

Pharmacists' perceptions on the implementation of Pharmaceutical Care in Primary Care

I¹ Renato Dias D'Andréa, ² Gabriela Arantes Wagner, ³ Mariana Cabral Schweitzer I

Abstract: The article describes the perception of 10 pharmacists from the Primary Health Care (PHC) of a region in the municipality of São Paulo that participated in the process of implementing the Pharmaceutical Care (PC). Based on qualitative research with focus groups and descriptive approach, contents were reviewed using the Content Analysis. The 52 registration units organized in 10 categories resulted in three summaries about the PC implementation process. In this context, we could describe the role of pharmacists in PHC after the implementation of clinical services, in order to identify their perceptions, difficulties and advances. Results unveiled positive aspects, besides the need for gradual change in the profile and competences of pharmacists to develop clinical services, extrapolating the category boundaries, and depending on the teamwork performed at PHC. Therefore, results promote the different roles of the players involved in this practice (users, health team, managers, and pharmacists), and value new forms of care in the Brazilian Health System (SUS).

► **Keywords:** Pharmacist. Clinical Pharmaceutical Services. Pharmaceutical Care. Primary Health Care. Family Health.

¹ Universidade Federal de São Paulo. São Paulo-SP, Brazil (renatopharma@gmail.com). ORCID 0000-0002-8065-5714

² Universidade Federal de São Paulo. São Paulo-SP, Brazil (gabriela.wagner@unifesp.br). ORCID 0000-0001-6070-7233

³ Universidade Federal de São Paulo. São Paulo-SP, Brazil (mariana.cabral@unifesp.br). ORCID: 0000-0001-9833-2932

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Introduction

Health Care management (CECILIO, 2011) counts on health technologies in different dimensions so as to overcome the fragmentation of health actions and services (MENDES, 2011). In it, the incorporation of new professionals and the enhancement of teamwork seek to offer continuous and comprehensive care considering the unique characteristics of the health setting.

Primary Health Care (PHC) is the preferred contact of users, and the main gateway to the health system is besides being the communication center of the *Redes de Atenção à Saúde*, RAS (Health Care Networks), playing a key role in its structuring as the organizer of the RAS, and coordinator of care (BRASIL, 2017). Thus, the work of pharmacist in health services becomes a social need and is grounded on the premise of redefining their practice, based on the society's health needs, incorporating new health care strategies with a sanitarian focus (MENDES, 2014).

This professional takes on a core role in communion with other professionals and the community by establishing an extended look at the population's well-being (SANTOS; SILVA; TAVARES, 2018) to fight the irrational use of medicines and events linked to drug-related morbidity and mortality (TELES, 2013; SOUZA *et al.*, 2014; RAMOS *et al.*, 2016). The expansion of the pharmacist's clinical activities (OKOYE *et al.*, 2014; RIORDAN *et al.*, 2016) through the practice of Pharmaceutical Care (PC) results in the identification, resolution and prevention of problems related to patients' pharmacotherapy. These services enable improving the process of use of medication, the resources and health outcomes, the quality of life of users, family and community (BRASIL, 2014a; CFF, 2016).

Brazil (2020) defines PC as:

[...] a set of actions and services performed by the pharmacy professional, taking into account the concepts of individual, family, community, and health team with a focus on the prevention and resolution of health problems, in addition to their promotion, protection, damage prevention and recovery, including not only the clinical-assistance dimension, but also the technical-pedagogical dimension of healthcare work. (BRASIL, 2019, free translation).

Studies on the work of pharmacists in the practice of care in community pharmacies (DOSEA *et al.*, 2015; KENNELTY *et al.*, 2015; MOULLIN *et al.*, 2016; NIK *et al.*, 2016; FAKEYE *et al.*, 2017), outpatient care centers and hospitals

(AL-AZZAM SI *et al.*, 2013; ALCÂNTARA *et al.*, 2018), suggest positive impact on the clinical (ALHABIB S *et al.*, 2016; SANTOS, 2018; NOGUEIRA *et al.*, 2020), economic (BORGES, 2011; CAZARIM *et al.*, 2016) and humanistic contexts (MOHAMMED *et al.*, 2016), reducing the morbidity and mortality of these patients, their adverse reactions, number of drugs used and physiological parameters. This allows the pharmacist to act directly on the social health needs, lines of care in actions aimed at the clinical-pedagogical-assistance (BRASIL, 2020).

