

# *Situational analysis of a Speech, Hearing and Language clinical school at a federal university in Bahia: a focus on problems*

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**Abstract:** This work describes a situational analysis of a Speech, Hearing and Language clinical school at a federal university in Bahia, examining how it functions and coordinates with the municipal health system in Salvador, Bahia. It is a descriptive case study, whose methodological strategy is based on Carlos Matus' Situational Strategic Planning (*Planejamento Estratégico Situacional*: PES) with a Focus on Problems. Our methodological strategy employed document analysis, participant observation, semi-structured interviews and a focus group with institutional actors. The results indicate weaknesses in four of the five categories of analysis, which were: infrastructure, funding, organization, and management. These have led to failings in student training and in the institution's integration with the municipal health system. Of the twenty identified problems, ten related to the institutional actors' capacity for both governance and governability, in other words, problems that are amenable to intervention. We conclude that the clinical school must institutionalize the practice of situational strategic planning to combat improvisational practices and enable it to effectively fulfil its two important functions: teaching and healthcare.

► **Keywords:** Speech, Hearing and Language Therapy. Clinical School. Unified Health System. Situational Analysis.

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## Introduction

In order to address fragmentation in healthcare and health management, Ministry of Health (*Ministério da Saúde*: MS) decree 4279/2010 instituted guidelines for the organization of the Healthcare Network (*Rede de Atenção à Saúde*: RAS) within the Unified Health System (*Sistema Único de Saúde*: SUS). In this document, the RAS is defined as constituting organizational arrangements for health activities and services, grouped according to different levels of technological intensity, varying from the lowest level (primary healthcare), through the intermediate (secondary healthcare) to that of highest technological intensity (tertiary healthcare). These should be organized according to technical support, logistic and management systems, all aimed at comprehensive care (BRASIL, 2010).

According to Mendes (2010), healthcare systems should work cooperatively and interdependently, in a horizontal and continuous manner, in promotional, preventative, curative, caring, rehabilitative and palliative interventions, with no hierarchy between the points of care. In this sense, health integration, via the organization of regional and integrated healthcare systems, plays a fundamental role in filling care gaps and in rationalizing and optimizing available care resources (SILVA, 2011). Although, these healthcare systems have achieved increasing prominence in the organization of care within SUS in recent years, some authors claim that their evaluation in the field of Collective Health remains nascent (AMARAL; BOSI, 2017).

In the healthcare network, secondary healthcare provides benchmark services for SUS users. This level of care is composed of specialized services at outpatient and hospital level, known as medium complexity procedures (ERDMANN *et al.*, 2013). This medium complexity has been identified as one of the major obstacles to effective comprehensive healthcare and is referred to as a SUS “bottleneck,” due to significant difficulties accessing services at this level of care (SILVA *et al.*, 2017, SPEDO; PINTO; TANAKA, 2010). Among the factors outlined are difficulties in interaction and coordination between primary and specialized care, insufficient funding, the reduced incorporation of technology, poor maintenance of equipment and a lack of trained professionals to work in management (ERDMANN *et al.*, 2013).

Within the healthcare network, Speech, Hearing and Language (SHL) Services form part of specialized care within SUS. When assessing the evolution of SHL

care in SUS in the years 2000, 2005 and 2010, Miranda *et al.*, (2015) observed that there had been significant growth in relation to the number of professionals connected to the system, the quantity of registered procedures, the increased cost of these services and an expansion in SHL care at all levels of healthcare. However, despite this growth, the authors noted that in all the country's regions the number of professionals remains below the population's needs - there should be 01 SHL therapist for every 10,000 inhabitants in primary care, 01 for every 50,000 inhabitants at secondary level and 01 for every 100,000 at the tertiary level of healthcare (LESSA; MIRANDA, 2005 apud MIRANDA *et al.*, 2015, p. 72). The authors also state that, in 2010, 89.8% of Brazilian municipalities did not record any SHL procedures in SUS. Further, data referring to the same year attests that the number of SUS SHL procedures per thousand inhabitants in the Northeast region was lower (4.31) than the national average (6.07).

