

## Clinical pharmaceutical services of primary health care of the Federal District: A discussion based on the SWOT matrix

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In the epistemic field, several studies demonstrate the importance of pharmaceutical services in health care networks. Nonetheless, literature still addresses the strengths and barriers present in the provision of these services in an incipient way. Thus, this study aimed to understand these contexts in the development of clinical services for primary health care in the Federal District, Brazil. A qualitative study adopted the technique of open-script interview, structured based on the logic of the SWOT matrix. Pharmacists reported weaknesses such as precariousness and scarcity of physical infrastructure, material, and human resources. As threats, they discussed the lack of social recognition, discontinuities of government actions, and lack of preparation of the pharmacist for the provision of clinical services. Regarding themes pertaining to the service's strengths and opportunities, the advances in propositions and executions of public policies, actions, and governmental programs that have expanded the pharmaceutical workforce in primary care and that are impelling the accomplishment of clinical services were listed. This study contributes to understanding the scenario of the development of clinical pharmaceutical services, and consequently provides subsidies for the actions of planning, evaluation and qualification of health services.

**Keywords:** Pharmacists. Pharmaceutical care. Pharmaceutical services. Primary health care. Health services research.

### INTRODUCTION

Many advances have been obtained over time in pharmaceutical care of the Unified Health System (SUS) in Brazil, with emphasis on the expansion of funding, organization, and mobilization of pharmacists to perform services for users (Carvalho *et al.*, 2016; Gadelha *et al.*, 2016; Araújo *et al.*, 2017a; Carvalho *et al.*, 2017; Costa *et al.*, 2017a). Nevertheless, some challenges remain, and for its full implementation and evaluation, the set of actions and services included in the broad concept of pharmaceutical services remain the object of analysis of scientific productions.

At the heart of pharmaceutical services, the importance of providing clinical services based on the theoretical postulate of pharmaceutical care has been addressed so that patient care can provide better health and life conditions for the population (Araújo *et al.*, 2017a; Araújo *et al.*, 2017b; Blondal *et al.*, 2017; Shao *et al.*, 2017). However, when it comes to primary health care, the level of care that should be the focus of coordination and continuous care to users, few studies focus on the analysis of pharmaceutical services, which impairs planning, organization, execution, evaluation and improvement (Araújo *et al.*, 2017a).

In addition to the macro-, meso-, and micro-management axes, the spawning of health has different influences and interfaces, as discussed by the theoretical frameworks of the social determinants of health (Braveman, Gottlieb, 2014). In addition to the scenario of institutions

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that administer and provide health services, there are external factors, political, economic, and social arenas that intertwine and influence the quality of care (Scherer, Menezes, 2016). Thus, it is fundamental to understand the weaknesses and potentialities within and outside the organization in order to provide management with an expanded vision that supports health decision-making.

Recently, the Federal District underwent a reorganization in terms of regionalization in health. In total, seven health regions were created: East, South, North, North-central, South-central, West and Southwest. Within each health region, there is a core of primary care logistics. In this sector, a pharmacist integrates data to supply health technologies of the units of that region. Pharmacists in the basic units work in care, developing pharmaceutical, clinical, and pharmacovigilance services. Centrally, the Directorate of Pharmaceutical Assistance (DIASF), which deals with the standardization of actions and programs of pharmaceutical services in the public health network of the Federal District, is located at the headquarters of the Federal District Health Department. This directorate deals with pharmaceutical services as a whole, and in recent years, through the Pharmaceutical Care Program, has offered special attention to the pharmacist's practice in the practice of patient care.

Although it is indispensable to know the scenario of the services included in the concept of pharmaceutical services (Gerlack *et al.*, 2017), initiatives of this nature are still scarce in Brazil (Araújo *et al.*, 2017a). Thus, considering the importance and complexity of the implementation of pharmaceutical care in health care networks, this study aimed to understand the weaknesses and potentialities present in the context of the development of clinical services of primary care in the Federal District, Brazil.

## MATERIAL AND METHODS

A qualitative study adopted the technique of open-script interview with the pharmacists working in the basic health units of the Federal District.

The process of recruiting study participants began with a formal electronic request of the list of basic units with pharmacists to the local Health Department (SES).

DIASF e-mailed these data in October 2016, which at the time reported the existence of 49 pharmacists allocated to primary care. Of these, two cases could not be reached by telephone (one from the South and one from the East) and two other pharmacists refused to participate in the study (one from the Southwest and one from the West). Due to medical leave, seven pharmacists could not be interviewed (two from the South-central, two from the North-central, two from the Southwest and one from the West), and four did not participate in this phase of the study since they agreed to collaborate in the pilot study (one from the Southwest, one from the East, one from the West, and one from the South).

