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Pharmaceutical services performed in primary health care: a conjunctural analysis of the performance of pharmacists in a municipality in southern Brazil

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Abstract

Objective: To identify the pharmaceutical services provided in Primary Health Care (PHC) in a city in southern Brazil and understand the potential and weaknesses in carrying them out, according to the perception of pharmacists. **Methods:** This is a qualitative study with pharmacists and residents who work in District Reference Pharmacies. Pharmacists completed a questionnaire to help identify pharmaceutical services provided in PHC. A pharmaceutical service was considered performed when the level of agreement was greater than or equal to 70% (Delphi technique). The services that did not reach agreement were selected and discussed in a face-to-face workshop, using a consensus technique (traditional committee). After the workshop, a focus group was held to understand the potential and difficulties in implementing the identified services. **Results**: Eight managerial technical pharmaceutical services and 26 technical assistance pharmaceutical services were identified, carried out or with the potential to be carried out in PHC services in the city studied. Among the potentialities, the recognition of pharmaceutical services by health teams and the support of local management stands out. Pharmacists pointed out the work overload caused by the great demand for activities and the absence of pharmacy teams and the lack of clinical training of professionals to work in PHC as a complicating factor, especially when carrying out technical pharmaceutical assistance services. **Conclusion**: The research findings reinforce the need to expand Reference Pharmacies, as well as pharmacists trained to work in PHC.

Key Words: Pharmaceutical Services, Primary Health Care, Pharmacists, Community Pharmacy Services.

Serviços farmacêuticos executados na atenção primária à Saúde: uma análise conjuntural de atuação dos farmacêuticos em município do sul do Brasil

Resumo

Objetivo: Identificar os serviços farmacêuticos realizados na Atenção Primária à Saúde (APS) em uma cidade do Sul do Brasil e entender quais as potencialidades e as fragilidades para a sua realização, segundo a percepção dos farmacêuticos. **Método:** Trata-se de um estudo qualitativo com farmacêuticos e residentes que atuam em Farmácias de Referência Distritais. Os farmacêuticos responderam um questionário para auxiliar na identificação dos serviços farmacêuticos realizados na APS. Considerou-se serviço farmacêutico realizado quando o nível de concordância foi maior ou igual a 70% (técnica Delphi). Os serviços que não obtiveram concordância foram selecionados e discutidos em uma oficina presencial, utilizando uma técnica de consenso (comitê tradicional). Após a oficina, realizou-se um grupo focal para compreender as potencialidades e dificuldades de execução dos serviços identificados. **Resultados:** Foram identificados 8 serviços farmacêuticos técnicos gerenciais e 26 serviços farmacêuticos técnicos assistenciais executados ou com potencial de execução em serviços da APS na cidade estudada. Entre as potencialidades, destacam-se o reconhecimento dos serviços farmacêuticos pelas equipes de saúde e o apoio da gestão local. Os farmacêuticos apontaram a sobrecarga de trabalho causada pela grande demanda de atividades e pela ausência de equipes de farmácia e a falta de formação clínica dos profissionais para a atuação na APS como um dificultador, em especial para a realização de serviços farmacêuticos técnicos assistenciais. **Conclusão:** Os achados da pesquisa reforçam a necessidade de ampliação das Farmácias de Referência, assim como de farmacêuticos capacitados para atuação na APS.

Palavras chave: Serviços farmacêuticos, Atenção Primária à Saúde, Farmacêuticos, Serviços de Farmácia Comunitária.

Introduction

Pharmacists work in Primary Health Care (PHC) in the Unified Health System (Sistema Único de Saúde, SUS) in two main areas. The first is made up of technical-managerial activities, which range from the selection to the distribution of medications and are related to the management of this input[1]. The second, regulated more recently, refers to clinical care activities associated with pharmaceutical care[2]. The main focus of pharmacists' work in Brazil is still limited to the control and distribution of medications and, despite institutionalized practices for pharmaceutical care, this activity is still incipient in health services, especially in PHC[3,4].