In Brazil, these activities have expanded due to the legal support granted by regulatory agencies (BRASIL, 2009; 2014), the *Conselho Federal de Farmácia* (Federal Pharmacy Council) (CFF, 2013a; 2013b), initiatives of the Brazilian government (BRASIL, 2012), municipalities (SÃO PAULO, 2016) and of projects focused on PC through the PROADI-SUS (HAOC, 2019; BRASIL, 2019).

In this context, systematic reviews (LUFT, 2015) and studies have reviewed the implementation of PC in PHC (SANTOS; SILVA; TAVARES, 2018), investigating facilitators, barriers, and strategies for the implementation of clinical pharmacy services (CPS) in health services (DOSEA *et al.*, 2017; SANTOS JÚNIOR *et al.*, 2018a) and in health systems (BRAZINHA; FERNANDEZ-LLIMOS, 2014; GUÉRIN *et al.*, 2015; AUTA; STRICKLAND-HODGE; MAZ, 2016).

Knowing the perceptions of pharmacists who promote CPS may improve quality and the implementation of PC, besides adding value to the pharmacist's role in providing care to patient (BRYANT *et al.*, 2009). Although studies have investigated the perception of pharmacists (ARYA; PINTO; SINGER, 2013; DOSEA, 2015), and used methodologies similar to the proposed study (FEGADOLLI, 2017), they were conducted in other countries and/or in other service modalities, with dynamics and realities different from the context presented, besides not conducting research in the light of care.

Since experiences of PC implementation are recent in Brazil, with little use of qualitative research in the PHC in the light of care, the aim of this study was to describe the perception of PHC pharmacists in the implementation of PC in a region of the municipality of São Paulo.

Materials and Methods

This is a qualitative study with a descriptive approach.

Population

The study included 10 pharmacists working in 10 Health Units (HU) with Family Health Teams located in the region of Itaim Paulista, of the *Coordenadoria Regional de Saúde Leste*, in the city of São Paulo, who participated in the process of implementing the PC. The PCS were implemented and institutionalized from a project carried out by the Social Health Organization (SHO) Santa Marcelina, in partnership with the Technical Health Supervision (THS) of Itaim Paulista in the year 2016, and included training and monitoring of pharmacists in the territory (SANTOS, 2017). Pharmacists who underwent resettlement of HU and/or of this health region at the beginning of 2018 were excluded.

Pharmacists of these HU previously carried out sensitization with their managers and health teams, showing how the project would look like, time of execution, the workload allocated to clinical, pedagogical and technical-managerial activities, and criteria for eligibility of patients for clinical-pedagogical activities. Simultaneously, workshops, in-service training, discussion of clinical cases, and follow-up of these pharmacists with a tutor for training in relation to PCS and PC were carried out.

Data collection

Data collection was conducted by the principal researcher through focus groups between May and August 2018. Two focus groups were assembled during the monthly meetings of pharmacists organized by the THS of Itaim Paulista and SHO Santa Marcelina. The first focus group comprised eight pharmacists, and the second comprised 10 pharmacists.

The focus group strategy was adopted for analysis of users' perception of the service, used to identify perceptions and experiences through interaction between those involved in order to discuss issues leading to greater problematization and argumentative reasoning than individual approaches (MINAYO, 2014).

Focus Group Scripts

The focus group scripts were designed according to the proposed objective, and targeted to understand: (a) the beginning of PC implementation in the Itaim Paulista region; challenges, expectations, and anxieties to start the activities; sensitization

and feedback of the teams; strategies used to capture patients and fill the agenda; interaction with the multiprofessional team; (b) conceptualization; importance of the training process; aspects needed to implement PC; services or activities that should be performed by the pharmacist; aspects of the insertion of the pharmacist in the health care network; interaction with the multiprofessional team, patient capture, and agenda filling after the PCS implementation; profile of the professional to work with the PCS.

