

Organization of the work process for comprehensive care: strengths and challenges

Organização do processo de trabalho para atenção integral: potencialidades e desafios

Organización del proceso de trabajo para atención integral: potenciales y desafíos

ABSTRACT

Objective: To characterize the influence of family health team organization of the work process on the comprehensive health care for the population. **Method:** Descriptive research, qualitative, in ten units. 78 professionals participated. Target group technique guided by the Self-Assessment guide for Improving Access and Quality of Primary Care. **Results:** From the analysis, categories were grouped: Strengths in the coordination of care in family health units and Challenges for a comprehensive approach in family health units. The short time of work, the turnover and the low investment in complementary training in the area of primary care can corroborate the findings. **Conclusion:** It reinforces the importance of investing in human resources, capable of conducting the work process in order to implement better practices of attention to the comprehensive.

Key-words: Primary Health Care; Family Health Strategy; Administrative Requirements, Healthcare; Health Management; Comprehensive Health Care.

RESUMO

Objetivo: Caracterizar a influência da organização do processo de trabalho de equipes de saúde da família na atenção integral à saúde da população. **Método:** Pesquisa descritiva, qualitativa, em dez unidades. Participaram 78 profissionais. Utilizou-se técnica de grupo focal guiada pelo roteiro Autoavaliação para Melhoria do Acesso e da Qualidade da Atenção Básica. **Resultados:** Da análise agruparam-se categorias: Potencialidades na coordenação do cuidado nas unidades de saúde da família e Desafios para uma abordagem integral nas unidades de saúde da família. O pouco tempo de atuação, a rotatividade e o baixo investimento na formação complementar na área da atenção primária podem corroborar para os achados. **Conclusão:** Reforça a importância do investimento em recursos humanos, nesta área, capazes de conduzir o processo de trabalho para efetivar melhores práticas de atenção à abordagem integral.

Descritores: Atenção Primária à Saúde; Estratégia Saúde da Família; Demandas Administrativas em Assistência à Saúde; Gestão em Saúde; Assistência Integral à Saúde.

RESUMEN

Objetivo: Caracterizar la influencia de la organización del proceso de trabajo de los equipos de salud de la familia en la atención integral a la salud de la población.

Método: Investigación descriptiva, cualitativo, en diez unidades. Participaron 78 profesionales. Técnica de grupo focal, conducida por Autoevaluación para la Mejora del Acceso y la Calidad de la Atención Primaria. **Resultados:** Del análisis se agruparon las categorías: Potencialidades en la coordinación de la atención en las unidades de salud de la familia y Desafíos para un abordaje integral en las unidades de salud de la familia. El breve tiempo de trabajo, la rotación y la baja inversión en formación complementaria en el área de atención primaria pueden confirmar los hallazgos. **Conclusión:** Refuerza la importancia de invertir en recursos humanos capaces de liderar el proceso de trabajo para llevar a cabo las mejores prácticas de atención al enfoque integral.

Descriptores: Atención Primaria de Salud; Estrategia de Salud Familiar; Reclamos Administrativos en el Cuidado de la Salud; Gestión en Salud; Atención Integral de Salud.


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INTRODUCTION

In the Unified Health System (SUS), the provision of health services through Primary Health Care (PHC) has strengthened the fight against health inequities and PHC is central to the organization of access and care. However, due to the expansion of access, health management requires organization of structure and financing, investment in people management and encouragement of training for multidisciplinary action; production and dissemination of knowledge that incorporate technologies for the care and regulation/coordination of services making PHC mediator of the health system⁽¹⁾.

In this sense, the organization of the work process is essential to achieve the set of actions coordinated by the PHC, to enable comprehensive care, in addition to advancing the management of care for the organization of the health care network⁽²⁾.

The National Program for Improvement of Access and Quality of Primary Care (PMAQ) was created to evaluate actions provided for in PHC, which is structured in dimensions, allowing to express strengths and weaknesses in the performance of the teams, in addition to the capacity to expand the care model⁽³⁾. In this context, at the place of this study, little familiarization was found in the use of the PMAQ standards to assess the work process and comprehensive care, in addition to the need to institute reflection on professional actions in the daily life of the team⁽⁴⁻⁵⁾. In this sense, the question is: How is the work of family health teams organized in terms of comprehensive health care for people? Are there any limitations to the work of these professionals?

