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Analysis of problems associated with the quality standards of primary care in the Federal District

Análise dos problemas vinculados aos padrões de qualidade da atenção primária no Distrito Federal

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ABSTRACT *This article analyzes the priority problems established in the local management action plans within the scope of the Federal District's Primary Health Care Qualification Program – QualisPHC. It is a descriptive study, with a qualitative approach, based on the self-assessment described in the Quality Action Plans drawn up by 100 managers of the Primary Health Care Service Departments in 2022. The results showed that of the five dimensions of the quality self-assessment instrument, user care and work organization are the key ones for improving Primary Health Care. In the thematic analysis of the problems, critical nodes were identified that indicate priorities for intervention by managers: territorialization; planning and monitoring; communication with users; work organization; structure; qualification of professionals; and the pandemic. The results show that the continuous process of identifying priorities is essential to support health planning by managers and teams, and the QualisPHC is a good step towards fostering experiences with a strategic planning approach in other local systems.*

KEYWORDS *Quality of health care. Primary Health Care. Family Health Strategy. Health planning. Health evaluation.*

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RESUMO Este artigo analisa os problemas prioritários estabelecidos nos planos de ação da gestão local no âmbito do Programa de Qualificação da Atenção Primária à Saúde do Distrito Federal – QualisAPS. Trata-se de um estudo descritivo, com abordagem qualitativa, conforme autoavaliações descritas nos Planos de Ação para a Qualidade, elaborados por 100 gestores das Gerências de Serviços de Atenção Primária em 2022. Os resultados demonstraram que, das cinco dimensões do instrumento de autoavaliação da qualidade, a atenção ao usuário e a organização do trabalho são as centrais para a melhoria da Atenção Primária à Saúde. Na análise temática dos problemas, foram identificados nós críticos que sinalizam prioridades de intervenção dos gestores: territorialização; planejamento e monitoramento; comunicação com o usuário; organização do trabalho; estrutura; qualificação dos profissionais; e pandemia. Os resultados demonstram que o processo contínuo de identificação de prioridades é essencial para subsidiar o planejamento em saúde pelos gestores e equipes e que o QualisAPS constitui um acertado passo para fomentar experiências com enfoque de planejamento estratégico em outros sistemas locais.

PALAVRAS-CHAVE Qualidade dos cuidados de saúde. Atenção Primária à Saúde. Estratégia Saúde da Família. Planejamento em saúde. Avaliação em saúde.

Introduction

The Primary Health Care (PHC) is characterized by the set of actions that cover health promotion and protection, disease prevention, diagnosis, treatment, rehabilitation, harm reduction, and health sustenance. Given its strategic importance, ensuring a PHC of quality has been of significance in issues addressed to health systems in several countries[1,2]. This assumption strengths on the evidence that systems prioritizing primary actions, as the organizing axis of sanitary practices, reach better health indicators, lower costs, and greater user needs fullfilment[3].

The recognized PHC potential in Brazil, delivered by means of the Family Health Strategy (FHS) for redirecting the health care model in the Unified Health System (SUS), placed aspects related to problem-solving capacity and the ability to articulate with other levels of care at the center of the discussions[4]. Such initiatives made it possible to bring the evaluation of health services closer to the daily management of PHC, having the territory as the organizational core and using a wide range of indicators related to the quality of health care, i.e., focusing on the user preferences and needs[4,5].

However, Facchini, Tomasi and Dilélio[6], in an essay on PHC quality in Brazil, emphasized the need for a set of quality indicators that purport organizational processes and professional practices of each FHS team in the health service network and its relation with the territory. In that scenario, among the most effective strategies for qualifying PHC, strategic planning stands out, in which teams identify health problems in the area covered by the units to carry out the local programming of actions, so to lay down an intervention and follow-up plan by means of permanent monitoring and evaluation[7].

Following that perspective, and in the context of both PHC Policy carried out and the eSF laying down as the only PHC model[8,9], the need to qualify health actions and services emerged in the Federal District (DF) as a strategic issue. Thus, to strengthen and institutionalize the practice, the Primary Health Care Qualification Program of the Federal District (QualisPHC) has structured evaluation in a participatory way since 2019, monitoring and promoting PHC improvement in the Federal District by means of permanent evaluation cycles. These cycles are organized into three phases, the first of which is preceded by a diagnosis of the Basic Health Unit (UBS) structure and by self-assessment of the care and local management team work processes, instituting a baseline study[10-12].