There have been countless efforts to increase the population's access to medications, as well as the challenges of making the necessary changes to the organization of pharmaceutical services in the country[5]. The changes have brought new perspectives for professional practice and the introduction of new roles, emphasizing the shared responsibility between patient and pharmacist, which has required pharmacists to take responsibility for the needs of individuals and not just for dispensing medications[6]. In this sense, Pharmaceutical Services is established as a practice that involves medications and is no longer centered on them[7].

Faced with the difficulty in consolidating Pharmaceutical Services in the SUS, a reference tool was created for Pharmaceutical Services in Primary Care. One of the main professional lines pursued by this instrument is the promotion of pharmaceutical care, which implies the consolidation of pharmacists integrated into the PHC team, in addition to pharmaceutical services being part of the services offered to the population by health establishments[8]. Pharmaceutical services in PHC must respond to the needs of the health system and the reality of the professionals' work, corroborating the consolidation of resolutive, integrative pharmaceutical care aimed at improving people's health, seeking to overcome technical and bureaucratic paradigms[9].

In the context of structuring the health care system and considering pharmaceutical services as part of the PHC logic, the training of pharmacists and their preparation to deal with the care network must include comprehensive care in a regionalized and hierarchical system, as well as teamwork, with an emphasis on strengthening the SUS[2,10].

In order to do this, it is necessary to identify local needs regarding pharmaceutical services and seek strategies for planning and investing in the Pharmaceutical Services workforce, effectively contributing to the needs of the population. Therefore, the aim of this study was to identify the pharmaceutical services provided in PHC in a city in Southern Brazil and to understand their potential and weaknesses, according to the perception of the pharmacists who work in the pharmacies where they are present, known as District Reference Pharmacies (Farmácias de Referência Distritais, FRD).

Methods

This is a qualitative study that used an online questionnaire, a consensus workshop, and a focus group as data collection tools. These strategies sought to identify and bring about group reflection on the attributions of pharmacy services that are carried out in the network, and to create a dialogical space for exchanges and construction for potential transformations in day-to-day practices.

The study was carried out in a city with around 500,000 inhabitants in the southern region of the country, with the highest Human Development Index (HDI-M) among the capitals (0.847), and which ranked third among the country's municipalities. The municipality was considered one of the capitals with the best PHC coverage and services in the country and had 50 Basic Health Units (BHUs) that distributed part of the Basic Component medications.

Prior to the workshop, the pharmacists completed an online questionnaire on Google Forms to help identify the pharmaceutical services provided in PHC reference pharmacies. The pharmaceutical services mapped by the study by Mendes *et al.*[14] and those described in the document prepared by Conasems "Reference Instrument for Pharmaceutical Services in Primary Care" were considered[8]. A total of 41 pharmaceutical services were listed, of which 12 were technical management services and 29 were technical assistance services. For each service, the pharmacist was asked to indicate whether they "Perform/Have performed" or "Do not perform/Have never performed". This questionnaire was sent to the pharmacists who worked in the FRDs, including the resident pharmacists of the Multiprofessional Residency programs in Family Health, via e-mail with the help of the Pharmaceutical Assistance Department. The professionals had 30 days to answer the questionnaire.

In the process of building consensus on pharmaceutical services, Delphi techniques were used in the online questionnaire and the traditional committee in the face-to-face workshop with the experts[15,16].

A pharmaceutical service was considered to be carried out or potentially carried out in PHC when the level of agreement was greater than or equal to 70%, corresponding to the agreement of at least 3/4 of the pharmacists[17]. The services that did not obtain 70% agreement in the previously completed questionnaire were selected and served as a basis for discussion in a workshop with pharmacists that took place in person in August 2022, using the traditional committee technique[15]. After the workshop, a focus group was held to understand the potential and difficulties in implementing the services identified. The aim was not to create a service charter, but to understand the pharmaceutical services provided in PHC and to understand the potential and difficulties in their implementation.

