

HOW TO BUILD A STRONG PRIMARY CARE IN BRAZIL?

TECHNICAL SUMMARY FOR POLITICIANS, MANAGERS AND HEALTHCARE PROFESSIONALS WHO ARE RESPONSIBLE FOR ORGANIZATION AND TEACHING FROM THE REPORT OF:

IT IS POSSIBLE TO TRANSFORM THE VICIOUS CYCLE OF LOW QUALITY IN A VIRTUOUS CYCLE OF HIGH QUALITY, IN THE CLINICAL AND COMMUNITY PRIMARY CARE WORK IN BRAZIL

Project to assess the Family Health Strategy (FHS) in environments with a low Human Development Index in Brazil, developed by visiting Basic Family Health Units (BFHUs), with leader doctors and/or tutors

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According to Family Health Strategy theory, in creating a National Policy for Primary Care, health centers should be resolute and accessible, able to provide a preventive and curative answer to acute and chronic problems, at health centers and in the community, with scheduled and on-demand activities. Such health centers are called Basic Family Health Units (BFHUs), where Primary Care teams work applying the FHS.

The end goals of FHS coincide with those of the health system: 1/ preventing, treating and alleviating acute and chronic diseases and lesions and 2/ giving support for a good death (at the hospital and at the patient's home)³. However, has the FHS met all its goals? And, if no, how to do so?

In this Project the Family Health Strategy has been evaluated and proposals are made for its improvement from the general theory and field work at Basic Family Care Units (BFHUs), with leading doctors and/or tutors, in environments with a low Human

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³ Hasting Center. The Purposes of Medicine. Barcelona: Víctor Grifols and Lucas Foundation; 2004. http://www.ehu.es/SEMDE/archivos_pdf/Los%20Fines%20de%20la%20Medicina%20%28Informe%20Hastings%29.pdf

Development Index in Brazil.

ABOUT THE PROJECT

This Project:

1. Has as a research question, “is it possible to improve the development in practice of the Family Health Strategy in Brazil?” If yes, how?
2. Is focused on actions, from identifying problems to proposing solutions. It combines research and teaching.
3. Is primarily clinic and aimed at service organization, with an emphasis on population health, and is aimed at improving the work of Primary Care professionals in Brazil. Its focus, therefore, is the work of the professionals, the interaction between themselves, and between them and their patients and the population. It observes, thus, the work of doctors, pharmaceuticals, psychologists, dentists, nurses, assistant technicians, receptionists, nutritionists, social workers, managers, community health agents and others, according to opportunities.
4. Has as its main hypothesis “the Family Health Strategy in Brazil is adequate to the health needs of the Brazilian population, but the lack of means and organization may generate a negative cycle of low quality in the clinical and community work”.
5. Has two secondary hypotheses a/ “it is possible to transform the vicious cycle of low quality into a virtuous cycle of good quality, in the clinical and community work” and b/ “the findings on environments with low Human Development Index and with leading professionals and/or tutors serve as a marker of the major difficulties and best responses in the application of the Family Health Strategy”.
6. Is an empirical and theoretical work. Empirical, of observation and direct participation in the work at Basic Family Health Units (health centers) in Brazilian territory, and of personalized education to the professionals observed. Theoretical, of extrapolation of empirical findings to make recommendations applicable to all over the country.
7. Is a qualitative work, both in the health field as sociological and anthropological ones.
8. Is centered in the observation of the application of the Family Health Strategy in environments and populations with a low Human Development Index and at urban and suburban teaching Basic Family Health Units. And
9. Hopes that its findings are relevant to the improvement of all working conditions in Family Health Strategy in Brazil.

It is the general purpose of the project to aid leading and/or tutoring general practitioners (preceptors) to break the vicious cycle that leads to abandonment of responsibilities, to lack of commitment with patients and communities and to health work of low-quality conditions, particularly in environments with a low Human Development Index.