The program is substantiated on the systematic logic of evaluation as a training device by and for work, articulating assessment actions of the Family Health teams (eSF), Oral Health teams (eSB) and UBS management teams, combining institutional support practices, permanent education and strategies to foster greater empowerment of managers[13].

QualisPHC evaluation process is grounded on locally defined quality standards, built by means of suggestions obtained in workshops with professionals from all teams, as well as workshops with members of the Health Council of the Federal District and representatives of the organized civil society. The ideas received were analyzed in triangulation with the norms guiding work in PHC and generated self-assessment instruments. The first evaluation cycle began by the elaboration of the Quality Action Plan (PAQ), in which the primary care teams selected priority problems to be faced as from the self-evaluation results[10].

In the midst of that process, it becomes evident the need for studies to analyze the most significant problems for PHC teams observed in the PAQ. Previous studies[14,15], despite evaluating PHC in the Federal District, have not been able to analyze the problems upon a participatory process for defining quality standards and prioritizing interventions. Just like the operational logic of the ongoing

QualisPHC program. Thus, this article aims to analyze the priority problems chosen in the action plans for the improvement of PHC quality in the Federal District.

Material e methods

This is a descriptive study that applies qualitative approach and was carried out in the Federal District in 2022. DF has a population of 3,094,325 inhabitants as estimated by the Brazilian Institute of Geography and Statistics (IBGE)[16]. It is organized into 33 Administrative Regions (RA), which correspond to cities when compared to the remaining states of the Brazilian federation, but distinguish themselves by not having the autonomy entitled to municipalities[17].

The primary care network is allocated among seven Health Regions (RS) composed of the 33 RAs. During the research period, there were 175 UBS, 10 of which in prisons. The 165 UBS that serve the general population work, in total, with 100 Primary Care Service Managements (GSAP), 609 eSF, 286 eSB, and 59 teams linked to the Expanded Core for Family Health and Primary Care (eNasf-AB) (*table 1*).

Table 1. Number of UBS, eSF, eSB and GSAP teams as per Administrative Region and Health Region in the Federal District, 2022

Health Region	Administrative Region	UBS	eSF	eSB	GSAP
Central	Cruzeiro	2	10	3	2
	Lago Norte	1	4	1	1
	Plano Piloto	5	24	5	4
	Varjão	1	3	1	1
	Total	**9**	**41**	**10**	**8**
South central	Candangolândia	1	5	2	1
	Guará	5	23	11	4
	Núcleo Bandeirante	2	7	3	1
	Park Way	1	1	1	0
	Riacho Fundo I	2	10	4	2
	Riacho Fundo II	5	16	4	2
	Scia/Estrutural	2	12	6	1
	Total	**18**	**74**	**31**	**11**
North	Fercal	3	4	3	1
	Planaltina	20	48	20	9
	Sobradinho	6	24	14	3
	Sobradinho II	7	21	11	3
	Total	**36**	**97**	**48**	**16**
West	Brazlândia	9	16	8	3
	Ceilândia	18	80	36	18
	Total	**27**	**96**	**44**	**21**

Table 1. Number of UBS, eSF, eSB and GSAP teams as per Administrative Region and Health Region in the Federal District, 2022

Health Region	Administrative Region	UBS	eSF	eSB	GSAP
Southwest	Águas Claras	2	7	4	1
	Recanto das Emas	9	36	21	5
	Samambaia	13	60	37	9
	Taguatinga	7	49	21	7
	Vicente Pires	1	8	3	1
	Total	**32**	**160**	**86**	**23**
South	Gama	10	39	20	7
	Santa Maria	8	28	14	5
	Total	**18**	**67**	**34**	**12**
Total		165	603	286	100

Source: Prepared by the authors based on research data.

Each UBS in the Federal District is managed by a Primary Care Service Manager and by a PHC Service Supervisor. In some configurations, the same manager is responsible for more than one UBS.

As to analyze the priorities for improving PHC in the Federal District, data were collected from the PAQ and prepared from December 2021 to March 2022 by 100 managers of the 7 RS' GSAP, responsible for managing the 165 UBS. Data are available on QualisPHC Platform[18], a tool created for PHC teams to respond to the self-assessment instruments, to monitor self-assessment development, and to prepare and monitor PAQ.