A study comparing 2007 and 2014 data revealed an increase in the total number of SHL professionals within the public health system under direct municipal administration in all the capital cities of the Northeast, except in Natal and Salvador, where the level of provision fell. Salvador had the lowest number of SHL professionals in the municipal public health system, despite being the capital with the largest resident population (SANTOS *et al.*, 2017). Despite the increase mentioned above, we should note that, for a long time, these professionals' work and training has been centred on therapeutic and clinical practice, on the individual in isolation from their cultural and historical context and on working in private practices and rehabilitation clinics (PENTEADO; SERVILLEHA, 2004; OLIVEIRA, 2002), some distance from public SHL services.

Clinical schools, linked to SHL universities and faculties, have emerged as an alternative for users, given difficulties accessing these services within the public health system. Their principal purpose is training and they help increase the provision of SHL treatment. We found few studies in this area that address the evolution of care, analyse the workforce, and the social and historical constitution of this field. This work aims to analyse the current situation of a SHL clinical school in relation to how it functions and how it connects to the municipal health system in Salvador, Bahia.

Although we did not identify any studies of situational analyses of SHL clinical schools, some works apply this methodology to other areas - medium complexity health services (DIAS *et al.*, 2012; LEMOS, 2012), the Bahia Haemovigilance

System (ARAÚJO, 2016); human resources in Salvador's Health Surveillance Service (Leal & Teixeira, 2009); Situational Strategic Planning (*Planejamento Estratégico Situacional*: PES) in primary care (the majority) and public hospitals (JUNGES; BARBIANI; ZOBOLI, 2015; SANTANA *et al.*, 2014; KLEBA; KRAUSER; VENDRUSCOLO, 2011; ROSSANEIS *et al.*, 2011; CAMPOS, 2009) - all of these suggest its power to expose critical nodes.

## Methodology

This is a qualitative descriptive case study with a focus on problems arising from the institutionalization of an agreement between the clinical school and the Municipal Health Department (*Secretaria Municipal de Saúde*: SMS) between 2016 and 2018. The adopted focus was the situational analysis of health described in Teixeira's (2010) Local Health Planning and Programming (*Planejamento e Programação Local em Saúde*: PPLS) which is organized according to the points laid out in Carlos Matus' (1993) PES. A situational analysis of health involves the identification, description, prioritization and explanation of problems to determine local needs and define priorities for action, either for the population's health or for the health service system itself (TEIXEIRA, 2010) - the latter is the object of this study.

Data was produced via (i) an analysis of 50 documents (Table 1), organized by date, type and content; (ii) participant observation over a week, applying a script that contained guidelines, with perceptions and information regarding work routines recorded in a field diary; (iii) semi-structured interviews with 10 managers and workers, conducted and transcribed by the authors, using Laville and Dione (1999) as a reference – these authors advocate for flexibility of technique, enabling interviewees to provide richer information and a more accurate picture of the complexity of situations, phenomena or events, since they have the freedom to construct their responses; and (iv) a focus group with 05 SHL professionals who work at the institution, also recorded and transcribed, held with an experienced external moderator. As Trad (2009) recommends, the participants formed a homogenous group in terms of characteristics that could interfere in their perception of the addressed topic, combined with ease of scheduling, due to their working hours.

In total 15 subjects, who work, either directly or indirectly, at the service participated in the study: one member of the commission to monitor the agreement;

one SMS representative; the Director of the Health Sciences Institute (*Instituto de Ciências da Saúde: ICS*) to which the institution is connected; the Department Head of the SHL Course; the Collegiate Coordinator of the SHL Course; the Clinical School Coordinator; two teachers who coordinate internships, two secretaries and five SHL professionals who work at the institution. The participants were all involved in service activities, participated in the study context and had knowledge of existing problems.

**Table 1.** Documents selected for analysis from the SHL clinical school at a federal university in Bahia. Salvador, Bahia, Brazil, 2018

DOCUMENT TYPE	QUANTITY
Contract for the agreement between the clinical school and the SMS	01
Annual Operational Plans	03
Minutes of clinical school meetings	04
Management reports	16
Productivity bulletins	19
Minutes of meetings of the commission to monitor the agreement	06
The clinical school's internal regulations	01

Source: Authors' own.

