

## The Interface between Primary Care and Emergency Dental Services (SOU) in the SUS: the interface between levels of care in oral health

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**Abstract** *Considering that emergency dental services include the referral network and the counter-referral network, interacting at the intersection between primary, secondary and tertiary healthcare, this study aims to describe the interface between primary healthcare (APS – Atenção Primária a Saúde), particularly of the Family Health Strategy, and secondary care in oral health, using the Emergency Dental Services (SOU), in the municipality of Recife. It is a qualitative, exploratory and descriptive case study. The data was collected through semi-structured interviews. Classical ALCESTE analysis was used based on the Descending Hierarchical Classification Dendrogram, making it possible to understand the expressions and each one of the words spoken by the dental health professionals, analyzing them using their social places and contexts as a starting point. What we found was only a fragile degree of integration, and little capacity for solution, between the levels of care – a partially disconnected network. Undoubtedly the problems with the interface between primary care and the emergency services in oral health are multiple and complex. The individual solutions have low efficacy, and are complex in their operation.*

**Key words** *Healthcare network, Oral health, Emergency, Oral health services*

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## Introduction

Brazil's Unified Health System (*Sistema Único de Saúde* – SUS), since it was created as an institution in 1988, has been issuing rules and guidelines aiming to systematize health services in increasing degrees of complexity, defining referral and counter-referral, and points of entry, aiming to regulate the access and organize the health services through an integrated health network<sup>1</sup>.

In oral health, in spite of the progress made, the organization of a model for dental care is still one of the great challenges to be overcome by the SUS, with a need for reformulation of its practices, taking into account the quality and a supply of more dense techniques for resolution of the population's oral problems<sup>2,3</sup>.

The starting point of an extensive process of debates and construction of strategies was the year 2004, when the Brazilian National Oral Policy (PNSB) was formally and launched on the political agenda, expressed in the 'Smiling Brazil Program', presented officially as an expression of a sub-sector policy contained in the document 'Guidelines of the National Oral Health Policy'<sup>4-6</sup>.

Since then, important progress has been seen, and there have been achievements of considerable importance. The results of the surveys made in 2002/2003, and in 2010<sup>7,8</sup>, with their respective Caries in Permanent Teeth (CPOD) indices of 2.78 and 2.1, place Brazil in compliance with some of the World Health Organization oral health targets, and free it from its former status as a country with extremely high occurrence of caries at age 12<sup>9</sup>.

These figures show that the principal problems of oral health to be dealt with are caries, their consequences (pain and loss of teeth), and the absence of access to oral health action and services. They also indicate social disparities in indicators of the health-illness relationship, implying inequalities in the patterns of illnesses and also in the way of use of the services, with a loss experienced by those at higher social risk<sup>10-12</sup>.

In the context of this reality, the PNSB highlights that remission of pain and minimization of people's suffering calls for resolute strategies of organization of the services of first aid and emergency, in the SUS, and, finally, shows that absolute priority should be given to cases of pain, infection and suffering<sup>4,13</sup>.

These establishments have great importance within this network, being characterized as services that operate in a way that is complementary

to the basic healthcare services. The emergency services thus receive a highlight role and the PNSB, when referring to emergency care, underlines and emphasizes that it comes to have a position of importance in the organization of the services, assuming multiple attributions<sup>13,14</sup>.

Having in mind that these services also comprise the network of referral and counter-referral, interacting at the intersection of primary, secondary and tertiary healthcare, so as to enable compliance with the principal of integration of actions<sup>13,14</sup>, this study aims to characterize the interface between primary care and the emergency oral services (SOU) in the public health network of Recife.

Thus, an attempt has been made to describe and analyze the interface in oral health between primary care, particularly of the Family Health Strategy, and secondary care, using the emergency dental services, in the municipality of Recife, so as to identify the current position of integration between these types of care, taking as a starting point recognition of the SOU as a support for the family health teams, from the point of view of the organization of healthcare networks.

## Methodological treatment

This was a qualitative, exploratory and descriptive case study, to provide data for possible comprehension of the interface between primary care and emergency oral services in the SUS of Recife.

The conceptual basis guiding this investigation was the principle of being an integral unit or system, worked from the point of view of the interface as described by Morris and Burke<sup>15</sup>, characterized by interdependence, integration and complexity.

