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Pharmaceutical Services in Primary Health Care (PHC) in São Paulo: a participant observation study

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Abstract

Objective: To understand how pharmaceutical services happen, based on reflection on the different models of Primary Health Care. **Method:** The study is a Participant Observation, which uses ethnography as an approach. Data collection took place in three Primary Healthcare Centers (UBS) in three different regions in São Paulo. Analytical induction and rooted theory are the guiding references for the analysis of Participant Observation field notebooks**. Results:** The conceptual categories are grouped into those related to the pharmacist himself, facilitators for the services, limiters for the services and aspects that are fundamental, such as the dispensing of medicines as a central service in PHC. Three models of the pharmacist's performance were observed, and all pharmacists have work processes linked to PHC precepts. The evidence obtained was demonstrated in conceptual categories related to the different perspectives of pharmaceutical services in PHC, which enabled the understanding that the pharmacist is the reference in medicines in health units. **Conclusion:** Using participant observation, it was possible to visualize that pharmaceutical services in PHC tend to understand that people are not equal, and that it is necessary to recognize health and, therefore, social needs in order to build results in health. However, different models can be found, which generate different pharmaceutical service conceptions related to PHC models, some of which are universal and integral versus models of universal coverage, more focused and selective.

Keywords: pharmaceutical services, universal access to health care services, universal coverage, primary health care, qualitative research.

Serviços Farmacêuticos na Atenção Primária à Saúde (APS) em São Paulo: um estudo de observação participante

Resumo

Objetivo: Compreender como acontecem os serviços farmacêuticos, a partir da reflexão sobre os diferentes modelos de Atenção Primária à Saúde. **Método:** O estudo é uma Observação Participante, que utiliza como abordagem a etnografia. A coleta de dados aconteceu em três Unidades Básicas de Saúde (UBS) de três regiões distintas em São Paulo. A indução analítica e a teoria enraizada são as referências norteadoras da análise dos cadernos de campo da Observação Participante. **Resultados:** As categorias conceituais estão agrupadas naquelas que dizem respeito ao próprio farmacêutico, em facilitadores para os serviços, limitadores para os serviços e aspectos que são fundamentais, como a dispensação de medicamentos enquanto um serviço central na APS. Foram observados três modelos de atuação do farmacêutico, sendo que todos os farmacêuticos seguem processos de trabalho muito ligados aos preceitos da APS. As evidências obtidas foram demonstradas em categorias conceituais relacionadas às diferentes perspectivas dos serviços farmacêuticos na APS, o que possibilitou a compreensão de que o farmacêutico é a referência em medicamentos nas unidades de saúde. **Conclusão:** Utilizando da observação participante, foi possível visualizar que os serviços farmacêuticos na APS têm uma tendência de compreender que as pessoas não são iguais, e que é preciso reconhecer as necessidades de saúde e, por conseguinte, sociais para, então, construir resultados em saúde. Porém, pode-se encontrar modelos diferentes de trabalho, que geram concepções de serviços farmacêuticos distintas, relacionadas aos modelos de APS, sendo alguns mais universais e integrais *versus* modelos de cobertura universal, focalizados e seletivos.

Palavras-chave*:* serviços farmacêuticos, acesso universal à saúde, cobertura universal em saúde, atenção primária à saúde, pesquisa qualitativa.

Introduction

Primary Health Care is a promising field of debate and construction for the improvement of people's living conditions, but it has currently also been a space for disputes regarding conceptions and models, in which proposals for universal systems compete, and others, for universal health coverage[1,2]. As is the case in PHC, pharmaceutical services also involve a dispute of models, between clinical and management; between specialized care and primary care; between individual and multiprofessional teamwork; between services focused on medication or centered on people[3,4].

This is an international debate: in countries such as England and Canada, PHC pharmacists perform a clinical, managing and social caregiving role, a key figure in the communities where they work[5,6,7]. Others highlight the transition from pharmaceutical services to a patient-related focus in which pharmacists work in a multiprofessional team, investing in training for interprofessional collaboration, forms of communication and their performance in health care[8,9].

By departing from the original conception of the Alma-Ata Charter, health systems have been betting on a PHC model based on universal health coverage, which weakens the integral approach and reinforces the focus of vulnerable groups[1,10]. In this model, actions are directed towards the diseases, and their resoluteness is physician-centered and medicalizing[11,12].

