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Visibility, stigmatization and territorialization: perceptions about vulnerability in Primary Health Care

Visibilidade, estigmatização e territorialização: percepções acerca da vulnerabilidade na Atenção Básica à Saúde

Visibilidad, estigmatización y territorialización: percepciones sobre la vulnerabilidad en la Atención Primaria de Salud

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Abstract

The aim of this study is to analyze perceptions of workers of Primary Health about the vulnerability. We focused on workers who work in the north of the city of São Paulo, more specifically in the region of Freguesia do Ó / Brasilândia location that are assigned high vulnerability indices, trying to understand how they recognize people and vulnerable situations and the way they perceive its health promotion and vulnerability reduction strategies. The notion of vulnerability has been adopted in Brazil by the Ministry of Health as one of the fundamental objects of intervention of the National Health Promotion Policy (PNPS) (2006), producing profound changes in the way of identify, intervene and prioritize the population, and causing various effects on the practices of workers and users of public health services in the country. We interviewed 14 professionals from the primary care Coordination of the Municipal Health Department and the Health Supervision Technical of the Freguesia do Ó / Brasilândia, in the north of São Paulo. In this study, we highlight three categories addressed by the professionals interviewed: the visibility of population, the dangers of the stigmatization and the relationship with the territorialization. We conclude that the notion of vulnerability arises as a potential instrument for the transformation of health practices,

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if exercised the active participation of the population in the analysis and the weighting of problems and health needs, permanently questioning the stigmatizing effects and colonizers of these same practices.

Keywords: *Public Health; Primary Health Care; Vulnerability; Health Promotion; Unified Health System.*

Resumo

A noção de Vulnerabilidade vem sendo adotada no Brasil pelo Ministério da Saúde como um dos objetos de intervenção fundamentais da Política Nacional de Promoção da Saúde (PNPS) (2006), produzindo mudanças profundas no modo de definir, identificar, intervir e priorizar a população a ser atendida, e provocando efeitos diversos nas práticas dos trabalhadores e dos usuários de serviços de Saúde Pública no país. O objetivo deste estudo é analisar percepções de trabalhadores da Atenção Básica à Saúde acerca da vulnerabilidade. Enfocamos trabalhadores que atuam na zona norte da cidade de São Paulo, mais especificamente na região da Freguesia do Ó / Brasilândia, local ao qual são atribuídos altos índices de vulnerabilidade, buscando compreender o modo como reconhecem pessoas e situações de vulnerabilidade e o modo como percebem suas estratégias de promoção da saúde e redução de vulnerabilidades. Foram entrevistados 14 profissionais pertencentes à Coordenação de Atenção Básica da Secretaria Municipal de Saúde de São Paulo, e à Supervisão Técnica de Saúde da Freguesia do Ó / Brasilândia, na Zona Norte de São Paulo. Neste estudo, destacamos três dimensões da noção abordadas pelos profissionais entrevistados: a visibilidade da população, os perigos da estigmatização e a relação com a territorialização. Conclui-se que a noção de vulnerabilidade coloca-se como potencial instrumento para a transformação das práticas de saúde se exercitar a participação ativa da população na análise e no equacionamento de problemas e necessidades de saúde, interrogando permanentemente os efeitos estigmatizantes e colonizadores destas mesmas práticas.

Palavras-chave: *Saúde Pública; Atenção Básica à Saúde; Vulnerabilidade; Promoção da Saúde; Sistema Único de Saúde.*

Resumen

La nocion de Vulnerabilidad ha sido adoptada en Brasil por el Ministerio de la Salud como uno de los objetos fundamentales de intervención de la Politica Nacional de Promoción de la Salud (PNSP) (2016), lo que produjo cambios profundos en la manera de definir, identificar y priorizar la población a ser atendida, y también creando diversos efectos en las practicas de los trabajadores y de los usuarios de los servicios de Salud Publica en el país. El objetivo de este estudio es analizar las percepciones de los trabajadores de la Atención Primaria de Salud acerca de la vulnerabilidad. Nos centramos en los trabajadores que actuan en la zona norte de la ciudad de San Pablo, específicamente en la región de la Freguesia do Ó / Brasilância, donde se asignan índices de alta vulnerabilidad, tratando de entender como los trabajadores reconocen a las personas y situaciones vulnerables y la forma en que perciben sus estrategias de promoción de la salud y reducción de la vulnerabilidad. Entrevistamos a 14 profesionales de la Coordinación de Atención Primaria de la Secretaria Municipal de la Salud de São Paulo, y la Supervisión Técnica de Salud de la Freguesia do Ó / Brailandia, en la Zona Norte de São Paulo. En este estudio, se destacan tres dimensiones de la noción abordada por los profesionales entrevistados: la visibilidad de la población, los peligros de la estigmatización y la relación con la territorialización. Hemos concluido que la noción de vulnerabilidad surge como un instrumento potencial para la transformación de las prácticas de salud, si se ejerce la participación activa de la población en el análisis y la ponderación de los problemas y necesidades de salud, cuestionando permanentemente los efectos estigmatizadores y colonizadores de estas mismas prácticas.