The pilot study was conducted in October 2016 and consisted of a test to improve the research instrument. Four pharmacists (10% of the interviewed population, randomly selected from four different basic health units of the Federal District) were interviewed and, based on the information obtained from the interviewees, the instrument was readapted and attained its final version.

Data collection, with the final version of the instrument, was performed through an interview with the other pharmacists (34 professionals) between December 2016 and March 2017.

The study participants consisted of pharmacists with experience in primary care in the Federal District for a period equal to or greater than six months. Professionals who had experiences in primary care but were allocated to other levels of health care at the time of the research, as well as those who were away from the workplace due to medical leave, were not included in the list of interviewees.

The open script was structured based on the SWOT matrix logic, which stands for: Strengths, Weaknesses, Opportunities and Threats (Van Durme *et al.*, 2014). This matrix is a tool widely used by companies and institutions in the search for strategic guidelines, and recent studies point to their valuable utility in the evaluation of health services (Van Durme *et al.*, 2014). This instrument, also known as FOFA in Brazil, facilitates the systematization and visualization of potentialities (strengths and opportunities) and fragilities (weaknesses and threats), which distinguishes what is internal (strengths and weaknesses), regarding which one has governability, from what is external (opportunities and threats), whose

characteristics and particularities need to be known (Gomide *et al.*, 2015).

All interviews with pharmacists were recorded. For the publication of the different speeches of the participants of the study, a numerical identification (pharmacist 1, pharmacist 2 and so on) was attributed in order to preserve the secrecy of the information.

The information recorded during the data collection was transcribed and analyzed to identify and organize the categories of speeches. Content analysis was performed using the encoding aided by the use of Nvivo® software. All the data obtained were convergent and the subjects that had the highest frequency of citation (according to the software used) and relevance (according to content appreciation by the researcher) were approached in this study.

The participants' speeches were organized according to the response pattern for each component of the SWOT matrix. The statements classified in the axes of weaknesses and strengths are those with processes under the governance of the Health Department of the Federal District. Narratives included in comprehensive content, in which the above mentioned secretariat has no domain, were reserved for the sessions of threats and opportunities.

The research project was approved by the research ethics committee of the Foundation of Education and Research in Health Sciences (FEPECS) under opinion number 1,806,928. In addition, all the participants signed the Informed Consent Term.

## RESULTS

The population of primary care pharmacists of the Federal District were interviewed, and, thus, all

local health regions participating in the study were represented by pharmacists: one from the East, four from the South, six from the North, three from the North-central, six from the South-central, five from the West, and nine from the Southwest. Of these, six declared participating in the activities of the Family Health Support Center (NASF). In terms of placement, one was allocated to the family clinic, three to basic health units and the remainder, 30, worked in health centers. No visited health unit had more than one full pharmacist. The difference in the number of pharmacists per region followed the supply of basic health units. For example, the Eastern health region had fewer pharmacists in primary care, as fewer units existed. Even with these variations, it was possible to interview pharmacists from all health regions who fulfilled the inclusion criteria and who agreed to cooperate with the research. At the time, in a universe of 172 health units that constituted primary health care in the Federal District, only 49 had pharmacists.

The mean age of the pharmacists was  $39 \pm 8.1$  years and 64.7% of them were female. The majority (64.7%) holds a specialization. Most pharmacists worked in primary care for a period of 40 hours (91.2%) and had no other labor relationship (76.5 %). Those who claimed to have external jobs, in general, also acted in the public sector (75 %). All were hired under the statutory regime.

The themes that were addressed as weaknesses of the Health Department in relation to the practice of pharmaceutical care are mentioned in Table I. Essentially, the various reports express the material and human resources shortages that are present in the reality of these services.

