

# CONFORMITY AND NON-CONFORMITY ANALYSIS IN FAMILY HEALTH UNITS

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## ANÁLISE DE CONFORMIDADE E NÃO CONFORMIDADE DE UNIDADES DE SAÚDE DA FAMÍLIA

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## ANÁLISIS DE CONFORMIDAD Y NO CONFORMIDAD DE UNIDADES DE SALUD DE LA FAMILIA

Mariluce Karla Bomfim de Souza<sup>1</sup>  
Leidiane Andrade Barreto<sup>2</sup>  
Elaine Andrade Leal Silva<sup>3</sup>

**How to cite this article:** Souza MKB, Barreto LA, Silva EAL. Conformity and non-conformity analysis in the family health units. Rev baiana enferm. 2017;31(4):e18418.

**Objective:** to identify and discuss conformities and non-conformities of family health unities in two municipalities in the state of Bahia, Brazil. **Method:** descriptive study and of normative evaluation carried out in 23 health unities of one large and one medium sized city, in northeastern Brazil, in the year of 2014. Was used a checklist script elaborated from a ministerial manual about the unities' physical structure, observing the technical regulations by the Brazilian Regulatory Agency and the EpiData program for data registering and filing. **Results:** adapted structural conditions and building adjustments for the operation of health care facilities may interfere on the offered service quality. **Conclusion:** the necessity of structuring and prioritize the Primary Health Care, in order to not compromise the change in the assistance model, was confirmed.

**Descriptors:** Evaluation in health. Service structure. Primary Health Care.

*Objetivo:* identificar e discutir conformidades e não conformidades de unidades de saúde da família, de dois municípios do estado da Bahia, Brasil. *Método:* estudo descritivo e de avaliação normativa realizado em 23 unidades de saúde de um município de grande e outro de médio porte, no Nordeste brasileiro, no ano de 2014. *Utilizou-se um roteiro de check-list elaborado a partir de manual ministerial sobre a estrutura física de unidades, sendo considerada a regulamentação técnica da Agência Nacional de Vigilância Sanitária e o programa EpiData para registro e arquivamento dos dados. Resultados:* condições estruturais adaptadas e adequações de imóveis para o funcionamento de estabelecimentos de saúde podem interferir sobre a qualidade da oferta dos serviços. *Conclusão:* constatou-se a necessidade de estruturação e de priorização da Atenção Primária à Saúde, a fim de não comprometer a mudança do modelo assistencial.

*Descritores:* Avaliação em saúde. Estrutura dos serviços. Atenção primária à saúde.

*Objetivo:* identificar y discutir conformidades y no conformidades de unidades de salud de la familia, de dos municipios del estado de Bahía, Brasil. *Método:* estudio descriptivo y de evaluación normativa realizado en 23 unidades de salud de un municipio de grande y otro de mediano porte, en el Nordeste brasileño, en el año 2014. *Se*

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<sup>1</sup> Nurse. Professor at Universidade Federal da Bahia. Salvador, Bahia, Brazil.

<sup>2</sup> Nurse. Epidemiological Surveillance Coordinator. Muniz Ferreira, Bahia, Brazil. leilla-06@hotmail.com

<sup>3</sup> Nurse. Professor at Health Sciences Center in Universidade Federal do Recôncavo da Bahia. Santo Antônio de Jesus, Bahia, Brazil.

*utilizó un guión de check-list elaborado a partir de manual ministerial sobre la estructura física de unidades, siendo considerada la reglamentación técnica de la Agencia Nacional de Vigilancia Sanitaria y el programa EpiData para registro y archivo de los datos. Resultados: condiciones estructurales adaptadas y adecuaciones de inmuebles para el funcionamiento de establecimientos de salud pueden interferir en la calidad de la oferta de los servicios. Conclusión: se constató la necesidad de estructuración y de priorización de la Atención Primaria a la Salud, a fin de no comprometer el cambio del modelo asistencial.*

*Descriptores: Evaluación en salud. Estructura de los servicios. Atención primaria a la salud.*

## Introduction

Brazilian Health System (SUS) principles drive the discussion about access guarantee to health as a right that constitutionally places the Brazilian public health system as a universal public policy. In this sense, more than five thousand municipalities challenge their limitations, structural included, in order to assure the access and the integral care to their residents.

Aiming to increase access, since 1990's, the Health Ministry has influenced the expansion of the Family Health Program (PSF), the current Family Health Strategy (ESF), in order to guide the assistance model in accordance to the Basic Care National Policy. However, ESF's operation is responsibility of the municipality's administrators, which face several challenges with the purpose of guarantee the provision of services according with the integrality principles, to health regulation, equity, and based on reception, health care and humanization<sup>(1,2,3)</sup>.