Palabras clave: *Salud Publica; Atención Primaria de Salud; Vulnerabilidad; Promoción de la Salud; Sistema Único de Salud*

Introduction

The notion of vulnerability has been adopted in Brazil by the Ministry of Health as one of the objects of fundamental intervention in the agenda of the Brazilian National Policy for Health Promotion (PNPS) (2006), thus producing significant changes in the way we define, identify, intervene and prioritize the population to be served, and causing distinct effects in the practices of health care professionals and users of Public Health Services in the country.

According to Ayres, Paiva and Buchalla[1], the notion of vulnerability in the 20th century was disseminated worldwide from the book "AIDS in the World"[2], which was published in 1992 as a compilation and produced by Jonathan Mann, Daniel Tarantola and Thomas Netter in the United States. This book was produced by the Global Policy Dialogue on HIV/AIDS, which was characterized as an initial format of the United Nations Programme on HIV/AIDS (UNAIDS), with the support of the Association François-Xavier Bagnoud and the Harvard School of Public Health[1]. According to Ayres, Paiva and Buchalla[1], it was the first time that an analysis of the world situation of the AIDS epidemic in terms of vulnerability was presented. It would start from the behavioral aspect and from the epidemiological risks presented to then identify social factors and access to services that could increase or decrease the individual capacity of perception and action on the risk of exposure. The concept of vulnerability sought to understand the social, ethical and political implications of the risk behavior[3]. Thus, there was an analysis of the degree of exposure and protection of populations from different countries of the world, in such a way that a ranking was developed to classify the vulnerability as low, medium and high, from a scale based on health and sociodemographic indicators, as well as on assessments of AIDS control programs[1].

There is a displacement of the intervention focus in health policies in Brazil in the 21th century, which started to prioritize less the disease over the individuals' ability to manage and ensure their own health and well-being[4,5]. The Ministry of Health (MOH) establishes as its goal the co-responsibility and empowerment of individuals in the population for the management of their own health[6], defining Health Promotion as "community qualification process to act on improving their quality of life and health, including greater participation in the control of this process"[6]. During this period, the vulnerability is accepted as a concept that defines one of the intervention objects of the National Policy of Health Promotion[7], in 2006, adding to the concept the size of the social, political, and geographical implications of risk behaviors, and highlighting, among other aspects, the duty of citizens to manage their health while avoiding risks and reducing their vulnerability.

However, while the PNPS highlights the importance of the individual and collective co-responsibility and autonomy, strengthening the relevance of social participation[5], it's also defined as a strategy for the regulation and control of the population, through the relationship between individual and collective actions, providing demands of care, which often produce weaknesses, vulnerabilities and exclusion of liability, even if the policy has aimed to reduce them[8, 9].

Pettengill and Ângelo[10] report that the meaning of "vulnerability" is defined by households classified in this circumstance as a "threat to autonomy", which is exercised under pressure of the disease, of the family and of the team. Characterized by a lack of dialog and by the perception of the family that they are being inferiorized and removed from the process and decision-making, or even being disrespected, the conflicts between staff and family constitute an intensification context of the vulnerability of the family, which feels that their autonomy is threatened.

As stated by Méndez[9], weakened subjects are often produced through the very notion of vulnerability, to the extent that they are taken as intervention objects of a policy that classifies them as fragile. According to the author, much more than wordplay, the construction and the classification of the subject as fragile, which is performed through the notion of vulnerability, produces real effects. Thus, certain uses of the vulnerability concept have as a purpose the production of the vulnerability itself, through identification and classification practices that define them as weak and disabled. According to Ayres, Mello and Souza[11], despite the development of strategies to reduce vulnerabilities by the Government, certain practices still seem to be producing vulnerabilities, or failing to reduce them.

In this sense, an approximation on how professionals who work in public health policies and

services understand and produce health promotion and vulnerability reduction strategies seems essential for reflection and constant creation of Health Promotion practices in Brazil.

This study aims to present perceptions of public health care professionals about the vulnerability. We focused on health care professionals who work in the Northern area of São Paulo, more specifically in the area covered by Freguesia do Ó/Brasilândia, a location to which high vulnerability rates are assigned[12], aiming to understand how these professionals recognize people and situations of vulnerability and how they conceive their strategies for health promotion and reduction of vulnerabilities. This territory was also selected on the basis of the partnership of PUC-SP with the health territory studied that was established since 2008 as part of the Reorientation National Program in Health Professional Formation (Pro-Health), which is a partnership with the Ministry of Health that aims to promote the teaching-service integration process.

Method

This study is part of a doctoral research whose purpose is to analyze the emergence of the notion of vulnerability in public health policies in Brazil and their uses in the context of health services. For this research, 14 healthcare professionals of the Primary Care Coordination of the Municipal Health Department of São Paulo were interviewed, among them "health analysts" that are responsible for technical areas of specific populations, as well as professionals in the management of Health Technical Supervision of Freguesia do Ó/Brasilândia, in the Northern area of São Paulo. Among these professionals, there were the "Institutional Supporters" who advise all the demand management of the health network services for this area, as well as the assistance evaluation and planning. The choice of professionals was conducted according to tasks defined by PNPS[7], which states that health promotion strategies must be articulated to "all health production equipment of the territory, such as the primary health care, [...] priority networks, among others", as well as indications of the professionals interviewed. Throughout 2016, group and individual semi-structured Interviews were conducted with the consent of the healthcare professionals involved. These interviews focused on how the vulnerability is used to identify specific individuals, groups and populations and the response provided to the situations of vulnerability identified. In this study, we highlighted three dimensions addressed by healthcare professionals interviewed, which refers to the uses and perceptions of the notion of vulnerability in the Public Health field.