In Brazil, the characteristics of pharmaceutical services are intrinsically linked to this PHC context, in which public pharmaceutical policies have promoted significant advances, which resulted in an expansion of access to medications through the state[13], as well as in deepening of several activities developed by pharmacists in multiprofessional teams[14].

The concept of pharmaceutical services used in this study adds the understanding that service is work in progress, with a dynamic conception of the term, it is work in action. Unlike a product, which results from the process, a service is accumulated work, with characteristics such as intangibility, unstockability and interactivity, as the interaction between providers and users is a fundamental condition for the provision of any service[15].

Due to this, pharmaceutical services are work in progress that creates and adds value, considering the health/disease process, health promotion and the resoluteness associated with the services[16,17]. This concept has meaning in a model that focuses on access to medications, considering it as a strategic public policy and the social need of pharmacists as health care professionals, especially in Primary Health Care (PHC)[18].

In this context, the objective of this study is to understand how pharmaceutical services take place, based on the reflection on the different Primary Health Care models.

Methods

This is a Participant Observation study with an ethnographic approach, based on the Malinowski's precepts, who grounds his description on the need for scholars' scientific knowledge, the Participant Observation values, and the techniques of collection, ordering and presentation of what he calls evidence. The anthropologist suggests a new research style based on constant dialog between participant observation and ethnographic descriptions[19].

Ethnography aims at describing and analyzing a culture or community, either in whole or in part, its beliefs and practices, showing how the various parts contribute to culture, as a unified and consistent set[20]. In Participant Observation, field research is interpretive or subjectivist, as it will contribute in apprehending the meanings of the object. It is interpreting more than explaining and intends to show the significations experienced by people or the phenomenon they attribute to their actions[21].

The context of this study is PHC in the Unified Health System, with pharmaceutical services in PHC as the phenomenon in question. The same happened in the city of São Paulo, which is divided administratively in six health territories and has around 570 SUS pharmacies[22]. There are 363 pharmacists and 1,253 pharmacy technicians in PHC[23].

Data collection took place in three BHUs from three different regions. All of them are managed by Social Health Organizations (SHOs) and all the professionals are outsourced.

The observation sample is of the non-probability or theoretical type, constituted as an intentional sample, being a strategy that makes it possible to know general aspects of the studied phenomenon, giving access to the circumstantial knowledge of social life[21]. It is determined by the research problem: a place or group is chosen based on its pertinence to clarify the phenomenon researched in the best possible way[20, 21]. The central management of Pharmaceutical Services and Regional Health Coordination contributed to determination of the BHUs, considering the following: the countless management offices in which the research needs to be authorized; time for approval; and strangeness of the professionals to participate in scientific research.

There was a total of 166 observation hours, within a 1-year period between October 2017 and November 2018. The collection procedure was divided into 3 cycles, one for each BHU. In this article, the cycles are called Case 1, Case 2 and Case 3, and the pharmacists are Ph1, Ph2 and Ph3. The information was recorded in field notebooks following this structure: raw data (dates, times); data from the experiences or observation notes; personal impressions and feelings; and pre-analysis or analytical data[24]. The study by Mendes et al. (2022) was a basis in the description of the pharmaceutical services offered in the field[14].

In this study, the data collection moment in the field was structured in six phases: entering the field, obtaining informed consent, becoming invisible, building harmony, deciding what to observe (permanence phases) and leaving the field[24]. Entry into each unit occurred with similar characteristics. One of them was the informants' strangeness about having a researcher in the environment. At BHU 1 there was some sort of calibration of the perspective about the research. All field exits occurred at the time of data saturation or subjection[25].

Analytical induction [26] and the rooted theory[20] are the guiding frameworks for the analysis of the Participant Observation field notebooks. After extensive reading of each notebook, the records were organized using the Atlas.ti 8 ® software. The field notebooks were organized into 322 sections/incidents.

The objective of the rooted theory is theoretical re-signification and constitutes the formation of concepts, which are the basic unit of analysis. The concept does not designate the incident itself but what it represents, what it refers to. A single incident observed can refer to several concepts. The concepts belonging to the same universe are subsequently gathered in a conceptual category[20].

In determining the conceptual categories, it is time to minimize the differences observed, in order to detail and consolidate the content of the categories. Each new incident is compared to the content of the already assembled conceptual categories, which leads to improving their properties or to creating other categories. When any new incident fails to trigger a reformulation of the concepts and categories, saturation will be reached[20]. Figure 1 illustrates the process described above.