Thus, considering the relevance of the findings, it was justified to expand the investigation about the perception of the professionals of the family health teams about the development of their health work process. The results contribute both to professionals and managers who work in similar contexts and to centers that train new professionals, to work in the context of PHC, especially in the family health strategy.

In this sense, the objective was to characterize the influence of the organization of the work process of family health teams in comprehensive health care for the population.

METHOD

This is a descriptive research, with a qualitative approach, developed in a municipality in the southwest of the state of Mato Grosso, which, after emergency provision of physicians by the PMM, demanded from the local management the (re) organization of health services, staff review with quantitative increase and fixation of physicians and, consequently, of other professionals, in addition to the first adherence to the PMAQ assessment, in its 3rd Cycle⁽⁴⁾.

To compose the study, ten family health units were invited. This selection was justified by convenience, as they were the first units in the municipality registered for evaluation in the PMAQ. An agenda was created, with the acceptance of the participants, with possible dates for meetings that was made available to the team. The proposal resulted in the possibility of a consensual choice of date to favor the participation of the greatest possible number of professionals. Seventy-eight (78) individuals participated who met the inclusion criteria of being linked for at least six months in the unit, not being on premium or health leave and who agreed to participate on the day of the scheduled meeting with the team.

Data were collected in the second half of 2017, using the focus group technique⁽⁶⁾ and included the presence of a moderator and two observers. A script was applied, constructed by the researchers, in order to know the socioeconomic and professional profile of the participants and, subsequently, the group was guided with the Self-Assessment script for Improving Access and Quality of Primary Care (AMAQ), dimensions organization of the work process and comprehensive care PMAQ⁽⁷⁾. To facilitate monitoring, a printed copy of the instrument was made available to each participant and also projected on a multimedia device. In reading the questions of the dimensions, after evaluating the action, justification was requested considering the reality experienced.

There were ten meetings, audio-recorded with an average duration of four hours. The material was transcribed, and its identification was made with the name of the profession followed by the Arabic numeral, according to the increasing chronological order of the realization of the groups and each participant, in order to preserve anonymity.

For data interpretation, thematic analysis was used, a method that identifies analyses and reports patterns (themes) within the data; it organizes and describes its data set in detail, which, through its theoretical freedom, provides a useful and flexible research tool that can potentially provide a rich, detailed and complex report⁽⁸⁾. In this sense, the corpus of the analysis was related to two categories: Potentialities in the coordination of care in family health units and Challenges for a comprehensive approach in family health units.

Ethical aspects in research were respected, in accordance with Resolution 466/12 and approval by the Ethics Committee in Research with Humans number CAEE: 51340215.0.00005166.

RESULTS AND DISCUSSION

Seventy-eight (78) team members participated, 10 (12.8%) nurses, 10 (12.8%) physicians, 07 (8.9%) were dental surgeons, 10 (12.8%) nursing technicians, 07 (8.9%) oral hygiene technicians, 24 (30.7%) CHA, and 10 (12.8%) receptionists. Nurses assume the coordination of the PHC team. As for the time working in the team 52 (66.6%) reported having less than one year and 10 (12.8%), up to two years, indicating important turnover in the service, which may result from salary and/or work conditions.

Of the medical professionals, nurses and dentists, 15 (55%) declared to have completed or to be attending graduate school. Only 1 (10%) of the physicians and 3 (30%) of the nurses declared that they were attending or specializing in the PHC area. In addition, 63 (80.7%) of the team members said they participated in moments of training actions offered by the municipal management.

Potentialities in the coordination of care in family health units

There is a wide range of definitions for the coordination of care that articulate elements of vertical and horizontal integration between actions, services and different health professionals with the use of specific mechanisms and instruments for planning care, defining flows, exchanging information about and with users, monitoring of therapeutic plans and health needs, in order to facilitate the provision of continuous and comprehensive care, at a suitable time and place⁽⁹⁾.

In the perception of the participants, actions in a defined territory and the service schedules,

both individual and collective, are considered important facilitators for interprofessional care and for the organization of the work process, as can be identified below: "(...) Working with a specific group, which gets to know each other gradually, it becomes easier to plan and know what to do"^(Physician 3); "(...) The territory is important to know the users' conditions and vulnerabilities, constantly a trainee helps to update the live map"^(Nurse 8); "(...) We work with an agenda, by groups and by necessity that comes from the demand, the physician and I share work in what is possible and gradually we are trying to talk to the CHA to see if there is need to visit someone"^(Nurse 10).