Results

The Primary Care Coordination studied has at least 5 technical areas designed to meet specific populations: 1) technical area for health care of the indigenous population; 2) technical area for healthcare of the homeless population, with the medical clinic in the street; 3) technical area for healthcare of the black population; 4) technical area for healthcare of the immigrant population; 5) technical area for healthcare of the LGBTT population[I]13. The Municipal Health Department of São Paulo comprises a determination of their own PNPS through this strategy, which highlights the importance of maintaining relationships with "public policies provided to the population, including those of the Healthcare Sector", [such as the] "National Integral Health Policies for Specific Populations, such as those for the black population and the LGBTT population"[7].

Each technical area is composed of the professionals who work designing health care strategies to the population in their area, along with the Health Technical Supervision of São Paulo, as well as the services, their teams and the healthcare professionals in each region of the state capital. Thus, it enables the technical areas to act in a decentralized way, considering the specificity of each service and team in their regions, while respecting their diversity and seeking to promote the "construction of spaces for social production, healthy environments and the pursuit of equity, ensuring human rights and social justice"[7]. In this sense, their performance in the Brasilândia district faces and deals with the effects of historically produced fights and achievements.

Brasilândia district began in 1947, from the farm of the Brasilio Simões family, which provided the land division of Vila Brasilândia. Later, the place was sold to the Empresa Brasilândia de Terrenos e Construções, which explored the sale of land lots

I. Interview conducted in the Primary Care Coordination of the Municipal Health Department of São Paulo, in April 2016.

during the second half of the 20th century. The people who moved there to the land lots was coming from low-income housing and tenements located in the center of São Paulo, which were demolished for the construction and expansion of the São João, Duque de Caxias, and Ipiranga avenues, during the term of Mayor Prestes Maia (1938-1945). The Portuguese and Italians immigrants also settled in Brasilândia, as well as migrants from the interior of several states in the country, with emphasis on the Northeast region, who were looking for work opportunities. On the one hand, the Veja-Sopave company had great influence on the installation of several families in Brasilândia, as they offered housing for their employees, and on the other hand, the payment facilities of the land to new residents of the region were very attractive, since the donation of bricks was offered to stimulate the construction of homes[14]. The occupation of Brasilândia took place within the limits of the Freguesia do Ó district, whose history dates back to the 16th century, with the construction of the farm of Manoel Preto, a Portuguese trailblazer, in 1580, on the banks of the Tietê River. The district retains features of the past century with old trees and the Nossa Senhora do Ó Church, which was built in 1901[14]. In 2010, the population of Freguesia do Ó and Brasilândia combined was 407,245 inhabitants in an area of 31.5 km^2. Brasilândia concentrates 264,918 inhabitants in an area of 21m^2, which corresponds to 65% of the population of the two districts combined[14].

Acting in this context, the professionals in the Primary Care Coordination of the Municipal Health Department and in the Health Technical Supervision of Freguesia do Ó/Brasilândia expressed their thoughts on the vulnerability, which could be divided in at least three dimensions: the **visibility** that the policy provided to certain sectors of the population, the risks of its **stigmatization**, as a correlate of the visibility and the territory as a locus of production/reversal of vulnerabilities.

Visibility of the populations in situations of vulnerability

Some of the health analysts that were interviewed attributed a particular importance to the recent concern with social issues, translated into social inclusion policies, as they provide visibility to the segments that were invisible to society. From this perspective, one of the interviewees highlighted the difference with respect to the long history of the habits of hiding, for example, the lepers, TB patients and people with mental disorders, which were related to policies implemented in the 19th and 20th centuries, such as the hygienists policies, who aimed to remove "bad looking views" of the city, such as things that smell very bad, and things that people don't like to live with.[II]

In this sense, the policies aimed to specific populations set by the Municipal Health Department (SMS) are configured as policies for integral care of vulnerable populations, offering integral health care to the indigenous population, as well as to black, homeless population, immigrant and LGBTT populations. In this way, populations at risk become visible and start to guide the health care.

Professionals from the Primary Care Coordination that were interviewed reported that they started to conduct meetings with public sectors, along each of these technical areas. This strategy allowed knowing and learning more on populations considered at risk, which later would have to be identified as vulnerable populations, in the perspective of some of the health analysts. In this sense, they believe that it is very important that the territories, districts and the technical supervision of regional health provide a visibility for these territories, thus making "patients" visible.

The importance of creating visibility is also underlined by the National Policy for Primary Care (PNAB)[15], which sets out as responsibility of Municipal Health Departments the deployment and expansion of Family Health Strategy (FHS) teams in their network of services, defining their Health Municipal Plan, with objectives, goals and follow-up mechanism for these teams. One of the indicators of Health Municipal Plan of São Paulo[16] to evaluate and adjust the number of people registered by the ESF teams is the "periodic variation in the number of consultations and visits offered before and after the implementation of the ESF teams". The health care model in Primary Care, and especially in the FHS, with its itinerant strategy of home visits, is capillary and close to the people, enabling the identification and the approach of situations of vulnerability.