The focus group was recorded and transcribed, and the textual data was analyzed using the content analysis proposed by Pope, Ziebland and Mays[18]. Two researchers repeatedly read the material in order to classify the statements into thematic categories, seeking to organize and aggregate the content according to the topics brought up by the pharmacists.

All the notes taken on the central themes brought up in the participants' statements were reviewed, enabling a global understanding of the data and familiarity with the content. Based on this, the categories were identified as factors that facilitate and hinder the performance of pharmaceutical services. Anonymization was guaranteed and the participants were coded as "Farm" in reference to pharmacists.

This study was approved by the Research Ethics Committee under CAAE number 58643822.6.0000.0121. All participants in the stages of the study signed the Informed Consent Form (ICF).

Results

In 2020, the percentage of residents with private health insurance was 36.11%19 in the city studied. The city had 10 FRDs, pharmacies that dispense medications controlled by MS Ordinance 344/98 and which are staffed by pharmacists, distributed across the four Health Districts. It is noteworthy that only six of the 10 FRDs were located in BHUs, so that in 44 BHUs, pharmacy management was not the responsibility of pharmacists.

During the data collection period, 38 pharmacists worked in the FRDs, as informed by the Department of Pharmaceutical Services, and all were invited to answer the online questionnaire. Twenty-eight pharmacists (73.68%) answered the questionnaire, of whom 18 were civil servants and 10 residents. At least one participant from each of the 10 FRDs answered the questionnaire.

Of the 41 services questioned as to whether they were carried out by pharmacists, 21 (51.2%) did not obtain a level of agreement greater than or equal to 70% in the answers "Perform/Have performed" or "Do not perform/Have never performed", of which 6 were Management Technicians and 15 were Care Technicians. These services were discussed later in the face-to-face workshop.

Eleven pharmacists took part in the consensus workshop and focus group, representing five FRDs. The sample was considered heterogeneous, as it was made up of pharmacists with more and less time working in the SUS.

At the workshop, in a debate on the 21 pharmaceutical services not agreed upon in the questionnaire, two managerial technical pharmaceutical services and 12 care technical pharmaceutical services reached consensus, adding to those already agreed upon in the previous stage. Considering the questionnaire and the face-to-face workshop, a total of eight technical management pharmaceutical services and 26 technical care pharmaceutical services were agreed upon by the pharmacists as described in Table 1, i.e. they were services performed in PHC or had the potential to be performed.

Only seven pharmaceutical services were not agreed upon by the participants and are shown in Table 2. Although these were considered pharmaceutical services by the participants, they were not carried out.

In the focus group, central themes were raised regarding the limitations, difficulties, and challenges of consolidating pharmaceutical services. In order to understand the factors that facilitate or hinder the implementation of pharmaceutical services in PHC, as shown in Table 1, the participants' statements were explored inductively using content analysis[18] to generate the categories shown in Table 3.

Discussion

From the results presented, it is possible to identify the fragility of municipal Pharmaceutical Services in PHC, in terms of the pharmacists' distribution in the network, since only 12% of the BHUs have pharmacists and only in one unit does the pharmacist remain during all opening hours. Although all the BHUs have a pharmacy, they are not duly registered with the Regional Pharmacy Council and the Municipal Health Surveillance. They therefore operate irregularly, given that the law requires pharmacists to have technical responsibility for all health establishments (pharmacies and drugstores) during opening hours[20]. The professional is also not currently part of multi-professional teams. Thus, although the city where the study was carried out is considered a reference in PHC in Brazil, with around 90% coverage of the family health strategy and 50.5% coverage of oral health, there was a low supply of pharmaceutical services[21,] even though the survey points to a large number of services being carried out or with the potential to be carried out, since they are restricted only to the population in the area covered by the FRDs (Table 1).