This study retrieved from the QualisPHC Platform[18] database, for each health region, the four main quality standards included in the managers' PAQ during the first evaluation cycle, that depict the problems to be faced, as per results of self-assessment guided by an instrument containing 36 standards (*table 2*).

Table 2. Quality patterns as per dimension and subdimension – a self-assessment tool for GSAP

Dimensions	Dimensions	Nº of patterns
User care	Access	2
	Integral care	3
	Education and Communication in Health	1
	Participation and Social Control	3
Structure	Physical Structure and Equipment	2
	Materials, Inputs and Medicines	2
Work management	Work Force	3
	Permanent Qualification and Education	2
Care network organization	Integration to the network	5
	Teaching-Service Integration	2
Work organization	Actions in the territory	3
	Planning, Monitoring and Evaluation	8

Source: Cadernos QualisAPS[10].

The selection of patterns for PAQ adopted the following criteria: inclusion of at least four patterns, two of which were classified as grade I – priority areas for PHC quality – and associated to indicators of the Local Management Agreements (AGL); and two others of free choice, considering criteria of low compliance, specificities of the territory, magnitude of the problem in the face of the population demands, outcome of the user service quality, governability of the team in the fulfilling of the actions to be proposed. In situations where more than one pattern was considered in fourth place, it was decided to include all of them.

Subsequently, for the seven RS and for each of the selected patterns, the problems object of intervention were located by means of the managers' description. A problem is considered to be something outside the standards of normality, defined upon knowledge, interest and ability to act of the social actor who analyzed the situation, i.e., it is always situational[19].

It was noted that the participants, in many cases, instead of describing a problem, repeated the quality standard wording or described causes or consequences, being excluded from the analysis.

So, the problems were submitted to the content analysis proposed by Bardin[20], went through the procedures of floating reading, interpretation, identification of themes, grouping as of semantic criteria, and categorization that followed what emerged from the analysis.

In the subsequent phase, problems were organized as from the presence in each pattern, as per health region, allowing comparison between the regions. Then, to identify the priorities contained in action plans, a cross-sectional analysis of the problems identified in all patterns was carried out, selecting those that repeat themselves and create critical nodes. In other words, a selection of problems that are crucial – under-problems that, if changed, modify the problems – and that explain the problem[21]. The critical nodes were systematized a posteriori into six thematic categories, indicating the priority actions for PHC improvement in the Federal District: territorialization methodological tool; planning and monitoring; communication with user; work organization; UBS structure; qualification of professionals; and pandemic.

This study is the result of a collaboration between professionals from the technical and management areas of the State Department of Health of the Federal District (SES-DF) and researchers from the University of Brasília. It was approved by the Research Ethics Committee of the Faculty of Health Sciences at the University of Brasilia under the Certificate of Ethical Evaluation (CAAE) No. 29640120.6.0000.0030 and opinion No. 5.396.127, having complied with all ethical precepts for research with human beings, in accordance to what is defined by the National Health Council by means of Resolutions No. 466, of December 12, 2012, and No. 510, of April 7, 2016.

Results

The results obtained from the GSAPs' PAQs show that, of the five dimensions composing the PHC quality self-assessment instrument (*table 2*), 'communication with user' and 'work organization' are the ones harboring the priority problems to be faced by RS managers for PHC improvement.

As for the dimension 'communication with user', the pattern 'the management team provides information on the USB functioning in a clear and accessible way to the population' was selected by six of the seven RS, while the pattern 'the team defines parameters for the organization of the programmed and spontaneous agenda of demands' was chosen by four regions. Also in the same dimension, the managers of three regions included in their PAQ the standard 'the management team promotes the delivering of Integrative Health Practices (PIS) in PHC'.

Box 1 summarizes the problems related to each pattern of the 'communication with user' dimension described by the managers, standing out: the lack of materials and information maps; updating and uniformity of information; definition of UBS flows and health education actions; prioritization of spontaneous demand; difficulties in organizing the planned demand and scheduling; weaknesses of the population's recording; in addition to the underutilization of UBS extended hours; shutdown of collective activities due to the pandemic; lack of physical space and materials; weaknesses in the qualification of management and care professionals.