To this end, the Brasilândia region has 10 units of the Family Health Strategy (FHS) that are part of the care and intervention strategies in situations

II. Interview conducted in the Primary Care Coordination of the Municipal Health Department of São Paulo, in April 2016.

of vulnerability. Such number of ESF teams in the area is five times greater than the number of ESF teams in Freguesia do Ó, precisely because of the discrepancy between the rates of situations of risk and vulnerability of both regions, as reported by the professionals interviewed.

With regard to the 10 units of the Family Health Strategy (FHS), the institutional supporters report that it is important to ensure the ongoing training of community healthcare professionals and nurses of these 10 units, so that they have a "distinctive" look on children, for example, when the ACSs (community healthcare professionals) conduct home visits. So, when the ACS conducts the home visit, they should notice various aspects and also should make significant questions to the family. According to the supporters, the purpose is to empower the ACSs so they can be able to look children and analyze and bring relevant information to their teams. For example, we seek to ensure if a 6 or 8 month-old child is able to sustain their body alone, if the child is not able to leave the cot, if the child has toys, or if the 1 year-old child remains in front of the TV for a long time, if there are playful activities, or if the child only watches television, or even if a child remains only in the playpen. The supporters claim that the qualification of the ACSs work on the child is the target, so that these can bring this information and create an intervention with the team.

About the speech on vulnerable populations that is stated on health polices, some health analysts consider it as a recent practice. The policies towards immigrants, to the LGBTT population, for example, would be very recent and would mean a breakthrough, as they enable the knowledge and the construction of the own rights of each of the segments. From this perspective, the dignity of these segments would still be strengthened through joint and intersectoral actions, in the connection between the Health, Social Assistance and Development, Human Rights and Education Departments.

Therefore, one of the respondents emphasizes that, given the demands that emerge with the implementation of the integral healthcare policies to specific populations, some situations begin to "change, [with new] needs, and so the institution has to provide answers. The institution, the Public Authority, is required to answer that. However, they cannot repeat mistakes as before." In this sense, the professional cites the example of some people who claim that the homeless population needs to be institutionalized, hospitalized, and emphasizes that he/she "strongly" disagrees with that position. As reported, "First, I believe that we need to recover the family and social ties that this particular person had, or has. Somewhere, he/she must have a link in some space of his/her life. And that's what we should recover", the respondent emphasizes, and then asks: "Why should we create large shelters for this segment?". In this regard, the respondent underlines the wrong actions with the lepers, tuberculosis hospitals, asylums, which still continue, with many patients who have lost everything and who are hospitalized for a long time. So, even though there is no definitive formula, there are several examples proving that the type of asylum admission does not meet the needs of health and social development.

"When you start to look like this to this segment, every minute you discover a need," says another respondent. "And every minute of an action, as it has several relationships, until you reach the capillarity of the implementation... It is difficult to wonder how would be the deployment of these micropolices". In this sense, it's important to highlight the importance of each UBS in São Paulo to effectively address their territory, knowing all conditions associated to it, so that, little by little, this strategy can be able to institutionalize small policies that could not only prioritize vulnerable populations, but also promote equity, providing special treatment to people that are different. This means, in the case of the LGBTT population, for example, to ensure the right of a person to have a social name and gender option when asking for their SUS card, or their registration certificate at the UBS.

In this sense, an institutional supporter also highlights the importance of completing the race/color question, since the completion of the SUS card, justifying that the Pap test, for example, requires such information. According to the respondents, there was a time in which it was not relevant, but certain stages have been overcome in the health field and today the importance of designing health policies for this population is recognized. In view of the importance of collecting the answer of the color/race item, supporters emphasize their insistence on the units to collect this information. However, they report that they already witnessed situations

in which the user who lives in the community feels embarrassed to answer to this question, refusing to answer or responding harshly. The supporter also says that the "prejudice exists, but it is not only related to race, but also concerning low income people and women", for example, thus providing aggravating aspects in the access of such persons to certain services, such as prenatal care. Supporters claim that seek to work in this matter, but they find it difficult, as the comprehension that this is not an easy task to work. The work is then focused on the procedures of the teams, with respect to the prenatal care, sickle cell disease, among others conditions that need such care. This specificity in the care and preparation of technical information reached this level over the last 8 years, since before it was not so specific, as reported by a supporter.

From this perspective, the health analysts further highlighted the need for ensuring rights and assistance to the people where they are, but without losing the perspective of a social rehabilitation, with a guarantee of employment and occupation. Thus, even if the Health, Welfare and Social Development Departments are asked to provide care to vulnerable populations, it is understood that if these people had access to education, work, culture and sports, then they wouldn't lack health and care. That's because it is the lack of other sectors on complementary actions, which often ends up driving cases of vulnerability to health policies. As an example, one of the analysts mentioned the high rate of mortality of children due to diarrhea in the 1980s, which was drastically reduced when sanitation policies to regulate the construction of sewer networks, or even the rates of death due to child malnutrition, which were reduced when health posts started to deliver soup for pregnant women and milk for the children. These are policies that were carried out in seasons to reduce damages, but they would not be necessary if access were provided to other sectors. In this case, the health sector should be triggered only if the services provided by other sectors were not enough.