The information obtained from these sources was collated and triangulated in order to make interpretations based on Bardin's thematic content analysis, which is broken down into three phases: a) pre-analysis material exploration and treatment of the results, inference and interpretation; b) detailed material exploration to identify the problems; c) the analysis itself, based on identified problems, systematized into an analysis matrix and classified according to the health system's components, according to Kleczkowski, Roemer and Van Der Werff (1984) in dialogue with Teixeira (2010).

These authors classify the system accordingly: infrastructure, which covers the physical space, human resources (employee number and distribution), available supplies and equipment, maintenance of furniture and equipment, and investment in ongoing education; funding, which refers to funding sources, amounts, means of distribution and use; the organization, which involves the structuring and the intra- and inter-institutional relationship between human and technological

resources; management, which includes the management model, decision-making characteristics, the organization of work processes and regulatory controls for service functioning; and service delivery, which refers to the actions through which the different types of practices are delivered, which are: health promotion, risk and injury prevention and medical/social care.

Based on this categorization, we described the problems, identifying organizational inadequacies, a lack or unsatisfactory resource allocation, management failures, and others. This phase therefore corresponds to the treatment of the results, making inferences and interpretations, which resulted in a clear and precise description of the problems identified (TEIXEIRA, 2010).

The problems were analysed according to the institutional capacity for governance and governability, two theoretical categories from Carlos Matus (1997). One of these problems, which reflects the clinical school actors' capacity for governance and governability is also a determining factor for several other problems which, in the same way, are also within the capacity for governance and governability, which is why it was selected as a priority for intervention and explanation.

In order to explain this problem, we constructed a Problem Tree (TEIXEIRA, 2010), which is a simple diagram that aims to organize the explanation of the problem and identify its causes, which are represented by the tree's roots and its consequences, represented by its branches.

The study was approved the Research Ethics Committee of the Institute of Collective Health (*Instituto de Saúde Coletiva*: ISC) at the Federal University of Bahia (*Universidade Federal da Bahia*: UFBA) under opinion no.: 3.045.657, on 29 November 2018.

## Results

### Speech, Hearing and Language Service Characteristics

The clinical school studied here is connected to the SHL Undergraduate Course of a federal university in Bahia, located in the city of Salvador, Bahia. This is an arena for both academic and service activities, in which medium complexity procedures are performed, aimed at the habilitation and rehabilitation of people of all ages who have communication disorders in the areas of language, voice, Orofacial Myofunctional Disorders (therapeutic support centre) and audiology

(hearing diagnosis centre). As well as functioning as an arena for undergraduate internships, SHL research and extension activities linked to the university are also undertaken at the clinic (SOARES, 2016).

The therapeutic support centre has six treatment rooms, while the hearing diagnosis centre has four examination rooms. Teachers, students and six SHL professionals work at the clinical school; as well as providing SHL services, the SHL professionals also function as tutors. There are two secretaries at the clinical school, which is coordinated by a course teacher.

Until the beginning of 2016, the institution provided free-of-charge SHL services provided by students and supervised by teachers or tutors for patients referred by health professionals or via spontaneous demand. The institution was entirely focused on academic issues at this time.

In March 2016, the clinical school signed an agreement with the municipal health service in Salvador, Bahia, formalizing secondary healthcare service provision for users of the municipality's healthcare system with the creation of quantitative and qualitative targets, thus constituting a new form of service. This agreement triggered the need for changes to the health working process in order to meet SUS principles and the demands laid down in the contract. However, at the same time, the clinical school's main role as an academic arena cannot be overlooked. Reconciling the two objectives is a huge challenge, principally because of the complex nature of the academic activity to guarantee training for SHL undergraduates in line with the National Curricular Guidelines (Brasil, 2019) as well as to meet the needs of SUS. This necessitated an analysis of the main problems related to this health service within the terms of the agreement with SUS.

## **From clinical school to integration with the public health service in Salvador, Bahia**

The clinical school was set up in 2001, originally to meet the need to train students from the SHL course of a federal university in Bahia, and served as an arena for practice in and internships for future SHL professionals, with an exclusive remit to teach.