The following are operational goals:

1/ To analyze the daily local general practice, to identify a/ successes, b/ failures, and c/ needs in the application of the Family Health Strategy both regarding professionals and Basic Family Health Units; these professionals and their Basic Family Health Units may act, for instance, in a benchmarking work.

2/ To demonstrate how to use the daily general practice to identify and answer the teaching needs that facilitate the resolution of problems of patients and communities, fitting education to local needs.

3/ To promote the achievement of healthcare goals (preventing, treating and aiding regarding diseases, and providing services to aid in dying with dignity) especially through the practice of quaternary prevention (preventing damages caused by healthcare activities, with emphasis in rejecting unnecessary activity) and the network integration with other resources.

4/ To promote the best clinical values, as the best use and distribution of work-time, control of uncertainty, dignity in attending, working and follow-up of patients and a culture of repairing errors and mistakes, and

5/ To prepare some general practical recommendations bringing together the essence of the project, with the purpose of spreading it to promote the practice of a clinical and community work of high quality particularly in environments with a low Human Development Index.

MATERIAL AND METHODS

The initiative came from the Brazilian Society of Family Medicine and Community (SBMFC), which managed to obtain financing from the Federal Ministry of Health for the Project prepared by the two authors. SBMFC organized the visits, accommodation and transport. SBMFC is committed to the advance of FHS as the best answer to the health problems of Brazilian population.

This Project has begun on March 2010, with the review over one year of theory and publications on the application of Family Health Strategy (FHS) in Brazil. The field work was carried out over April, May and June 2011, in two stages, each of them lasting a

month and a day. A provisional list of recommendations was made half-way through the study, on May 2011. The final Report was prepared on July and August 2011. The work will not be finished until February 2012, to meet questions, suggestions and comments that facilitate the interpretation and application of the recommendations [to jgervasc@meditex.es and mpf1945@gmail.com].

During the field work they visit 70 health centers, generally those where the Family Health Strategy is applied, the Basic Family Health Units (BFHUs) [with a family doctor and a Primary Care team], [six of them, also with annexed Basic Health Units (BHUs), centers following the old model with direct access to pediatricians, gynaecologists and internists, and five more with Emergency Units, for emergencies and out-of-hours service], during an average of seven hours per Unit. From the total, 11 BFHUs were non-teaching units; and 10 rural units.

Additionally, special units have been visited, such as NASF (Family Health Support Center), Teams in the Area of the Fight Against Dengue, PACS (Community Health Agents Program) and Mental Health Unit.

In total, we have interviewed 506 professionals in different fields and categories, and attended and participated in 150 meetings between professionals and patients-groups-communities.

The election of the Units followed the criteria of the SBMFC coordinators in each State, with the norm of having teaching activities and/or leading professionals, and being at environments with a low Human Development Index.

19 Brazilian States (Alagoas, Amazonas, Bahia, Ceará, Espírito Santo, Goiás, Maranhão, Minas Gerais, Pará, Paraíba, Paraná, Pernambuco, Piauí, Rio de Janeiro, Rio Grande do Norte, Rio Grande do Sul, Santa Catarina, São Paulo and Sergipe) were visited.

22 trips (three by bus, the rest on regular-line planes) were made between States, in two circuits starting and ending in São Paulo and a total of more than 25,000 km (excluding the 16,000 km between Madrid and São Paulo).

32 populations were visited, including State capitals. The field work trips were usually made on the cars of doctors or managers of each BFHU, or the coordinators; in one case by boat, from Salvador to Vera Cruz, in the State of Bahia, and in another by air-taxi, from Fortaleza to Sobral, in the State of Ceará.

Field annotations were made over more than 1,500 handwritten pages, plus 7,000 photographs of the Units and their personnel.

32 conferences (lectures) and workshops were carried out, most at universities, and two dinner-seminaries were held, with politicians, managers and doctors with clinical practice,

in additions to meetings with nine Municipal and one State Health Secretary. The organizers of the 19 visits (local/national persons responsible for the SBMFC, and their State affiliates) have also been interviewed in depth.