Box 1. Problems listed by Health Region (RS) as per the pattern that follows the user care dimension of PHC management self-assessment instrument and priority patterns by each region, Brasília-DF, 2022

RS	Pattern	Problems
Central	Information availability on UBS operation	Work overload of the health service; focus on pandemic actions; lack of updated information; non-standard mode of operation; divergences in information; inadequate communication with the population.
South-Central	Parameters for schedule arrangement	Weaknesses of records; difficulty in scheduling a programmed care; lack of service optimization at alternative work times.
	Provision of information on UBS operation	Lack of clear information; lack of materials; work overload of the health service.
East	Parameters for schedule arrangement	Programmed non-serviced demand due to the pandemic; difficulty in controlling agendas by managers; professional absenteeism
	Carrying out integrative health practices in PHC	Inadequate physical space; need for permanent education focused on integrative practices.
	Provision of information on UBS operation	Cease of meetings with local leaders; inadequate physical space; inadequate communication; lack of human resources.
North	Parameters for schedule arrangement	High spontaneous demand; parameters focused on the pandemic; difficulty in organizing the care schedule in cases of scheduled or unforeseen absence of professionals.
	Carrying out integrative health practices in PHC	Demobilization of collective activities during the pandemic; inadequate physical space for PIS; managers not qualified for the promotion or valorization of PHC'PIS; professionals without specific knowledge on PIS; difficulty to schedule protected time for carrying out PIS; lack of interest of professionals in training on this topic
	Provision of information on UBS operation	Focus on actions on the pandemic, ceasing some offers; lack of updated information on UBS available services; work overload of the health service
West	Carrying out integrative health practices in PHC	Lack of necessary material for PIS development; lack of financial resources; lack of clear information; lack of human resources; Inadequate unidentified physical space.
	Provision of information on UBS operation	
South-west	Provision of information on UBS operation	Absence of UBS territorialization tool maps; absence of reterritorialization tool; absence of updated information; lack of standard information; inconsistencies among information on the SES-DF website; absence of health education actions.
South	Parameters for schedule arrangement	Non-inclusion of PIS actions in the organization of the team or professional's agenda; fear of resuming collective activities; work overload of professionals.
	Provision of information on UBS operation	Lack of materials to carry out activities in the service; outdated information: health service overload; professional absenteeism

Source: Prepared by the authors as from QualisAPS database[18].

As to the dimension of work organization, the pattern 'the team owns a situational diagnosis of the territory' was included in the PAQ by the managers of the seven RSs; 'the management team monitors and evaluates the indicators provided for in the AGL' was selected by six RS; 'the management team defines mechanisms for planning, monitoring and evaluating the actions developed in PHC' was included in three RS; and the pattern 'the management team creates guidelines, protocols and flows to guide the UBS work team processes', was included in two RS.

Box 2 shows the problems referring to each pattern of the work organization dimension described by the managers, such as: low percentage of population recording; human resources deficit and function deviation, mainly from the Community Health Agents (ACS); difficulties of access to the territory; inappropriate use of information systems; existence of a floating population and territories larger than recommended. The lack of permanent education actions was highlighted, together with professional work overload; difficulty in prioritizing monitoring and planning; ensuring team meetings to discuss data; as well as the access to information systems in a context of restrictions of various kinds during the pandemic. Besides, low adherence of professionals to protocols; non-standardization of work flows and processes; and human resources deficit were also noted.

Box 2. Problems listed per Health Region (RS) following the pattern as to the work organization dimension retrieved from PHC self-assessment instrument management and patterns prioritized per each region, Brasília-DF, 2022

RS	Pattern	Problems
Central	Situational diagnosis	Recording deficit; absenteeism; inconsistency of records; work overload; lack of ACS institutional identification; deficit of human resources; e-SUS instability; difficulty in recording the floating population; maps outdating; deficit of ACSs.
	Monitoring and evaluation of the indicators provided for in the AGLs	E-SUS slowness of e-SUS; lack of permanent education recording; absenteeism; work overload; lack of planning; low quality of records; e-SUS instability; lack of permanent education recording; inconsistent records; difficulty in recording the floating population.
South central	Situational diagnosis	Deficit of records; incomplete and inconsistent records; need for permanent education recording; lack of recording due to non-visitation; residents' turnover; lack of transportation for user recording; outdated recording; deficit of records; inconsistent recording; lack of prioritization of the territorialization tool by the team; territory of difficult access.
East	Monitoring and evaluation of the indicators provided for in the AGLs	Spontaneous demand without connection with the team; absence of protected hours for data analysis; absence of an instrument for data analysis; difficulty in accessing e-SUS reports; managers do not prioritize indicators; fluctuation of users in the territory.
	Building of planning, monitoring and evaluation mechanisms	Unstable internet and computer operation; work overload with administrative activities; inexistence of a schedule for the collegiate manager of units; lack of management devising; difficulty in following up the teams; professionals do not prioritize the evaluation of indicators; manager work overload; lack of e-SUS training; difficulty in accessing the territory.
North	Situational diagnosis	Low percentage of records; difficulty in recording during the pandemic; difficulty in collecting and updating data during the pandemic; changes in priorities due to the pandemic; human resources deficit; ACS deficit; difficulty in accessing the territory; work overload of professionals; inconsistencies in e-SUS recording; lack of information on the territory.

