CSP CADERNOS DE SAÚDE PÚBLICA
REPORTS IN PUBLIC HEALTH

**ARTIGO**
ARTICLE

# Comprehensiveness of practices by Cuban physicians in the More Doctors Program in Rio de Janeiro, Brazil

## A integralidade das práticas dos médicos cubanos no Programa Mais Médicos na cidade do Rio de Janeiro, Brasil

## La integralidad de las prácticas de los médicos cubanos en el Programa Más Médicos en la ciudad de Río de Janeiro, Brasil

*Cassiano Mendes Franco* [1]
*Patty Fidelis de Almeida* [2]
*Lígia Giovanella* [1]

doi: 10.1590/0102-311X00102917

**Abstract**

*The shortage of physicians in remote and underprivileged areas poses an obstacle to universal access and quality of health care. Through the More Doctors Program (PMM), as of 2015, 18 thousand physicians had been incorporated into Brazil's Unified National Health System (SUS) to work in basic care, 79% of whom were Cubans. This article analyzed the comprehensiveness of practices by Cuban physicians in the PMM using a qualitative study in the city of Rio de Janeiro, Brazil, based on interviews with Cuban physicians (24) and a focus group with supervisors of the PMM (4). Comprehensiveness was analyzed in two dimensions: the community-oriented biopsychosocial approach to care and the range of activities in health promotion, prevention, and care. The work by Cuban physicians presents elements that are consistent with the comprehensiveness of practices in primary care, providing a wide range of care and services, in keeping with the health problems' complexity and the plurality of settings. These health workers show outstanding capacity for community interaction, a preventive focus, planning of activities, and positive interpersonal team relations. The study identified attitudes and techniques of solidarity, physician-patient bonding, and community accountability. Challenges were identified in the promotion of participatory practices with communities, the expansion of users' autonomy in clinical decisions, management of psychological problems, systematization of approach tools, and performance of invasive procedures. The study furnishes strong evidence that the PMM, in addition to medical consultations, provides comprehensive health care and contributes to strengthening basic care in Brazil.*

*Integrality in Health; Health Knowledge, Attitudes, Practice; Primary Health Care; Human Resources*

**Correspondence**
*C. M. Franco*
*Rua Pedro Américo 166, Bloco A, apto. 706, Rio de Janeiro, RJ 22211-200, Brasil.*
*casmenfran@gmail.com*

*[1] Escola Nacional de Saúde Pública Sergio Arouca, Fundação Oswaldo Cruz, Rio de Janeiro, Brasil.*
*[2] Instituto de Saúde Coletiva, Universidade Federal Fluminense, Niterói, Brasil.*

## Introduction

Health workforce shortage is one of the bottlenecks to universal access to health care [1]. Factors such as the demographic and epidemiological transition and the implementation of new health care models affect the need for health workers, and less developed and peripheral regions are generally the most underserved in terms of the availability and quality of the health workforce [2].

In fact, in addition to posing a problem for equity, workforce concentration leads to inefficiency in health systems [3]. As for global distribution of physicians, despite an increase in the total number, the pattern is one of concentration in large cities and shortages in rural areas [4].

Regulation of the health workforce has been a global challenge. The migratory movement of physicians, according to Rovere [5], tends to follow a "market-oriented" logic as opposed to a "policy-oriented" or "needs-oriented" logic. The medical profession's interests are not impartial; on the contrary, the profession takes organized moves to maintain the undersupply through regulation of human resources and pressure on health systems in favor of liberal medical practice.

Brazil presents similar problems that date to before the Brazilian Unified National Health System (SUS), with a history of ineffective health workforce policies and planning, subordinated to private interests [6].

Implementation of the SUS, with its guidelines of universality, comprehensiveness, and decentralization, demanded an increased supply of human resources, especially in primary health care, which faces major challenges for retention and qualification of physicians for adequate action by the family health teams [7]. In addition, limited state regulation of the health care labor market, especially the market for physicians (a profession that maintains strong power for self-regulation), is another factor that hinders the attraction and retention of physicians in priority areas for the SUS [8].

Brazil suffers from sharp disparities in the distribution of physicians, concentrated in cities to the detriment of the country's less developed regions [9]. In 2013, in a context of serious political and social tensions, the More Doctors Program (PMM, for its acrononym in Portuguese) [10] was established during a "window of opportunities" in this scenario [11]. The PMM was structured along three strategic lines, involving changes in medical training, improvement of infrastructure for the basic health units (UBS in the Portuguese acronym), and emergency provision of physicians [10].

Three years since the establishment of the PMM, with the recruitment of more than 18 thousand physicians from 2013 to 2016, there has been an improvement in the shortage of physicians in basic care, especially in more vulnerable areas [12]. The Program's capillarity reached nearly the entire territory of Brazil, predominantly with Cuban physicians, who accounted for 79% of the participants as of 2014 [13].

Implementation of the PMM met strong resistance from the medical profession. The controversy over participation by foreign physicians, especially Cubans, involved not only issues related to the work market and training, but questions as to the width and breadth of the practices by these professionals [9]. What was questioned was the quality of Cuban medical training to deal with the complexity of actions required for work in basic care in the SUS.

This article aims to analyze the comprehensiveness of practices by Cuban physicians in the context of the PMM. Comprehensiveness is a guideline of the SUS [14]. It is determined both at the level of health work and in the sphere of policies capable of intervening in the determinants of the health-disease-care process to guarantee satisfactory wellbeing for the population [14]. The comprehensiveness of practices in primary health care involves a biopsychosocial approach to care for individuals and families, actions in the territory, and an expanded scope with case-resolution capacity [14,15,16]. This study seeks to analyze whether, beyond decreasing the shortage of physicians and disparities in their distribution in Brazil, the work by physicians in the PMM is consistent with comprehensive practice.

## Methodology

The comprehensiveness of practices by Cuban physicians in the PMM was analyzed in two dimensions. The dimension of the community-oriented biopsychosocial approach to care consists of elements that expand the objectives of care in primary health care beyond the biomedical aspects to

involve psychological and social features, besides focusing further on work in the community [14,15]. It includes components that deal with a view to the territory [16], the centrality of subjects and their autonomy [14,16,17], inter-sector collaboration [15], valorization of social determinants [15], and active collective participation in building health projects [14,16,18].

The dimension of the range of actions in health promotion, prevention, and health care includes aspects in the physicians' activities that point to comprehensive care with case-resolution capacity, such as: a wide portfolio of services for promotion, prevention, and care [19], attention to both the spontaneous and scheduled demand [14,15], integration with other health services, interdisciplinarity [16,19], planning of interventions [15], and use of clinical protocols [14,16,17]. Box 1 shows the matrix developed by the authors, based on a literature review [14,15,16,17,18,19] and used to analyze the comprehensiveness of practices with their dimensions, components, and categories.