The study follows the international recommendations set forth in the Standards for Reporting Qualitative Research (SRQR) guideline[27].

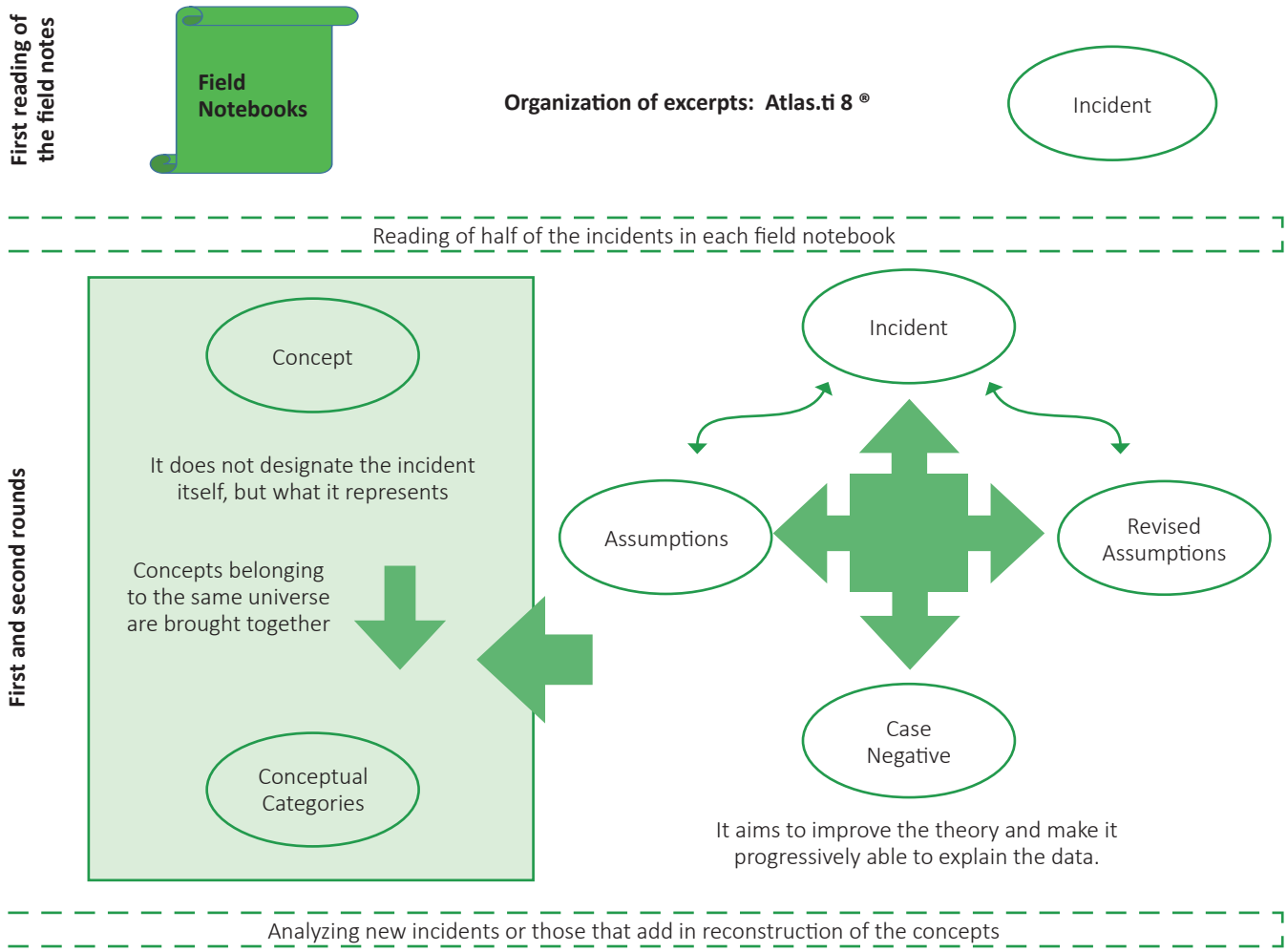
It was approved by two Research Ethics Committees (CAAE: 54854416.4.0000.0067) and (CAAE: 54854416.4.3001.0086).