Data Analysis

The focus groups audio records were transcribed and analyzed based on Content Analysis (BARDIN, 2009). Reports were organized into registration units, categories, and summaries. The material was pre-analyzed for text clippings, systematization of initial ideas, and aggregation into categories. Material was interpreted during the summaries formulation. The MAXQDA software (2019) was used to elaborate the word cloud.

Ethical considerations

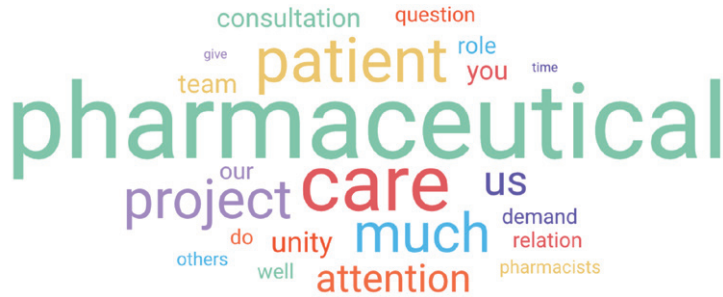
The research project was approved by the Research Ethics Committees of the *Escola Paulista de Medicina* (opinion n° 2.480.641) and the *Secretaria Municipal de Saúde de São Paulo* (opinion n° 2.587.651).

Results

Description of participants and focus group dynamics

A total of 10 pharmacists were interviewed in two focus groups, with ages between 20 and 40 years old, eight females and two males. The groups lasted an average of 50 minutes, generating about 100 minutes of recording. From the focus groups, a word cloud (figure 1) was generated to express the most prevalent concepts mentioned by the professionals. The cloud shows that the most cited concepts among the professionals were: “pharmacist”, followed by “care” and “patient”.

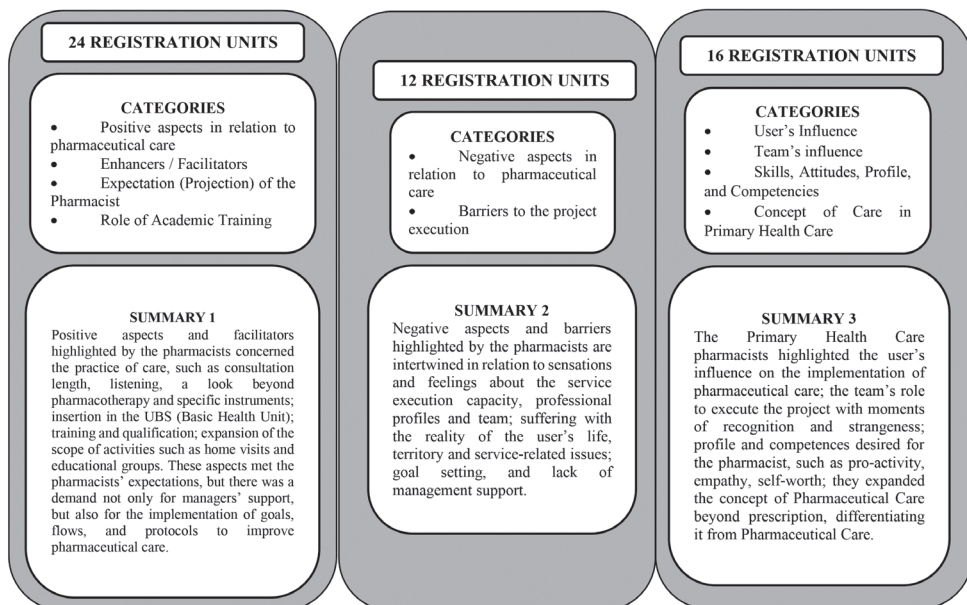
Figure 1. Word cloud about Pharmaceutical care. MAXQDA, 2019.