A qualitative study was performed in the city of Rio de Janeiro, Brazil, which received 165 physicians from the PMM (148 of whom were Cubans) from October 2013 to September 2015 (Departamento de Informática do SUS. Cadastro Nacional dos Estabelecimentos de Saúde. http://cnes.datasus.gov.br, accessed on 20/Oct/2015). The study selected the Territorial Planning Area (AP 3.1) with the most family health teams and UBS with physicians from the PMM. In June 2016, there were 30 physicians from the PMM working in 16 UBS in this territory. Field data were produced using interviews with physicians from the PMM and a focus group with the supervisors of the selected territory, from June to August 2016. The study visited 14 UBS and interviewed 24 physicians (M), whose profile is shown in Table 1. There were 6 refusals to participate in the study.

The work by the supervisors of the PMM, based on technical and pedagogical follow-up, aims to qualify medical practice [10], influencing practices by participating physicians. The supervisors' perspective helped identify changes in practices over time, besides either producing a counterpoint or lending validity to the physicians' perceptions. Of the total of six supervisors (S) in the selected territory, four participated in the focus group. The focus group technique allows extracting different perceptions from social groups affected collectively by specific situations, complementing individual approaches, triangulating views, and obtaining more information about the reality at hand [20].

The script for the interviews was based on the analytical matrix (Box 1), which also guided presentation of the results. The focus group included a moderator and a secretary and was guided by triggering questions.

The interviews and focus group were submitted to thematic analysis, consisting of the following phases [20]: ordering the material according to the analytical categories; horizontal and exhaustive reading for empirical categorization; cross-sectional reading based on the analytical categories; and clarification of the internal logic of the context in which medical practice takes place, in relation to comprehensiveness.

The study was approved by the institutional review boards of the Sergio Arouca National School of Public Health, Oswaldo Cruz Foundation and the Rio de Janeiro Municipal Health Department, under case reviews 1.526.773 and 1.558.250.

## Results

### Community-oriented biopsychosocial approach to care

- **Territorial dynamics**

Territorial dynamics are valued in the practices by the Cuban physicians in the PMM. The physicians identified the risks affecting the population covered by the program through the team's planning routine, including analysis of health indicators and priority-setting for scheduling appointments, and especially the health surveillance exercised by community health agents (ACS, for its acrononym in Portuguese), who had more detailed information on the territory. However, few of these physicians (3) used a map to locate environmental, biological, and social risks, since the abundance of risk conditions and their uniform distribution across the territory hindered drawing a map.

**Box 1**

Analytical matrix of comprehensiveness of practices.

| Dimension: community-oriented biopsychosocial approach to care | |
|---|---|
| **Components** | **Analytical categories** |
| Consideration of the territorial dynamic | Identification of the geographic area covered |
| | Knowledge of the covered area's socio-epidemiological profile |
| | Intervention in the territory's health, environmental, and social risks |
| The person's centrality and autonomy | Knowledge and use of the person-centered approach |
| | Exploring feelings and anxieties related to complaints |
| | Agreement with users on the treatment approach |
| Inter-sector collaboration | Linkage with services from other sectors |
| Valorization of social determinants | Follow-up of all people enrolled in the Brazilian Income Transfer Program in the territory |
| | Special action in cases of social vulnerability |
| Active participation in community building of health project | Community diagnosis with local leaders |
| | Community accountability |
| | Participation in local health council |
| **Dimension: expanded and integrated range of actions in health promotion, prevention, and care** | |
| **Components** | **Analytical categories** |
| Broad portfolio of services in health promotion, prevention, and care | Individual counseling on healthy eating, smoking cessation, and harm reduction in alcohol and drug abuse |
| | Canthoplasty, sutures, removal of earwax, intrauterine device insertion |
| Attention to spontaneous and scheduled demand | Definition of places on the agenda for same-day consultations |
| | Follow-up of pregnant women, children, diabetics, hypertensives, TB, and users with mental disorders |
| Integration with other health services | Exchange of information with secondary and/or tertiary health professionals |
| Interdisciplinarity | Collaboration with nurses in the family health team |
| | Collaboration with community health agents in the family health team |
| | Relations with NASF |
| Planning interventions | Team analysis of population health indicators |
| | Development of planned activities based on health indicators |
| Use of clinical protocols | Knowledge of lines of care defined for the municipal health network |
| | Use of national and international clinical guidelines |

NASF: Nucleus to Support Family Health.

Source: prepared by authors based on Mattos [14], Almeida et al. [15], Silva Junior et al. [16], Silva Junior & Mascarenhas [17], Pinheiro & Silva Junior [18] and Starfield [19].

The Cuban doctors showed extensive knowledge of the demographic and epidemiological profile of the population covered in the territory. Some reported the precise number of families and groups they accompanied, emphasizing the large population contingent. The population surplus led to heavy pressure for care from the team and was intensified by the territory's extreme vulnerability and the severity of the diseases, due to the difficulty in access to medical care before the arrival of the PMM (Box 2, M17).

**Table 1**

Profile of physicians interviewed in the More Doctors Program (PMM) in the AP 3.1 administrative area in the city of Rio de Janeiro, Brazil, 2016.

| Characteristics | Number of physicians |
|---|---|
| Nationality | |
| Cuban | 23 |
| Brazilian | 1 * |
| Sex | |
| Women | 14 |
| Men | 10 |
| Age (years) | |
| 26-30 | 3 |
| 31-39 | 6 |
| 40-49 | 11 |
| 50-54 | 4 |
| Training | |
| Cuba | 24 |
| Year of graduation | |
| 1986-1995 | 10 |
| 1996-2005 | 7 |
| 2006-2015 | 7 |
| Complementary training | |
| General and Integrated Medicine/Family and Community Medicine | 23 |
| Other specialties | 12 |
| Master's | 7 |
| Number of previous international missions | |
| 0 | 1 |
| 1 | 18 |
| 2 | 4 |
| 3 | 1 |
| Length of previous missions (years) | |
| 0 | 1 |
| 1-2 | 6 |
| 3-4 | 7 |
| 6-11 | 10 |
| Time in the PMM (months) | |
| 0-6 | 3 |
| 28 | 8 |
| 32 | 13 |

Source: prepared by the authors.

* The only Brazilian physician in the study sample did her medical training in Cuba.

All 24 physicians identified flagrant social inequalities in the territory, expressed in important social determinants such as poor hygienic conditions in the homes, poverty, unemployment, and work informality. Violence, closely associated with the drug traffic, was a sensitive point frequently cited by these doctors.

The epidemiological profile identified by the Cuban physicians was largely related to the prevalence of chronic diseases and the adverse living conditions in the territory. The high rates of sexually transmissible diseases, especially syphilis, as well as tuberculosis, were associated with severe social vulnerability. High tuberculosis incidence was emphasized in the interviews, since the disease is rare in Cuba, representing a novelty for them in management in primary health care (Box 2, M16).