At its foundation, the physical space was improvised and initially contained only three clinical-therapeutic treatment rooms and one hearing examination room. Since its creation, the clinical school has had structural issues.

Subsequently, the school received financial investment through REUNI<sup>1</sup> and the physical space was expanded to include six therapeutic treatment rooms, one observation room and four rooms for a range of hearing examinations; this is its current structure. As well as an expansion of the physical space, REUNI support led to an increase in the number of vacancies for new students from the SHL Course and more teachers were contracted. The arrival of new teachers triggered reflections about the need to change the institution's exclusively teaching remit.

From 2013 onwards, one important landmark in this change in the school's remit was the admission of SHL professionals to the institution through public examinations, although this was not the university's initial intention. As the course grew, the increasing number of students resulted in a lack of teachers and these professionals were contracted to occupy the main role of tutor. As a consequence, a new arrangement was made, also aimed at service provision. Based on the 2016 establishment of the agreement with SUS, this change in remit became even more evident, requiring many more changes and the reorganization of the clinic.

It should be noted that, after so many years operating as an establishment whose original role was training, this change in remit did not occur quickly. We were able to gather from the interviews that the institution still does not have a clearly defined identity, as noted in the divergence in participants' understanding of its current design.

Our analysis of the clinical school's history provides evidence of a lack of clarity about the institution's role within the university and within Salvador's health services.

## **Problems identified in the clinical school**

The empirical material described problems in relation to almost all the health service components, as summarized in Table 2, except in the service provision component, which signalled failings in the students' training and the institution's integration into the municipal health system. The management component, followed by infrastructure, were notable for their large number of problems.

**Table 2.** Problems identified in the SHL clinical school of a federal university in Bahia, Salvador, Bahia, Brazil 2018

COMPONENTS	PROBLEMS
INFRASTRUCTURE	Insufficient physical space
	Inadequate physical space
	Lack of human resources
	Lack of equipment and supplies
	Lack of equipment maintenance and inadequate cleaning
FUNDING	Insufficient funding
	Lack of regularity in the transfer of funds
	Lack of actor knowledge of the <i>modus operandi</i> for the release of funds from the SMS agreement
ORGANIZATION	Failings in teaching-service coordination
	Insufficient regulatory documents
	Failings in coordination between the clinical school and the municipal health system
MANAGEMENT	Inadequate management model
	Lack of management experience or qualification to coordinate the clinical school
	Inadequate fulfilment of the qualitative and quantitative target percentages agreed between the clinical school and the SMS
	Mismatches between quantitative goals and service responsiveness
	Absence of planning and programme management practices
	No institutionalization of administrative and technical meetings
	No meetings to discuss clinical cases as part of the SHL work process
	General inadequacy of the roles of clinical school actors
	Disorganization in the secretarial work process

Source: Authors' own.

## Analysis of the problems

Our analysis of the problems was based on Matus' (1997) proposed governance triangle to examine the problems that relate to the institutional actors' capacity for governance and governability. Based on these concepts, the twenty health service

problems identified in the interviews and focus group were arranged into an analysis matrix (Table 3) and from the ten governance and governability problems, we selected “Absence of planning and programme management practices” to construct our explanatory tree.

Although many of these governance and governability problems are amenable to intervention by institutional actors, most are linked to an absence of planning. In other words, incorporating planning as a management practice may have a positive impact on the other problems. For this reason, we took this problem as a priority for action.

**Table 3.** Correlation between governance and governability capacity in relation to clinical school problems

ZONES	I. Within governance capacity	II. Outside governance capacity
I. Within governability capacity	<ul style="list-style-type: none"> <li>- Absence of planning and programme management practices;</li> <li>- Failings in teaching-service coordination;</li> <li>- Insufficient regulatory documents;</li> <li>- Failings in coordination between the clinical school and the municipal health system;</li> <li>- Inadequate management model;</li> <li>- Inadequate fulfilment of the qualitative and quantitative target percentages agreed between the clinical school and the SMS;</li> <li>- Mismatches between quantitative goals and service responsiveness;</li> <li>- No institutionalization of administrative and technical meetings;</li> <li>- No meetings to discuss clinical cases as part of the SHL work process;</li> <li>- Disorganization in the secretarial work process.</li> </ul>	<ul style="list-style-type: none"> <li>- Lack of management experience or qualification to coordinate the clinical school.</li> </ul>

continue...