Records and categories based on the focus groups

Data generated 52 registration units organized into 10 categories, from which three summaries were obtained regarding the PC implementation process, described in figure 2.

Figure 2. Summary of the main findings of the Focus Groups carried out with pharmacists - Pharmacists' perceptions on the implementation of Pharmaceutical Care in Primary Care, 2019.



Categories

- Positive aspects regarding pharmaceutical care: this category gathered the following registration units: experience acquired over time, consultation time allows more complete listening, care to patients whose demands go beyond pharmacotherapy, knowing the health care network in their HU, home visits and consultation at the unit, creation of educational groups or participation in those that already existed in the unit, and recognition of the role and function of the professional, as we can see in this excerpt:

Since then we started applying the clinic, and today I am a real pharmacist, right! I do what I have studied to do! (focus group 1, recognition of the role and function of the professional).

- Enhancers /Facilitators: adaptation of the script of activities to the reality found, positive motivation regarding the beginning of the project, space within the THS meetings for training, initial follow-up performed by tutors with a training process for initial project implementation, recognition of the importance of this training format by pharmacists, and managerial support as marketing for the beginning of the project were considered as enhancers for the implementation of the PC, as in the excerpt below:

It is a differential (capacity building and in-service training process), actually, the way it (project) was structured and as we talk to other people, it was the differential of the project [...]. For me, who do not have a graduation degree or anything, it was a surfactant liquid in my lungs, when there was someone there for me to look at and say: this is really it, this is what you should do, because I was feeling completely lost. (focus group 2, recognition of pharmacists regarding the importance of training).

- Pharmacist's expectations (projection): the expectations generated with the project development and performance of the PC activities among pharmacists, the expectation that only care activities would be performed; expectation of external sensitization with the whole team on PC; possibility of time enough for case studies; expansion of the scope of activities; valuation of charges/goals and bureaucracy, increasing the recognition of activities performed and implementation of documents/protocols/flows, as we can see:

Me being able to request exams would be a facilitator. Some exams within what is focused on Primary Health Care. (focus group 2, expansion of the scope of activities)

- **Role of academic training:** this category discussed the role of academic training, the initial in-service training to execute the project, clinical cases, lack of subjects on pharmaceutical care in undergraduate courses, emphasizing that practice adds more than theory. Example:

The training brought us degrees, but the practice brought us the necessary experience to provide quality care. (focus group 1, practice adds more than theory)

- **Negative aspects regarding pharmaceutical care:** the negative aspects regarding the application of the PC unveiled anxieties and fears, work overload, questionings regarding the ability to perform, suffering related to the interaction with the reality of the user's life, and lack of demand of attendance goals with professional devaluation in relation to other professionals, as highlighted in the following excerpt:

My manager has a doctor, a nurse and a pharmacist, only that his management contract depends on the exclusive production of the doctor and the nurse; do you think he will look at the pharmacist? He won't. (focus group 2, lack of demand for attendance goals, and professional devaluation).

- **Barriers to project execution:** six topics were classified as barriers to the execution of the PC, such as lack of support from the health unit management; issues related to territory and service routine that impact PC execution; lack of knowledge of other professionals; impossibility of prescribing; passivity or lack of interest from the pharmacist; intervention of the pharmacy technician's profile in the PC activities; and individuality interfering on patient referrals to the pharmacist, as observed in the excerpt below:

And I think that's why we must have protocols, otherwise it becomes something personal. I have two cases: for example, in the first one, a nurse that neither like me, nor refer anyone to the pharmaceutical service; in the second one, another team, in every insulin that the doctor prescribed as the beginning, the user would come to me so I could instruct them, because the professional created a bond with me. (focus group 2, individuality interfering on referrals of patient to the pharmacist).

- **User's influence:** The user's role and influence on the implementation of pharmaceutical care were perceived by their interest based on exchange; lack of appreciation by the user or lack of knowledge about the service delivered; positive perception and, finally, attraction strategy/patient's eligibility criteria. Example:

They generate a demand for what you cannot do. Sometimes it is also for not knowing what a pharmaceutical can or will do for them, so at the end of the consultation they say:

Doctor, can you write a prescription for dipyron because I have a pain. (focus group 1, lack of appreciation by the user or lack of knowledge about the service delivered).