Even with almost 20 years since the National Pharmaceutical Services Policy (*Política Nacional de Assistência Farmacêutica*, PNAF) was enacted in Brazil[22] and all the legal framework resulting from its implementation, there are still situations that do not comply with the legislation, according to the data in this study. Although the city has experienced significant expansion and structuring of Pharmaceutical Services, following the development of national policies, it still has a small number of pharmacists working in the BHUs[23,24,25]. The low presence of pharmacists in BHUs is reported in several studies, such as by Rodrigues, Aquino, and Medina[26] in Salvador, where less than 1/3 had a pharmacist, and by Oliveira *et al.*[12]. Something similar occurs in the city studied when only the BHUs with FRDs have a pharmacist. The presence of pharmacists in BHUs teams is lower than that found by a nationwide study, which found pharmacists in 37.9% of BHUs[27].

The expansion in the number of pharmacists working in the public service occurred mainly after the creation of the Family Health Support Center (Núcleo de Apoio à Saúde da Família, NASF), which aimed to broaden the scope and scope of PHC. The pharmacist thus became part of a multi-professional team with the opportunity to integrate the work process and contribute to access and the rational use of medications. This was accompanied by difficulties in organizing the work process, which still persist[28,29]. However, in 2020, with Technical Note No. 3/2020-DESF/SAPS/MS3[30], the regulations that structure the NASF-AB were revoked, with the Previne Brasil Program as the background. The legislative changes led to pharmacists leaving the NASF and centralizing their work in FRDs or central pharmacies, corroborating the findings of Oliveira *et al.*[12].

At the time of the study, the city investigated had recently adopted a new reorganization of multi-professional teams to the detriment of the funding changes imposed by the Federal Government in 2019 in Ordinance No. 2,979. However, the pharmacist was not part of these teams, which hinders multi- and inter-professional work. Barberato, Scherer and Lacourt[31], advocate the importance of including pharmacists in multi-professional teams and their participation in the planning and management of health units, as a significant factor in strengthening pharmaceutical services in PHC. One of the factors that sets pharmacists apart from the other categories that make up multi-professional teams is the fact that pharmaceutical practice encompasses technical-managerial and technical-assistance areas, and not just assistance, like many of the other professional categories[32,33].

The pharmaceutical services shown in Table 1 include technical management services for proper pharmacy management, which guarantee access to quality medications, and technical assistance services, which propose acting in the patient care process, whether dispensing, in a pharmaceutical consultation or in matrix support

Table 1. Pharmaceutical services that reached a consensus on their realization or potential realization in PHC, according to survey participants.

Type of pharmaceutical service	Pharmaceutical service	Consensus obtained in the online questionnaire or face-to-face workshop
Managerial technical	Medication stock control (receipt, storage, conservation, movement control and traceability)	Online questionnaire
Managerial technical	Management of medication storage conditions	Online questionnaire
Managerial technical	Stock control of other health materials and supplies	Online questionnaire
Managerial technical	Supervision of pharmacy staff	Online questionnaire
Managerial technical	Pharmacy staff training	Online questionnaire
Managerial technical	Participation in the health unit's planning activities	Online questionnaire
Managerial technical	Preparation of documents that guide pharmacy management	Face-to-face workshop
Managerial technical	Development of pharmacovigilance actions	Face-to-face workshop
Technical assistance	Guidance for patients on access to and use of medications	Online questionnaire
Technical assistance	Guidance for other professionals in the healthcare team about medications	Online questionnaire
Technical assistance	Dispensing medications and other materials	Online questionnaire
Technical assistance	Prescription review	Online questionnaire
Technical assistance	Medication conciliation	Online questionnaire
Technical assistance	Prevention and identification of medication erros	Online questionnaire
Technical assistance	Pharmacotherapeutic follow-up	Online questionnaire
Technical assistance	Disease prevention and health promotion actions	Online questionnaire
Technical assistance	Documentary record of services provided (e.g. electronic medical record)	Online questionnaire
Technical assistance	Participation in family health team meetings	Online questionnaire
Technical assistance	Discussion of clinical cases with the health team	Online questionnaire
Technical assistance	Discussion of clinical cases with the multi-professional team (NASF)	Online questionnaire
Technical assistance	Production of health education materials	Online questionnaire
Technical assistance	Guidelines for access to medications from the Specialized Component of Pharmaceutical Assistance	Online questionnaire
Technical assistance	Participation in therapeutic groups/health education	Face-to-face workshop
Technical assistance	Pharmaceutical prescription	Face-to-face workshop
Technical assistance	Evaluation of signs and symptoms	Face-to-face workshop
Technical assistance	Capillary blood glucose measurement	Face-to-face workshop
Technical assistance	Blood pressure measurement	Face-to-face workshop
Technical assistance	Home visits	Face-to-face workshop
Technical assistance	Guidance for community health Workers	Face-to-face workshop
Technical assistance	Participation in the Municipal or Local Health Council	Face-to-face workshop
Technical assistance	Development of health surveillance actions in support of family health teams (e.g. active search)	Face-to-face workshop
Technical assistance	Use of PICS in pharmaceutical care	Face-to-face workshop
Technical assistance	Inter-consultation with family health team or multi-professional team (NASF)	Face-to-face workshop
Technical assistance	Rapid Tests (HIV, syphilis and hepatitis B and C)	Face-to-face workshop