**TABLE I** – Weaknesses of the Health Department impacting the provision of clinical services by pharmacists

<b>Weaknesses</b>	<b>Participant speeches</b>
Precarious physical infrastructure and furniture	<i>I do not have a room. So, I think it's important to have this privacy. The patient won't stay here in the middle of all the people (pharmacist 19). [...] Sometimes we do not have a shelf! The closets are falling apart, we do not have the space here to put a computer [...] How will you file patient records? [...] (pharmacist 20). [...] There is infiltration, cracks, old furniture. That is, you do not have the basics for the inventory, imagine for attending to the patient? (pharmacist 32).</i>
Information technology	<i>There is no internet here, so I bring my computer and pay for the internet and access to the health portal to study cases (pharmacist 3).</i>
Resources to support educational activities	<i>There is a lack of material resources, no visual, audiovisual material... It makes it difficult to give lectures to a group of patients, and such things [...] (pharmacist 25). I think the pharmacy needed a color printer, because it's no use if you're treating an illiterate patient without having any color [...] (pharmacist 33).</i>
Transport	<i>To move around in the activities here I always need my car. Many times we stop going home because we do not have a car (pharmacist 3).</i>
Drug shortages	<i>I've worked at the secretariat for about 10 years. I've never gotten to at least 90% of the index of drugs. So we've been doing war medicine for a long time [...] I go to a doctor and say: "This beta-blocker causes interaction. Let's change the other!" "Come on! Good idea!" But then I do not have that one available, see? (pharmacist 10).</i>
Scarcity of human resources and work overload	<i>I see colleagues who have only the pharmacist in the pharmacy. Then, he has to control stock, to supply material [...] to enter everything in the computer, to make a request, to program. So how do you want a person like this to still be careful? (pharmacist 17). The secretary shoots itself in the foot when it there is none (pharmacist). We are very cheap professionals for the waste and loss that happens when there's none of us. Everyone tells me that this was open, and everyone was coming in and picking it up (pharmacist 5).</i>

The contents belonging to the strengths of the Department of Health for the accomplishment of clinical pharmaceutical services correspond to the actions of

training and the program of pharmaceutical care, as well as to the expansion of the list of services offered in primary health care to local health (Table II).

**TABLE II** – Strengths of the Department of Health for the development of clinical pharmaceutical services

<b>Strengths</b>	<b>Participant speeches</b>
Pharmaceutical Care Program	<i>[...] I think this proposal of pharmaceutical care [...] The Ministry of Health is proposing based on the experience of Curitiba. Now we're going to have it here in the Federal District [...] I think this is a very important step (pharmacist 5).</i>
Training offered by SES	<i>About a year and a half ago, the secretary shifted its focus to the pharmacist and began investing in a clinical pharmacy course. This is all for us to do clinic service too. In the hospital, this is already more advanced (pharmacist 25).</i>

**TABLE II** – Strengths of the Department of Health for the development of clinical pharmaceutical services

Strengths	Participant speeches
Destination of servers for primary health care pharmacies	<i>Hiring more colleagues is one thing we can name and that is a very positive thing. [...] The secretary's orders, for me, were great advances (pharmacist 15).</i>
Expansion of family health strategy	<i>The ordinance was published last week, that I even told you that you can have everything in family health strategy. This also includes pharmaceutical care in basic care (pharmacist 11).</i>

On the axis of threats, pharmacists mentioned that deficiencies in training, lack of social recognition, neglect of the population with services provided, and

fluctuations in the political-economic scenario are factors that make it difficult to perform pharmaceutical care (Table III).

**TABLE III** – Threats in the SUS service scenario that negatively affecting the provision of pharmaceutical care

Threats	Participant speeches
Deficiencies in academic training, little training and experience in the clinical area	<i>I would like to feel calmer and more confident in what I would be doing because it turns out that the academic training I had was very much in need of it. I think that whoever graduated before 2002 had a disability in relation to this [...] (pharmacist 1).</i>
Lack of social recognition of the pharmacist as a healthcare professional	<i>Primary care professionals have no idea what we can do. Today, even talking to a medical colleague, he was surprised to know that I have already done a home visit. A nurse to whom I have a lot of affection, who is a colleague, he already turned to me and said: if I wanted to work with patient care, I should have done nursing (pharmacist 17). Because until then, they do not know, most managers don't even know what the duties of the pharmacist are. They think we'll get there and fix the supplies. They just see the logistics part. The technical-assistance part nobody knows, and sometimes don't want to (pharmacist 29).</i>
Layoff with public products and services	<i>Otherwise they believe: 'If I shout, if I make a scandal, I get things.' In the emergency room of a private hospital you stay two, three hours, sitting without breaking anything. In the public, it is to pick up a chair, break the glass... The person does that scandal, feels mistreated, because she has arrived, she has the right to have that answer at the time. 'It's just a question.' He does not understand that sometimes he is explaining something to another patient and that if he stops, he breaks up a whole line of reasoning [...] (pharmacist 29).</i>
Oscillations of the political-economic scenario	<i>The NASF is at a standstill. It's not having matriciality, but when it does, we participate [...] (pharmacist 7). Until a while ago, we had some groups here. Groups of hypertensive and diabetic, I liked to give lectures. Groups of pregnant women as well. For now, it's kind of stopped because of these political changes (Pharmacist 2).</i>

The activities of the study participants, as evidenced in Table IV, were the themes approached by them, such as supervision, regulation, training, elaboration of

public policies, expansion of funding and campaigns of professional valorization by the class councils and the Ministry of Health.