Box 2. Problems listed per Health Region (RS) following the pattern as to the work organization dimension retrieved from PHC self-assessment instrument management and patterns prioritized per each region, Brasília-DF, 2022

RS	Pattern	Problems
	Monitoring and evaluation of the indicators provided for in the AGLs	Lack of permanent education recording; absenteeism; work overload; outdated data; lack of planning; low quality of records; e-SUS instability; difficulty in recording the floating population.
	Implementation of guidelines, protocols, and flows to guide work processes	Low adherence to the spontaneous demand protocol; care weakness; focus on pandemic actions; work overload; turnover of managers.
West	Situational diagnosis	Need for permanent education; low quality of records; difficulty in accessing the territory and recording; difficulty in recording due to the floating population; data unavailability; fragility of records; non-prioritization of situational analysis; territory of difficult access.
	Monitoring and evaluation of the indicators provided for in the AGLs	Work overload; managers and professionals do not prioritize the evaluation of indicators; difficulties in systematizing information system data; Unqualified managers
	Building of planning, monitoring and evaluation mechanisms	Non-prioritization of indicators; difficulties in holding a team meeting
Southwest	Situational diagnosis	Inconclusive recording; recording weakness; lack of interest from teams; reterritorialization; deficit of human resources/ACS; deviation of ACS attributions; non-compliance with actions by ACS and team coordinators; inappropriate use of information systems.
	Monitoring and evaluation of the indicators provided for in the AGLs	Difficulty in holding team meetings; absence of permanent education; managers work overload; system instability: e-SUS, Sisab, Auxílio Brasil and e-Gestor; difficulty in accessing data; lack of action plan.
	Building of planning, monitoring and evaluation mechanisms	Difficulty in prioritizing data planning and monitoring; difficulty in following recording; lack of knowledge of teams on number of records; low knowledge of the territory; lack of planning, monitoring and evaluation actions; lack of material resources; lack of integrated planning among teams; difficulty in adjusting records inconsistencies; lack of structural resources as for data monitoring; difficulty in improving local management tools.
	Implementation of guidelines, protocols, and flows to guide work processes	Permanent education; computer knowledge; deficit of human resources; recording inconsistencies; managers work overload; lack of material resources; lack of engagement; teams' different ways of working; workflows and working processes without technical standardization; resistance to operational changes.
South	Situational diagnosis	Coverage area larger than recommended; ACS deficit; lack of team knowledge; lack of information on the territory; difficulty of recording in e-SUS; deficit of human resources; deviation of ACS function; change of assigned territory.
	Monitoring and evaluation of the indicators provided for in the AGLs	Work overload; deficit of human resources; management unpreparedness; difficulty in monitoring teams by management.

Source: Prepared by the authors as from QualisAPS database[18].

The cross-sectional analysis of the problems identified in all the patterns of the dimensions selected by the managers in the RS set selected 'critical nodes', which are described below by thematic grouping.

Territorialization methodological tool

Aspects related to the territorialization of primary care were claimed by managers as capital for PHC organization and provision

of services. Low coverage of the population recording, inconsistent or outdated records result in the restraining of collecting updated information on the territory, which would enable teams to carry out diagnoses that guide the health care of their population.

Planning and monitoring

The condition concerning territorialization weakens the planning and monitoring of actions, weaknesses that are also evidenced by the difficulty of accessing strategic information as by having techniques for data analysis and professional knowledge capable of managing them.

Communication with user

Inadequate communication with the user is a restrictive aspect of access to services, and become a priority theme for the managers' PAQ carried out in 2022. It is noteworthy that professionals are not clear about what information to provide, about the lack of updated information and support materials on existing services able to easy dissemination, and on the shutdown of team meetings with local leaders.