Studies show that problems related to the services' cultural organization, as well as the deficiencies in the unities' infrastructure may compromise since the access, resolution, humanization, and even conflicts among the users and professionals and difficulties in performing and executing the practices with quality<sup>(4)</sup>. However, when sanitary conditions are adequate, the unities may improve the care offer in a way that contribute to the safety and quality of care. Among the challenges and problems to be faced by the local managers, stand out the structural, organizational and operational non-conformities of the family health unities, taken as discussion objects in this article. As a result, this study questions: What are the non-conformities identified in the

Health Unities and how such non-conformities may interfere in the operational structure of the services? This study is justified by the importance of the recognition and knowledge and discussion about the structural and organizational difficulties found in the Health Unities, which may provoke reflection about the strategies, and stimulate the development of confronting actions for such problems.

Therefore, the objective is: to identify and discuss conformities and non-conformities of family health unities of two municipalities in the state of Bahia, Brazil.

## Methods

This is a descriptive and of normative evaluation study, developed in two distinctive municipalities realities in the state of Bahia, northeastern Brazil. Salvador (SSA) and Santo Antônio de Jesus (SAJ), a large sized and a medium sized city, respectively, are located in the East Health macro region.

Salvador, the state capital, is the seat of a health region and has over 12 million 800 thousand inhabitants. Its territory is divided in 12 sanitary districts (DS), in which is distributed the varied services for the population, being worthy to note the short Basic Care (AB) or Primary Health Care (APS) coverage, that reaches a little over 30%<sup>(5)</sup>. On the other hand, Santo Antônio de Jesus, located in the Recôncavo Baiano, also a seat of a region of same name, is divided in four DS's and has a population of over 90 thousand people and almost 100% of the AB coverage, of which almost 90% of Family Health Strategy coverage<sup>(6)</sup>.

Aiming to comprehend and discuss the conformities and non-conformities of the Family Health Unities (USF) of both cities, were included

15 health unities from SSA and 8 from SAJ, ensuring that each DS is represented. Unities were randomly selected, totalizing 23 health unities.

Among the unities from SSA, included in this study, the majority (12) allot more than one family health team (EqSF) and ten unities have an oral health team (EqSB). In contrast, in SAJ, only one unity allots more than one EqSF.

As a tool for data collection was used a checklist script elaborated according to the information in the Basic Health Unity Physical Structure Manual: Family Health<sup>(7)</sup>, which follows the principles of the Collegiate Board Resolution – RDC n. 50/Anvisa/February/2002, which provides the technical Regulations for planning, programming and evaluate physical projects for Health Care Facilities (EAS)<sup>(8)</sup>. Such tool allowed to comprehend the conformities and non-conformities related the conditions of ambience, ventilation, luminosity, flow of users and ease for cleaning and disinfecting, waste management and considerations over each room that integrates the family health unity.

The checklist was carried out during the months of April and May 2014, in SAJ, and in SSA from February to July of that same year. EpiData program, version 3.1 was used for data registering, documentation and filing. Result analysis was carried out in three phases: 1) repeated reading and verification of the registered data; 2) identification of four thematic groups physical space and ambience of the family health unities; waste management; furniture, equipment and instruments; clinical and dental practice and support premises conditions; 3) compared presentation and interpretative analysis concerning the conformities and non-conformities, taking as reference normative recommendation, regulations, other studies and references.

Ethical principles required for the development of a research involving human beings were followed in accordance to the Resolution n. 466/2012 of the National Health Council<sup>(9)</sup>. The submission of both projects was done separately for both fields of research. The Ethics Committee in Research of Community Health Institute of the Federal University of Bahia (ISC/UFBA), approved

both projects under the protocol n. 364.713 and CAAE: 17842013.0.0000.5030, for SSA; and n. 520.954, CAAE: 24516113.1.0000.5030, for SAJ.

## Results and Discussion

### *Physical space and ambience of family health unities*

This study's results pointed out at the operational conditions of the unities in relation to the physical space in terms of building, thus in Salvador, it was found that 14 of the unities operate in their own building, while in SAJ, almost all the unities operated in rented properties, that were adapted for the purpose.

According to the Basic Care National Policy, it is used as a parameter in great urban areas, one basic unity (UBS) with Family Health for up to 12 thousand people<sup>(10)</sup>. The great concentration of population in the peripheries of the Brazilian state capitals require a bigger number of family health teams that can be allocated in the same USF as an strategy to increase offer and access as well as optimizing costs. However, in many cities' realities, such units operate in rented buildings, with adapted physical structure, as in SAJ, for instance, as demonstrated by this study.

Rented structures constitutes themselves as challenges to the health professionals in order to adapt their practices within the space restriction in the unities, whether by the rotation of rooms or by the improvised disposition of equipment and material. Inadequacy of the unities' infrastructure may be explained, according to the study of Oliveira et al., by the fact that most of the unities were not allocated in buildings made for this end, compromising, thus, the compliance to the normative requirements for adequate implementation, as governed by the Ministry of Health<sup>(11)</sup>. Therefore, adaptations through reform and expansion characterize the reality of unities allocated in rented properties, as evidenced by a study carried out in the state of Goiás<sup>(12)</sup>.

Besides the service offering, the existing physical and architectural barriers may compromise

accessibility, usage and circulation inside the unity. Results reveal that none of the unities visited in SAJ, for instance, had handicap adapted bathroom, grab bars or handrails, nor non-slippery floor, yet in six of them ramps were adapted. Also, in half of the visited unities in SAJ, the circulation space was restricted because the corridors width was smaller than 120 cm.

