them to consider the needs of a community through the context in which it is inserted. For this specific moment of the project, the legacy left by the activity was made present in that school, through the informative posters spread in the corridors, accessible to those who pass through it.

The insertion of primary health care in the psychosocial care network for integral care

One of the activities performed made it possible to recall the networks of health care through the Psychosocial Attention Network (RAPS). This network was established by Administrative Rule 3088 of December 23rd, 2011; and aims to improve care for people with any type of mental disorder, including those who use psychoactive substances. [14]

The networks seek the autonomy of the individual with the purpose of working through a consensus; contribute to the improvement of SUS, since there is still much difficulty in qualifying care management in the modern context. Since PHC services are also part of this network, a visit was made to the Psychosocial Care Center for Alcohol and Drug users (CAPS-AD).

There was a clear concern among those who work there to try to provide a quality of life for those who, for some reason, have become addicted to licit and / or illicit drugs. Actions are developed aimed at the individual feeling important before the society, without discrimination or any type of prejudice.

The patients go to this service by free and spontaneous desire and always seek to adhere to the proposed activities carried out in the space made available for that purpose. The site director provided valuable information about this rehabilitation center. The proposals offered are aimed at the care, the integral and continuous attention to people with needs due to the use of alcohol, crack and other drugs. The work accomplished aims to reinsert the individual in the social environment and allows him to return to his work, his leisure activities and a good relationship with the family, which is often unstructured.

The service that provides this support to the population is located in a strategic space in the center of the municipality to facilitate access to users and the community. Regarding routine, three meals a day are performed and as leisure activities they watch television, read books, listen to music, participate in educational lectures and have the presence of a physical educator designed for the physical activities they practice once a week. Two therapeutic workshops per day of cognitive stimulation and popular education in health are developed, as well as conversation circles and moments related to spirituality.

It has therefore been a rewarding experience to be able to understand that there are so many people who are convinced that they need specialized assistance and are looking for CAPS AD. Although with all the difficulties, due to the lack of reform many years ago, because of the insufficient investments, the professionals of the visited service worked daily to provide the enrollees with an integral and differentiated attention, with the right to carry out a normal routine, free of addictions.
Discussion and general reflections about the experiences in the basic health unit and the territory

These understandings were extremely important, since they only ratified the need to make a health diagnosis and understand the work process in PHC, which has as one of its aims directed to the health and illness needs of individuals and communities. These aim at a significant improvement in the quality of general care and can satisfy the community involved, and thus direct health actions to the evidenced difficulties.

This model contrasts with the exclusively curative purposes that are based on the spontaneous solicitation of people when they are already sick. This pattern of conduct does not have a level of commitment to the health needs of a population and the community is little known either in terms of actual existence or in terms of health indicators. Additionally, there is no bond between users and professionals, there is no work on environmental problems, nor are there any goals to be achieved. Unfortunately, this is a model of distorted attention that society believes offers satisfactory answers, since it is health that should be prioritized rather than disease. [15] Patients need to have continuity in treatments and health promotion and disease prevention must be prioritized, to the detriment of only the cure of diseases.

In most cases, because of cultural issues, Brazilian citizens usually seek services only in cases of emergency or only when they have some suspicious symptoms, which results in a chronic inefficiency of the system, in low levels of humanization of services and in a poor doctor-patient relationship. The FHS is based on a direct relationship with the patient through the home visit and the Community Health Agents Program (PCHA). [3]

It also organizes the provision of services and establishes a demand / need consistent with reality. Also, the FHS allows action on known environmental risks of the team and the community and establish lasting links between professionals and users.

From the above information, the AIH I module not only provided the possibility of recognizing the attributes that cover the APS, but also allowed to discern how the territorialization relates to the services offerings, which fit a specific part of the territory. FHS work with the organization of available resources and seek to solve complex issues that involve the multiple senses of the demarcation of areas of range.

The word witnessed many times, by sharing these experiences with process connoisseurs, made it possible to construct a vision about the importance of prioritizing the users that enter the BHU, in addition to developing permanent bonds with the attached communities. These bonds are formed through home visits and the follow-up of individuals and groups on health-related issues so that control of the territory can always be kept and the population can be distanced from risk factors. Besides, direct contact with people has led to the development of a more critical and reflective look at this issue in its overall context, making the service of service more meaningful.

The home visits showed the need to recognize how to conduct a conversation well and to direct carefully the words to be used. Success in the proposed aims was often perceived through the creation of empathy, which brings security and reliability to individuals. It was observed that exercising silence when needed and providing a differentiated attention are fundamental resources for the well-being of the population. Although people belong to the same family, each individual has his accuracies and needs, so it is necessary to act in accordance with these intrinsic characteristics and always respect his cultural, moral and ideological values.

The importance of PHC is precisely because it can act in the promotion of health, in the prevention of illnesses and in the care of patients, and enables
the patient to be seen as a human being in its entirety. [2] The practice of these actions is a positive way, since all the descriptions aim to take care of the patient so that he can be free of diseases and complications.

It was also gratifying to develop the PTS and the intervention project, since, bit by bit, the people to whom these actions were directed, showed to understand the purpose of these for their lives.

Finally, an essential benefit that this experience report brought was contributing to the academic growth and the acquisition of knowledge for professional practice in family and community medicine. These points are essential in order to recognize how the public health issue in the country is based and how the PHC is articulated, being the first source of care with the person and the territorialization of the process that is in permanent construction and acts fulfilling the Guideline to prioritize actions to promote health and prevent diseases and aggravations.

Conclusions

It is clear that there are still many challenges in PHC. A key factor considered as an obstacle is the culture, responsibility and education of each person towards his health, because in Brazil the model of curativist medicine is very ingrained and makes part of society seek help from professionals in extreme cases.

Even before these impasses, PHC has a real commitment to the health of individuals and territorialization; an activity belonging to the FHS work process that helps to cooperate with the understanding of the health situation of the community and to constantly propose interventionist ideas for the Obstacles.

When one comes to know the territorialization in health in its largest concepts, it is possible to understand that it gives the services of the SUS and its theoretical propositions are positive, because if it is a relation of power and means, consequently, that its magnitude is democratic.

In these case studies, the exploration of some aspects showed from the perspective of the authors how basic units were characterized and the resources that they were made available to the population. The socio-environmental profile reveres the housing conditions of the territory, including housing, basic sanitation, water supply, among others. The areas of social vulnerability, of community equipment for the efficacy of citizenship, institutions that serve as social support and physical exercise and leisure activities also comprised the process of territorialization.

It was an invaluable learning to be able to act more in the routine of medical practice and to untie some erroneous paradigms about the model of health care in force. SUS was shown as a system of several challenges to overcome the articulation of the services offered, but with several proposals already completed.

The AIH I module motivated the student to be able to apply the concepts of family and community medicine and the attributes of PHC in teamwork, in addition to applying the concepts of epidemiology as a tool to support diagnosis and therapy. The student was able to develop a critical evaluation about the concepts of SUS, besides being able to act proactively in the process of future changes as a physician based on ethical principles and relationships with patients and other professionals.

Finally, AIH I guided the students in the adequate fulfillment of medical forms and in incorporating biosafety measures into clinical practice. In academic formation, these learning nowadays will serve as a basis for preparing a professional who can really make a difference in the professional practice of a more humanized family and community medicine.
References