- **Team's influence:** The multiprofessional team played an important role in welcoming the pharmaceutical care proposal, influencing its execution through the incorporation and recognition on the professional practice; strangeness in relation to some pharmaceutical care instructions, and difference between teams in the referral of patients. This influence of the team's role became evident below in relation to gaining trust:

The team started giving more credibility for us, from the moment that the returns came in, I mean... the results. Today doctors trust us when we tell them it's time to initiate insulin, when it's time to change the antihypertensive. So we had to win the team's trust. (focus group 1, winning the team's trust, and starting to refer patients).

- **Abilities, attitudes, profile and competences:** in this category four topics emerged regarding the expected profile and competences of pharmacists in the perspective of delivering pharmaceutical care: professional proactivity and awareness regarding the activities developed; difficulties regarding the change on the professional profile; abilities and new strategies developed with the pharmaceutical care process: self-worth, empathy, listening, and the profile needed to perform pharmaceutical care, represented in the excerpt below:

There is no way someone can deliver care, at least in our primary health care, without a team vision; a user-centered vision; capacity for empathy. They do not need to be great at logistics, but they need to come with this broad view of the person, and be interacting with them all the time. (focus group 2, required profile to work with pharmaceutical care).

- **Conceptualization of care in Primary Health Care:** expansion of the concept of Pharmaceutical Care; expansion of this concept to look beyond the issue of prescription; relationship with the family context, and distinction between the concepts of Clinical Pharmacy/Pharmaceutical Care. This conceptualization is perceived in the following excerpt:

I think that now practical care for me covers a little more functions, things to be done, than assistance. (focus group 2, expansion of the concept of Clinical Pharmacy).

Recommendations for practice

Based on the categories and summaries, recommendations for the practice were organized and structured in table 1.

Table 1. Recommendations for the practice of Pharmaceutical Care based on the Perception of pharmacists in the implementation of Pharmaceutical Care in Primary Care, 2019.

N	Recommendations for the implementation of pharmaceutical care
1	Value the length of the pharmaceutical visit in relation to the length of other professionals' visits
2	Invest in soft technologies that may be developed in PHC: Singular Therapeutic Project, empathy, bond, expanded clinic
3	Develop Continuing Education including Pharmaceutical Care
4	Include the pharmacist's care into the list of professionals that impact the transfer of funds in the city of SP
5	Adopt the model of initial training and in-service training to implement Pharmaceutical Care
6	Discuss managers the importance of Pharmaceutical Care
7	Sensitize users about Pharmaceutical Care
8	Invest in the monitoring of tutors, meetings and discussion of clinical cases to implement Pharmaceutical Care
9	Develop protocols, flows, and goals
10	Recognize and incorporate the pharmacist into the PHC and Centers of Support to Family Health (<i>Núcleos de Apoio à Saúde da Família</i> , NASF)
11	Differentiate Pharmaceutical Care from Clinical Pharmacy
12	Develop a professional profile and skills that include proactivity, empathy, self-worth.

Source: prepared by the authors.

Discussion

This study describes the perception of pharmacists who participated in the implementation process of the PC in the PHC, unveiling the importance of training and in-service training, time allotted to pharmaceutical visit, need to implement goals, flows and protocols for professional equity, as well as the identification of the required profile and competencies to work in the PC. Our results showed that the pharmacists' perceptions identified positive aspects, such as the time allotted for visits, and the importance of technical support received in the teaching-service training process. Another relevant point was the need for a gradual change in the profile and competences of pharmacists for the development of clinical services, as well as the recognition of obstacles that have been overcome.