Performance of the interprofessional team, in the territory favors spaces of citizenship and shares with the users the objective of the work, allowing to outline proposals for promotion and prevention, considering epidemiological, demographic, socioeconomic and cultural characteristics to support local planning⁽¹⁰⁾.

For the participants, attending to the population, welcoming spontaneous demand, and carrying out first calls to the emergency department and home visits in a systematic, permanent and timely manner, help in establishing a link in educational actions, coordination of care and in the registration of the production of the service, in the information system, as can be seen in the following statements: "(...) At reception, we always orient the unit's agenda, but there are cases that it is good to communicate to the nurse and fit in to avoid problems"^(Receptionist 8); "(...) The population likes to go to the UPA, we have talked to CHA to instruct about our role, in an attempt to regulate and create a greater bond"^(Nurse 9); "(...) I have a visit book, record demands, post reminders, so it is easier to talk to responsible CHA"^(Nurse 2); "(...) We have used the information system to screen and monitor specific groups. The physician and I take a report every month, normally I compile and we talk"^(Nurse 6).

Investing in opportune situations that promote improvements in the scheduling model can increase access to PHC. A format that can help and enhance care is the implementation of advanced access, which is an organization of an agenda that dislocates the practice of dividing routine and urgent demands, making it possible to reduce the repressed demand for care and absenteeism, which can strengthen the reduction of waiting time in the scheduling⁽¹¹⁾. However, there is still a challenge in the work process in the units, when the focus is on attention centered on

groups that does not have the effect of intensifying universal, longitudinal and integral care.

Participants recognize the development of actions for the mother-child binomial in capturing pregnant women, in the first trimester of pregnancy, requesting and evaluating the tests recommended during prenatal care, through nursing and medical consultations, monitoring growth and development from the child until the second year of life, as shown below: "(...) CHA are important to warn if a woman is likely to be pregnant, so I ask them to be attentive during visits" (Nurse 5); "(...) Prenatal care, to be successful, you have to follow the booklet, thoroughly, all the criteria that are in the standard, so as not to have any losses" (Nurse 2); "(...) There are a lot of children, the vaccination room is always full, every day there is an appointment with a child, even those who are not scheduled" (Receptionist 5); "(...) There is always activity with the little children, if it is not at the time of the weight, it is in the appointment schedules" (Receptionist 8); "(...) Consultations are scheduled, monthly, they are registered in the notebook and in the system, if there is a lack, the reception already warns us and I inform the CHA to go and check what happened" (Nurse 3).

Attention to the mother-child binomial is a priority of attention in the family's health. The guarantee of growth and development adequate to the physical, emotional and social aspects are important considerations in professional practices to advance comprehensive care for this life cycle, however, PHC practices focused on caring for sick children are still found ⁽¹²⁾.

For participants, actions to identify, early, cervical and breast cancer are frequent routines in health units, as in the statements: "(...) Every week on the agenda there is space for cytological collection, in addition to campaigns that the municipality does" (Nurse 10); "(...) We accompany the priority risk group, we try to schedule with those who work for a suitable time, on break, in the late afternoon, we can't always do it, but that's what we can do" (Nurse 7).

PHC actions such as health education, vaccination of indicated groups and early detection of cancer and its precursor lesions, through its screening, strengthen comprehensive care for the prevention of cervical cancer. However, it is noteworthy that dialoguing with health teams about the elements that contributed to the failure to perform preventive exams that were found in the trajectory of women with cervical cancer, from diagnosis to treatment, for example difficulties in

accessing services due to availability, in addition to low information about the disease⁽¹³⁾, constitutes constant reflection in the team's work process and in the organization of the care network.