However, if the visibility includes SUS principles, such as equity and universality, it produces challenges in working in the health field. The speech on vulnerable populations, which is considered a recent practice, is not so questioned yet, and can produce effects of stigmatization. We will address this issue next.

Stigmatization

Some professionals claim to know that there is a concept and a definition of vulnerability, but they understand that their use is performed in two ways. First, it can be used as a "thing" that can help, including the principles of equity and universality of the SUS, being used to set priorities. Then, in the second way, the vulnerability could be used as a "thing" that can stigmatize. In the perspective of some professionals, when they refer to the health technical area of black population, they tend to state that the reason for this area to exist is not because black people have more diseases than white people. These professionals believe that it is important underlining that black people are not a sick population, but there are some issues worsened by lack of access to services, and many other reasons. These professionals realize that there are people who think that the reason for the existence of this technical area for the black population is that all black people are sick. In this sense, they wonder if someone would give employment to a whole segment that is considered sick. It should be clear that "not every black person is vulnerable", and that when one is vulnerable, he/she will not spend the rest of his/her life in such condition. If the policies are effective, this person will be just temporarily vulnerable.

According to some health technical analysts, African descendant are not vulnerable, since nobody would born as vulnerable. They emphasize the historical aspect constituent of black population, which dates back to the trafficking and slavery of African descendant, as well as the process of abolition of slavery. For some health analysts, the African descendant people brought from Africa knew arts and technologies, such as handling iron, construction of houses and roads, production of tiles, and they wonder how it is even possible to say that this population is vulnerable. The remnants of slavery are also a stigma, and the classification of someone or a population as vulnerable can trigger memories, and traces of that period, say analysts.

This vulnerability issue is really deep. In the black population, with all these issues that were left by slavery period, this permanent demotion, this stigma. Because as much as you know that you are not demoted, that you are not an inferior person, it is difficult to face it every day. You have to prove [it], [...] it's very difficult. I believe that the worst

thing that can happen to a population is slavery, the remnants. To this day people can't have a normal life, they just can't. As they will always remember this. So you need to be strong and steady, and you must know where you're going. And also, you can't let people come to us and put "us" in a hodgepodge. As sometimes they are not doing it for bad, but it can hurt your self-esteem, if you understand me. When you are almost classified as vulnerable...[III]

In this sense, these professionals highlight the risks of not only undermining self-esteem, but also the development of this policy, as far as financial resources are concerned, so that we have people capable of working in a more advanced and efficient way.

It should be emphasized the risks of a stigmatizing analogy to those populations, which would result in the conclusion that a black person, is, therefore, vulnerable. In addition to the application of the same rationale for immigrant, LGBTT, indigenous and homeless populations.

In this sense, there are controversies among professionals, as some of them believe that all homeless people are vulnerable, while others disagree. And the same discussion on immigrants. With respect to the black population, some professionals pointed out that there are 4 million black people in São Paulo, so if we admitted that they all are vulnerable, it would be necessary to create a department only for this population, according to the analysts. Thus, it may even be stated that a large part of a population is vulnerable, but they are not vulnerable for life. In addition, it may be the case that a person becomes a homeless, and that this person is also part of the LGBTT population, or even a woman, needing to be served by policies designed to protect women. But, fundamentally, the aim is to have policies that meet people when they are in a situation of vulnerability, regardless of the population to which they belong.

These analysts also mentioned the example of TB and AIDS in the territory of Brasilândia, pointing out that the highest rate of AIDS mortality in this territory is for the black and women population, and considering also that these women died within the first year after diagnosis. It was found that these women did not have early access to the diagnosis, and if they did, they were not treated. The diagnosis was made in the hospital because they were already developing AIDS, they were not only carriers of the HIV virus. Therefore, the problem was that women had problems accessing the diagnosis. With regard to tuberculosis, it was also noted that black people were the majority of the population that was dying due to the disease. This time, the problem was the adherence to the treatment, because people were even diagnosed, but they discontinued treatment. So, the same work being conducted with respect to AIDS, to identify which regions that are facing this issue, will also be done with tuberculosis, in order to know how it would be possible to work directly with these surveillance, since the Health Surveillance is the authority responsible for working with TB. Therefore, for some health analysts, it is necessary to contact the Health Surveillance to identify which districts have more problems in relation to discontinuation of treatment, to develop a targeted work. They say that the idea is to remove the person from the situation of vulnerability, so that he/she can have a normal life and compete with others in the labor market.

Territorialization

Unlike the perspective that includes population in a segmented way, the prospect of territorialization, as understood by PNPS as a mode of organization of health actions, provides a way of thinking on vulnerability in a broad and complex way[7]. Understanding that the "territory" is vulnerable, at the expense of the conception of "vulnerable populations", the professionals point out that some programs and projects, such as the "*São Paulo Carinhosa*", are conducted only in areas where a high vulnerability is identified. Brasilândia, in the Northern zone, is identified as the high vulnerability territory, according to the supporters, mainly because it is close to regions where there are many areas of occupation.