**Box 2**

Practices by Cuban doctors and assessment, by supervisors, of the community-orientated biopsychosocial approach to care in the More Doctors Program (PMM). City of Rio de Janeiro, Brazil, 2016.

| Components | Quotes from interviews |
|---|---|
| Territorial dynamic | "*I now have four thousand six hundred and thirty-some people enrolled, plus about a thousand more who don't have a taxpayer number or ID. They're extremely poor, because within the favela there's a smaller favela where I have 500 enrolled. But besides the ones I don't have enrolled, whom I also see, there must be eleven hundred, so it's a lot of people*" (M17) |
| | "*So, I've seen many diseases that I'd really never seen before, that I'd only seen in the textbooks. For example, tuberculosis, I'd only seen one case of TB in my life. Nearly ten years since I graduated before seeing a tuberculosis patient. Just one. And here I'm treating fourteen. All at once, understand?*" (M16) |
| | "*We hold, at least I hold, on Friday, every Friday morning, I hold a lot of groups. I go out into the community. We go there, thank God, they know me, I've worked there for practically three years. And they say, 'Doctor, hello there. How are you? Hey doctor!' Understand? And we have a partnership. 'Let's go, we're going to do the little test for everybody.' The 'little test' from the scale. We go there, take the sample, do the rapid test* [for syphilis and HIV] *out there, too. We give a lot of talks and distribute condoms*" (M6) |
| | "*All the doctors I supervise form a group. The patient received the doctor at home, opened the doors to his home, to be able to hold the group inside the community. In the patient's home. Everybody knew them*" (S1) |
| Centrality and autonomy of the person | "*Each person has their view of life, illness, and health. That's how I assess patients. And always remembering that the patient is a biopsychosocial being. The patient is not just a heart, not just a liver, not a finger, not a hand. The patient here is seen as a whole, let's say*" (M4) |
| | "*The patient comes here in pain, needing a kind word. When they come here, they sit over there. They're not used to it. I do like this with the patient* [pulls the chair over next to the table]*. I want to speak with them, so I sit here* [next to the patient]" (M12) |
| | "*If in the exercise the method* [person-centered clinical method] *works – you realize in their relationship with the patient, in the bond they create, in the exercise of discovering the patient's relationship with the illness itself, etc. – I don't know if we have to be all that academic*" (S2) |
| | "*Because the patient may know about the illness, but he doesn't know anything about medicine, understand? So, you orient them on treatments and tests, for example. And you talk with them about the importance of what to do, what's going to be done. And sometimes they make suggestions, and you may or may not agree with their suggestions*" (M3) |
| Inter-sector collaboration | "*We hold scheduled and planned activities in the school with these children. We hold activities here in the shipyard. But mainly with the School Health Program*" (M1) |
| | "*The neighborhood association lets us use their center for any activities here by the health unit. It's a big place, and they help the Family Clinic to hold any activity*" (M7) |
| | "*The CRAS* [Reference Center for Social Assistance]*? I'm not familiar with it personally, but I know the reference. So, we have the support of the NASF, I don't know if you know it, the Support Nucleus, and they have a social worker. So, when we have any problem like that, we rely on their support the same way. I can't make this kind of link because it's too complicated for me to leave my consultations to go there*" (M16) |
| | "*When inter-sector collaboration works a little better or exists, it's because the manager is more involved or more proactive in this sense. And that's how they're able to practice linkage in the territory. Or with the community health agent, but the community health agents have more to do with the neighborhood association. With other sectors, it's more with the managers*" (S3) |
| Valorization of social determinants | "*The doctors I supervise are able to set priorities, organizing care for the vulnerable population. Most of them work with the vulnerable population. So, when I do supervision and talk with them, they tell me, 'I saw such-and-such a case, and I'm doing home visits every week, or the nurse goes first and I go the same week*" (S1) |
| | "*When I live in a community that has no places for leisure-time activities, no options for recreation, only the drug traffic, only violence, only gunfire, only police raids, substandard housing, the person may not be sick right now, but the disease can come any time. The main problem for being able to make changes is to combine this desire for health, the knowledge that health workers have, to achieve change with this outside social investment*" (M5) |

(continues)

**Box 2 (continued)**

| Components | Quotes from interviews |
|---|---|
| Active participation in collectives in building health projects | "*We consult the neighborhood association and community leaders to learn about the community's history. Because when I arrived here, for example, I didn't know anything. In each micro-area, we need to identify the leaders to facilitate our work. They mainly point to the piled-up garbage, the streets full of potholes*" (M8) |
| | "*We work together, and work with formal and informal leaders. With the head of the community, we try to talk even with the head of the drug traffic*" (M6) |
| | "*The analysis of the health situation involves numerous variables and multiple stages that have to be complemented. So, to survey the health situation, we use the patient charts. But we don't say that everything's done, because not everything can be done. This discussion with the entire community, we can't get there now. We can't get there, because it's very difficult to convene the entire community*" (M14) |

NASF: Nucleus to Support Family Health.

Source: prepared by the authors.

All the interviewees (24) reported a wide range of measures to deal with the risks they identified. They acted case by case, through patient consultations and home visits or broader proposals for the entire population, mainly using health education groups, suggesting an approach to population risks beyond the more individual patient-centered pattern of medical work (Box 2, M6 and S1). All such actions relied on linkage with the professionals from the Nucleus to Support Family Health (NASF) as well as partnerships with community leaders.

- **Centrality of subjects and their autonomy**

All the interviewees reported adopting attitudes and techniques to approach individuals as the center of care. Most of the physicians (18) cited the need to understand the user's family and social context. Another important tool in the person-centered approach was the valorization of attentive listening. Some physicians (8) cited exploring such subjective aspects as knowledge of the illness, the way sick individuals are perceived by others, and feelings, expectations, and reactions to health problems.

They also highlighted the unique manifestations of diseases in each person and the data from the clinical examination that led them to reflect on personal factors to understand the patient's condition (Box 2, M4). There were also answers (8) suggesting rejection of medicalization and the "complaint-approach" model of medical practice, pointing to forms of humanization of care as a counterpoint. Others (7) underscored the user-physician bond and solidarity (Box 2, M12). The bond was emphasized in the relationship of trust between the patient and physician, fostered by continuous follow-up over time, promoting the assimilation of idiosyncrasies and vicissitudes.

Another strategy in the person-centered approach was ollaboration with other professionals from the family health team and especially from the NASF. A few interviewees (3) reported difficulty in focusing more time on individual patients due to the overload of consultations.

Meanwhile, the supervisors expressed ambiguity towards application of the person-centered approach. Based on their experience with specific training in the person-centered clinical method, the supervisors argued that the Cuban physicians lacked the training to explore the method's steps and that they performed the steps intuitively, although the specialization course in family health provided the conceptual fundamentals. They felt that the Cuban doctors were concerned with the care, had ample knowledge of the users under their care, and worked to create a bond and understand the patients' own experiences with their illness (Box 2, S2). Still, the supervisors argued that given the lack of specific training with the method, the physicians would experience difficulties managing the person-centered approach within the short time available for each individual consultation. However, two supervisors said that the more intuitive approach did not jeopardize the centrality of the person in the Cuban physicians' approach.