NASF = Family Health Support Center; PICS = Integrative and Complementary Practices (Práticas Integrativas e Complementares, in portuguese); HIV = Human Immunodeficiency Virus.

with a health team, or even in actions in the territory, such as home visits. These services should be organized based on the essential attributes of PHC (first contact access, longitudinality, comprehensiveness, coordination of care) and should be structured considering user-centeredness and proximity to Family Health teams and multiprofessional teams, to promote access to medications and the inclusion of pharmacists in the population's care process and in health surveillance.

In BHUs with FRD, the reality is that both management and care services are almost exclusively centralized in the hands of the pharmacist. The participants say that their work is limited to the FRD environment because of the dispensing of controlled medications, and it is not possible to provide the matrix support that was previously provided by the NASF. The tendency to centralize the dispensing of psychotropic medications was also observed in the study by Peixoto *et al.*[34]. In this respect, pharmacists are overworked, mainly due to the small number of these professionals working in the services, with some places only having one pharmacist for all the activities. This model corroborates the perpetuation of the pharmacist's role in technical management services and does not make room for the development of pharmaceutical care[35]. Regulatory aspects, accompanied by managers' low perception of the pharmacist's role, both in the proper management of medications and in the user care process, can be limiting factors in the decentralization of pharmacy and medication dispensing services[34].

Another result to be discussed from the participants' statements is the lack of understanding of "pharmacy team". Teamwork is a skill that requires the aggregation of different types of knowledge with new work processes, presenting different possibilities for construction[36]. One of the main forces at work in Pharmaceutical Services in the SUS is the nursing technicians, who are sometimes not identified by the pharmacists as members of the team, nor as professionals who contribute to the development of pharmaceutical services. This organization of work, with the distribution of tasks, could optimize the pharmacist's activities. For this to happen, technicians need to be trained and the dispensing of medications needs to be systematized, in order to help identify and resolve certain problems related to the use of medications[37]. In this sense, it is possible to infer that it is necessary to defend the concept of the pharmacy team, with the sharing of functions according to the competencies of each team member (pharmacists and mid-level professionals), with adequate training through permanent education actions.

By categorizing the participants' statements, it was possible to see factors that facilitate and others that hinder the effective implementation and performance of pharmaceutical services, as shown in Chart 1. There was a predominance of categories of hindering factors since the discussion was centered on understanding why some services were not carried out.

Good relations between pharmacists and the healthcare team are a driving force behind the implementation of pharmaceutical services[26]. Participants say that they are recognized by family health teams and multi-professional teams for collaborating in the process of users adhering to treatment and the rational use of medications, something that is closely related to the pharmacist's work. This recognition brings opportunities for the pharmacist to be inserted and consolidated as a promoter of care and to take responsibility for users' care, developing health surveillance practices in the territory. Direct agreements with local coordination can also help to change work processes. The study by Nakamura and Leite[28], identified this practice as far back as 2008, when the NASF was set up. However, for the work to function properly, management needs to recognize the pharmacist's activities as essential and these services need to be standardized[35,39].