Besides, the Tele-Health service in Manaus was visited, and also on the same city the Regional Medicine Council-Amazon. In Salvador (Bahia) the State Foundation for Family Health was visited, and in Maceió (Alagoas) the Family Medicine Service of CASSI (the healthcare plan for Bank of Brazil employees and their family). Other activities were carried out, with personal contacts with private practice doctors, trade unionists, entrepreneurs and funeral homes.

The work, the interpretation of results and recommendations have being shared with the set of “observed” professionals (and others) that attended the 11th SBMFC Congress, in Brasília, on June 2011 (during a workshop held with on purpose). They were also evaluated by the continuous participation on debates in the SBMFC electronic list, many of them generated while commenting some of the results of the Project’s field work.

FINDINGS AND RECOMMENDATIONS: KEY POINTS

1. The visit revealed that the Family Health Strategy (FHS) in Brazil was and is a needed and correct Strategy.
2. The highest successes of FHS are a/ its mere existence over decades, b/ the change in the model with generalists professionals, keeping the community health agents (ACSS) while at the same time introducing the family doctor, c/ the inclusion of pharmacy and odontology services at BFHUs, d/ the Federal, State and Municipal commitment to its development, e/ the independence of clinical practice from direct influence by the pharmaceutical industry, f/ the variety of the staff, grouped on multidisciplinary teams and their commitment to deliver their work, g/ the inclusion of supplementary medicine, h/ the development of Tele-Health, and i/ the priority implementation in zones with a low Human Development Index.
3. Its worst problems are a/ the lack of technological, managerial and scientific development of the FHS, anchored in a poor country model despite Brazil being today a global economic power, b/ the insistence on a “vertical view” of programs and protocols that compartmentalize the clinical practice, foster a rigid and fragmented service model and, also, often have a weak scientific foundation, c/ the emphasis in a “preventive view” that results in the limited development of clinical curative activity (failing to comply with the principle of integrality), d/ excessive referral to specialists and emergency units (and their resulting waiting lists) by an

organization in which almost all professionals do less than they can, e/ the “occupation” of health centers-BFHUs and, in general, of services, by “stable and obedient” patients and healthy individuals (able to follow rigid rules and norms), f/ the routinely excessive use of available resources (for instance, screening by assistants of all patients whenever they have a consultation, or the insistence of use of nebulization rooms, or excessive use of antibiotics in cystitis) and g/ a very variable personnel, salaries and benefits policy, which does not foster the permanence of professionals in the communities they serve.

4. Its greatest needs are a/ lack of provision of a broad range of curative and preventive services, for “normal situations” and emergencies, at the BFHUs premises or at patients' home (which explains, among others, the waiting lines for specialists care and the overwhelming deployment of Emergency Units-*Unidades de Pronto Atendimento* and the success of several “private healthcare plans”), b/ poor coordination between levels of care, with duplication of services, c/ the lack of qualified family doctors to cover all positions (they reach only 5% of the total of primary care teams) and, in general, the lack of doctors (many BFHUs routinely work with teams where there is no doctor, or there is one only for short periods of time), d/ the lack of development of functional primary care teams in which roles and responsibilities can be delegated so that each professional can face complex cases appropriate to their education and skills, and e/ the absence of a policy to promote full-time work.
5. We would suggest that the FHS be defined more accurately to become a Federal strategy with a broad common denominator, that involved all political parties in the improvement of the Unified Health System (SUS), and that the referred FHS should expand to cover 100% of the population to maintain and improve the health and competitiveness of Brazil. A FHS only for the poor will end up being a poor FHS.
6. The FHS defined as a common Federal model would implicate the development of a/ a Primary Care focused on the patient and on the community, universal, integral (preventive, curative and rehabilitative), decentralized and with participation of the people, b/ a strong Primary Care, very accessible, with polyvalent professionals able to answer at that level 90% of the needs of the population, c/ a Primary Care with the family doctor as the first medical contact, in a balanced way with a capable functional team equipped with the appropriate technology, d/ a SUS where all specialists (including pediatricians, gynaecologists and internists) would work as consultants for family doctors, so the latter effectively coordinate the services

(independently from the place and time where/when they are provided) and e/ a SUS in which the Primary Care is that of a developed country (well equipped with technology and science), and a filter for the specialized level, as befits a modern, healthy and competitive Brazil.