## Field work

The research project was approved by the Research Ethics Committee of the Federal University of Pernambuco, and subsequently presented to the dental surgeons of the health districts (DSs) that had emergency dental service (SOU). The method used was semi-structured interviews, and eight individuals took part in the study: four were duty attendants of the four SOU's in the municipality of Recife (DS II, DS III, DS V and DS VI), and four were primary care dental surgeons of the Family Health Units of the related DSs.

### Analysis of the information

Collection of data consisted of recordings in audio, using an interview script divided into two blocks, having to answer questions designed to elucidate the status of the interface between oral healthcare and oral emergency services, on the basis of the studies by Morris and Burke<sup>15</sup>. As well as the key characteristics presented by these authors, the blocks referred to also included as a category for analysis the 'care pathway', which appears with emphasis in the PNSB/MS.

The information was analyzed using ALCESTE, version 13, a program that uses calculations on the co-occurrence of words in segments of text. The program's classical analysis was used, based on the Descending Hierarchical Classification Dendrogram, making it possible to comprehend the expressions and each one of the words spoken by the dental professionals, analyzing them based on their position and social contexts<sup>16</sup>.

## Results and discussion

### The oral health network in Recife and its policy

In oral healthcare, the PNSB introduces innovations in the field of care, with expansion of access to primary and secondary care, to produce a larger and better supply of services, in an articulated network that provides for integrated actions between the basic and specialized levels<sup>17</sup>.

The guidelines of PNSB aim to 'Guarantee a basic care network articulated with the whole of the network of services, and as an inseparable part of that network; [...] to ensure integration of action in oral health, articulating the individual with the collective, promotion and prevention with treatment and recovery of the health of the population concerned', thus creating integrated healthcare networks<sup>4</sup>.

The knowledge of the respondents about the structure of the municipal healthcare network, in relation to both the professionals of the APS and the SOU, is still very rooted in the concepts of the fragmented and hierarchical network.

This is the situation also found by Mendes<sup>18</sup>, in an analysis of the healthcare systems, made from an international point of view, which shows that their systems are predominantly fragmented. Conceptually, these systems organize themselves through a group of isolated points of healthcare

that are not in communication with each other and which, as a result, are unable to provide continuous care to the population. It is known that, in oral health, the dental care model and its organization are a challenge yet to be met by the SUS. And although its actions and progress have been consolidating in the public health services, reformulation of their practices is still necessary<sup>2,3</sup>.

The testimonies of the professionals, as shown in the examples below, demonstrate how the oral healthcare network is structured:

*We have the basic care service, today most of it is inside the PSF [Programa Saúde da Família – Family Health Program]; there are still some services that function in the traditional basic units, but the greater part are inside the PSF. The secondary care has the CEOs, the emergency services, and the municipality does not offer tertiary care. Normally, patients that need care of high complexity are sent to the state. (Subject 2 psf)*

*Recife has the entry point, which are the family health units. The entry, then, for oral health would be the primary health team. And it has average complexity, which would be the CEOs and the other services of the network, the high complexity, and it also has some partnerships of the network, which, here, we have the universities, and there are also services other than those of healthcare. (Subject 6 urg)*

*In Recife, the secondary care is not being structured; it's being de-structured. And indeed, also, it's de-structuring our work. That makes things difficult – there's a bottleneck....it's very difficult. We have a waiting list here, for endodontics, of 30 months! It's one patient, in a population of 5,000 people, it's one patient per month, in the appointments system! Then, when we send the patient to endodontics, they already start saying to him: 'look, try somewhere else, seek another service, you will be here in the waiting list, but try to get what you need some other way because if not, you'll never get there, ever'. And, very often, 60% of the cases culminate in extraction... (subject 4 psf)*

When asked questions about how the oral healthcare network is today, the professionals' awareness and understanding as to the concept of the APS and its role within that network is evident.

We highlight that only one of the spoken replies referred to the polyarchic approach, to the Healthcare System – worked by Mendes<sup>18</sup>:

*And we work as a network so that there can be a polyarchic system, as if everyone were important. And we no longer have to follow that pyramidal system. It's a network. So, this is to include the concept of integration. (subject 5 urg)*

In the healthcare networks, this conception of hierarchy is replaced by the concept of polychy and the system is organized in the form of a horizontal healthcare network. Thus, in the Healthcare Networks there is not a hierarchy between the different points of healthcare, but shaping of a horizontal network of healthcare points with distinct technological densities, without order and without degree of importance between them. All the points are equally important for the objectives of the healthcare networks to be achieved. They differ only in their different technological densities<sup>19</sup>.