The services shown in Table 1 are not carried out by all pharmacists at the FRDs, whether due to the organization of the service, poor incentives for continuing education or even a lack of services' standardization. The lack of pharmaceutical services' standardization identified in this study is similar to the findings of Soares, Brito and Gelato[39], in relation to the discrepancy in the provision of services in different BHUs. The lack of standardization can be seen as an opportunity to create documents that consolidate pharmaceutical services, such as service portfolios, as well as to carry out permanent education actions aimed at increasing the services that can be offered to the population and family health teams[40]. The demands for technical and managerial pharmaceutical services often overlap with care services[28]. In addition, there is a lack of documents indicating the sanitary conditions for pharmaceutical care in PHC, which represents a legal limitation for the pharmacist's work with users[39].

The medical-centered model is also a point to be discussed. The findings of this research show that services such as health screening are not carried out due to the perpetuation of this model. Thus, the inclusion of pharmacists in these processes is challenging, especially when the service is not organized with this flow of demand.

Although Pharmaceutical Services is a recurring theme, it is necessary to qualify the debate through permanent education and greater inclusion of the pharmaceutical profession in social control spaces[41]. This aspect was raised by the participants in this research and can be recognized as a weakness, since decision-making is done by other professionals, and they end up defining the direction of the pharmacist's profession.

Finally, most of the pharmaceutical services that are not carried out in PHC in the city studied, shown in Table 2, are related to the organization of pharmaceutical services management. The centralization and verticalization of decisions on pharmaceutical services at the central management level was identified as an ethical problem by Molina *et al*.[25]. The functions of acquiring and selecting medications are centralized in the Department of Pharmaceutical Services, which makes it difficult for pharmacists working in the service to participate. Even though they are under the responsibility of the central level, it is important to provide mechanisms for the participation of PHC professionals in the creation of protocols, definition of work processes, among others.

This study had some limitations. Data collection took place in a single city in the southern region of Brazil, so the findings cannot be generalized. The research strategies involved the partial participation of pharmacists working in PHC, and pharmacist managers were not included.

Table 2. Pharmaceutical services that did not reach a consensus on their realization or potential realization in PHC, according to survey participants.

Type of pharmaceutical service	Pharmaceutical service
Managerial technical	Participation in multi-professional team/NASF meetings
Managerial technical	Support for the medication procurement process
Managerial technical	Supporting the medication selection process
Managerial technical	Participation in the Pharmacy and Therapeutics Commission (Comissão de Farmácia e Terapêutica, CFT)
Technical assistance	Application of injections
Technical assistance	Health tracking
Technical assistance	Initial consultation on the use of antiretroviral medication (PVHIV)

NASF = Family Health Support Center; CFT = Pharmacy and Therapeutics Commission; PVHIV = people living with HIV

Figure 1. Facilitating and hindering factors for the implementation of pharmaceutical services in PHC identified in the study.