In relation to Chronic Non-Communicable Diseases (CNCDs), participants recognize the importance of identifying and updating the register with risk factors. They report promoting the strengthening of self-care in consultations and prevention and promotion actions for arterial hypertension, diabetes mellitus, obesity, asthma and chronic obstructive pulmonary disease (COPD), as can be seen below: "(...) In the care of hypertensive and diabetic patients, the use of risk stratification has been interesting for the management of consultations" (Nurse 4); "(...) I have used Brazilian society guides to assess obesity, however, it is not always an action in consultations, it is for a demand that the patient requests" (Physician 3); "(...) I care for many hypertensive and diabetic patients. Several users come to the consultation and discover that they need to monitor for a while to close the diagnosis" (Physician 1); "(...) We realize that several patients did not know that they had a CNCD" (Nurse 1); "(...) Many of the users with CNCD are able to control the problems that result, most are disciplined with treatment and food" (Physician 10); "(...) They follow the guidelines, during consultations and visits I ask questions to check how they are eating and, in relation to the practice of physical exercises, in addition to medications. Many users are exemplary" (Nurse 7).

The follow-up of chronic patients is challenging, it must be longitudinal; it is part of the agenda of health priorities and assistance strategies, especially in PHC, which contribute to ensuring the promotion of quality of life and comprehensive care for these individuals⁽¹⁴⁾.

In relation to communicable diseases, there is an articulation of care with epidemiological surveillance in prevention and/or monitoring of users with leprosy and tuberculosis. For HIV/AIDS and other Sexually Transmitted Infections (STIs), the presence of the Testing and Counseling Center (TCC) and Specialized Assistance Service (SAS) in the municipality was seen as a possibility for a faster response to the problem identified in the territory: "(...) I am very concerned with the supervised dose, I like to follow up, if I have any complaints or a sign that could lead to the investigation, I am already around" (Nurse 10); "(...) There are always actions with epidemiological surveillance personnel and TCC/SAS personnel in campaigns, tuberculosis and leprosy are already on

the agenda, on specific dates, HIV and STIs” (CHA 12); “(...) It is always necessary to explain in the guidelines the effects that are caused by the reaction episode of the medication, especially patients with HIV. So, the help of the specialist's staff is essential to support the guidelines and also in the evaluation” (Nurse 8); “(...) Whenever I attend an STI patient, I try to explain how important his participation in the treatment is, self-care and care for others, even more when he is single” (Nurse 7); “(...) Suspected cases and those that close the diagnosis of any communicable disease, are very important for other sectors, so I usually detail the records in the chart very well” (Nurse 2); “(...) The inclusion of a rapid test, now in partnership with TCC/SAS, was important to know who in the area has it, before it was more symptomatic demand” (Physician 7).

The prevention of communicable diseases is part of the daily actions of PHC, however, weaknesses in the training and qualification of professionals for counseling on STIs/HIV/AIDS cause difficulties in approaching the users (15).

Actions to minimize aggravation related to dengue were evident as a collaborative work agenda in the team to meet demands of prevention and care: “(...) The dengue season comes, the work rate increases so that we do not have many cases. We partner with endemic agents; we try to cover as many residences as possible, guiding, removing rubble. There was already a year to do a cleaning task force” (CHA 13).

In Brazil, dengue has become a public health problem that affects health work. Therefore, monitoring of indicators and the attitude of the users of health services strengthens health education in environmental control.

Potentialities identified demonstrate the effort, involvement and investment of professionals and managers for health actions and services to happen. Next, the challenges to be faced in coordinating care are being discussed to expand the comprehensive approach in family health units.

Challenges for a comprehensive approach in family health units

In the organization of the work process, there are difficulties for professionals in the use of tools to assist the management of care in complex situations: “(...) Some situations are complex, of difficult action, I would need to be prepared to deal with them. There are very particular questions that

need experience in directing the consultation and making a decision, even about how to talk to the team about the subject” (Nurse 4); “(...) Some cases are complex, they need a network of attention, support. Only referral is not effective, the CHA realizes this when he visits. The question-answer conversation does not always happen, communication with the person who is a reference is flawed and communication with us is even more flawed. This is very bad. We have lost control of the situation. So, in complex cases, it is the patient who coordinates and monitors his treatment”. (Nurse 6).

To face the emerging and complex challenges that are in the territory, an important tool is the management of care to be provided in a timely manner. The need for the Health Care Network (HCN) strengthened in the diversity of actions and services, which causes the integration of professionals in daily work practices, can improve care management. To overcome gaps in care management, it is necessary to intensify communication in the HCN, although reference and counter-reference are normative devices, it is important that there are mutual efforts in the levels of care, to connect the access points of users and facilitate the obtaining of care of health, a situation that goes beyond just entering the service. Another aspect is the use of the Singular Therapeutic Project (STP), as it has interdisciplinary actions in its core, which enhances the production of comprehensive care (16) and provides a better space for dialogue with those involved in care. However, the analysis and use of logistical systems should be intensified to seek the coordination of care by PHC.