One of the steps that characterizes the individual's centrality and autonomy is negotiation of the case management with the user. The great majority (22) of the physicians stated that their conduct was carefully explained to the patient in order for him or her to understand the clinical decision, as a form of participation and point of departure to reach a consensus and increase treatment adherence. However, some contradictions were identified in the comments, with an emphasis on the need for compliance with prescriptions and the predominance of medical knowledge as a guide for the therapeutic and diagnostic process (Box 2, M3).

- **Inter-sector collaboration**

Among the 19 physicians that cited collaboration with other sectors, all of them mentioned activities with schools and daycare centers, mainly through the School Health Program (Box 2, M1). Some mentioned activities with churches, sports, and the neighborhood association (Box 2, M7). Four physicians mentioned collaboration with the social workers in the NASF, conducted in a few cases (Box 2, M16). Six had made contact with the Reference Center for Social Assistance.

Pressure from the overload of consultations was cited as a limiting factor for collaboration, and the physicians also emphasized difficulties due to the lack of social infrastructure in the territory. The supervisors stated that inter-sector collaboration is a challenge for any physician practicing in primary health care. When such activities occurred, they were undertaken by the UBS management or at the initiative of the community health agent (Box 2, S3).

- **Importance of social determinants**

The importance of social determinants of health was acknowledged by the Cuban doctors in the PMM. All the physicians (24) said they were familiar with the Brazilian Income Transfer Program (*Programa Bolsa Família*; conditional cash transfer) program and participated in the follow-up of the enrolled users. A few (3) reported limitations for expanding their participation in the follow-up of Brazilian Income Transfer Program users, citing the stigma associated with this social benefit and (again) the overload with patient consultations.

They reported different experiences in relation to social vulnerability. The most frequently cited conduct was involvement by the team, NASF, and/or social assistance. Some doctors also conducted more home visits and consultations for the more vulnerable cases, as also reported in the focus group (Box 2, S1).

Another form of work was keeping the team available to receive patients, both with their immediate demands and on preventive issues. The physicians mentioned the priority of scheduling, coordination of more systematic care, support for the role of community health agents in surveillance, and material assistance (donation of food, diapers, cleaning products, etc.) in cases involving greater social vulnerability. Some (3) reported that beyond their own work, more government funding was needed (Box 2, M5).

The focus group emphasized that the Cuban doctors were more sensitive to issues of social risk, but that they showed weaknesses in differentiating some cases of social vulnerability, for example, a more systematic approach to domestic violence.

- **Active participation in community groups building health projects**

The majority of the Cuban physicians (22) participated in developing the community diagnosis and considered the demands and the support of local leaders when analyzing the territory's problems and potentialities (Box 2, M8). The physicians worked with both formal and informal community leaders (Box 2, M6). Still, the community diagnosis was based on the study of the electronic patient file, with the main focus on diseases (Box 2, M14).

Some Cuban doctors cited the annual accountability seminar required by the municipal administration as the time for conducing the community diagnosis. In addition to the health councils that existed in some UBS, regular meetings were held with users for accountability and clarifications. Most of the doctors (21) did not participate in these meetings or in the health councils.

## Range of activities in health promotion, prevention, and patient care

- **Extensive portfolio of services in promotion, prevention, and care**

Among the practices in health promotion and prevention of individual health problems, such as counseling on life habits, all the interviewees reported orienting patients on healthy eating and smoking cessation and recommended harm reduction measures for alcohol and drug users, with the greatest difficulties in the latter cases (Box 3, M20). Prejudice and social stigma hindered the approach to (and identification of) alcohol abusers and especially illicit drug users.

There was some variation among the doctors in relation to performing invasive procedures: according to their reports, 18 removed earwax, 12 inserted intrauterine devices, eight performed sutures, and six removed ingrown toenails (Box 3, M18). Few said they lacked training, and those that did not perform such procedures voiced various justifications: lack of material and adequate spaces, lack of demand for the service at the UBS, insufficient time, and avoiding the creation of a demand for treating wounds from armed confrontations. The supervisors realized that not all these physicians performed invasive procedures, despite requirements by the municipal administration (Box 3, S4), due to training and pressure from patient consultations.

- **Attention to spontaneous and scheduled demand**

All the interviewees (24) reported treating the spontaneous demand. There were various ways of dealing with the spontaneous demand, highlighting "advanced access", which aimed to provide as many places as possible for medical consultations on the same day, thus reducing the waiting time (Box 3, M5). According to the supervisors, welcoming the spontaneous demand was incorporated without the physicians having to limit it or refuse to see patients. They reiterated the practice of "advanced access", a contribution by the supervisor that proved opportune for the physicians' reality.

All the Cuban physicians (24) reported accompanying priority groups, organizing follow-up, and attempting to adhere to protocol for each condition, but with flexibility. This care was shared with the nurses from the family health team (Box 3, M19, M21).

The quotes by the focus group agreed with the interviews but highlighted limitations in the approach to mental health cases. Supervisors mentioned a disadvantage in the specialized training of some professionals from the PMM in managing psychiatric conditions in primary health care, in addition to the language barrier.

- **Integration with other health services**

Half of the Cuban physicians (12) only had contact with professionals in secondary or tertiary care through the referral guides. The other half communicated with specialists, but infrequently. Two underscored the importance of structuring and integrating the health network to improve relations with other levels of care (Box 3, M3). The interviewees voiced their fear of contacting Brazilian doctors in the health care network, due to heavy rejection of the PMM by the Brazilian medical profession, especially in the initial stage (Box 3, M21).

Even with the referral guide, interprofessional communication was not rated positively, since only seven Cuban doctors said they received counter-referrals regularly. The focus group also identified difficulties with direct communication in the municipal health system.

- **Interdisciplinarity**

The Cuban doctors' integration in the family health team was emphasized by the doctors themselves and by the focus group. Most of the Cuban physicians (18) highlighted the technical preparedness and capacity of the Brazilian nurses ("they're almost doctors", said some of the interviewees), as important partners for shared follow-up of users in teams with a surplus population to cover.