In relation to the structure of the Oral Health Policy, there were responses that were somewhat vague and, on some points, even disagreeing with each other, which can probably be considered as understandable, since Recife's oral health policy, named 'Recife Smiling More', is still not very widely disseminated, having been presented in November 2013, after the period of the interviews (May to July), during the first Oral Health Forum of Recife, held by the Municipal Health Council of Recife and indeed the National Oral Health Policy itself was a late arrival on the government's agenda.

The study by Santos and Assis<sup>20</sup> revealed that, at a national level, in the first decade of implementation of the SUS, no official document was identified that stated an oral health policy. This of course characterizes a certain omission in relation to the area at the central level, in spite of the Five-Year Health Plan (1990–95) having presented targets for control of mouth and throat cancer, as well as the reference to the reduction of caries, and periodontal disease among school pupils – and this tends to justify the low level of knowledge by the professionals involved in the service.

Going over the points made in this section, above, it is clear that although the various levels of healthcare are aware, even if in a still fragmented way, of the roles to be carried out by them, their knowledge of how the integration of these services, and their role in the Healthcare System, so as to ensure that there is integrated care, is still obscure.

#### **Limits and possibilities of the interface**

The secondary health services, because they are subject to various influences that can interfere in the rates and patterns of referral in oral health, make the interface complex. It is known that the process, in most cases, is controlled in accordance with the perception of the professionals

and users. Also, we highlight the multiple local contexts, which can influence this interface.

Considering that the interface between the levels of attention in healthcare presents various factors that limit and/or make possible the interdependence, integration and complexity of this process, we present below the considerations put forward by the actors involved in this investigation.

According to the characterization of the interface made by Morris and Burke<sup>15</sup>, who indicate that in provision of dental care between the levels of complexity each is dependent on the other, an analysis was made of the professionals' comprehension of the importance of the other level of care for the continuity of care.

When asked about secondary care, especially in this case of the emergency services, the dentists conceptualized it as an offer of clinical odontological procedures that are complementary to those carried out in primary care; and they did not omit to demonstrate and state the importance of the latter services. However, integration, and recognition of the interdependence of these services, is considered to be almost non-existent.

*The integration between the SOU and PSF is still very precarious. There's nothing very official to create this integration between one service and the other. Also, there is a meeting with the other oral care teams of the district. It's a little bit more spaced-out now, at this moment, but there have been meetings. There was a time when there was contact. But with the SOU, no. With the CEO, yes there has been. (subject 1 psf)*

*We don't have an effective integration which, in reality, deals with the problems. We have only the knowledge that the service exists, we have the service as a reference, but there's no integration with the service (SOU) Of how it works, the protocols followed in the service. We have never had access. (subject 2 psf)*

*In reality, it doesn't work. There used to be integration with me, with the PSF of 'A' and my healthcare post, the post where I serve. Because sometimes, from knowledge, they know my work shift (the patients), so, sometimes, patients from 'B', a patient from 'C', where I worked for 15 years, turns up here. But, in reality, there is no integration of the PSF with the emergency service. (subject 6 urg)*

Respondents emphasized the difficulty of communication between these two levels, which they referred to as precarious, resulting in a weakened integration, which is set against the statements of the authors Hartz and Contradiopoulos<sup>21</sup> and Almeida et al.<sup>22</sup>, on the constitution of integrated networks, the construction of

which necessarily recognizes that independence is fundamental in guaranteeing healthcare, since none of the instances by itself has the totality of the resources.

In the view of Morris and Burke<sup>23</sup>, both sides should have clarity of each other's role, where the coordination of the relationship between the levels is fundamental, because what is being sought is complementarity of the care model.

We agree with the study by Dias<sup>24</sup> who, when analyzing the strategies of coordination between primary and secondary healthcare in the SUS, in the municipality of Belo Horizonte (Minas Gerais State), dealt with problems relating to the coordination of healthcare as one of the principal challenges in organizing health systems, in view of the fragmentation of the care network and the insufficient communication between providers. His results point out that the combination of strategies of integration between levels of assistance strengthens primary care as coordinator of the care and contributes to the continuity of care and the supply of full integrated care.