Work organization

Managers of the Federal District focus on problems related to the organization of management and care teams' work. The high demand for care and the work overload hinder professional performance. Also mentioned were the hindering aspects as to ACS deviation of function, difficulties in accessing UBS territory due to long distances, presence of a floating population or the absence of residents in homes, and lack of protected time for the teams to hold meetings.

UBS structure

Regarding UBS structure, managers mention on the existing physical, organizational and human resources in the health services: deficiencies in the management of equipment – especially computers and connectivity –, inputs and materials; inadequate physical infrastructure; absence of transportation to travel within the territory; and lack of human resources, especially ACSs', in addition to absenteeism problems.

Qualification of professionals

Among problems impacting the quality of health services, the insufficient investment on professional qualification, specifically few permanent education initiatives, as for managers, results also in scarce knowledge about primary care and low adherence to eSF model as in the use of PHC'e-SUS electronic medical record.

Pandemic

As for external factors, although reported in fewer numbers, coping against the covid-19 pandemic correlated with changes in the priorities of the services offered in PHC and with a certain shutdown of actions, mainly regarding the organization and implementation of collective activities involving health education, data collection, and updating of assigned users recording.

Discussion

The results of this study, collected from the managers impressions in their action plans, indicate intervention priorities in the dimensions 'communication with user' and 'work organization' so to improve PHC quality in the Federal District. There are problems to be faced as to those dimensions, especially with regard to territorialization, planning and monitoring of actions, availability of information and communication with users, organization of the work process and qualification of professionals, in addition to UBS structural

component. Issues arising from covid-19 pandemic appear to be transversal to the entire process.

Low coverage of recorded population, inconsistent or outdated recording result in harming the collection of updated information on the territory, necessary to enable teams to access diagnoses that ground their population health care. During the research period, PHC in the Federal District administered 955 ACS, or less than one agent per eSF, a much smaller number than that recommended by the national and district PHC regulations. Consequently, it impacts on the planning of actions and services to be offered by the teams and on the organization of Health Care Networks' flows.

Territorialized care by SUS' PHC teams is central for the reorganization of care based on the FHS. However, it is an aspect understood as fragile or non-existent by DF teams in what the definition of the political-administrative limit is concerned, either due to insufficient territorial planning or to difficulties in accessing territories that are geographically distant or permeated by specific social conditions.

This is a recurring problem that unfolds into organizational difficulties like recording of families and individuals, sociodemographic analysis and care difficulties, such as low capacity for adequate response to the population's health problems[22]. Those difficulties hinder the coping against social inequities in vulnerable territories[23], biasing the community approach, specifically home visits and articulation with intersectoral actions, such as the Bolsa Família Program and the Health at School Program[24].

At the national level, FHC e-SUS' strategy structures the collection and availability of PHC data with the aim of qualifying care and information management. DF late deployed, only in 2018, the FHC e-SUS Electronic Citizen Medical Record (PEC), triggering a process of training multipliers to configurate and use of the medical record, a process based on planning, monitoring, and evaluation strategies[25].

Operational difficulties mentioned by managers corroborate other studies[26-28] by unveiling demands related to the handling of digital tools, such as the electronic medical record, as well as errors in filling in the system and updating data, consequently loosing patient data. They also mention structural aspects related to UBS technological infrastructure, damaged computers, lack of technical support and training or permanent education of health professionals.

Another issue that deserves to be noted is the communication and dissemination of information, important tools in FHC context, since they provide eSF, its professionals and the assisted population with the means to improve health care and epidemiological surveillance and its indicators[29]. It is essential for all eSF professionals to use the set of data structured by health information systems so to outline strategies, define goals and identify interventions needed for the care of the population within their respective coverage areas, as well as to evaluate the results of the work developed by the team[30]. Those conditions confirm the lack of security and reliability, and the fragility in decision support, impairing user care or service and making it difficult for professionals and managers to work.

Regarding data knowledge and information output, gaps identified may be associated to problems in communicating with users. In this sense, the lack of interaction with local leaders, added to outdated or inadequate information, can directly impact PHC essential attributes.

Among the various tools available to improve communication within the scope of PHC, the WhatsApp® application is one of the most used means to bring information to teams and the population. Within the scope of SES-DF, it is common for GSAP to create groups to disseminate the most varied information and subjects of interest to eSF. There are also some UBS that adopt the application for direct communication with the community, either for general information about the

services offered by the Unit or as a channel for the dissemination of technical or scientific content[30-32].