**TABLE IV** – Opportunities that favor the practice of pharmaceutical care in primary health care

Opportunities	Participant speeches
The actions of inspection, standardization, training, elaboration of public policies by the Ministry of Health and Federal Council of Pharmacy	<p><i>The action of the pharmacy council fines the establishments that do not have a pharmacist, checking the question of the workload, I see all this contributed. We are in transition. Now they have the courses that they offer as well. I did a prescription distance pharmacist one (pharmacist 13). Collaborate, I think these advances in legislation. Public policies that prioritize this issue including financing. Because funding is very important for pharmaceutical care (pharmacist 18).</i></p> <p><i>So, I think we have improved a lot. Because in the old days the pharmacist was a being in the worst place in the hospital. Not today. The pharmacist is already inserted in much. I believe that it will value even more, not only in basic care, but in every segment of society... These campaigns to spread the profession by the council... all this helps (pharmacist 27).</i></p>
NASF as a space that promotes creativity	<p><i>Look, it's great working with the NASF. Here they support me in everything, we are a family. Me and the doctor set up this medical garden here in the back of the health center. So every time we do a workshop, we already explain with the plants here (pharmacist 22). As I am from the NASF, I always demand the explanation of how the population should keep the medicines. So, because we do not have the resources, I and NASF staff have developed these boxes to store medicines at home, all with recyclables. We also use materials that the community brings (pharmacist 12).</i></p>

## DISCUSSION

In general, the profile of the pharmacists interviewed is similar to that indicated by the National Survey on Access, Use and Promotion of Rational Use of Medicines in Brazil (PNAUM), the Training and Quality Improvement Project of the Health Care Network (QualiSUS- Rede) and other studies in Brazil, in which there is a predominance of professionals who age from 30 to 59 years, are female, have completed *lato sensu* post-graduation and entry into public administration through a competition (Araújo *et al.*, 2017a; Araujo *et al.*, 2017b; Carvalho *et al.*, 2017; Gerlack *et al.*, 2017).

The insufficient infrastructure present in most primary care pharmacies in the Federal District suggests difficulties for managers and professionals to understand pharmacy as a space for health production that should be cherished by the user (Leite *et al.*, 2017). In addition,

this same context illustrates noncompliance with the principle of humanization, since the lack of healthy environments for both workers and users reduces comfort in the construction of bonds among the actors involved (Araújo *et al.*, 2017b; Martins, Luzio, 2017; Leite *et al.*, 2017). In addition, structural deficiencies may hinder the operationalization of elementary principles of primary care, weakening the formation of professional-user bond, the continuity of care, and the integrality of health care.

Today, much has been discussed about the advantage of the pharmaceutical office in ensuring the privacy of individuals in care. However, if the existence of a single pharmacist per unit is considered, in contrast, this physical displacement removes him from his strategic position as a professional readily available for the population for the provision of guidelines in other physical spaces of the pharmacy. Thus, far from underestimating the importance of clinical pharmacy services practiced

within the clinic, the reflection presented here endorses the indispensability of recognizing the importance of services that are performed in other settings, such as those provided in other locations in shared care as in other environments within pharmacies.

Data from the PNAUM report the great presence of computerized systems for the management of pharmaceutical assistance in the municipalities, which was not observed at other times (Costa *et al.*, 2017b; Gerlack *et al.*, 2017). On the other hand, in addition to this advance, it is fundamental to expand and ensure the availability of computerized tools aimed at the operationalization of pharmaceutical care in the SUS. Ensuring access to databases that allow clinical reasoning in reviews of pharmacotherapy, multiple-function medical records, and resources such as printers and other devices is essential for registration, clinical interventions, and evaluation of results in pharmaceutical care (Farina, Romano-Lieber, 2009; Araújo *et al.*, 2017b).

The lack of information technologies and related equipment hampers the development of pharmaceutical interventions, the preparation and availability of educational materials, communication with other health professionals and users. Thus, for the provision and qualification of clinical pharmaceutical services in the primary care of the Federal District, observing the above data, there is a need for re-adapting the environments and investing in multiple resources (Farina, Romano-Lieber, 2009).