Some Cuban doctors (2) expressed difficulties with the turnover of nurses. According to one interviewee, there were some clashes with the nursing staff at the beginning of the PMM, because the

**Box 3**

Practices by Cuban doctors and assessment, by supervisors, of the range of activities in health promotion, prevention, and health care in the More Doctors Program (PMM). City of Rio de Janeiro, Brazil, 2016.

| Components | Quotes from interviews |
|---|---|
| Broad portfolio of services | "*Alcohol and drugs are a much more difficult case. I say, 'Do you drink?' 'No, just a beer once and a while'. Understand? I can't say, for example, 'Do you take drugs?'. Because these are words.... there's a lot of prejudice about drug use*" (M20) |
| | "*Oh yes, I do canthoplasty. And I also insert IUDs. I perform sutures as well. Flushing earwax? I do it here. It's common, every week*" (M18) |
| | "*I have the impression that some of the doctors I supervise perform procedures, while others don't. There's a difference in the training and in urgency in the management of the basic health unit. Sometimes the management encourages them, asks them, say they're not inserting IUDs*" (S4) |
| Attention to spontaneous and scheduled demand | "*I believe that for any doctor, any health worker, today, the agenda is a problem. Because the agenda is one thing, and the demand is something else. The population had appointments scheduled, but the agenda was full, without much room for the free demand. How are we doing it now? I talked with a coworker about another kind of experience. I leave the agenda open*" (M5) |
| | "*If the child is healthy overall, the follow-up visit is with the nurse. That's protocol. But, for example, if there's a child that's not gaining weight, that's not thriving, that needs the follow-up, I'm the one that schedules the follow-up with me* [before the schedule per protocol]. *The same thing with pregnant women*" (M19) |
| | "*The other day a nurse from another team said, 'I don't know how you manage to have the children come for routine neonatal care'. I managed, and the children come. And all my children come. They're born, and before they're two weeks old I see them for the first visit*" (M21) |
| Integration with other health services | "*In my opinion, there should be a little more interrelation between basic care and secondary care. Because sometimes you aren't able to do a lot. So, it's not the fault of primary care or secondary care. Because there are patients that are treated adequately in primary care and that go to secondary care for some, for inadequate treatment in secondary care. And there are patients that aren't supposed to be treated and that need secondary care*" (M3) |
| | "*I was kind of fearful* [of contacting another service]. *There's a lot of prejudice [in the medical profession], so at first I was very fearful*" (M21) |
| Interdisciplinarity | "*We left there* [Cuba] *to come here, and we thought we were going to get here and teach community medicine. We have learned a lot of things that we didn't know. And here, I needed more ideas, communication, and suggestions, from my coworker [a nurse] than there* [in Cuba]" (M8) |
| | "*There's a lot of active participation by them* [from the NASF]. *As for the physical therapist, and the psychologist, everyone's great. They even came here, and we at least were less tired. There was a lot for us to solve. In psychology, we can't solve it all alone*" (M17) |
| Planning interventions | "*I have the printout here [the performance indicators report], because I prepare one every month. I'm holding it here. It's on the other side, but I print it out for the team meeting. Okay, as for the amount of home visits that have to be done. So, we call in each community health agent. You have five pregnant women, if you don't work every week, understand? Hypertensives, you have to monitor every quarter, on the month. Because if there's one missing here, you have to go find them, right?*" (M21) |
| Use of protocols | "*But I think Brazil also has an American academic approach.* (...) *Here there are a lot of flowcharts, you just learn the flowchart and go to work! There [in Cuba] you have to know the diseases, you have to know the pathology, more in-depth, there you work more like that. And not here, you get here and already have a protocol, a kind of care, you see everything. There, you need to have this experience, I think it's a great experience*" (M23) |
| | "*There's a doctor that came and said to me, 'I wrote the prescription for vitamins and ferrous sulfate for the children', and I don't know what all. I say, 'There's no evidence for that'. I did the on-site supervision and she said, 'There are protocols here, but I'm going to do what I think*" (S1) |

NASF: Nucleus to Support Family Health.
Source: prepared by the authors.

nurses were not used to the range of activities by the PMM group in primary health care. The fact that nurses in Brazil perform consultations was new to the Cuban doctors and led to a more egalitarian relationship with greater dialogue (Box 3, M8).

The Cuban doctors highlighted the importance of the community health agents and the fact that their work expanded the possibilities for care. They mentioned the NASF at various moments in the interviews, especially the support in mental health and social assistance (Box 3, M17). The focus group reported that, with few exceptions, the Cuba physicians enjoyed good relations with all the members of the Family Health Strategy (ESF, in the Portuguese acronym), collaborating in patient care and case discussions.

- **Planning of interventions and use of clinical protocols**

The Cuban doctors reported using the indicators provided by the electronic patient chart. The majority (20) planned activities based on the problems identified, such as active search and campaigns (Box 3, M21). Two doctors emphasized that the main focus of care was the quality of patient follow-up. The focus group also pointed to the use of performance indicators from the electronic patient chart for organizing work by the family health team, however, based on a notion of primary health care limited to health programs, with little emphasis as a device for discussing the process of care.

The great majority of the physicians (23) said they were familiar with the manuals produced by the Municipal Health Department for health care practices and patient flows in primary health care. The majority used the municipal or national protocols, emphasizing the importance of respecting the country's guidelines. Few physicians (5) reported also using foreign references such as Cuban guidelines, guidelines of American medical societies, or others in the Spanish language.

The interviewees stated not having experienced difficulties in adapting to the Brazilian protocols. "The medicine is the same" was a common remark. The difference in relation to Cuba related to care for users with tuberculosis (since tuberculosis patients in Cuba are referred to specialists), maternal and child care, which is more rigorous in Cuba, and flowcharts, which are rarely used in Cuban practice (Box 3, M23). The focus group voiced a different position in relation to adequate use of clinical protocols and evidence-based medicine by the Cuban physicians. According to the supervisors, some of the Cuban doctors based their practice on empiricism, with resistance to reliance on scientific evidence (Box 3, S1).

The results indicate that the practices by Cuban physicians in the PMM displayed full or partial presence in all the components used to analyze comprehensiveness of practices. The dimension of actions in promotion, prevention, and care was somewhat stronger than the dimension of the community-orientated biopsychosocial approach to care, although strengths and weaknesses were found in both dimensions. However, the weaknesses in the list of activities related mainly to limitations that are outside the scope of the physicians' work (for example, violence in the territory). Box 4 summarizes the main strengths and weaknesses in achieving comprehensiveness based on the assessment of the physicians interviewed and the supervisors' viewpoints.

## Discussion

The PMM raised questions as to its potential for offering quality health care to the population [2]. Nevertheless, in relation to comprehensiveness, the study indicated good practices.

Strong territorial integration and community interaction are consistent with findings from other studies on practices in the PMM [21,22,23]. Cuban medical training, targeted to the provision of community-oriented services [24], may have been a facilitating factor. More precise activities in territorialization could empower the action in settings of social reproduction of health-disease processes in areas covered by the family health teams [7].