That relationship with users causes a recurrent problem for the work organization, which has been the ACS deviation of function, well described in studies[33,34] that deal with the importance of that professional for the existence of UBS, which is not a DF exclusivity. There is a growing bureaucratization of their work, which is very much focused on filling out forms and collecting data, deviating the ACS from their community activities[34,35]. As for Santos et al.[36], ACS are seen as multipurpose workers, carrying out an unclear definition of their attributions that are often unaware to the team itself, what relates to low appreciation of their performance, demotivating the worker.

As to PHC structural issues, local managers also raised as main problems the UBS physical structure and inadequate means of transportation; the difficulties in managing equipment, materials and inputs; and the existence of incomplete teams or high professional absenteeism. The structure refers to the physical, organizational and human resources existing in health services. Thus, it is recommended to adapt to PHC teams' broad scope of action so to provide efficient professional performance, user satisfaction and better quality and health results[37].

Regarding normative sphere, both the DF Primary Care Policy[38] and the National Primary Care Policy[39] define the guidelines for ensuring adequate infrastructure and good conditions for the UBS functioning. However, the results for the DF' UBS structure typology reveal that only 1.9% of the 157 UBS evaluated reached the maximum classification, type A, which corresponds to 3 UBS. The evaluation encompassed types of teams, list of professionals, available services, physical structure, inputs and Information and Communication Technology (TIC) equipment. The remaining were classified as type B (33.8%), type C (33.1%), type D (19.1%) and type E (12.1%)[40]. This study evidenced the differences among UBS distribution of types within RS, being the lowest scores attributed to the dimensions of available services and types of teams.

Regarding the problem of professional work overload – one of the most mentioned critical nodes –, managers only refer to the high demand for care, although the literature emphasizes as aspects related to it the precarious working conditions, the difficulties of interpersonal relationships in the core of the care team and between the care team and the management team, as well as the work in areas of great social vulnerability and risk of violence[10].

The results of this study show that training and permanent education of professionals are a critical node that permeates all thematic groups analyzed so far, such as the inappropriate use of PHC' e-SUS, with regard also to planning and monitoring as to communication with user. In this context, it is noteworthy that, in addition to the provision of professionals in the composition of the teams, better results derived also from their training and qualification focused on PHC specificities – bringing them closer and closer to the needs of the community –, as from the length of stay in the teams[41].

Managers mention the need to expand the knowledge of professionals on PHC aiming to their adherence to the family health model. However, careful is needed to avoid making a linear association between cause and effect, since other aspects will contribute to a greater or lesser adherence to a collective project, such as people's values, work experience in PHC, the existence of democratic management and spaces that allow creativity.

Literature reports difficulties to build Permanent Health Education (EPS), which are related to lack of resources, conceptual misalignment, managers turnover, fragmentation of the areas that form human resources management, lack of knowledge and bureaucracy in the provision of actions, even often enjoying financial resources. The existence of regionalized actions, collegiate spaces

involving workers, and the building of convergences between the areas of education and work would be facilitators of EPS processes[42].

It is worth noting professional absenteeism as an important problem in health services, which also stands out for DF managers, and yet to positioning the issue in the pandemic reality, since studies have shown an impact on the reasons and duration of leaves[43]. In addition, changes are added to the work process due to the inclusion of digital technologies, especially to offer the monitoring of cases in the territories, to be adapted to physical distancing measures, and to ensure the continuity of care and individual and family monitoring.

The pandemic scenario was claimed by managers in their records as difficulties to keep PHC routine activities, such as health education and care collective activities for people carrying chronic non-communicable diseases, a result also found in other studies[44,45] that impacts the planning of health actions.

Final comments

The findings of this study evidence the existence, in the Federal District, of a movement that enhances the processes of planning and monitoring of the actions and services offered by PHC. However, the weaknesses in the formulation of the problems indicate the need for support from the central management to local managers to further qualify their action plans.

As a limitation of the study, existing problems could not have been properly explained by managers in the action plans nor analyzed, due to the lack of data. In addition, this study was limited to a specific cut of the researched scenario, thus evidencing the challenges of the work process inscribed in a singular context and based only on the managers' perspective.

The planning experience here analyzed can guide contributions on important elements so to promote planning and evaluation strengthening not only in the Federal District but also in other local health systems.

Collaborators

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