Results

Case 1 was in a BHU from a neighborhood with little commerce, many people living in houses and some schools. It offers easy access to the public transportation options. The closest underground station is located 11 km away. The BHU is the only health service in the neighborhood, and has six Family Health Strategy (FHS) teams. The pharmacy has a pharmacist, three assistants and two pharmacy technicians. Ph1 stays most of the time in the pharmacy, performing services necessary for management, supervises the pharmacy team and whenever the other professionals of the team demand it, makes home visits, monitors the smoking therapeutic group and guides professionals and patients on use of the medications available at the BHU.

Case 2 was developed in a BHU located in a neighborhood with many commercial shops. The BHU has five FHS teams. The pharmacy has a pharmacist and two pharmacy technicians. Ph2 performs several services, stays inside the pharmacy all the time necessary to ensure that the pharmacy technicians feel supported, but performs home visits whenever the teams request so in cases such as polypharmacy or in situations with a drug-related problem, always with requests from family health teams; holds his own therapeutic groups such as glycemic self-monitoring (GSM), and also assists in groups such as smoking or with NASF professionals.

Figure 1: Analysis process of the field notes using analytical induction[26] and the rooted theory[20]



Case 2 took place in the setting of a health unit different from the others, as there is an outpatient medical service integrated to the BHU. This unit has two FHS teams. The pharmacy has a pharmacist (8h/day) and four pharmacy technicians (6h/day). In this case, Ph3 performs several clinical services, has his own schedule at the unit's reception and a weekly routine with activities divided between the smoking therapeutic group, pharmaceutical consultations, dispensing of inputs for the GSM, therapeutic groups of feeding, auriculotherapy and others that are necessary. He only stays in the pharmacy during one work period.

After performing the analysis, a number of conceptual categories emerged from Participant Observation. They were organized into four groups.

The observation was made by the sum of the data collected in all three health services, which have different characteristics, important in representing the meaning of pharmaceutical services in PHC. The data were not analyzed separately or making comparisons between the BHUs, but represent the composition of the phenomenon observed.

Table 1 shows the conceptual categories, comprised by the concepts, which are the interpretation of the incident, that is, each excerpt from the field notes.

Table 1. Conceptual categories and excerpts from the field notebooks

Group of categories	Concept[a]	Excerpts from the field notebooks	Conceptual categories[b]
Those referring to the pharmacists themselves	The pharmacists build up their performance from the local health needs of the team and this can be dynamic, as they do not need to stay in the pharmacy all their scheduled work time, but they still supervise their team.	Patient assisted by telephone at the reception, they bring the doubt to the pharmacy, I find interesting the view that the pharmacy understands what is related to medications, and also to decision-making, and responsibility, Ph1 is the one who tried to solve the user's insistence. (FN 01). Ph2 is also in the GSMP (Glycemic Self-Monitoring Program) room, glycemic control, she helps in management of the stock of inputs, but the main focus are the patients, because she can see how they are, they measure the glycaemia at the time and she can already see (FN 02).	They refer to the pharmacists as the professionals that perform the pharmaceutical services and have centrality of the services in the PHC included in their job.
	Pharmacists are the reference in terms of medications in the BHU and have become essential for the population	On Tuesday Ph3 just made an appointment with a schedule in the SIGA, scheduling every 30 minutes. It's scheduled at the reception and Ph3 doesn't know most people. They were referred by the doctors, and Ph3 was doing this, doctor by doctor, but I also don't understand that it has a greater link with family health, but P3 is trying to do a more clinical service (FN 03).	
	In PHC, the meaning of the professionals who only take care of medications as the end of their work changes since, in this space, pharmacists must be sensitive to people's needs.	Ph2's schedule is on paper, it's not in SIGA [appointment scheduling system for all BHU professionals]. Pharmacists can't only be stuck in the office as doctors, but also need to be included in the team and, for this, they also need to leave the protection of the room referred to as "Pharmacy". This doesn't mean that they are not health and technical authorities on medications (FN 02). She developed a GSMP [Glycemic Self-Monitoring Program] schedule, of groups for diabetes, so the first she does with nursing, the second with the physical educator, the third with physiotherapy and the fourth with a nutritionist, there's also programming with a psychology and a dentist. I believe that, in the coming days, I will see the group with the psychologist, this is a group that was her idea, it started from the analysis of the follow-ups at GSMP, she invites patients also through the CHAs and does a work with head nurses of the teams (FN 02).	
	The clinical activities developed by pharmacists can be an integral part of pharmaceutical services since, what stands out is not the clinic itself, this is the work in PHC in the universalization model, considering the real health needs.	Ph2 scheduled as she knew the patients and their needs, through dispensations and referrals by the CHAs and staff (doctor, nurse). With Ph3 here, it's demand, the consultation for the consultation, to clear the queue, because not everyone has some problem with medications (FN 03). Ph3 is an excellent clinician, he does what is expected, leaves the pharmacy, does other activities well beyond that and the tutelage of the "Pharmacy Space", but it's based on what the needs are. (FN 03).	
	The pharmaceutical consultation is a space where pharmacists provide clinical services; however, it has greater potential to produce meaning, integrating with other services, when it is carried out based on the needs of the patients and the health team.	It's a return visit. Ph2 already looks at the records of each patient, starts by asking about sleeping pills, catches an error in use, asked about sleeping, how the patient is reacting to the use of sleeping pills, talks about fibromyalgia of Mrs. X, she doesn't use any medication for that (FN 02).	