Although not highly systematized, the six steps to the person-centered approach [25] were present in practices by physicians in the PMM. Other studies have also identified the presence of elements of the person's centrality and autonomy in the work by physicians in the PMM [21,23,26]. The assessments by the supervisors on this point appear to identify a certain tension and the defense of a Brazilian

**Box 4**

Strengths and weaknesses of the components in the dimensions of comprehensiveness for Cuban physicians in the More Doctors Program (PMM). City of Rio de Janeiro, Brazil, 2016.

| **Dimension: community-orientated biopsychosocial approach to care** | | |
|---|---|---|
| **Components** | **Strengths** | **Weaknesses** |
| Territorial dynamics | Knowledge of the social and cultural dynamics, in addition to epidemiological and social risks.<br>Interventions in the territory together with the Family Health team and other community partners for health education. | Imprecise mapping of risks in the territory |
| Person's centrality and autonomy | Various stances and techniques for the person-centered approach. | Contradictions in negotiating case management with the user. |
| Inter-sector collaboration | Work facilitated by some devices (School Health Program and Reference Center in Social Assistance) focused on inter-sector integration | Insufficient structuring of the person-centered approach |
| Valorization of social determinants | Follow-up of users in the Brazilian Income Transfer Program.<br>Special action in cases of social vulnerability, in collaboration with the family health team. | Weak inter-sector linkage of municipal policies. |
| Active participation in communities in building health projects | Establishment of community partnerships.<br>Community diagnosis partially performed with local leaders.<br>Annual accountability with management and invitation to the community. | Difficulties in identifying and approaching some vulnerable cases (e.g., domestic violence). |
| **Dimension: expanded and integrated range of activities in health promotion, prevention, and care** | | |
| **Components** | **Strengths** | **Weaknesses** |
| Broad portfolio of services in health promotion, prevention, and care | Holding activities in health promotion, prevention, and health care.<br>Counseling on healthy eating and smoking cessation.<br>Performance of minor invasive procedures. | Difficulties in harm reduction counseling for alcohol and drug users.<br>Insufficient infrastructure in the Basic Health Units.<br>Limited patient demand for invasive procedures. |
| Attention to spontaneous and scheduled demand | Care for acute situations in the Basic Health Units, especially "advanced access".<br>Systematic follow-up of health conditions per program. | Excessive spontaneous demand in relation to the total number of consultations.<br>Difficulties in follow-up of users with mental disorders. |
| Integration with other health services | Preocupação em acompanhar casos encaminhados a outros serviços. | Pouco contato com profissionais da rede especializada.<br>Fragmentação do sistema municipal de saúde. |
| Interdisciplinarity | Concern with follow-up of cases referred to other services. | Little contact with professionals in specialized services.<br>Fragmentation of the municipal health system. |
| Planning interventions | Analysis of health indicators provided by electronic patient charts with planning of activities together with the Family Health team. | Conception limited only to meeting targets for performance indicators. |
| Use of protocols | Knowledge of the municipality's rapid referral guides.<br>Use of municipal and national protocols and guidelines. | Divergence in adequate adherence to clinical guidelines. |

NASF: Nucleus to Support Family Health.

Source: prepared by the authors.

concept of family and community medicine, with limited openness to practices from other experiences. The person-centered approach and clinical method and the skills-based curriculum elaborated by the Brazilian Society of Family and Community Medicine are considered essential attributes in various fields of the specialty [27], which may explain the emphasis on more rigorous systematization of the method, based on the training model in Brazil.

The results indicate that inter-sector collaboration is facilitated when there are devices in place, like the School Health Program or to a lesser degree the Reference Center for Social Assistance. Still, problems identified in the communities appear to receive little or no attention through linkage at the local level alone. Giovanella et al. [28] point to a lack of inter-sector policies in management, stating that when actions are taken by the municipal executive, they strengthen the Family Health teams' community activities in the territories.

Other studies have shown that professionals from the PMM value social determinants in their practices [22,26]. This aspect relates to comprehensiveness to the extent that it demonstrates capacity for expanded action beyond clinical care and suggests care with a focus on the sources of social reproduction of diseases [17].

The physicians from the PMM interviewed here showed the capacity to identify leaders and establish important partnerships in the community, but low participation in local health councils. In Brazil, other authors have also pointed to health professionals' difficulties in mobilizing and encouraging the populations to promote joint interventions. They have also emphasized the need to promote quality representation and expand the impacts of social control in health in policy decisions [19,29].

The dimension of the actions in health promotion, prevention, and care was achieved more fully by the Cuban physicians in the target categories. Girardi et al. [30] found similar results with a diversified scope of actions, while identifying such limitations as lack of training, limited demand by users, and especially inadequate infrastructure in the UBS.

The difficulty in dealing with alcohol and drug users can be discussed from the perspective of the territory's characteristics. A case study by World Helath Organization/Pan American Health Organization [26] in the city of Rio de Janeiro showed similar findings in regard to the challenges of dealing with drug and alcohol problems, which were unfamiliar to the physicians from the PMM.

Physicians and supervisors both felt that even in territories with serious social and epidemiological problems, the family health teams cover an excessive number of users. The population surplus hinders the teams' capacity to develop comprehensive practices. Santos [31] shows that UBS with excessively heavy demand display precarious physician-patient bonds and fail to ensure a continuous relationship over time or access to timely first contact, which can reduce the FHS to a "complaint-management" outpatient clinic with disease-centered care.

Corroborating previous studies, we found a receptiveness to the spontaneous and scheduled demand based on strategies for its absorption [21,23,26]. Follow-up of various population groups is another positive aspect of the practices by physicians in the PMM.

Difficulties in the follow-up of mental health cases reflect inadequate training to deal with these problems, similar to Brazilian physicians, who often resist addressing mental health problems in the context of the FHS [32]. Violence and precarious living conditions in large Brazilian metropolises, as in this study's context, not only fuels the incidence of mental problems, but also complexifies them [26].

Insufficient coordination of care, a common problem in the SUS [33], also appeared as a weakness in the current study. According to Almeida et al. [33], the referral guide is a poor instrument for dialogue between specialists and generalists and requires users to serving as messengers of their own clinical data, besides placing them in the middle of disputes for professional recognition between specialists and basic care physicians, which was also evidenced here in the PMM.

The study showed predominantly favorable responses in relation to the Cuban physicians' collaboration with nursing staff, community health agents, and the NASF, in keeping with other studies on practices in the PMM [21,22,26]. Cultural differences, especially regarding language and the roles of different health workers in the health team, were scarcely important and were attenuated over time, consistent with the findings by Comes et al. [21]. The NASF was called on extensively, with regular and frequent relations for inter-consultation and pedagogical support, notably for mental health and social assistance. Previous studies have shown that contact with primary health care physicians by

the NASF teams is unusual, and that what predominates is referral, with inter-consultation occurring mainly between nurses and community health agents [32].

The physicians from the PMM analyze the population's health indicators and develop planned activities. This kind of work has also been found by other studies [21,23,26]. The preventive focus, an established principle of the Cuban National Health System, especially in primary health care, where the practice is systematized through action planning mechanisms [23], may be a practice that favors the physicians from the PMM.

In the use of clinical protocols, elements of professional conduct and the physician-patient relationship related to quality of care [17] were present, such as technical skill, clinical actions associated with the social approach (especially in the home visits), valorization of the clinical examination, and rational use of diagnostic resources.