This is reported in the following comment:

*In reality, this integration that you're talking about does not exist. I mean, this is unfortunate, because I believe that if there were more contact between these two levels of care, perhaps we could see or aim for some improvement. I work in the two services – PSF and SOU – and I can guarantee that the users of my PSF are better referred. There is no contact of the professionals of the PSF with those of the SOU. The meetings that take place are at the level of PSF, with their team itself. Here in emergency, we don't have much contact.* (subject 5 urg)

Integration is prejudiced by the lack of, or little, communication between the levels of care: there seems to be a lacuna, which is also observed in prior studies on coordination of the care or interface<sup>13,15,24</sup> and it was also seen that good cooperation and communication between the professionals are essential for a successful interface<sup>23</sup>.

Morris and Burke<sup>15</sup> state that the generalist dental surgeons need a place to refer the cases for more specialized treatment, while the specialist dental surgeons need to counter-refer the completed cases for continuity of attention by the primary care dentists. Changes on one or the other side of this equation can adversely affect the interface, affecting the flow of users between the primary and secondary care, also compromising other levels of care and provision of care. It is our conclusion that this statement can be considered for the care in the SOU as an integrating factor of secondary care.

*There is referral for the emergency services. Because of this, I see the need for, for example, if there is some possibility of carrying out the care here, generally, the emergency care is given here. In the majority of cases, it is given here. If there is no possibility of resolving the case here, I make the referral via a prescription. I refer the patient to the service due to the need for urgent treatment. There's no protocol. For the SOU, there isn't. The patient that I refer comes back, but not in the form of flow. He comes back spontaneously, to seek another type of service, another need. The counter-referral does not happen.* (subject 1 psf)

One can see a consensus between the various statements by those interviewed as to the need to overcome the obstacles in access to medium complexity to make progress in advancing the integral quality of the system.

We also observed, in the speeches of the interviewees that work in the emergency services, that there is no protocol that defines the flow of referral of these users, who seek the service to give the due continuity to their treatment and, thus, to achieve longitudinally of their care within the network.

*We do not refer to the health post because we don't even have any way of doing so. Our patients don't even get into making appointments for specialties, we simply orient them to seek the health post closest to their home, where they are registered. And generally, what they're saying is that either the post does not have a dentist, or at the post the dentist is on leave, on holiday, that the place is being painted, that there's a lack of water. That's always what we hear here.* (subject 7 urg)

In relation to the referral of the patient, in Basic Healthcare Manual No. 17 (Oral Health), we find only the reference to the CEOs, stating that referral should be made through the referral/counter-referral forms, accompanied or not by complementary examinations and radiography images. However, there are no referrals to the first aid services<sup>25</sup>.

Although there is no protocol, in the SOU, for referral and counter-referral to the PSF or CEO, in practice, it is understood that there is a need for referral, for continuity, to achieve longitudinality in its care, strengthening the integral nature of the services.

We highlight that this process should not go through a bureaucracy, as is stated by the study of Spedo et al.<sup>26</sup>, in relation to medium complexity medical care, in which the first aid services were obliged to refer patients that needed a specialized consultation or examination to a Basic Health

Unit (UBS), because only that service had access to a computerized appointment-making system, thus bureaucratically transforming the UBS into the entry point of the SUS, in the municipality of São Paulo. This measure had two important repercussions: it obstructed access for patients who, indeed, needed specialized services and needed to fight for the few vacancies available for medical consultations of the UBSs, with merely bureaucratic procedures, of 'exchange of forms' of referrals.

In the document presented by the Municipal Oral Health Coordination Office, 'Recife Smiling More', the SOU is indicated as being the one that has the purpose of solving the problems of emergencies in the maxillofacial complex, or referring them when they need specialized care. The demand of the SOU is spontaneous and its objective is to serve the population in an immediate and uninterrupted way, giving solutions to cases of urgency. Under Decree 7508 of June 28, 2011, these services also act as a point of entry into the system<sup>27</sup>.

So as to ensure continuity of healthcare, in all its modalities, in the services that are part of the healthcare network, the patient should thus be referred to the family health strategy to which he is connected, or, even, to the Dental Specialties Center (CEO), or oriented to seek continuity of the treatment in traditional units<sup>28</sup>.

### Integration

Integration is one of the principals of the SUS and it means helping the user and his needs, that is to say, the user having his problems solved. In this study we chose some parameters available in the work carried out by Morris and Burke<sup>15</sup>, where integration, together with equity, efficiency and efficacy, are among the characteristics considered necessary for an ideal interface.