<p><b>II. Outside governability capacity</b></p>	<ul style="list-style-type: none"> <li>- Insufficient physical space;</li> <li>- Inadequate physical space;</li> <li>-Lack of human resources;</li> <li>- Lack of equipment and supplies;</li> <li>- Lack of equipment maintenance and inadequate cleaning;</li> <li>- Insufficient funding;</li> <li>- Lack of regularity in the transfer of funds;</li> <li>- Lack of actor knowledge of the <i>modus operandi</i> for the release of funds from the SMS agreement</li> <li>- General inadequacy of the roles of clinical school actors</li> </ul>
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Source: Adapted from Figueira (2018).

### Explanation of the problem: Absence of planning and programme management practices

To explain the selected problem, its causes and consequences were systematized into Table 4; a Problem Tree was then constructed (Figure 1).

**Table 4.** Matrix to construct the Problem Tree

<p>CONSEQUENCES</p>	<p>Failings in teaching-service coordination          Insufficient regulatory documents          No institutionalization of administrative and technical meetings          No meetings to discuss clinical cases as part of the SHL work process          Disorganization in the secretarial work process          Failings in coordination between the clinical school and the municipal health system          Nascent nature of activities for health promotion and the prevention of risk and injury          Low turnover of user slots          Low effectiveness in treating users          Fewer gains in student training</p>
<p>PROBLEM</p>	<p>Absence of planning and programme management practices</p>
<p>CAUSES</p>	<p>Inadequate management model          Lack of a qualified management professional          Insufficient work time to dedicate to management          Insufficient funding          Bureaucratic barriers to the transfer of agreement funds          The public university budget crisis          The clinic's low visibility at the ICS and UFBA</p>

Source: Adapted from Teixeira (2010).



## Discussion

Some of the main problems identified in this study of the functioning of the clinical school have also been observed by secondary healthcare service managers, staff and users in the city of Florianópolis. A lack of infrastructure, a scarcity of funding and the nascent nature of service planning and work routines were some of the difficulties outlined in the organization of health practices at this level of healthcare (EDRMANN *et al.*, 2013).

Infrastructure also appears to be a problem in other areas of health. Studies about the relationship between infrastructure and secondary healthcare practices have demonstrated that professional nursing activities in primary healthcare also suffer from the negative impacts of a lack of adequate physical structures, equipment, materials and supplies. As reported by the actors at the clinical school here, these professionals refer to dissatisfaction, exhaustion, interruptions to service provision, difficulties meeting targets and other obstacles (PEDROSA; CORRÊA; MANDU, 2011).

Although there is no regulation for the recommended infrastructure for specialist SUS outpatient clinics, the study evidenced structural inadequacies that significantly affect the clinical school's functioning and interfere in other components, such as organization and management. Undoubtedly, a lack of funding impacts on human resources, the lack of equipment and supplies, and their maintenance, as well as the organization of the healthcare system. For the interviewees, infrastructure issues and difficulties arising from the teaching-service relationship were noteworthy. This can perhaps be explained by the institution's history of insufficient budgetary resources.

Although insufficient funding was only cited by one of the three managers interviewed, that does not diminish its importance, given that it negatively affects the institution's double function.

In relation to the lack of human resources in particular, increasing the number of employees would be the easiest solution, however, this is hampered by the institutional actors' lack of governability capacity. The redistribution of functions between team members is, therefore, a viable alternative.

For their part, the clinical school's historical issues influence the organization of services, given that the institution was set up to meet academic needs. Integrating teaching and service provision is an important challenge, because of the need to strengthen relations between the different institutional actors involved. This

difficulty has also been highlighted in studies about the integration of teaching and health services (KUABARA *et al.*, 2014; BREHMER; RAMOS, 2014).