7. The global goals of SUS, the improvement and promotion of health in Brazil, demands a “good governance” that ensures the best use of public resources, with transparency, and with the promotion of the FHS (and universal implantation of the BFHUs) as a way of giving the best answer to the needs of the population and the patients. The “good governance” is defined by a commitment with the transparency in publishing government accounts (revenues and expenses) and achievement of goals set to fit social and health values, as well as the successes and outcomes in healthcare, and the monitoring of the principles of democratic ethos, which are fundamentally equity and efficiency.
8. The patient’s needs become the core around which the services are organized. The BFHUs and SUS should organize themselves “around” the patient, and not around the professionals (and that would require, among others, reviewing the concept and application of the “medical act” as well as of activities “prohibited” to several professionals and the whole organization of the “professional categories” and their attributions). The patient should not have to go from service to service, but be the center around which such services move; that is, patient displacement should be avoided at most and a maximum of services be provided at the BFHUs premises (and even at home, as needed), through appropriate technology and timely training.
9. This is about offering “maximum quality, minimum quantity, with appropriate technology, timely, by the appropriate professional, and as close as possible to the patient’s home” (for example, weekly adjustment of diuretics by the family of an elderly, *bedridden* patient with heart failure, by controlling his weight with a home scale). This implies that the BFHUs offer a “modern” service portfolio (shown at the center’s entrance), which includes, for instance, vaccinations and the monitoring of family planning, pregnancy, child-birth and puerperium, but also the care for non-acute morbidity in less than 48 hours, home monitoring of terminally ill patients and the provision of basic emergency care (defibrillator, sutures and others). Additionally, contingency plans are needed for unusual events and catastrophes, for instance, death at the BFHU premises of a patient with acute myocardial infarction, or a gas explosion in the community.
10. Therefore, an increase in the pro-content reform (improving the

structure/organization, professional training and contracts, and technology in BFHUs) and a pro-coordination reform (making family doctors and their teams the “proxies and agents” of their patients and their community, and the filter for specialist care, being the specialists family doctor’ consultants) are needed.

11. The pro-content reform requires an increase in the technological endowment of the BFHUs and the training of professionals for the direct use of the referred resources. This is about increasing the capacity for diagnostic and therapeutic response of the BFHUs. This means, for instance, equipping and training for use of urine strips, optotypes, electrocardiograph, spirometer, ophthalmoscope, digital camera for retinal photography and others, and basic service providing such as performing the tuberculin test (PPD-Mantoux), cleaning earwax, skin biopsies, urethral sounding, opioid analgesia, “crash carts” and others. In case of ACSs, for instance, means of transportation, notebook or the like, and basic diagnostic equipment (peak-flow, thermometer, scales and others). One should not forget the constant and general supply of water, paper and soap on all clinical care points and WCs, essential materials for the simple and important hand washing. The improvement of communication technologies is also indispensable (at the centers-BFHUs there usually is only one landline telephone and no mobiles, and Internet access is difficult, even when the center-BFHU has computers).
12. The pro-coordination reform transfers to the family doctor and their team the end responsibilities in the process of care. This means, for instance, control of medication in general, or receiving in all cases the specialist report (counter-reference) after the consultation, the discharge from the hospital or Emergency care unit, or the reinforcement of the filtering role of the family doctor.
13. It is a key issue to facilitate the access of patients to both the BFHUs and needed specialized services. Many waiting lines are reasonableness. There is no sense in the “reception consultations” at the BFHUs when they become barriers to access and can be substituted by scheduling by the receptionists or ACSs. It is indispensable to redraw patient flows to prevent the referred waiting lines and ensure that non-urgent demands are met by the family doctor-nurse within 48 hours at most, and by the specialist within a month at most. Requests for supplementary tests (diagnostic processes) shall have a maximum waiting period of two weeks. Regarding urgencies and emergencies, there should be immediate care at the centers-BFHUs, according to severity (being referred to the Emergency Care Unit, as appropriate). The opening hours in the BFHUs should offer alternatives for

caring to patients who do not work at home.