According to the opinion of professionals, what differentiates a vulnerable area to another are characteristics such as the lack of Family Health Strategy teams, the absence of nearby UBSs and sanitation, the accumulation of groups of shacks and houses on stilts, as, for example, in the regions in which they are close to stream channels. The professionals highlight the difficulty of implementing a project to build two more UBSs in the areas

III. Interview conducted with a health analyst in the Primary Care Coordination of the Municipal Health Department of São Paulo, in April 2016.

of occupation in Brasilândia, also emphasizing that there are appropriate places in which the municipal government can build or lease a property. That's because it's necessary to have taxes settled and the proper documentation to lease a property and adapt it as a health unit. However, in addition to a lack of available land, many of the buildings already constructed do not have its documentation properly updated. So the location can't be rented for subsequent adaptation to an UBS. As an example, an UBS that was recently established in the region, which located in a corner near a bus stop, is mentioned. This place is very unfavorable according to some supporters, since all the buses that travel through this corner, drive very close to the UBS, which is a concern with regard to children. Often, mothers come in for their consultation and the children are left unattended, running in the UBS space, near the space where the buses make a turn. They even reported that they have made requests to change the location of this bus stop.

Another negative aspect attributed to the location of the unit is the two floors of the building, which hinders the accessibility. The SMS accessibility department provides a negative evaluation for this structure and prohibits the use of the upper floor. The administrative sector works on the upper floor, and the care assistance is on the lower floor. However, the upper floor is the only floor with enough room to work with groups, making it difficult to work since it's the only building with proper documentation to be leased.

According to one of the institutional supporters, the residents of the territory were responsible for searching this place to build an UBS. They found and took over the land, so that it would not be invaded, in view of the constant attempts. It was even necessary to put up fences around this place. Since there was great difficulty on the part of the teams of the municipal government and of the health services in finding a suitable place, the residents mobilized to find a location in a collective struggle for the construction of the UBS. "All this causes a huge vulnerability," according to institutional supporters.

In this sense, this vulnerable territory aggregates such issues related to infrastructure, which are historically produced by how the place is developed, expanded and occupied, thus exemplifying the inadequacy of certain health equipment facilities. Even though the financial reserve has already been authorized to do so, it's not easy to find and define suitable locations for new services. Such situations hamper the access of professionals to these people, and vice versa, as stated by professionals.

With respect to the difficulty of access to people, supporters mention the example of a region of occupation, where people only perceive the possibility of access to the community health agent. And this person would be someone living on the place and someone known by others, who is part of the UBS team, so that people know that the healthcare is the reason for this person to move there, to "check the health, and this is the only way to access the location". Professionals reported that the inhabitants of this region have requested a meeting with the health technical supervisor, who positively responded to the request, moving to the location with a supporter and an ACS. The meeting request was made by the people of the community, as they had problems with the nearest UBS, and they said that they wanted to talk to the Supervisor.

Some time ago, an authorization was requested to the leadership of the region so that a "health day" could be conducted. Upon authorization, "the team went to the scene and provided vaccines, many things, in order to check who needed it, who was pregnant, so that prenatal care was done." However, some residents do not allow the access to the locations. From the perspective of one of the institutional supporters, all this makes it very difficult to identify pregnant women, as well as to visit newborn babies who have just arrived to motherhood.

Many strategies are being developed in face of this vulnerability. For example, supporters reported that although rates are high, there are many programs to combat child mortality. Maternal mortality is also being increasingly addressed, but women are still dying with high blood pressure, as well as with complications in childbirth, as eclampsia and pre-eclampsia, which result in the death of the baby. There is a high rate of infant mortality due to asphyxia and bronchoaspiration, even though teams are guiding mothers. There are also cases in which the mothers sleep with more than three people in one double bed, next to the baby, or even sleep and fall on top of the baby, who suffocates. Bronchoaspiration cases occur when the mother has just breastfed and immediately places the baby in bed, resulting in death by aspiration of gastric contents through the lung. According to an institu-

tional supporter, the region has a high rate of death due to these two reasons, which, therefore, would be directly related to socioeconomic aspects and housing situation. "The reason [of infant mortality] is accidental, and not intentional," he says, this is "due to the precarious conditions, [...] because there are no suitable places to accommodate the baby".

Another problem, also mentioned by the supporter, occurred with people who lived near the *Serra da Cantareira*, since apes began to invade the homes in search of food, and began to transmit diseases, so that the Supervision of Health Surveillance (SUVIS) was contacted. Thus, the professionals understand that there is always a new problem.

One of the institutional supporters reported the problem of lack of rainfall, which occurred two years ago, emphasizing that they began to realize that the problems that occurred in the territory were "not only a matter of rain, it was a matter of managing the emergencies of the territory". The lack of rain was related to dengue fever, with accumulation of water, which was related to the trash, which was related to flooding, in such a way that was a group involving Civil Defense and Education Department was created to design projects covering such issues. All these questions allow understanding the territory and realizing all the vulnerabilities.

"So, if it's a community that has poor housing conditions, poor eating habits, no entertainment, poor education opportunities, then health conditions will also be impacted. So, I think that the vulnerability is related to the territory, and it is associated with all areas, not just vulnerability in health, there is vulnerability in care".

The support person suggests that Brasilândia is a "vulnerable territory with regard to housing, leisure, and it's excluded from the culture, [thus emphasizing] that all of this is vulnerability". "We work in an area of extreme vulnerability in every way [...] including violence, health, everything is in need of a lot of things," he emphasizes. This supporter also mentions the garbage trucks that do not access the alleys, causing people to have to take the garbage to the street. However, even if there is a specific time for the garbage truck to collect the garbage in each location, the person who lives in the alley won't wait for the right time, since he/she will not leave the garbage inside the house, precisely because this garbage will attract rats, roaches, etc. In addition, there are people who live near stream channels, and who have their home invaded by the water of the stream channel whenever it rains. "This is a matter of vulnerability and health".