On the other hand, it also generates significant gains for the academy, the service and the community. Studies on this issue demonstrate a reduction in the dichotomy between theory and practice, an approximation to SUS principles, assistance for services that provide both activities and professional training, improving the quality of care ((VENDRUSCOLO; PRADO; KLEBA, 2016; KUABARA *et al.*, 2014; BREHMER; RAMOS, 2014).

The finding about a lack of coordination between the institution and the health system is in line with Lavras (2011), who describes SUS as a fragmented system, which hinders access, generates a lack of continuity in care and compromises the comprehensiveness of care. More recently, Freitas and Araújo (2018) confirmed that integration remains a challenge for healthcare systems. The problems we found included lack of information for professionals about how SUS functions, the absence of a referral and counter-referral system and the lack of formalized flows between points of care. Studies regarding secondary healthcare emphasize a lack of coordination between points of care within the system and indicate the need for coordinated action to organize services and work processes (PEREIRA; MACHADO, 2016; SANTOS; GIOVANELLA, 2016; PASSOS; ROCHA; VASCONCELOS, 2014; ERDMANN *et al.*, 2013; SPEDO; PINTO; TANAKA, 2010).

When we looked at comprehensive care, similar to Moll *et al.* (2017), we identified an urgent need to put strategies in place to enable communication between the various health services, such as referral and counter-referral flows. In this study, use of this tool remained nascent in nature and indicated deficiencies in the establishment of flows and counter-flows to organize user pathways within the system. In this way, an absence of, or nascent, counter-referral flows hampers communication between services at different levels of care and consequently impairs comprehensiveness of care (PEREIRA; MACHADO, 2016; ERDMANN *et al.*, 2013; ALMEIDA *et al.*, 2010).

Another factor that could prevent the clinical school from being incorporated into the municipal healthcare system is the fact that it does not provide appointments through the healthcare coordination system. Because of its specificities, the institution provides an open-door service, depending on spontaneous user

demand. Either way, it is important for the service to call on the SMS and explain its difficulties, seeking its support for improvements and participation in the construction of referral flows for its users.

Regarding the management problems identified, we note the absence of planning as a management practice, due to the powerful influence this problem has on several other issues. Planning is a process for the rationalization of activities aimed at problem-solving (TEIXEIRA, 2010), avoiding improvisation in order to make action more effective (MATUS, 1993). In this institution, management adopted an improvisational approach, with no programming or definition of priorities, compromising the effectiveness of its activities. This may be explained by a lack of time for the manager to dedicate to this role, given that they split their work time with academic activities, in addition to a lack of qualified training for this post. For Teixeira (2010), management amateurism hinders the institutionalization of planning in an organizational culture.

Another study also identified failings in the functioning of an important health service, due, among other factors, to an absence of strategic planning (ARAÚJO, 2016). Other works have provided evidence that PES significantly aids the management and organization of health services at all levels of care, demonstrating that it is a valuable instrument for the identification and systematization of service problems, supporting manager decision-making, motivating work teams and promoting close relations between people (JUNGES; BARBIANI; ZOBOLI, 2015; SANTANA *et al.*, 2014; DIAS *et al.*, 2012; LEMOS, 2012; KLEBA; KRAUSER; VENDRUSCOLO, 2011; ROSSANEIS *et al.*, 2011; CAMPOS, 2009). There is thus an evident need to incorporate and institutionalize situational strategic planning as a management practice within the clinical school.

Finally, we believe that the fact that the model of care, centred on curative and rehabilitative action within the service provision component, was not viewed as a problem by the institutional actors is due to the institution's position as an outpatient service within the health system. It should be recognized that primary healthcare is the level mainly responsible for health promotion activities and that the family health strategy promotes an expansion of the provision of such activities, despite persistent limitations (KESSLER *et al.*, 2018; BRIXNER *et al.*, 2017; SASAKI; RIBEIRO, 2013). However, these activities should not be restricted to services at this level of

care. The comprehensiveness of care the institution seeks in the healthcare system involves overcoming the fragmentation of activities and going beyond therapeutic behaviour of an individual and curative nature at all levels (BONFADA *et al.*, 2012).