Table 1. Conceptual categories and excerpts from the field notebooks

Group of categories	Concept[a]	Excerpts from the field notebooks	Conceptual categories[b]
Facilitating factors for the services	The Pharmacy as a space constituted within PHC and, in order to provide a PHC model built for health needs, this space should not be merely a warehouse.	The pharmacy window is right at the BHU entrance, but the internal door is in the corridor of the offices, which also facilitates interaction with the teams (FN 02). Still on the materials for use in the BHU, there are also 2 shelves that are organized in boxes and identified with very detailed labels, on the side there's a small room, like an extra warehouse, where some larger volumes and diapers are kept (FN 02).	All aspects involving these concepts are facilitators for the pharmaceutical services in PHC, as they constitute strengthening possibilities and constituted potentialities found in the spaces and processes.
	The performance of pharmacy technicians, professionals who are in the process of training and qualification to work in PHC, which makes pharmaceutical services dynamic.	The disposal, inventory, cleaning and organization activities, checking expired medications, control of psychotropic drugs and supply are daily, weekly, monthly routine activities (FN 03). The technician seems very empowered to me, he quickly solves issues, solves Nursing problems, manages to identify medications and their uses, assists the population without major problems, technicians in dispensations don't go beyond basic guidelines. (FN 02).	
	The concrete PHC reality predisposes team integration and, in some cases, pharmaceutical services have taken place under this logic.	In the afternoon I was also with Ph3 in a meeting about tuberculosis. The BHU manager, a nurse, Ph3 and the psychologist took part in the meeting. Team meeting aligning actions and issues, mainly on underreporting (FN 03).	
Limiting factors for the services	Some characteristics in the services observed can be attributed to the different SHOs. However, what can be seen is that pharmacists are not conferred much autonomy.	Ph1 spends a lot of time doing the services to send for the SHO, as well as filling out the HR reports (FN 02). Management that dictates rules for dispensing, for how Ph1 services should be, how does this happen in SP, considering the differences in the regions? Ph1 is in this management x patient relationship (FN 01).	This category corresponds to what hinders the development of pharmaceutical services as expected for the PHC model based on health needs and on a universal health system.
Aspects that are fundamental	Dispensing is a central service in PHC. Dispensing services are among those focused on health care, and can be included in the needs related to medication use. It is a connection service between the various types of knowledge that are so recurrent in PHC, such as the bond with patients and care continuity.	Ph1 took a 6-in-6-hours norfloxacin prescription, the assistants found the dosage strange, as it's usually 12 in 12 hours. Ph1 went back to the doctor to review it, the patient didn't understand and started to get angry. The prescriber saw the error and even changed the treatment. When Ph1 went back to the pharmacy, the patient didn't understand and was very angry, threatened Ph1 and the team, and called the police. When the police arrived, the BHU manager, P1, doctor and clinical manager of the BHU gathered. At the beginning of the conversation, the police even questioned the fact that Ph1 was not obeying the medical order, that is, the civil police have the same social imaginary, that doctors own health institutions. The woman took the medication, but destabilized the entire team. The police understood the situation, where Ph1 was protecting the patient from a possible use error, just as Ph1 is supported to not carry up dispensing in case of a prescription error (FN 01).	This category corresponds to aspects that are central and founding to pharmaceutical services in PHC if, in fact, such construction is based on the perspective of health needs based on a universal health system.

a- The concept does not designate the incident itself (excerpt from the FN) but what it represents (Laperrière, 2014).
b- Conceptual category: the concepts belonging to the same universe (Laperrière, 2014).