In this sense, one of the professionals realizes that they are dealing with issues that a few years ago they would never imagine that could be under their responsibility. Health is no longer restricted only to the dynamics of complaint and conduct, since it has become much broader. Many times, we realize that we can't reach all this complexity and scale, since "the whole territory is vulnerable and more and more people seem to be willing to take risks". In this sense, he mentions the example of families that were recently removed from the beltway, due to expropriation, and they were moved to a place in the region of Brasilândia that "has no basic conditions of housing".

Discussion

We identify challenges and tensions between the visibility and segmentation dimensions that are related to the concept of vulnerability. On the one hand, the PNPS highlights the importance of working with the policies to specific populations, but on the other hand, the population segmentation, when associated with the use of the notion of vulnerability, can produce stigmatization effects for individuals identified in certain populations.

The PNPS proposes to the entire Public Health field to make more visible each one of the multiple and complex aspects that constitute the health-disease process, so that in this way the linkage between sectors can stimulate the preparation of specific policies. Therefore, taking into consideration the conditions of vulnerability and risks, seeking to involve all sectors, so that health is present in all the agendas of public policies[7].

Visibility strategies also aim to meet the most basic principles of SUS, of equity and universality, to the extent that these strategies have as a scope to make visible those who were invisible before, those who used to live locked, isolated, in hospitals, boarding schools, nursing homes, among others, precisely so that there are appropriate policies to their specificities.

Despite all that ideology that may be assigned, or that may be wanted to be assigned, to these health care strategies, what can be seen in the end, in the capillarity of care networks and power over life, approaches, to some extent, to what Foucault pointed in 1976: effective instruments for training

and "accumulation of knowledge, [...] methods of observation, registration techniques, research and investigation procedure, [...] testing equipment."[17]

When exercising this practice to make visible, many challenges and tensions appear in the daily life of the supporters. One of them is the issue of racial and racist discrimination, as well as discrimination due to gender, and socio-economic condition. In the narratives of the supporters, there are several references to situations that produce issues, such as the smell and appearance of people, perceived, for example, in embarrassment and irritation at the time of answering the race/color criteria. We realize that even though there is no hospital admissions in the institutes that separate and isolate the undesirables, the ways of relating that separate, discriminate and isolate remain present. This issue is narrated by supporters as a very difficult task to be worked with teams, and it should be constantly conducted.

Corbin[18] notes that in Paris, since the 19th century, the senses began to be extensively used in the construction of images and perceptions of others, providing shape and contour to the social imaginary. Many of the ways that came to represent the other are due to the sense of olfaction, as much as the vision. The medicine practices of this period used the smell to designate and identify hazards, such as the fermentation of foods, the confrontations between people, who, according to this view, smell bad. According to this historian, the social distinction procedures and criteria between bourgeoisie and poverty, based on the odors and deodorizations are crucial to understand the French society of the 19th century. In the Brazilian context, this social distinction criterion seems to exists, being preserved and updated in natural situations. This cognitive-affective policy, which is based on the use of the senses as a social distinction criterion, seems to be preserved by cultural, political, geographical, decentralized, and capillary reiterations that are present in the daily life of the majority of Brazilians, including users, workers and managers of health services, who perceive the difficulty of producing changes in the way that people relate with themselves and with others.

On the one hand, producing care strategies to specific populations may strengthen segments that historically marginalized, ensuring their rights and access to social movements and specific policies of each segment; but on the other hand, assuming such specific populations as vulnerable may designate conditions and places to individuals, that stigmatizes them and keeps them away from certain opportunities.

No one disputes this fact in politics, but in practice it's complicated and complex. Since, in practice, it's simpler to bandage it, as each one knows how to bandage a particular symptom, pain, illness, etc. But vulnerability involves subjectivity. [IV]

Fineman and Grear[19] emphasize that many times the political and legal response for the so-called vulnerable populations is monitoring and regulation. And in some cases it may be stigmatizing, as in the case of young people who are considered in/at risk, mothers who need care, or even those considered priorities, such as the elderly, children, pregnant women, and people with disabilities, among others. In this perspective, the vulnerability perceived in them labels them as people who are less able, unskilful, or incapable. Also considering that vulnerable populations often include ethnic and racial minorities, poor people from urban and rural areas, undocumented immigrants, people without proof of residence, people with disabilities and with multiple and chronic diseases. According to Fineman and Grear[19], the conception that the vulnerability condition belongs to certain populations can produce dangerous effects, because when you define a population based on one or more characteristics in common, you also mask significant differences between individuals, especially when these characteristics are from identity groups defined through aspects such as race, gender, nationality or socioeconomic situation. On the other hand, claiming that certain populations have significant differences with regard to the general population, can obscure the similarities between the members of the specific population and the general population. These types of grouping would be under and over inclusive. In addition, this segmentation can also produce the idea that some of us are not vulnerable, since the existence of vulnerable people simultaneously indicates that there are invulnerable people.