Integrating the pharmacist into the activities of primary care is a cornerstone for the functioning, resolvability and improvement of health care (Jorgenson *et al.*, 2013; Tan *et al.*, 2014; Trinacty *et al.*, 2014; Lui, Ha, Truong, 2017; Tsuyuki, Berg, Khan, 2017). Therefore, moving with the health team among the social facilities of the community, carrying out the activities of health education, and performing home visits are part of the pharmaceutical work. That is, the precariousness of the provision of an efficient transportation service interrupts not only the supply chain of technologies in the unit, but it also makes the supply of continuous care to home users tenuous (Lui, Ha, Truong, 2017).

The unavailability of technologies impairs the selection of the best therapeutic scheme according to

the health needs of the users (Nascimento *et al.*, 2017). Thus, pharmaceutical interventions have often focused on solving pharmacotherapeutic problems by prioritizing the “necessity” parameter; this is selecting the drug as standardized and in stock, while the “effectiveness” parameter may be underestimated.

Clinical pharmaceutical services require different levels of technological density. There are “hard” technologies, such as drugs and equipment for monitoring biochemical and physiological parameters, for example; “light-hard” ones, which correspond to the well-structured knowledge in the process of health care, such as the implementation of pharmaceutical intervention based on norms, protocols and knowledge produced in specific areas of knowledge; and the “light” ones, which refer to the technologies of relationships, such as communicational skills and the capacity to foster reception and bonding, which are produced in living work in action, and condense in themselves the relations of interaction and subjectivity (Merhy, 2002).

Hard technologies were those that pharmacists immediately remembered, such as the shortage of offices, drugs, and material resources. The mention of other types of technologies, such as light-hard and light ones, has been reported indirectly and on a smaller scale. These were addressed when pharmacists addressed deficiencies in academic training, poor clinical knowledge, and a lack of skills to relate to the actors in the care process.

Regarding the educational issues of the category, even if some pharmacists did not feel apt, these actors emphasized governmental skill-building initiatives in the clinical area, as well as reported the changes in the curricular guidelines of the pharmacy course that, since 2002, propose general education (Brasil, 2002). In 2017, a new version of the guidelines was published, which, in addition to maintaining general education, included in the body of the text the axis “health care”, in which there are descriptions of a series of clinical services that this professional should be able to exercise, such as: health screening, health education, management of self-limited health problems, therapeutic drug monitoring, drug reconciliation, pharmacotherapy review, pharmacotherapeutic follow-up, clinic management, among others (Brasil, 2017).

On human resources, at first the pharmacists reported deficiencies in the quantity of workers in primary care pharmacies in the Federal District. However, they subsequently recognized the Government's efforts to expand the workforce in these settings. Carvalho *et al.* (2017) pointed out that, between 2008 and 2013, the number of pharmacists registered in basic health units grew by 75% in the country. The reasons for this phenomenon were: the creation and implementation of NASF, the growth of pharmaceutical assistance in SUS, and the incorporation of pharmacists as coordinators and providers of all activities related to the drug chain (Carvalho *et al.*, 2017; al., 2018). Nevertheless, faced with a scenario of recognition of the workforce advances in primary care pharmacies, challenges are still present, such as the absence of pharmacists in some basic SUS units (Pereira, Freitas, 2008; Gerlack *et al.*, 2017).

In this context, it is necessary to emphasize the need to prioritize the allocation of servers in quality and quantity in the pharmacies of the basic health units of the Federal District. More than filling a pharmacist per unit, general investments should be promoted in the installation of human resources in a sustainable manner, not only to supply the entire pharmacy opening hours, but to ensure that the services installed there allow the population's access to technologies of health and pharmaceutical care (Carvalho *et al.*, 2016; Carvalho *et al.*, 2017).

The principles of the legality and legitimacy of public administration make it clear that deliberations of the intentions of government, in favor of collective interests, should be defined and regulated (Silva, 2012). In the field of primary care, the creation and implementation of public policies provided several achievements, such as the proposal of the family health strategy and the NASF. Consequently, these phenomena, by encouraging multi-professional work in the model of health promotion and humanized care, encourage the operation of clinical pharmaceutical services and the creation of environments favorable to creative and unique interventions (Scherer, Menezes, 2016).

Even in view of the advances made in proposing and executing public policies that are transversal to the theme of pharmaceutical care, the ambivalent context of the political segment, due to discontinuities in government

actions, slowed the achievement and full compliance with the regulations (Mendes *et al.*, 2014; Gerlack *et al.*, 2017; Gadelha *et al.*, 2016).

The need for pharmacists to mobilize as a category was also emphasized, so that political-ideological activism may result in greater availability, maintenance, and qualification of clinical services in SUS, and in this context, the importance of this actors in the exercise of social participation (Vieira, 2007).