Discussion

The conceptual categories helped to understand the specificities of the phenomenon and became evidence of the different perspectives of pharmaceutical services in the PHC.

Among the conceptual categories there is the group that concerns the pharmacists themselves, referring to them as professionals performing pharmaceutical services, with those found in the services developed in PHC as centrality of their work.

At the end of the 1980s, in Brazil, pharmacists were already recognized as the most qualified professionals to perform actions aimed at improving access and promoting rational medication use[28].

The pharmacy is experiencing a transitory moment for the integration of clinical and management services, so that patients enjoy rational access to medications, using them properly. The pharmacist's practice is divided between actions that enable good sanitary practices on medications, as in the case of prescriptions and decisions to ensure full access, under the aegis of the right to health[29].

In the observation, it was possible to verify that pharmacists provide clinical services; however, they still do not have autonomy in the health team to perform some actions, for example in drug dispensing, such as dose substitutions.

In the PHC context, many clinical services can be performed in conjunction with the multiprofessional team, as well as to develop other possibilities of access and use of some medications, without being completely connected to the medical practice.

In the field, it was significantly observed that the BHU pharmacy remains a reference for the community. In PHC, pharmacists have been using the same strategies as the other professionals, as no standard established was observed in their practice in any of the three cases, but work carried out based on the organization of each pharmacist and the needs of each health service.

Some studies point out to the development of clinical pharmaceutical services occurring in PHC, as well as the existence of pharmacists with a profile for the clinical practice[30,31].

Ph3 provides countless clinical services and has a consultation schedule at the BHU reception; he has very similar activities to other professionals but, with this priority, there is lack of supervision in dispensing caused by absence in the pharmacy.

The major meaning of any pharmaceutical service should be its contributions to the health/disease process[32]. Regardless of the activity or occupation, pharmaceutical services continue to be work in process, which creates and adds value, and is carried out through the application of knowledge and skills for the benefit of the other[33].

The second group of categories corresponds to facilitators of pharmaceutical services in PHC, as they are strengthening possibilities and constituted potentialities found in the spaces and processes.

Ambience is fundamental for the construction of the PHC model[34] and can interfere in different forms of execution of pharmaceutical services. Ambience can be translated as environment; however, in terms of health services it does not only consists of the material environment, but of the moral effect that this physical environment induces in people's behavior, and in services in PHC[35].

Some records in the field notebooks (Table 1) show the strong potential of having a space called Pharmacy constituted within the BHU. All 3 scenarios had this space. A study carried out in 2017[34] in all Brazilian regions also points to the expansion of incentives for the physical structuring of pharmaceutical services, taking into account regional specificities.

The performance of pharmacy technicians was a unanimous characteristic in all scenarios.

Historically, and in many municipalities, it is still nursing technicians that are responsible for several activities in PHC. In a study by Nakamura and Leite[16], the teams reported that it is interesting to have a pharmacist in the health unit, more precisely, within the pharmacy, every day, showing that this is the expected activity of this professional, reflecting the social expectation about pharmaceutical services. However, it was possible to verify in several cases the observation that pharmaceutical services can have a diversified range in their concept[14] and involve other professionals, such as pharmacy technicians, in their direct and indirect execution.

The concrete PHC reality predisposes team integration and, in some cases, pharmaceutical services have taken place in this logic**.** The opportunity to be part of a multiprofessional team is mentioned by the pharmacists, as it allows exchanging knowledge with other professionals, qualifying and enhancing their work. The PHC challenge is to transform knowledge exchanges into professional practices[36].

A category was identified that limits the development of pharmaceutical services according to what is expected for the PHC model based on health needs grounded on a universal health system.

To understand a health service in Brazil, it is necessary to place it in the context in which it was built. In the study municipality, the motivations of public-private partnerships are the reality in the management of the health units, through Social Health Organizations (SHOs). One of the forms for privatization in public administration is outsourcing, representing an expression of work flexibility, which uses hiring of third parties[37].

Considering pharmaceutical services as a means that contribute to achieving resoluteness in health[38], for the companies managing the units it is important to have qualified professionals in the pharmacy. However, approximately 35% of the workers throughout Brazil who work in drug dispensing are hired or outsourced[39], which can pose a risk to the conformation of pharmaceutical services in PHC, as there is instability in the workers and low bonding with the community.