14. It would be convenient to maintain the base and foundation of the preventive and health promotion programs and protocols, yet establishing priorities and reducing them to those that have a proven effectiveness. Under such a layout that their provision generates the less bureaucracy and has the most impact (in prevention and promotion there should be caution, so that the protocols and programs do not become meaningless and boundless activities). The vaccination programs should be reviewed, for instance, for an updated of the tetanus vaccination (six dosages during childhood and adolescence and later re-vaccination at 65 years of age), or to reduce the unnecessary use of rabies vaccine.
15. Overall, the “vertical” programs (women’s programs, healthy children’s, hypertension, pregnancy and others) could become “horizontal” programs, to be integrated into daily clinical practice. In any case, service provision should not be “vertical” (one afternoon for pregnancies, one morning for children, one afternoon for home services, one morning for diabetics, one afternoon for Pap smears, etc.) due to the fragmentation and lack of completeness implied by such “vertical” care. A strong, “horizontal” Primary Care should be promoted, offering longitudinality, in one consultation solving several health problems. A Primary Care being able to, for instance, fighting against dengue and simultaneously dealing with the increase in chronic care at home, falling birth rate, the aging population and the influenza A crisis. Overall, it is a matter of “stop doing in order to do”, that is, moving from an overtly bureaucratic and rigid care, with a curative deficit and “fear” of uncertainty, to a flexible, comprehensive care, open to all sorts of problems, curative and preventive.
16. Incentives should be generally global (for instance, due to working in environments with a low Human Development Index), and only in very concrete cases refer to specific activities (and in these cases, being temporary, until obtaining the promotion of those activities that professionals “do not like”, but which have an important effect in health). For instance, responding to a death certificate out of working hours (a serious problem for the poor); or to promote home care (for instance, paying a collective insurance for professionals and their vehicles covering accidents during these activities, and/or financing the use of their own means of transportation). In any case, the information systems supporting incentives and “productivity” should turn from quantity to quality, and from process to outcomes. For instance, what matters is not the number of cytologies (Pap smears) performed,

but making them on women that most need it, and proving it is associated to a reduction in cervical cancer mortality. Information systems focused on outcomes and quality should include supplementary medicines, to evaluate their effectiveness and efficiency.

17. The work in rural and remote areas should be promoted with specific plans that help the professional and their family. For instance, higher salaries, better material supply at health centers, better Information and Communication Technology installations, longer holidays, support to temporary displacements with more possibilities of participation in continuous training, greater academic recognition (specific vacancies for rural professors at universities) and other incentives. It is basic to include the professional's families, for instance, with reservation of vacancies at universities and special grants and scholarships for their children, support for the spouse to find paid work, housing subsidies, etc.
18. It is deemed important by us to improve the conditions for contracting of professionals and promoting their stay in the same BFHU (to achieve the best of longitudinality, services should be provided for years by the same family doctor or team). For such, an incentive could be added for staying in a same BFHU (a growing complement, per year of permanence, which would be lost upon transference to another BFHU). The development and implantation of a "federal professional career" adding recognition over time and efficient performance of clinical and community work is also important. In any case, in the FHS there should be a certain homogeneity in the hiring condition throughout Brazil, for in some cases the conditions are poor and/or imply the tolerance of politicians and managers faced with reprehensible attitudes (noncompliance with schedules, for instance, as a way of "keeping" a doctor in rural areas).
19. It would be essential to offer to the professionals (family doctors, nurses, assistants, dentists, pharmaceuticals, technicians and community agents (ACSS), voluntary full-time work, as a strong specific incentive. Currently, the work in a BFHU is often complemented with being on duty at nights and other jobs; in an extreme case the professional has up to seven simultaneous jobs.
20. Those who accept the new full-time contract should have or receive specific training for the management of the most frequent situations in Primary Care, providing varied and very accessible services, preventive and curative, at the BFHU premises and at home, including the most common emergencies.
21. Overall, the new contract would require forty weekly hours or work, with six hours