Some barriers to the performance of clinical pharmacy services are the outcomes of how professional relationships are processed, how the power-knowledge structures are established, and how service providers recognize the role of the other components of the team. The conceptions of the work of other professionals can be formally recognized, by the officialization of role of attributions of a certain position, but are also determined culturally. In the field of care for the primary care user, a practice territory that transcends the various professional categories, there is an arena that reflects the poor recognition of the potential contribution of pharmaceutical care to health care (Arora *et al.*, 2015).

Still on the interpersonal issue, now discussed considering the pharmacist and the user, the data of this research illustrate an important symbolic violence. This phenomenon is perpetuated in the language, behaviors and relational practices of subjects, whose invisibility impute the perception that it is something natural to be reproduced by the groups (Zizek, 2014). That is, some users adopt reactionary behaviors, perhaps as a coping resource in the context of scarcity of institutions and services, which weakens the construction of ties with the pharmacist and other professionals, and harms the collective construction of unique therapeutic plans. In addition, the pharmacist can still respond with equal hostility, weakening the harmonic link that must be present in the practice of care.

The actions of class councils that represent the category, whether in the formulation of norms, inspection actions, and advertising campaigns, were other opportunities found in the theme of valorization and re-signification of professional practice. Similarly, the literature proposes that mechanisms for periodic disclosure of clinical pharmaceutical services by the

State and by professionals themselves should also be in operation, to highlight the potential of pharmaceutical care for quality of care (Jorgenson *et al.*, 2013).

Similar to the results of this study, the national and international literature report some difficulties that pharmacists present in relation to clinical services: lack of physical space and time, insufficient human resources in pharmacies, lack of specific training, among others (Okonta, Okonta, Ofoegbu, 2012; Hatah *et al.*, 2012; Araújo *et al.*, 2017b).

The study by Hatah *et al.* (2012) evaluated the perception of general practitioners about clinical pharmaceutical services in New Zealand. The interpretation of the data obtained in the qualitative interviews was oriented based on the SWOT matrix logic. The knowledge and skills of pharmacists in promoting the rational use of drugs and other forms of therapy, such as herbal medicines, were considered as strengths. Listed as weaknesses, were: the work of the clinical pharmacist with the physician may be permeated by conflicts, clinical pharmaceutical service may be hampered by lack of access to the user's medical history, and some doctors considered that the pharmacy space may not ensure the necessary care confidentiality. Opportunities have been identified as possibilities for improving communication and for the close integration of pharmacists with other professionals. The threats listed by the interviewees were: pharmaceutical guidelines could conflict with those provided by the physician, and the need for medical-pharmaceutical interaction could increase workloads (Hatah *et al.*, 2012).

Similar to the objective of this research, Tegegn *et al.*, (2018) presented the results of a study in Ethiopia that evaluated the opportunities and challenges of clinical pharmacy services, according to the perspective of the professionals of a university hospital. Qualitative interviews revealed opportunities such as the recognition of the importance of clinical pharmaceutical services by health professionals, the strengthening of pharmaceutical activities in an interdisciplinary context, as well as the new governmental policies that are stimulating the pharmacist's clinical activity. However, in the axis of the challenges, they reported: medical resistance in accepting pharmaceutical

interventions, insufficient quantity of pharmacists, little clinical experience of the pharmacist during academic training, difficulty in integrating the pharmacist with multi-professional work, discontinuity in the provision of clinical pharmaceutical services, lack of commitment of some pharmacists, and some do not feel confident to perform these actions (Tegegn *et al.*, 2018).

## CONCLUSION

According to the exposed scenario, the participants' discourses revealed a systemic framework of subjugation of elementary aspects for the provision of clinical pharmaceutical services within the scope of the Health Department of the Federal District. The context of inconsistency is represented by the deprivation of material and human resources in primary care, which obviously does not only affect the quality of care from the point of view of pharmaceutical care but is a harmful and possibly transverse phenomenon to other health services.

A possible limitation of this study is the difficulty of understanding for pharmacists in relation to the SWOT matrix. Although at the time of the interview the meaning of the questions was explained, according to the different axes of the matrix, some pharmacists failed to report their perception about the themes of opportunities and threats.

There are different health technology needs in the provision of clinical pharmaceutical services, both in terms of drug shortages and low supply of equipment, as expressed in the deficiencies of academic training and the lack of multi-professional interactions.

For the interviewees, the advances in pharmaceutical assistance of primary health care in the Federal District in recent years are irrefutable, but some problems were also posed as permanent, such as the precariousness of physical infrastructure, and of material and human resources.