According to our respondents, problems in the assurance of an integral care, as to the integration between APS and SOU, exist, and it seems that the objective of promoting a complete care between these two levels does not in fact happen.

*I think that integration still needs to improve. Both between PSF and CEO, and also between PSF and SOU. In a certain way it exists, in another, no. I believe that there is some integration with the CEO, but not with the SOU. (subject 1 psf)*

*I think that the main problem is this lack of meeting. I think it is the lack of interaction between the two classes, between the two, the emergency and the units of PSF and traditional units. (subject 7 urg)*

In the view of Hartz and Contandriopoulos<sup>21</sup>, theoretically, integration means coordination and cooperation between providers of care services to create an authentic health system but, in practice, this has not yet happened and there are few initiatives for monitoring and systematically evaluating their effects. Based on the statement of the authors, through the interviews held in this survey, it can be seen in the speeches of the dental surgeons that, in practice, very little is realized in terms of integration of the various services.

Now comparing what we have found in the study in relation to integration, we see in the European health systems ample attention in their recent reforms with initiatives to strengthen primary healthcare, including (among the possible forms of interface with secondary care, as well as the traditional referral for carrying out a procedure) consultation of 'short or long-term' and the common definition of protocols for handling cases, and also the development of programs of shared attention between specialties and professionals of the primary care network. These paths can also be constructed in the local health systems<sup>15,29</sup>.

The degree of integration of the healthcare should be inserted in the day-to-day life of the public service, independently of at what level of care this is inserted. To offer the right technology, in the right space and at most appropriate occasion, to give reality to the meaning of integrated care in the SUS. Thus, integration must incorporate finalization of care, with maximum solution power, considering the knowledge presently available for the health problem that the individual is going through<sup>30</sup>.

*I think it's a question of sitting down, having a conversation, and seeing what it is that I do and what it is that you do, what is within my competency, of emergency, and what is in the competency of the Health Post. [...] I think that, in this case, there's a lack of orientation, perhaps even by the managers, to put all the professionals interacting on the same problem, which is the patient. In reality, we don't have this interaction between the health posts and the emergency. (subject 8 urg)*

*One thing in which we are really failing to act: we should be looking for management. Seeking direction more, and really demanding it. (subject 7 urg)*

*I think it's lack of communication from management, making us aware of the network. (subject 5 urg)*

The speeches by the professionals on the spot (dental surgeons) report exactly what was stated in

the systematic revision made by Armitage et al.<sup>31</sup>, in which the presence of the manager in this process of integration is important, not only to clarify the role of the actors of each level, but also to list the deficiencies that exist in the network. For the purpose of filling a lacuna identified by the managers and planners in health on the integration between the levels of healthcare, several models were highlighted, tools of measurement and results of integration that can help in the planning and implementation of integrated health systems.

Therefore, we agree with Campos<sup>32</sup>, who puts forward, as a challenge in the quest for full integrated care, restructuring of the way in which the various establishments and organizations of the health sector have worked up to the present day. There needs to be a change in health practices at both levels. The first is institutional, of organization and articulation of the health services. And the second is of the practices of the health professionals.

In relation to the barriers of access between levels of care, study indicates that, to minimize them, more synchronized healthcare should be offered and, at an opportune time, it can be optimized by implementation of mechanisms and strategies of integration of the care network, increasing the capacity of the health systems to provide more coordinated care<sup>33,34</sup>.

### ‘Care pathways’

Due to the reality in Brazil, as well as the characteristics of the theoretical pace of the interface of Morris and Burke<sup>15</sup>, we deal with the subject of the theme of ‘care pathways’, in which according to Cecilio<sup>34</sup>, and Franco and Magalhães Júnior<sup>35</sup>, to ensure the principle of integration is necessary to make changes in the production of the care pathway, this line being a strategy for action, a path for achieving integrated attention, that seeks to articulate the production of care from primary care up to the most complex level of care, also demanding interaction between the other systems.

In the course of the depositions, the question relating to care pathways appeared to be dispersive and insufficient at some moments. The professionals of the SOUs showed little knowledge about it.