Ramos *et al.* (2018) and Santos Júnior *et al.* (2018a) described facilitators and strategies for consolidating the PCS, thus supporting the findings of our study. These facilitators include patient satisfaction with services, and support for research to improve pharmacy practice (DOSEA *et al.*, 2015; GIL *et al.*, 2015; AWAISU; ALSALIMY, 2015), in addition to training and empowerment of professionals, positive patient outcomes, job satisfaction, sufficient time for service, private and comfortable environment for the patient, and partnership with other health professionals. Regarding pharmacists' expectations, studies indicate that the desire for job satisfaction, and for providing health care directly to the patient suggest the benefits that PCS may entail to the institution, the team, and the community (FELETTTO *et al.*, 2010; MANSOOR; ASLANI; KRASS, 2014; ROBERTS *et al.*, 2008; WOODS; GAPP; KING, 2015).

The demand for implementing goals, flows, protocols was also observed by Silva *et al.* (2018) as a strategy to ensure that clinical pharmacy services and the healthcare system work in an integrated way. Mendes (2010) portrays the improvement of continuous care flows, rational organization of reference and counter-reference, flow of people between different levels of care and services in the Brazilian healthcare services. The contracting of results is definitely present in performance assessments, regardless the management model. By electing goals, flows and protocols for the PC, it is assumed that this service is inserted into a model of healthcare network and multidisciplinary healthcare, in addition to comprising a diversity of clinical-care and technical-pedagogical activities in the context of PHC (HAOC, 2019b).

The training of professionals is one of the vital steps for the development of a comprehensive, effective, safe, quality, continuous and patient-centered PC (BRASIL, 2014b). All the study participants reported that the in-service training model adopted, with tutors, was a differential for the implementation of the PC. Our study supports the expectations regarding technical support for improving practices, and the influence exerted by the training model, which allows for teaching-service integration with professionals exchanging knowledge in meetings, training and discussion of clinical cases (DOSEA *et al.*, 2015; BOSSE; OLIVEIRA; BECKER, 2013).

Professional training seems to be one of the main difficulties found in the training of these professionals, since it is not yet focused on health care (FREITAS *et al.*, 2016). The practice was very significant, even for those who held *lato sensu* postgraduate degrees. As most of these courses do not include hands-on activities,

neither are linked to university extension services or any healthcare services (AMBIEL; MASTROIANNI, 2013), they do not provide professionals with the necessary skills for clinical practice nor direct them toward rational decision-making in pharmacotherapy (MENDONÇA; FREITAS; OLIVEIRA, 2017). The pharmacists surveyed considered training an obstacle to be overcome, i.e., as courses generally offer fragmented knowledge, without prioritizing the vision of the whole health-disease process of citizens, family and community, integrated with the epidemiological and professional reality (SOUSA; BASTOS; BOGO, 2013), there is a need for practical complements to training.

The identification of negative aspects and barriers are additional factors that influence the PC implementation process. Our work identified six topics considered to be barriers to the implementation of pharmaceutical care, such as lack of management support at the health unit; issues of territory and service that impact the implementation of pharmaceutical care; lack of knowledge by other professionals; impossibility of prescribing; passivity or lack of interest of the pharmacist; intervention of the pharmacy technician's profile on the PC activities, and individuality interfering on the referral of patients to the pharmacist.

In Brazil, studies report similar factors to those found in this study, in addition to barriers such as influence of the workplace, the team, and the pharmacists; implementation process; absence of an exclusive place for service delivery; and the patients (FEGADOLLI *et al.*, 2011; SANTOS JÚNIOR *et al.*, 2018b; ALCÂNTARA *et al.*, 2018). For Penm *et al.* (2014), the main barriers posed to consolidating these services in developing countries include shortage of qualified pharmacists, and lack of suitable physical structure.

These difficulties were identified in the review conducted by Luft (2015), who also highlighted the excess of administrative activities performed by pharmacists, keeping them away from the pharmaceutical clinic; shortage of human resources; inadequate structure of health units; lack of access to medicines by the population; in addition to the awareness of public managers about the importance of this practice.

Luft (2015) points out that incentives from public management may favor the consolidation of PC in the Brazilian Health System (SUS), in addition to the interest of the pharmacist. This would promote a joint action between pharmacist and municipal health secretariat toward formulating an action strategy for implementation.