The lack of social recognition and valorization of clinical pharmaceutical services, both by the affiliated community and by the health team, was also mentioned. However, pharmacists believe that the implementation of public health policy guidelines and governmental actions, in the long term, will act as strategic instruments for the re-signification of professional practice.

## REFERENCES

- Araújo SQ, Costa KS, Luiza VL, Lavras C, Santana EA, Tavares NUL. Organização dos serviços farmacêuticos no Sistema Único de Saúde em regiões de saúde. *Ciênc Saúde Colet*. 2017a;22(4):1181-91.
- Araújo PS, Costa EA, Guerra JAA, Acurcio FA, Guibu IA, Álvares J, *et al*. Pharmaceutical care in Brazil's primary health care. *Rev Saúde Pública*. 2017b;51(Suppl 2):6s.
- Arora DS, Mey A, Maganlal S, Khan S. Provision of pharmaceutical care in patients with limited English proficiency: Preliminary findings. *J Res Pharm Pract*. 2015;4(3):123-8.
- Blondal AB, Sporrang SK, Almarsdottir AB. Introducing Pharmaceutical Care to Primary Care in Iceland-An Action Research Study. *Pharmacy (Basel)*. 2017;5(2):23.
- Brasil. Conselho Nacional de Educação. Resolução CNE/CES 2, de 19 de fevereiro de 2002. Institui Diretrizes Curriculares Nacionais do Curso de Graduação em Farmácia. 2002. Available from: [http://www.cff.org.br/userfiles/file/educacao\\_farmacutica/Comissao\\_Ensino/Legislacao\\_MEC/ResolucaoCNECESn02\\_2002.pdf](http://www.cff.org.br/userfiles/file/educacao_farmacutica/Comissao_Ensino/Legislacao_MEC/ResolucaoCNECESn02_2002.pdf). Accessed in: 02 mar. 2017.
- Brasil. Ministério da Educação. Resolução nº 6, de 19 de outubro de 2017. Institui as Diretrizes Curriculares Nacionais do Curso de Graduação em Farmácia e dá outras providências. 2017. Available from: [http://portal.mec.gov.br/index.php?option=com\\_docman&view=download&alias=74371-rces006-17-pdf&category\\_slug=outubro-2017-pdf&Itemid=30192](http://portal.mec.gov.br/index.php?option=com_docman&view=download&alias=74371-rces006-17-pdf&category_slug=outubro-2017-pdf&Itemid=30192). Accessed in: 10 jan. 2018.
- Braveman P, Gottlieb L. The social determinants of health: It's time to consider the causes of the causes. *Public Health Rep*. 2014;129(12):19-31.
- Carvalho MN, Costa EMOD, Sakai MH, Gil CRR, Leite SN. Expansão e diversificação da força de trabalho de nível superior nas Unidades Básicas de Saúde no Brasil, 2008 - 2013. *Saúde Debate*. 2016;40(109):154-62.
- Carvalho MN, Álvares J, Costa KS, Guerra JAA, Acurcio FA, Costa EA, *et al*. Workforce in the pharmaceutical services of the primary health care of SUS, Brazil. *Rev Saúde Pública*. 2017;51(Suppl 2):16s.
- Costa KS, Tavares NUL, Nascimento-Júnior JM, Mengue SS, Álvares J, Guerra JAA, *et al*. Pharmaceutical services in the primary health care of the Brazilian Unified Health System: advances and challenges. *Rev Saúde Pública*. 2017a;51(Suppl 2):3s.
- Costa EA, Araújo PS, Pereira MT, Souto AC, Souza GS, Guerra-Junior AA, *et al*. Technical issues and conservation conditions of medicines in the primary health care of the Brazilian Unified Health System. *Rev Saúde Pública*. 2017b;51(Suppl 2):12s.
- Farina SS, Romano-Lieber NS. Atenção farmacêutica em farmácias e drogarias: existe um processo de mudança? *Saude Soc*. 2009;18(1):7-18.
- Gadella CAG, Costa KS, Nascimento-Júnior JM, Soeiro OM, Mengue SS, Motta ML, *et al*. PNAUM: integrated approach to Pharmaceutical Services, Science, Technology and Innovation. *Rev Saúde Pública*. 2016;50(Suppl 2):3s.
- Gerlack LF, Karnikowski MGO, Arede CA, Galato D, Oliveira AG, Álvares J, *et al*. Management of pharmaceutical services in the Brazilian primary health care. *Ver Saúde Pública*. 2017;51(Suppl 2):15s.
- Gomide M, Schütz GE, Carvalho MAR, Câmara VM. Fortalezas, Oportunidades, Fraquezas e Ameaças (Matriz FOFA) de uma Comunidade Ribeirinha Sul-Amazônica na perspectiva da Análise de Redes Sociais: aportes para a Atenção Básica à Saúde. *Cad Saúde Colet*. 2015;23(3):222-30.
- Hatah E, Braund R, Duffull S, Tordoff J. General practitioners' perceptions of pharmacists' new services in New Zealand. *Int J Clin Pharm*. 2012 Apr;34(2):364-73.
- Jorgenson D, Dalton D, Farrell B, Tsuyuki RT, Dolovich L. Guidelines for pharmacists integrating into primary care teams. *Can Pharm J*. 2013;146(6):342-352.
- Leite SN, Manzini F, Álvares J, Guerra-Junior AA, Costa EA, Acurcio FA, *et al*. Infrastructure of pharmacies of the primary health care in the Brazilian Unified Health System: Analysis of PNAUM – Services data. *Rev Saúde Pública*. 2017; 51(Suppl 2):13s.
- Lui E, Ha R, Truong C. Applying the pharmaceutical care model to assess pharmacist services in a primary care setting. *Can Pharm J*. 2017;150(2):90-93.
- Martins CP, Luzio CA. Política HumanizaSUS: ancorar um navio no espaço. *Interface (Botucatu)*. 2017;21(60):13-22.
- Mendes LV, Campos MR, Chaves GC, Silva RM, Freitas PS, Costa KS, *et al*. Disponibilidade de medicamentos nas unidades básicas de saúde e fatores relacionados: uma abordagem transversal. *Saúde Debate*. 2014;38(spe):109-23.
- Merhy EE. Saúde: a cartografia do trabalho vivo. São Paulo: Hucitec, 2002.
- Nascimento RCRM, Álvares J, Guerra-Junior AA, Gomes IC, Costa EA, Leite SN, *et al*. Availability of essential medicines in primary health care of the Brazilian Unified Health System. *Rev Saúde Pública*. 2017;51(Suppl 2):10s.
- Okonta JM, Okonta EO, Ofoegbu TC. Barriers to Implementation of Pharmaceutical Care by Pharmacists in