*‘Care pathway’ is just the name, it’s already saying that its care, it’s the act of taking care. And I always define that it’s the ACS. Thus, the health-care agent, he is an educator in health and he is the person that I most define as a carer.* (subject 7 urg)

*Our emergency service, I think it provides service, I think it is able, within some limitations, if there is a clinical emergency, to fulfil our role.* (subject 8 urg)

From these answers, we see the insufficient awareness, on the part of the emergency professionals, about the care pathway supported in the National Basic Healthcare Policy and in the National Oral Healthcare Policy.

We know that both the policies show that, among their various functions, there is accountability for care of users through a horizontal, continuous and integrated relationship, with the purpose of producing shared management of integrated care – making use, for this purpose, of care management tools and devices, including, among others, organized care protocols under the logic of care pathways<sup>4,36</sup>.

Thus, the care pathway is constituted in harmony with the universe of users, having as a prerequisite the constitutional principle of intersectorality and, as potential for solving problems, it makes possible the emergence of bonds of trust and links, that are indispensable for improving the quality of the health services and deepening the humanization of practices. The policy, finally, further states that absolute priority must be given to cases of pain, infection and suffering<sup>4</sup>.

*We work a lot on the line of priority cycles. That, in each cycle of life, we have to intervene in the odontological area.* (subject 2 psf)

*Thus, we focus on the pregnant woman, then, there is special attention for her, caring for her, working to make sure she takes good care of her child. In the next part, the health of the child, we try to work with promotion and prevention with collective activities, for us to act preventively and taking care of a whole population, with a larger number of people covered by that activity. And in the other cycles of life [...] the patient that most seeks out the service is not always the one who most needs it, the one who seeks out the service most finishes up having more care. We are not able always to manage to seek those who are more in need, but who do not come to the service.* (subject 3 psf)

We see in these speeches of professionals of the APS that their position corroborates with the PNSB, which provides in its directives that, for reorganization of the healthcare model currently in existence, it is fundamental that the care pathways (of the child, of the adolescent, of the adult and of the elderly person) should be thought out, with the creation of flows that result in problem-solving actions of the health teams, centered on welcoming, informing, providing the care

and making referrals (referrals and counter-referrals)<sup>4</sup>.

The evidence observed in the study, in most cases, is not in line with what Toledo<sup>13</sup> reports, that is to say, priority should be given to early detection, to immediate treatment of the damage in first-aid services and subsequent referral of a case to other levels of healthcare that each case requires and, this service should be provided immediately; thus characterizing the need for structuring of an organized health system, with an appropriate and agreed care pathway to absorb the demands coming from various points of entry.

### Final considerations

Undoubtedly, the problems with the interface between primary care and emergency services in oral health are multiple and complex. The individual solutions have low efficacy, and are complex in their operation. We consider that the majority of these initiatives aim to expand access, give support to decision-making, to referral and to efficiency.

The fragile integration found in this study, between the levels of care, and the low level of ability to provide solutions, leave innumerable actions and directives aimed for in the National Oral Health Policy unresolved. Thus, we find ourselves with a partially disconnected network, with a bottleneck in the APS and SOU, that is to say, an access that is still far from being universal,

which leads to awareness of an indisputable need for greater integration between the services.

We highlight that, looking at the theoretical implications of this survey, one thing that attracts attention is the low level of awareness on the part of the professionals of the SOU in relation to this theme. And this leads to certain questions: if the professionals do not perceive their real role within the network, or perceive it insufficiently, which is to promote integration – then where is the failing to be found? Few permanent education activities? Lack of personal interest and motivation? Absence, or little presence, of management? What needs to be done, and how, to promote continuity of this care, in fact? These are questions that need to be evaluated in further studies.

We believe that the results of our study can contribute to awareness about the interface of primary healthcare with the emergency oral care services in the SUS, in the municipality of Recife, broadening the base of evidences on the determining factors relating to lesser or greater success in the organization and integration of these services. Further, it seeks to be a contribution to parameters of management and care carried out in the municipal context and does not seek to be restricted only to the field of science.

For this, it is our view that facing up to the difficulties in achieving an ideal interface calls for major investment by the managers of the SUS. For this, we believe that articulated actions should be implemented, both in the APS and in the SOU, oriented by the health needs of the citizen-users.

### Collaborations

SC Austregésilo contributed to the preparation and conception of the study and data collection, as well as writing the manuscript. MCC Leal e N Figueiredo contributed with a critical review of the content and were responsible for the final version approval to be submitted for publication. PSA Góes contributed to the study design, data analysis, read and approved the final manuscript.



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