	Category	**Excerpts from the speeches**
Facilitators	Team recognition	*"Often the team comes to request records that they don't have access to, to check treatment adherence for example"* [Farm 5]
	Agreements with management to develop actions	*"Home visits could be resolved by agreeing with local coordination"* [Farm 2]
Difficulties	Low incentive for continuing education	*"We have no preparation to work with PICS, it is not available to pharmacists in the network for training, part of their own initiative or pharmacists graduating from residencies"* [Farm 3]
	Standardization of services	*"The service is not organized to receive this patient and carry out active screening, such as requesting tests (...)"* [Farm 4]
	Function overload	*"Most things that go beyond dispensing always fall under the mandatory presence of the pharmacist"* [Farm 3] *"How am I going to leave the pharmacy to do a PICS if the service depends on me to be available"* [Farm 3] *"In practice, as a result of Ordinance 344, which provides for the control of medications subject to special control, the pharmacist is only allocated to reference pharmacies because of these medications, and in their absence, it is not possible to dispense these medications and, therefore, the pharmacist is trapped within this service".* [Farm 5] *"In the BHU, when the pharmacist is on vacation it becomes chaos, because he's the only pharmacist and no one is responsible for the activities carried out when he's not there"* [Farm 5]
	Sub-registries	*"The health surveillance service is often not recognized as such, which is why it is not recorded in medical records, sometimes we don't know how to communicate with the team, and this is not taken forward. The team doesn't recognize that the pharmacy is an important point for this service. The service could establish agreements with the pharmacy to improve the follow-up of this patient"* [Farm 1]
	Dismantling the NASF	*"Group care has been greatly reduced with the dismantling of the NASF, (...) the current structure of the municipality does not favor group care. The multi-professional teams have been formed and the pharmacist is not included in them"* [Farm 1]
	Low participation of pharmacists in social control	*"The pharmacist is an important player and pharmaceutical care is stuck because we don't have pharmacists participating in social control"* [Farm 2]
	Lack of a pharmacy team	*"The pharmacy doesn't have a team, that's the central point"* [Farm 1]. *"There's no technician in the pharmacy and when there is, it's because there's no pharmacist. We have pharmacy trainees"* [Farm 1]. *"The technician who goes to the pharmacy is the one who has nowhere else to go" [Farm 2].* *"The great difficulty is in demanding help from the technician, because he doesn't answer to us, if it were a pharmacy technician it would be easier"* [Farm 2].
	Service organization	*"I don't think screening is our job here in PHC because we don't have the infrastructure to carry out this service, so I can't see it in our service portfolio, in our reality of seeing many patients a day, of not having a reserved place in most places, in the health centers, and you don't have the time, the infrastructure to carry it out. Maybe it should be done, but in the way PHC is organized today, when the user arrives with some sign or symptom, they aren't taken in by the pharmacy, they're taken in by the ESF. Occasionally they end up being seen at the pharmacy, but these are very specific cases. The model that the service is designed to use to receive users is different, we are not included in this reception to work on health screening"* [Farm 1]
	PA management centralization	*"In Florianópolis we don't have an active role in the medication acquisition and selection process"* [Farm 2] *"The medication procurement and selection process are still centralized in the secretariat"* [Farm 1] *"We have no governance or influence over the medication procurement and selection process"* [Farm 3]

PA = Pharmaceutical Assistance; PHC= Primary Health Care; ESF = Family Health Team (Equipe de Saúde da Família, in Portuguese); NASF = Family Health Support Center; PICS = Integrative and Complementary Practices; BHU = Basic Health Unit.

Conclusion

Numerous efforts are being made to qualify pharmaceutical services in PHC, but the importance of services being carried out by a trained team through permanent education must be taken into account. The pharmacy team needs to be defined, considering all the players who work in this service so that activities can be shared and there is no overload of functions, which places the pharmacy as an essential service and a place for health promotion.

Despite the difficulties presented, many pharmaceutical services are performed, and other services have the potential to be performed. For this to happen, there needs to be provision standardization, pharmacists need to be part of the team responsible for caring for users and they need to be encouraged to carry out continuing education in pharmaceutical care. Working according to the PHC logic requires professional skills, including taking responsibility for the care of users and the territory, as well as organizing pharmaceutical services based on social needs.

The dispensing of medications plays an essential role in the care and promotion of the safe and appropriate use of medications and should be recognized as a health service with premises, structure, workers, and management oriented towards people's health care.

BHUs that have a pharmacist present and an adequate structure (physical and human resources) to carry out pharmaceutical services have the possibility of providing a more resolutive PHC and the good relationships established between health team professionals favor the development of pharmaceutical services.

The results of this study can contribute to the organization of Pharmaceutical Services in PHC and help to establish effective pharmaceutical services in the SUS. The objective is to overcome the technicist model of pharmaceutical care and move towards a model that encompasses pharmaceutical care with a view to providing comprehensive care to users.

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Collaborators:

CGB, FM: Conception, design, data collection, analysis and interpretation. CGB, FM, SJM: Writing the article and relevant critical review of the intellectual content.

Declaration of conflicts of interest

The authors declare that there is no conflict of interest in relation to this article.

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