According to Brasil (2020), the challenges/barriers faced by the pharmacist in the implementation of the PC should be overcome, including the pharmacy's need to be understood and act as a care point within the RAS (Health Care Networks), breaking with the biomedical model centered on medication, and articulating interdisciplinary practices to promote the rational use of medicines. Another important point refers to the organization and dimensioning of the pharmacist's activities in Primary Health Care. It should comprise all the activities intended both for the PC and the medication logistics, thus requiring a work agenda agreed with the manager that encompasses all these activities, and technical support from professionals of the pharmacy team for the performance of administrative activities.

The influence of management was yet another point highlighted by pharmacists during the study development. Pharmacists should aim at resilience since, despite several studies showing the effectiveness of the PC, most managers have no interest in clinical activities, or do not recognize pharmacists as professionals linked to patient care (FREITAS *et al.*, 2016). The PC service management process, thus, requires managers to be familiar to the service, so they contribute to the qualification of healthcare, assessing the need for integration of the team with other health service. There is also a need for integrating their technical, administrative, cognitive, technological and economic requirements to lead the activities needed to the process of PC delivery and/or qualification (HAOC, 2019b).

As for users, studies have shown low receptivity of the population towards PC; difficulty of initial recruitment; lack of knowledge about the pharmacist's role; resistance; and lack of awareness of patients regarding the PC (FEGADOLLI *et al.*, 2011; SANTOS JÚNIOR *et al.*, 2018b; RAMOS *et al.*, 2018). Despite the pharmacist's easy access to users, high demands of patient for health service, and access to the patient's medical record were considered strategies identified in these studies to improve access to users.

All participants in this study reported the team's influence on incorporating and recognizing PC into professional practice. Similar studies report participation of the team (FEGADOLLI, 2017; RAMOS *et al.*, 2018; DOSEA *et al.*, 2015; ALCÂNTARA *et al.*, 2018; SANTOS JUNIOR *et al.*, 2018a; 2018b) and the increasing role of pharmacists as members of the health team in PHC, contributing and acting directly on patient care, and also on benefits associated with multidisciplinary teams (JORGENSEN *et al.* 2013; HARMS *et al.* 2017).

However, barriers related to the interaction of pharmacists with the healthcare team may hinder the PCS' implementation process (BRAZINHA; FERNANDEZ-LLIMOS, 2014), mainly due to limitations related to interprofessional communication (BRADLEY *et al.*, 2008), and as other professionals lack of clarity and expectations regarding the responsibilities of Pharmaceutical Care in the focus of the clinic focus, being often understood as a bureaucratic management process, and logistical limitation (BERGSTEN-MENDES, 2008; DUPOTÉY VARELA *et al.*, 2011; JORGENSON *et al.*, 2013). Consequently, with interprofessional collaboration, relationships should be encouraged to help decrease resistance and increase healthcare team's understanding and awareness about the PC implementation.

The PC establishes the reunion between pharmacist and patient. In order for the pharmacist to develop their role as patient's healthcare and well-being providers, their duties, responsibilities and competences should be well-defined (BRASIL, 2014a). Proactivity, self-worth and empathy were competences inherent to the pharmacist's good performance that were mentioned in this study. Aspects such as flexibility to acquire new knowledge, communication skills, ability to solve problems and make decisions, and critical thinking skills were listed in other studies (D'ANDREA *et al.*, 2012; FREITAS *et al.*, 2016). The professional thus seeks to develop their skills for clinical work, in addition to showing their potential to managers, other health professionals, and the community (FREITAS *et al.*, 2016).

A study conducted by Reis *et al.* (2015) reports that less than half of drugstore pharmacists are able to correctly conceptualize PC; other studies report it only as a patient counseling activity or even as a professional practice that promotes the pharmacist's interaction with patients for the rational use of pharmacotherapy (FEGADOLLI *et al.*, 2011; FEGADOLLI, 2017). Our study also found discrepancies regarding the use of the term Pharmaceutical Assistance or PC.