The conceptual category of drug dispensing is understood as fundamental for pharmaceutical services, as it is central in PHC and is characterized as a service of connection with other services of the multiprofessional team.

In the excerpts from the field notebooks, it was possible to verify how medications are central to health care. When pharmacists perform a professional act of not fulfilling a prescription with an error and potentially unsafe, such prescription becomes a police case, showing how overcoming the limited approach of making medications available in health services for a responsible technical-sanitary practice, but which also guarantees access to therapeutic resources as a need, requires understanding dispensing as a health service[40].

Soares et al.[17] (p. 109) propose that dispensing should "consider access as an attribute; welcoming, bonding and accountability, management and the pharmaceutical clinic as its components; and rational medication use as a purpose". It is necessary to overcome dispensing focused on product accessibility and to incorporate its centrality with a more integrated approach to the PHC precepts.

Pharmaceutical services have varied conceptions and denote the construction and consolidation stage of Pharmaceutical Assistance (PhA). In addition, they also reflect the pharmacists' work process, which is sometimes understood as centered on the medication logistics cycle, sometimes encompassing PhA conceptions that refer to practices aimed at user care.

In all three scenarios, the pharmacists have work processes closely linked to the PHC precepts, such as teamwork, bonding, territorialization and access to essential medications[41], although with different work dynamics. Ph1- The pharmacist only stays in the pharmacy; Ph2- The pharmacist performs all services, including clinical ones; Ph3- The pharmacist provides clinical services, and does not stay in the pharmacy.

The conceptual categories presented from the Participant Observation show diverse evidence on the development of pharmaceutical services in PHC and that relate in different ways to the PHC models found in health systems, including the SUS, some being more universal and integral, while others are marked by universal, focused and selective coverage.

Experiencing the concrete PHC reality, it is noted that many aspects observed already correspond to a PHC model that distances itself in the primary care demanded in Alma-Ata, and that are being dismantled at full steam in Brazil, after the update of the latest National Primary Care Policy in 2017[2].

In 2019, the Ministry of Health launched a Portfolio of Primary Health Care Services, which deals with a list of services divided and organized into thematic blocks, which is the focus of actions developed by the municipalities[42].

PHC development in Brazil should occur from what is experienced in this context, as it is a Latin American country, which differs from European ones, in which progressive inclusion of population groups was observed with expansion and standardization of benefits and universalization of access, especially with regard to health[43].

Universal coverage, strongly induced by the World Bank report [44] to Brazil, intends to keep the so-called developing countries only with a focused PHC, requiring low funding, with service packages established in view of pre-defined needs, without considering what, in fact, what the local population needs[43,45]. It is necessary to be attentive to pharmaceutical service models with pre-established activities, without understanding what each locus requires and what its needs are[46].

The limitations of this study are related to the negotiations with the Regional Health Coordinators of the municipality, as each one has autonomy over the acceptance for research projects, which generated a longer expected time for entry into the field. In addition to that, there are few studies on the theme of the article, hindering some discussions. One of the important limitations of the Participant Observation method is that, due to the time required in the field and the intention of in-depth reflections, it is not feasible to perform it in a larger number of health services. Therefore, in this study, the analysis inferences are related to the context of the 3 regions of a large municipality, which is a restriction to generalizations or standardizations.

Conclusion

A study like this has the possibility of unraveling and systematizing concrete data, based on facts, dimensioning the forces that interfere in the work processes. Using Participant Observation, it was possible to see that pharmaceutical services in PHC have a tendency to understand that people are not equal, and that it is necessary to recognize health and, therefore, social needs to then build health outcomes.

Finally, the study evidences characteristics of different models of pharmaceutical services in the PHC context from a large municipality, and warns about models with pre-established activities, without understanding what each locus requires and what its needs are, as they can compromise the essential characteristics of Primary Health Care in universal systems such as the SUS.

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Collaborators

Mendes SJ, 1. Conception of the project or data analysis and interpretation; 2. Writing of the article or relevant critical review of the intellectual content.

Soares L, 2. Writing of the article or relevant critical review of the intellectual content.

Leite SN, 1. Conception of the project or data analysis and interpretation; 2. Writing of the article or relevant critical review of the intellectual content.

Storpirtis S, 1. Conception of the project or data analysis and interpretation; 2. Writing of the article or relevant critical review of the intellectual content.

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Conflict of interests statement

The authors declare no conflicts of interest regarding this article.

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