In short, the work by the Cuban physicians in Brazil's PMM presents elements consistent with the comprehensiveness of the practices, according to the concept adopted in this study, with the provision of a wide range of actions and services, in keeping with the health problems' complexity and the plurality of scenarios. These professionals display a striking capacity for community interaction, a preventive focus, planning of activities, and good interpersonal relations, showing attitudes and techniques of solidarity, bonding, community accountability, and quality of care.

Challenges were also identified in the promotion of participatory practices in the community, patient autonomy in clinical decisions, more effective management of psychological problems, systematization of approach tools (person-centered and for more vulnerable cases, for example), and training in invasive procedures in basic care. The learning processes established in the Program provide possibilities for improvement and for overcoming these obstacles.

The study's results give strong evidence that the PMM has reached beyond increasing access to consultations [13] and procedures and decreasing inequalities in the distribution of physicians [12]. The practice by Cuban physicians in the PMM in the case studied here allowed supplying comprehensive health care, thereby helping to strengthen a comprehensive concept of primary health care and of the SUS.

## Contributors

C. M. Franco participated in the study conception and project; data analysis and interpretation, writing of the article, and has responsible for all aspects of the study, guaranteeing the accuracy and integrity of all parts of the work. P. F. Almeida collaborated in the study conception and project, data analysis and interpretation, writing of the article, relevant critical revision of the intellectual content, and approval of the final version for publication. L. Giovanella contributed in the study conception and project, data analysis and interpretation, writing of the article and relevant critical revision of the intellectual content.

## Acknowledgments

The authors wish to thank the physicians and supervisors of the More Doctors Program and the Rio de Janeiro Municipal Health Department for their support.

## References


1. Campbell J. The route to effective coverage is through the health worker: there are no shortcuts. Lancet 2013; 381:725.
2. Dal Poz MR. A crise da força de trabalho em saúde. Cad Saúde Pública 2013; 29:1924-26.
3. Araújo E, Maeda A. How to recruit and retain health workers in rural and remote areas in developing countries: a guidance note. Washington DC: World Bank; 2013. (Health, Nutrition and Population Discussion Paper).
4. Attal-Toubert K, Vanderschelden M. La démographie médicale à l'horizon 2030: de nouvelles projections nationales et régionales détaillées. Dossiers Solidarité Santé 2009; (12):1-66.
5. Rovere MR. El Programa Más Médicos: un análisis complementario desde la perspectiva de la salud internacional. Interface (Botucatu, Online) 2015; 19:635-6.
6. Carvalho M, Santos NR, Campos GWS. A construção do SUS e o planejamento da força de trabalho em saúde no Brasil: breve trajetória histórica. Saúde Debate 2013; 37:372-87.
7. Giovanella L, Mendonça MHM. Atenção primária à saúde. In: Giovanella L, Escorel S, Lobato LVC, Noronha JC, Carvalho AI, organizadores. Políticas e sistema de saúde no Brasil. 2ª Ed. Rio de Janeiro: Editora Fiocruz; 2012. p. 494-545.
8. Rodrigues PHA, Ney MS, Paiva CHA, Souza LMBM. Regulação do trabalho médico no Brasil: impactos na Estratégia Saúde da Família. Physis (Rio J.) 2013; 23:1147-66.
9. Morais I, Alkmin D, Lopes J, Santos M, Leonel M, Santo R, et al. Jornais Folha de São Paulo e Correio Braziliense: o que dizem sobre o Programa Mais Médicos? Rev Esc Enferm USP 2014; 48:107-15.
10. Brasil. Lei nº 12.871, de 22 de outubro de 2013. Institui o Programa Mais Médicos, altera a lei nº 8.745, de 9 de dezembro de 1993, e nº 6.932, de 7 de julho de 1981, e dá outras providências. Diário Oficial da União 2013; 23 out.
11. Couto MP. O Programa Mais Médicos: a formulação de uma nova política pública de saúde no Brasil [Maters Thesis]. Curitiba: Universidade Federal do Paraná; 2015.
12. Girardi SN, Stralen ACS, Cella JN, Maas LWD, Carvalho CL, Faria EO. Impacto do Programa Mais Médicos na redução da escassez de médicos em atenção primária à saúde. Ciênc Saúde Coletiva 2016; 21:2675-84.
13. Secretaria de Gestão e Educação do Trabalho em Saúde, Ministério da Saúde. Programa Mais Médicos – dois anos: mais saúde para os brasileiros. Brasília: Ministério da Saúde; 2015.
14. Mattos RA. Os sentidos da integralidade: algumas reflexões acerca de valores que merecem ser defendidos. In: Pinheiro R, Mattos RA, editors. Os sentidos da integralidade na atenção e no cuidado à saúde. 8ª Ed. Rio de Janeiro: Centro de Estudos e Pesquisa em Saúde Pública, Instituto de Medicina Social, Universidade do Estado do Rio de Janeiro/Abrasco; 2009. p. 43-68.
15. Almeida PF, Giovanella L, Nunan BA. Atenção integral à saúde – indicadores para avaliação. Rio de Janeiro: Ministério da Saúde; 2011.
16. Silva Junior AG, Alves MGM, Costa MGL, Lima RHP. Regionalização, integralidade e produção do cuidado no contexto da Estratégia Saúde da Família: pontos para o debate. In: Almeida PF, Santos AM, Souza MKB, editors. Atenção primária à saúde na coordenação do cuidado em Regiões de Saúde. Salvador: Edufba; 2015. p. 65-88.
17. Silva Junior AG, Mascarenhas MTM. Avaliação da atenção básica em saúde sob a ótica da integralidade: aspectos conceituais e metodológicos. In: Pinheiro R, Mattos RA, editors. Cuidado: as fronteiras da integralidade. Rio de Janeiro: Abrasco/São Paulo: Editora Hucitec; 2004. p. 241-57.
18. Pinheiro R, Silva Junior AG. Práticas avaliativas e as mediações com a integralidade na saúde: uma proposta para estudos de processos avaliativos na atenção básica. In: Pinheiro R, Silva Junior AG, Mattos RA, editors. Atenção básica e integralidade: contribuições para estudos de práticas avaliativas em saúde. Rio de Janeiro: Centro de Estudos e Pesquisa em Saúde Pública, Instituto de Medicina Social, Universidade do Estado do Rio de Janeiro/Abrasco; 2011. p. 17-41.
19. Starfield B. Atenção primária: equilíbrio entre necessidades de saúde, serviço e tecnologia. Brasília: Organização das Nações Unidas para a Educação, a Ciência e a Cultura/Ministério da Saúde; 2002.
20. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 14ª Ed. São Paulo: Editora Hucitec; 2014.
21. Comes Y, Trindade J, Pessoa VM, Barreto ICHC, Shimizu HE, Dewes D, et al. A implementação do Programa Mais Médicos e a integralidade nas práticas da Estratégia Saúde da Família. Ciênc Saúde Coletiva 2016; 21:2727-36.