It is unusual to hold periodic meetings to monitor/evaluate results achieved, as shown below: “(...) We hold a meeting when I need to pass a decision on the coordination, communication, campaign or change of some activity, but a meeting to evaluate the report, we never did it” (Nurse 3); “(...) There is no evaluation of the production of the month in meetings, we do not do it here” (Physician 5); “(...) We even talked, sometimes, about a goal that was not reached or information that the coordination provided, but before sending or even afterwards, we do not reflect the production” (Nurse 8); “(...) The meetings are sometimes held in campaigns or in reports, but this is very punctual” (Nursing technician 9).

Meetings are devices for structuring and organizing work, for socializing knowledge, joint planning, and providing support for assertive decision-making. However, teamwork in the FHS

has challenges that are inherent to the interpersonal relationship process, which reveal weaknesses specific to the professional identity of each team member⁽¹⁷⁾.

The participants recognize that the coordination of care in the territory is discontinued, both in the follow-up of registration and in the monitoring of requests for exams and in referrals to specialties: "(...) For some specialties, it is more difficult to control test results, some not even they return more here, the user already takes them straight to the specialist" (Physician 4); "(...) The request for an exam does not always guarantee its performance, many times, people do it privately or take it to another physician, because it takes time" (Nurse 8); "(...) It takes a long time the result of the exam and also to look at it in the consultation, in several cases that I attend to, it's kind of an illusion to use the result to make a decision" (Physician 8).

In the dynamics of coordination, care networks necessarily require cooperation and integration of the professionals, users, managers and services involved, however the position that PHC occupies in this network determines possibilities of exercising, or not, the coordination of care⁽¹⁸⁾.

Participants allege difficulties in using methodologies of group approach, family approach and specific social groups to act on the demands that are configured as systemic problems for care. The little use of actions involving therapeutic groups in the unit and/or in the territory and encouraging body practices/physical activity were considered difficult to perform at work: "(...) It would be good if we had a professional to support body practices, this it was incorporated into our demand and there is not always time to develop everything" (Nurse 7); "(...) It is interesting to have a group approach, but few even know how to make it happen properly. I need training to apply, I know how to consult individually" (Physician 10); "(...) Doing an intervention with a family approach would be interesting in complex cases, maybe it would solve more, but it is not easy to do that, it needs practice to conduct it, including a family assessment, I know there are instruments for that, but I never used it" (Physician 3).

The training, experience and professional training of professionals in PHC still come up against weaknesses that reduce the ability to expand PHC care in comprehensive care. The use of the National Policy for Permanent Education in Health (PNEPS) can be a strategy to minimize these findings; however PNEPS has not consolidated

itself as an institutional policy and the implementation of training actions below what is expected for the desired changes within the SUS context are obstacles in its execution⁽¹⁹⁾.

The situations exposed so far demonstrate that there are still PHC actions that need investment by managers and professionals, in addition to partnerships with training centers for the development of strategies that encourage teamwork and interdisciplinarity.

Among other challenges, we highlight the approach and monitoring of users in cancer treatment: "(...) The screening is focused on women, the majority of men happens when the user demands it" (Physician 1); "(...) Once the user is diagnosed, treatment does not happen in the city, many patients move home and when they return they do not attend the unit, only if it is for a necessary consultation" (Nurse 2); "(...) It is difficult to monitor who is undergoing cancer treatment, even when they need to do some approach, during treatment, we do not know what they are doing in the other service" (Physician 5).

Cultural issues in the male population, limited supply of health services and low demand for services in PHC have made it difficult screening prostate cancer⁽²⁰⁾. The follow-up of users with cancer and their families is still incipient in the practice of PHC professionals and the disarticulation with the service network fragments the attention⁽²¹⁾. In addition, issues that mark PHC's weaknesses in coordinating care also come up against the structural capacity, support and integration of a regional arrangement that guarantees organizational flows for cancer care in the country.