Nsukka and Enugu metropolis of Enugu State. *J Basic Clin Pharm.* 2012;3(2):295-8.

Pereira LRL, Freitas O. A evolução da Atenção Farmacêutica e a perspectiva para o Brasil. *Rev Bras Cienc Farm.* 2008;44(4):601-12.

Scherer, MDA, Menezes EL. Atenção primária à saúde: Espaço potencial de criatividade. *Tempus Actas de Saúde Colet.* 2016;10(3):137-46.

Shao H, Chen G, Zhu C, Chen Y, Liu Y, He Y, Jin H. Effect of pharmaceutical care on clinical outcomes of outpatients with type 2 diabetes mellitus. *Patient Prefer Adherence.* 2017;11:897-903.

Silva RN. Políticas Públicas e Administração Democrática. *Seqüência. Est Juríd Polít.* 2012;33(64):57-84.

Tan EC, Stewart K, Elliott RA, George J. Integration of pharmacists into general practice clinics in Australia: the views of general practitioners and pharmacists. *Int J Pharm Pract.* 2014;22(1):28-37.

Tegegn HG, Abdela OA, Mekuria AB, Bhagavathula AS, Ayele AA. Challenges and opportunities of clinical pharmacy services in Ethiopia: a qualitative study from healthcare practitioners' perspective. *Pharmacy Pract (Granada).* 2018; 16(1): 1121.

Trinacty M, Farrell B, Schindel TJ, Sunstrum L, Dolovich L, Kennie N, *et al.* Learning and Networking: Utilization of a Primary Care Listserv by Pharmacists. *Can J Hosp Pharm.* 2014;67(5):343-352.

Tsuyuki RT, Berg A, Khan NA. The ultimate opportunity for advancing pharmacy practice. *Can Pharm J (Ott).* 2017;150(4):225-226.

Van Durme T, Macq J, Anthierens S, Symons L, Schmitz O, Paulus D, Van den Heede K, Remmen R: Stakeholders' perception on the organization of chronic care: a SWOT analysis to draft avenues for health care reforms. *BMC Health Serv Res.* 2014;14(1):179-10.

Vieira Fabiola Sulpino. Possibilidades de contribuição do farmacêutico para a promoção da saúde. *Ciênc Saúde Coletiva.* 2007;12(1):213-20.

Zizek, Slavoj. *Violência: seis reflexões laterais.* Tradução Miguel Serras Pereira. -1. ed. - São Paulo: Boitempo, 2014.

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