The territorialization is provided by the PNPS[7] as a policy guideline that proposes the decentraliza-

IV. Interview conducted with an institutional supporter in the Health Technical Supervision of Freguesia do Ó/Brasilândia in São Paulo, in August 2016.

tion of actions and health services, thus organizing a network of health care, promoting intersectoral and intrasectoral associations with social equipment of the territory and of other regions. From this perspective, the locoregional singularities of the territory are taken into account, articulating the different services and policies present in each one of them[7].

According to the professionals, the precariousness of living conditions in Brasilândia produces the idea that this is a vulnerable territory. The diversity of factors that may put at risk the health and life of the inhabitants of this district seems to multiply in a combination of climatic, geographical, social, political and economic events. However, a characteristic of the territory seems to be preserved, often subtle, even though its effects produce discomfort and outrage. People are still evicted from the place in which they lived, moving then to Brasilândia, in large part, due to development projects of real estate, urban and industrial of the city and the state of São Paulo.

On this issue, it is possible to go back to the observation of Foucault[20], that after the 18th century, in Europe, the architecture began to be involved in problems related to the population, health and other urban issues, assuming the provision of urban space as a matter of economics and politics. If by the end of the 18th century buildings responded to the need to express the divinity, strength, and power, in the following centuries the architecture began to be planned and developed as a response to demands for maintaining order and progress, in order to avoid riots, epidemics, favoring family life and morals. This rationality is expressed in the history of Brasilândia, which became the place to where were those people who were unsuitable to certain urban regulatory moved to, whether by occupy places deemed unsuitable, either because they do not fit with the way of life undertaken by urban planning from São Paulo. The modern cities have emerged from social and geographical concentrations, as well as from the capitalist quest to find profitable spheres for the production and absorption of capital, which can be extracted from somewhere or from someone. In this way, the urban expansion and development, as well as real estate speculation, allow the most profitable use of the land, through expropriation of those who cannot prove their residence, and who will need to find another place to live[21] . This urban way of life actively produces the precariousness of life in Brasilândia, constituting a territorialization of what is understood as vulnerability, and materializes as a "vulnerable territory" that is recurrently pointed out by public health policies and services professionals.

Thus, through the visibility, stigmatization and territorialization categories, some practices were identified that combine with the focuses of interest of the capitalist system, as pointed out by Foucault. Among these, we can highlight the "mechanisms of exclusion, the surveillance apparatus, and [the] medicalization of sexuality, madness and delinquency " [17] .

Conclusion

Health managers and analysts' respondents presented us with some of the prospects for which the notion of vulnerability is perceived and adopted in their practices. If the notion of vulnerability is an "undisputed priority in politics", it is much more complex in practice. In fact, a tension was made explicit by professionals: that of the risk of visibility of the segments of population with vulnerabilities - a condition for completeness and fairness- producing effect of stigmatization, when vulnerability is treated as risk indexes, identity traits of sectors of the population, generally associated with the risks posed by such tensions. In this perspective, the concept of vulnerability can be used as a justification for the government to intervene in a repressive way in various groups that are considered weakened, to the extent that they enable the maintenance and permanence of interventions on individuals of which some of their practices started to be considered at risk, as occurs with drug users and the homeless population [22].

On the other hand, the perspective of looking at the territory can contribute to avoid this trap of visibility-stigmatization, since it proposes a more complex and longitudinal health care practice, as explained in the expanded clinical concept[23]. Such a concept, when we think in terms of vulnerability, can provide an opening for intersectoral actions and to the creation of care networks that may integrate health with other areas related to the health of the subject. With the implementation of the Brazilian Unified Health System (SUS), which presupposes the creation of strategies that promote universal access to health - and completeness - and states that these strategies should take into account the

complexity of the territories of users - the *itinerant work* technologies, such as the ESF, acquired a strategic importance[24]. Several care technologies have been implemented using the displacement in the territories of life of users. In two senses: first, with the aim to cover a larger territorial extension, to - in the logic of active search - achieve groups and people that are difficult to access and in a precarious situation of life; and then, with the purpose of building the intensity and singularization of actions, including populations traditionally refractory to health actions.

In this way, when pointing to the articulation between territory and vulnerability, we intend, as in the perspective pointed out by Ayres[25], to go beyond the individual dimension, covering collective aspects, contextual with respect to the availability or lack of resources to protect people. At the same time, this observation allows us to glimpse the processes of active production of the precarious nature of certain modes of existence, which do not comply with conducts and patterns of the capitalist urban life. Processes that in turn are explained repeatedly in the narratives of the professionals interviewed.

In this way, the notion of vulnerability, in constant (re)construction in the public health field, is positioned, as suggested by Sanchéz and Bertolozzi[26], "as a potential instrument for the transformation of health practices". However, as stated by Foucault[27], nothing is good or bad in itself, but everything is dangerous. Dangerous does not mean the same as bad, but it indicates that there is always something to be done. Therefore, it is important that the health care strategies for people, especially due to the risks of stigmatization, are worked in such a way as to enable the active participation of the population in the analysis and in the solution of problems and health needs. After all, getting closer to the territories and the singularities of the ways of life is part of the process of being opened to differences and a path to the deconstruction of the stigmatizing and colonizer look[28], in addition of providing an opportunity to interrogate the ways in which health practices are pressing or operating mechanisms of exclusion, surveillance and medicalization.

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