Another aspect to be considered is the dimension of the concept of health surveillance and its integration with PHC. In a continuous and systematic process that permeates the planning and implementation of actions for the protection of health and prevention and control of risks and illnesses, as well as for the promotion of health, professionals of the teams felt greater difficulty in working with the articulation in the territory to favor and expand actions of environmental, sanitary and worker health surveillance. "(...) There have already been situations in which you need an investigation of the water, it was a general problem in the municipality, then we talked to them, it was only in this case" (Nurse 6); "(...) The health and environmental surveillance team is there in the surveillance building, we rarely did actions together, they are more there and we are here"

(CHA13); "(...) In recent years, men's health has helped to think about workers' health, but it is not a general context of care in the unit" (Physician 4); "(...) We work a lot, but looking at our work is kind of complicated. Management does not think about it, and the teams are not assessing how sick they are at work. We know about absences, but nothing is done, except to remove the person" (Nurse 5).

Health professionals need to develop skills capable of incorporating tools that use research, registration, analysis, programming and planning into the work process (22). Little knowledge of the approach to occupational health in PHC has been a limiting factor for care, despite the implementation of the National Policy for Workers' Health (PNSTT) it has still been a dilemma for health management(23) to provide flows of attention and support to health professionals.

Actions to identify cases of violence or social inclusion were recognized as challenging in the teams' practice: "(...) Talking about violence is a challenge, imagine working with it in the territory without it having repercussions in scandals and more exposure of the victim, it is difficult" (Physician 4); "(...) It is not easy, you need a network, you need a trained professional, people with skills in the case, who can preserve the person so as not to make the situation worse for them" (Nurse 10); "(...) If there is no support for our work, it is no use, the unit cannot handle everything. Fostering social inclusion is not an easy task, and little is done about it in training and in day-to-day practice, you have to review some assignments and define who can help make this happen in the territory" (Nurse 3).

Violence is in the daily life of the territory and permeates the work of family health teams, it has become one of the challenges for health services in Brazil, especially those of PHC, therefore, reorganization of the work process, beyond the perspective complaint-conduct, requires intersectoral actions to cover the invisibilities of violence in the territory (24).

The use of Complementary Integrative Practices (CIP) was not recognized as a strategy of clinical approach, with reports of lack of training to instruct users: "(...) I have worked in three units and each one has a different population. The demands for services may be the same, but as users accept or repress treatment changes, it is clear to me that I worked at the center and now I am in a periphery unit" (Physician 2); "(...) Sometimes from one area to another you already notice a change, I changed areas this month and realized that my population is younger, I have to change the

way I talk to them" (CHA 17); "(...) Everyone is talking about complementary integrative practices, but I don't know how to do it, so I can't recommend it" (Nurse 4); "(...) I sometimes say: -_Patient, you can do integrative practice in therapy, but they are very resistant, they prefer medications" (Physician 1).

Complementary integrative practices are not instituted in all regions of the country, for this to happen it requires institutional strengthening and qualification of professionals and services in the perspective of comprehensive care (25).

In view of the results, it is understood that, in order to think about the organization of the work process of family health teams and the interface with comprehensive health care for the population, it is necessary to consider guidelines and scientific evidence, potentialities and limitations of each context, but also the dynamics of the living construction of the actors participating in the process, that is, although it is possible to indicate directionality, the make-happen occurs in the uniqueness of each space, which needs to be respected and understood.

FINAL CONSIDERATIONS

A strong relationship is perceived by the organization of the work process to achieve actions and services that promote a better approach to comprehensive care. This study was carried out in a specific territory of a region of the country, however, the potentialities and challenges foster evidences already verified and which reinforces the need for investment in the training of human resources for PHC.

It is noteworthy that intersectoral work is essential to support PHC in the coordination of care. However, communication weaknesses in the care network need management interventions to support communication spaces. However, rethinking the possibilities that strengthen PHC requires eloquent support for a National Primary Care Policy that respects the doctrinal and organizational principles of SUS and managers committed to health management in articulating the local system and encouraging a more comprehensive PHC that coordinate care and promote coordination under the dimension of comprehensive care. Several aspects involve this proposal, mainly the qualification of human resources and the financing of the health system.

This investigation, since it was built on the teaching-service integration, contributed as an inducer for the opening of a *lato sensu* graduate

course. It is considered that this movement constituted a device for reflecting on the daily work in PHC, both in the service and for the management of care.

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