There is a wide range of types of PCS offered in many countries that make up the PC, which hinder the standardization of services offered by the healthcare policies in those systems (MOSSIALOS; NACI; COURTIN, 2013; ZENZANO *et al.*, 2011; AHMED; HASAN; HASSALI, 2010). Alleman *et al.* (2014) carried out a systematic review and identified eight definitions for PC. That is why implementing PC in PHC is so important in the light of Collective Health. This is the space for health promotion, prevention of chronic noncommunicable diseases, and attention to morbidity and mortality related to the irrational use of medicines, in a

comprehensive and continuous approach, seeking the PCS effectiveness in the RAS when delivering care to the user, health team and community.

This study has limitations. Because it is a qualitative study with Content Analysis, we highlight: space allocated during the meeting between THS and SHO to assemble focus groups, site ambience, time reserved for the focus group close to the meeting end, relationships of the questions defined and the choice of Content Analysis as a method proposed to approximate the answer; however, the method allows the study of intertwined social phenomena (CAVALCANTE; CALIXTO; PINHEIRO, 2014).

Conclusion

Our results showed that the perceptions of pharmacists identified positive aspects, such as the time allotted for consultation, the importance of the technical support received in the teaching-service training process at the beginning of the project, the need for gradual change of pharmacists' profile and skills for the development of PCS, as well as the recognition of obstacles that have been overcome. It also found that the PC implementation goes beyond the boundaries of the category, and also depends on the teamwork carried out in the PHC, evidencing the importance of encouraging actions aimed at improving the training of pharmacists, enhancing their expertise, enabling opening new horizons, and the development of a new SUS-targeted profile.

The results intend to promote the different roles of the players involved in this practice (users, health team, managers, and pharmacists) and value new forms of care in the SUS. There is a need to strengthen evidence on the PC investigation, and the perception of pharmacists regarding the implementation of this practice in the PHC, based on the development of new research and approaches to better understand the phenomenon beyond the inclusion of different services of the RAS. It should consider users and the multiprofessional team, collect data from interviews, groups, observation of the practice, together or not with quantitative research, and may compose a mixed method, case study or action research.¹

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Note

¹ R. D. D'Andréa contributed to the conception, design, preparation, and interpretation of the study data, agreeing to take responsibility for all aspects of the work, ensuring issues related to the accuracy and integrity of any and all parts of the study. G. A. Wagner contributed to the analysis and critical review of the intellectual content, and approved the final version for publication. M. C. Schweitzer contributed to the analysis and interpretation, conception and design of the study data, critically reviewed the intellectual content, and approved the final version for publication.

Resumo

Percepção de farmacêuticos na implantação do Cuidado Farmacêutico na Atenção Básica

O artigo descreve a percepção de 10 farmacêuticos da Atenção Básica (AB) de uma região do município de São Paulo que participaram do processo de implantação do Cuidado Farmacêutico. A partir de uma pesquisa qualitativa com grupos focais e abordagem descritiva, os conteúdos foram analisados utilizando-se a Análise de Conteúdo. Das 52 unidades de registro organizadas em 10 categorias, resultaram três sínteses sobre o processo de implantação do CF. Nesse contexto, foi possível descrever o papel do farmacêutico na AB após a implantação dos serviços clínicos, de modo a identificar suas percepções, dificuldades e avanços. Os resultados demonstraram aspectos positivos, além da necessidade de uma mudança gradual no perfil e nas competências dos farmacêuticos para o desenvolvimento de serviços clínicos, ultrapassando os limites da categoria e dependendo do trabalho em equipe realizado na AB. Logo, os resultados promovem os diferentes papéis dos atores envolvidos nesta prática (usuários, equipe de saúde, gestores e farmacêuticos) e valorizam novas formas de cuidado no SUS.

► **Palavras-chave:** Farmacêutico. Serviços Farmacêuticos Clínicos. Cuidados Farmacêuticos. Atenção Básica à Saúde. Saúde da Família.