per day in direct patient-community care, on-demand and scheduled, at the health center. As a norm, in “horizontal” (mixed) consultations in which the patients-families receive integral care. In case of family physicians, for instance, minor surgery, direct use of ultrasound, and others. The two remaining hours per day, for home visits, community activities, continuous training and team meetings. It is essential to increase the home activity, both on demand and scheduled, for it to become a daily practice.

22. In five years, the title of specialist in Family Medicine should become mandatory to work at the Primary Care of SUS (at BFHUs) and the BFHUs would become universal to cover the whole population. During that same period the BHUs (old health centres) should disappear, and the Emergency Care Units be proportionately reduced.
23. The training of family physicians could be reached through residency in Family Medicine and through classroom and distance training workshops for doctors with a prior experience in Primary Care (in both cases, with the remuneration of preceptor-tutoring family physicians).
24. The BFHUs teams should become functional teams, with the transference of knowledge, skills and capabilities level by level until the ACSs. This way each level works as a resolute filter to the next, so that the family doctor receives complicated, difficult and complex patients (and he refers the few of those who need so to the diagnostic and therapeutic services of specialists). All team members should have a schedule open to programmed and on-demand consultations, be it from patients or from other team professionals.
25. These functional teams, with about nine polyvalent and resolute professionals, could provide services to a population of 4,000 people (including “non-resident” population and those “out of the *microarea*”).
26. The full-dedication family doctors should have, at the moment of their new contract, a list of patients (within the BFHU geographical area, with free choice by the patients) and the payment of an incentive *per capita*, around 20% of the salary (adjusted per patient age, geographic-urban, rural, remote environment, low Human Development Index and, in the future, per patient case-mix).
27. The family doctors coordinate all pharmaceutical prescriptions of their patients (even those prescribed by specialists) and prescriptions cannot be dispensed without his authorization. The same way, family doctors coordinate their patients’ sick leaves. Their electronic clinical record (electronic medical records) follows and

facilitates this care coordination. Basic improvements are needed in clinical records, both paper and digital ones, such as the inclusion of a “list of problems”, which would help improving coordination.

28. It would be very convenient to establish a benchmarking process, which requires absolute transparency of data on structure, process and outcomes (for instance, deaths by pneumonia among children younger than one year old, bacterial resistance rates, population coverage of Pap smears, amputations in diabetics, family physicians turnover rate and others). For such, those who provide the best practices/processes and obtain the best results in healthcare should be used as an example, with the purpose of transferring knowledge (benchmarking). The benchmarking process refers to family doctors and their teams, to other employees and to the BFHU, managers, alternative medicine, municipalities (Healthcare Secretaries) and States.
29. Odontology should include more curative services, in addition to maintaining the preventive ones already provided (that could be delegated to technicians and assistants). Currently, the organization of odontological services did not manage to revert the Inverse Care Law (the more services are needed, the less they are received) and oral health is reportedly worse in the lower classes.
30. It is essential to provide and maintain the BFHU’s pharmacies with varied drugs, including anesthetic eye drops, morphine and glucagon, in addition to antibiotics, psychotropics and others. The lack of basic medicines in the pharmacies of the BFHUs is unacceptable. The use of electronics, “bar-codes” and/or microchips, is required for the whole information flow of the BFHUs (from requests of lab tests to referrals) and particularly for drugs, both for stock control, and for the transfer of information on medications dispensed to the paper or electronic clinical record (electronic medical records).
31. The pharmacist must ensure the best pharmacy service at all BFHU pharmacies (for instance, declaration of adverse effects, analysis of problems related to the medicine, and others), but his or her continuous physical presence beside the drugs is not indispensable, nor at the UBSF. Pharmacovigilance (declaration of suspected adverse effects-*yellow card*) is an area that could be much improved by the participation of all professionals.
32. The number of Emergency Care Units should be reduced as the flexibility and resolution capacity of BFHUs increases. Additionally, they could collaborate with better care for the patients if each family doctor were sent daily a list of all their

patients who were attended at emergency units (name and surnames, age, sex and main problem treated).