22. Pereira LL, Silva HP, Santos LMP. Projeto Mais Médicos para o Brasil: Estudo de caso em comunidades quilombolas. Rev ABPN 2015; 7:28-51.
23. Pereira LL, Pacheco L. O desafio do Programa Mais Médicos para o provimento e a garantia da atenção integral à saúde em áreas rurais na região amazônica. Interface (Botucatu, Online) 2017; 21:1181-92.
24. Keck CW, Reed GA. The curious case of Cuba. Am J Public Health 2012; 102:13-20.
25. Lopes JMC. Consulta e abordagem centrada na pessoa. In: Gusso G, Lopes JMC, editors. Tratado de medicina de família e comunidade: princípios, formação e prática. Porto Alegre: Editora Artmed; 2012. p. 113-23.
26. Organização Mundial da Saúde, Organização Pan-Americana da Saúde. Programa Mais Médicos no Município do Rio de Janeiro: mais acesso, equidade e resolutividade na APS. Brasília: Organização Pan-Americana da Saúde; 2016. (Série Estudos de Caso Sobre o Programa Mais Médicos, 2).
27. Lermen Junior N. Currículo baseado em competências para Medicina de Família e Comunidade. http://www.rededepesquisaaps.org.br/wp-content/uploads/2015/04/Curriculo-Baseado-em-Competencias.pdf (accessed on 23/Oct/2017).
28. Giovanella L, Mendonça MHM, Almeida PF, Escorel S, Senna MCM, Fausto MCR, et al. Saúde da família: limites e possibilidades para uma abordagem integral de atenção primária à saúde no Brasil. Ciênc Saúde Coletiva 2009; 14:783-94.
29. Escorel S, Moreira MR. Participação social. In: Giovanella L, Escorel S, Lobato LVC, Noronha JC, Carvalho AI, editors. Políticas e sistema de saúde no Brasil. 2ª Ed. Rio de Janeiro: Editora Fiocruz; 2012. p. 853-84.
30. Girardi SN, Carvalho CL, Pierantoni CR, Costa JO, Stralen ACS, Lauar TV, et al. Avaliação do escopo de prática de médicos participantes do Programa Mais Médicos e fatores associados. Ciênc Saúde Coletiva 2016; 21:2737-46.
31. Santos AM. Posição da Estratégia Saúde da Família na coordenação do cuidado no município sede de Região de Saúde – o caso de Vitória da Conquista. In: Almeida PF, Santos AM, Souza MKB, editors. Atenção primária à saúde na coordenação do cuidado em Regiões de Saúde. Salvador: Edufba; 2015. p. 205-37.
32. Lima ED. Imaginário social sobre a loucura: cultura e práticas de cuidado em saúde mental. Curitiba: Appris; 2016.
33. Almeida PF, Santos AM, Oliveira SS, Heringer A, Martins Júnior DF. Posição da Estratégia Saúde da Família na coordenação do cuidado no município sede de Região de Saúde – o caso de Feira de Santana. In: Almeida PF, Santos AM, Souza MKB, editors. Atenção Primária à Saúde na coordenação do cuidado em Regiões de Saúde. Salvador: Edufba; 2015. p. 147-73.

## Resumo

*A baixa oferta de médicos em áreas remotas e desfavorecidas é um obstáculo ao acesso universal e à garantia da qualidade do cuidado em saúde. Por meio do Programa Mais Médicos (PMM), até o ano de 2015, 18 mil profissionais foram incorporados ao Sistema Único de Saúde (SUS) para atuação na atenção básica, sendo 79% cubanos. Este artigo analisou a integralidade das práticas dos médicos cubanos no PMM por meio de estudo qualitativo realizado no Município do Rio de Janeiro, Brasil, com base em entrevistas com médicos cubanos (24) e grupo focal com supervisoras do PMM (4). A integralidade foi analisada em duas dimensões: abordagem biopsicossocial do cuidado, com orientação comunitária; e elenco de ações de promoção, prevenção e assistência. A atuação dos médicos cubanos apresenta elementos condizentes à integralidade das práticas na atenção primária, com prestação de um leque amplo de ações e serviços, coerente com a complexidade dos problemas de saúde e pluralidade dos cenários. Os profissionais possuem marcada capacidade de inserção comunitária, enfoque preventivo, planejamento de ações e bom relacionamento interpessoal na equipe, identificando-se posturas e técnicas de acolhimento, vínculo e responsabilização. Desafios foram sinalizados quanto à promoção de práticas participativas com as coletividades, à ampliação da autonomia de usuários nas decisões clínicas, ao manejo de problemas de ordem psíquica, à sistematização de ferramentas de abordagem e à realização de procedimentos invasivos. Apontam-se fortes indícios de que o PMM, além do acesso às consultas médicas, oferta cuidados integrais em saúde e contribui para o fortalecimento da atenção básica no país.*



*Integraliadde em Saúde; Conhecimentos, Atitudes e Prática em Saúde; Atenção Primária à Saúde; Recursos Humanos*



## Resumen

*La baja oferta de médicos en áreas remotas y desfavorecidas es un obstáculo para el acceso universal y garantía de la calidad del cuidado en salud. Mediante el Programa Más Médicos (PMM), hasta el año de 2015, 18 mil profesionales se incorporaron al Sistema Único de Salud (SUS) para su actuación en la atención básica, siendo un 79% cubanos. Este artículo analizó la integralidad de las prácticas de los médicos cubanos en el PMM mediante el estudio cualitativo, realizado en el municipio de Río de Janeiro, Brasil, en base a entrevistas con médicos cubanos (24) y grupo focal con supervisoras del PMM (4). La integralidad se analizó en dos dimensiones: enfoque biopsicosocial del cuidado, con orientación comunitaria; y un elenco de acciones de promoción, prevención y asistencia. La actuación de los médicos cubanos presenta elementos coincidentes con la integralidad de las prácticas en atención primaria, con prestación de un abanico amplio de acciones y servicios, coherente con la complejidad de los problemas de salud y pluralidad de los escenarios. Los profesionales poseen una marcada capacidad de inserción comunitaria, enfoque preventivo, planificación de acciones y buena relación interpersonal en el equipo, identificándose posturas y técnicas de acogida, vínculo y responsabilización. Se señalaron desafíos respecto a la promoción de prácticas participativas con las colectividades, ampliación de la autonomía de usuarios en las decisiones clínicas, gestión de problemas de orden psíquico, sistematización de herramientas de enfoque y realización de procedimientos invasivos. Se apuntan fuertes indicios de que el PMM, además del acceso a consultas médicas, oferta cuidados integrales en salud y contribuye al fortalecimiento de la atención básica en el país.*



*Integralidad en Salud; Conocimientos, Actitudes y Práctica en Salud; Atención Primaria de Salud; Recursos Humanos*



Submitted on 15/Jun/2017
Final version resubmitted on 15/Nov/2017
Approved on 26/Dec/2017