The clinical school as a training arena for future health professionals and as a space for the provision of services for the public system has assumed an important role in the search for a care model orientated by comprehensive care and broader health needs, in line with the principles of SUS.

## Final considerations

The results of this work suggest that the current situation at the clinical school is influenced by historical and structural issues. Although initially designed to meet the demands of academic SHL training, by signing an agreement with the Municipality of Salvador, the institution took on new functions without, however, clearly defining its new identity.

We identified a series of problems related to infrastructure, funding, organization and management, which negatively affect its functioning and its coordination with Salvador's municipal health system. There was evidence of several problems in one component which influenced the occurrence of other problems in other components, demonstrating the interplay between them.

Some of the identified problems fell outside the institutional actors' capacities for governance and governability, for example insufficient physical space, the lack of equipment and supplies, and insufficient funding.

However, others are amenable to intervention, notably: the absence of planning and programme management practices, failings in teaching-service coordination, failings in coordination between the clinical school and Salvador's municipal health system, no institutionalization of administrative and technical meetings, no meetings to discuss clinical cases as part of the SHL work process, and the disorganization in the secretarial work process.

The Problem Tree was seen to be a powerful methodological strategy to organize the explanation of the problem we addressed.

Given that the absence of planning was the principal and most prominent problem for the lack of clinical school coordination, we suggest the incorporation and institutionalization of situational strategic planning as a management practice,

aimed at promoting better coordination with the municipality's health system and the reorganization of the work processes for institutional actors.

As a study limitation, we note that democratic participation was restricted to the interviews and focus group. There were no workshops between the different actors for a collective discussion of the problems. Further, we did not seek the participation of students and users.

It is hoped that, given the scarcity of research about problems in the functioning of clinical schools and services in secondary healthcare, this study will serve to fill this gap.

It is also hoped that this analysis can, particularly, support improvements to this important institution which has the noble functions of training future health professionals and serving the population of Salvador, so lacking in SHL care.<sup>2</sup>

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## Notes

<sup>1</sup> REUNI is the Programme to Support Plans for the Restructuring and Expansion of Brazilian Federal Universities (*Programa de Apoio a Planos de Reestruturação e Expansão das Universidades Federais Brasileiras*), part of a series of Federal Government actions within the Ministry of Education's Plan for Educational Development. It was established by Presidential Decree 6096 of 24 April 2007, with the aim of providing institutions with the necessary conditions to expand access and ensure students continue in Higher Education.

<sup>2</sup> N. V. de S. Andrade: devised the original idea, drafted the text, discussed the results, revised and approved the final version. C. Matos: supervised the research and contributed to the original idea, revised and approved the final version

## Resumo

### *Análise situacional de uma clínica-escola de Fonoaudiologia de uma universidade federal da Bahia: um enfoque sobre os problemas*

Trata-se de uma análise situacional de uma clínica-escola de Fonoaudiologia de uma universidade federal da Bahia que tange ao seu funcionamento e à articulação com a rede municipal de saúde de Salvador-BA. Estudo de caso descritivo, cuja estratégia metodológica foi baseada no Enfoque por Problemas na perspectiva do Planejamento Estratégico Situacional (PES), de Carlos Matus. A investigação empregou como estratégia metodológica a análise documental, a observação participante, entrevistas semiestruturadas e grupo focal com os atores institucionais. Os resultados apontaram fragilidades em quatro das cinco categorias de análise, quais sejam: infraestrutura, financiamento, organização e gestão, o que remete a fragilidades no processo de formação dos discentes e na integração da Instituição com a rede municipal de saúde. Dos vinte problemas identificados, dez encontram-se dentro da capacidade de governo e dentro da governabilidade dos atores institucionais, ou seja, são passíveis de intervenção pelos atores institucionais. Conclui-se que a clínica-escola deve institucionalizar a prática do planejamento estratégico situacional para combater a improvisação de ações e conseguir cumprir com efetividade suas duas importantes funções: ensino e atenção à saúde.

► **Palavras-chave:** Fonoaudiologia. Clínica-escola. Sistema Único de Saúde. Análise situacional.