33. The BFHU managers/authorities/directors would have to count on management and decision autonomy, so that delegation and trust are practiced (to eliminate a “mistrust management”). The goal of those responsible for the BFHUs should not be as much “*dar conta*/transfer data”, but the better use of resources and improvement of care and services provided to patients and to the community. For such it is necessary to bring the clinic to management, and bring management to the clinic (managers must focus in providing the best preventive and curative care, “normal” and urgent, in centers and at home, and the professionals should concern not only about the patient and the community, but also be aware that they manage the use of resources answering health needs, at their BFHU premises and at referrals). Overall, managers should have a status of independence from politics, with a professional career that set them free from political whims.
34. The clinical spaces are meeting points between people and, for such, should be “humanized”. It is very important that offices and dressing rooms, and generally all the BFHUs premises, change from the prevalent cold and dehumanized style to one more friendly and personal, where there are plants and flowers, and walls painted in different colors, for instance, where professionals and patients can feel comfortable and welcomed. This “humanization and customization” should not put at risk any infection control practice, which should be based in the promotion of the simple and important process of hand-washing among the professionals.
35. The teaching and continuous activity is an essential part of strong Primary Care. Therefore, every BFHU, even non-teaching ones, should have weekly teaching activities, to promote good practices, knowledge diffusion and the best skills and attitudes (also regarding ethical and values problems). These teaching activities, from the daily clinical practice, enable the adaptation of programs and protocols to local needs, and may substitute almost entirely the long periods of time dedicated to “meetings” (team meetings, BFHU meetings, workshop and other meetings).
36. The promotion of professionalism, ethical commitment and involvement in the goals of the FHS, plus appropriate means of control, could serve to reduce corruption (noncompliance with schedules, theft of drugs and material, compliance with absurd norms for fear of reprisals, duplicate charges for “combined”- externalized service providing, etc.).
37. The creation of a mini-unit of the Federal Sanitary Intelligence, able to transmit to all

professionals updated scientific knowledge in a simple and practical way, is required.

38. Due to the continental size of Brazil, and the several cultures of its population, a minimum common denominator should be ensured in all BFHUs (but not a single model) and at the same time promoting its adaptation to local uses, habits, environments and cultures.

PROJECT LIMITATIONS

The internal validity of these results largely depends on the honesty and openness of the professionals at the healthcare centers-BFHUs visited. The variety of situations and environments, and the number of professionals interviewed let us affirm that the results are coinciding and conclusive.

The external validity of these results depends on the representation of the centers-BFHUs selected. The sample is biased towards choosing BFHUs located at “difficult” environments, with low Human Development Index, which implies poverty, violence, prostitution, drugs and others. It is also biased towards the selection of teaching BFHUs and/or those with leading professionals. However, the contrast with non-teaching BFHUs visited enables us to affirm that the results are homogenous in both types. Additionally, when sharing the findings with SBMFC affiliates (through its electronic mailing list, and at their Congress) we were able to confirm the results are not “strange”, nor unusual.

The sample of BFHUs visited is biased towards urban and suburban areas, and we were able to verify that the rural professionals are more accessible, flexible and versatile. We can imagine the difficulties pertaining to the rural world, particularly on remote regions, from the comments made by the professionals who had a personal experience on the subject.

Qualitative studies have both advantages and disadvantages, in this Project, we tried to make use of the former and avoid the latter. We hope we have managed to achieve it.

TRADUCCIÓN DEL ESPAÑOL

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