In SSA, on the other hand, 4 out of the 15 USF's had no handicap adapted bathroom and grab bars, 02 unities did not have internal access ramps and 4 did not have neither external nor internal access ramps. In relation to the external area, all of SAJ USF's have protection sidewalk on the external perimeter of the building, and the same situation was found in the majority of the unities in SSA.

Confirming the investigated realities, other studies point to the existence of architectural barriers to elderly and disabled people. Studies carried out in Niterói, state of Rio de Janeiro; Campina Grande, state of Paraíba; in the state of Goiás; and in municipalities of the state of Rio Grande do Sul, denounce non-conformities in relation to accessibility<sup>(12-15)</sup>.

Therefore, the Brazilian Association of Technical Standards (ABNT), in relation to accessibility standards, provide that public and private areas of community usage must have adapted spaces, with the purpose of promoting the biggest accessibility possible to the individuals, and ramps must have non-slippery floor and handrails<sup>(16)</sup>.

Regarding floor, ceiling and wall conditions in the unities in SAJ, were identified that the majority (five) is not washable, while in SSA are all washables. In relation to wash basins and sinks, none of the SJA USF's comply with the regulations (Collegiate Board Resolution ANVISA – RDC n. 50)<sup>(8)</sup>, in respect to the depth that allows washing the forearm, nor do have hands-free faucet. In SSA this fact corresponds to 10 out of 15 unities visited, and 8 out of 15 have adequate taps.

A study realized in UBS's in Parnamirim-Rio Grande do Norte demonstrated that, in a total of 15 unities included in the study, 7 were allotted in rented properties, which were submitted to improvisations in order to make the services

available. This study also denounces problems such as: seepage; mold; surfaces, floors, ceilings difficult to clean; and electric and plumbing installations in need of maintenance<sup>(17)</sup>.

A common point between the results presented in both of the studied realities, refers to the benches, cabinets and shelves: all unities of both municipalities presented hard-wearing structure, with smooth surface ease to clean and disinfect.

Regarding to ambience, the investigated unities presented natural and artificial lightning, although, it was possible to hear noises originated by the location and neighborhood, both in SAJ (3 USF's) and SSA (12 USF's). However, in general, in both cities, the required aspects about ambience corresponded in part to which is determined by the physical structure manual, by the Ministry of Health.

According to the National Policy of Humanization, the health unities ambience stands out as a premise, being understood as a manner to provide to the user comfortability and the using of these places for encounter and exchange<sup>(18)</sup>. In this sense, the ambience guarantee is limited by the structural inadequacies that somehow may interfere in the service reception process. A study carried out in three northeastern states: Bahia, Sergipe and Ceará, demonstrated the USF's precarious facilities, as well as the absence of proper physical spaces in the unities, problems related to size and/or disposition of rooms, room climate and noises<sup>(19)</sup>.

In relation to work hours, the unities in both municipalities operates from 7 am to 5 pm, except two unities in SAJ, being one located in a rural area and the other one that was inserted in a violent context.

Almost the totality of the investigated unities presented identification for the existing services, and flow signals recommended by the Brazilian Technical Standard n. 9.050<sup>(16)</sup>, which provides criteria and technical parameters to be used in construction projects, installation and adaptation of buildings, furniture, space and urban equipment in relation to accessibility conditions.

In the heart of this discussion about physical space and ambience, it is worthy to highlight as

important the strategy created by the Ministry of Health, in 2011, the Requalifica program, which aims to support structuring and improving Basic Health Care/APS through financial incentives for construction, restoration and expanding of the UBS's<sup>(20)</sup>. Recent data indicate that both studied cities were contemplated with resources from this program that proclaim changes in the establishments of these two municipalities. Therefore, building unities, especially in the peripheral neighborhoods and with greater concentration of population, should be the priority.

### *Waste management*

About the waste management recommended by the RDC n. 306/2004<sup>(21)</sup>, it is noteworthy that none of the unities visited in SAJ had a copy of the Health Facility Waste Management Plan (PGRSS) in the moment of the visit, and in SSA, this reality corresponded to almost half (seven) of the unities.

According to RDC<sup>(21)</sup>, the health facility waste management refers to a number of management procedures, that aims to "reduce the waste production and handle the produced waste safely, in an efficient manner, aiming the protection of workers, the preservation of public health, natural resources and of the environment"<sup>(3,21)</sup>. Resolution Conama n. 358/2005 provides for the treatment and final disposal of these wastes, and in its article 4 the elaboration of PGRSS by health facilities that generates waste is presented, in accordance to the legislation in power<sup>(22)</sup>.

Regarding the storing of waste, in the case of SAJ, not all unities have an external area for storing solid waste; on the contrary, in SSA the majority of the unities (13) have an external and exclusive space for storing such wastes. In relation to liquid wastes, the reality in SAJ also presents that half of the unities does not keep in bottles of resistant material or in plastic vats with anti-leak cover.

About non-contaminated waste or those that may cause accident (gauze, gloves, plaster), in most of SAJ USF's, in the moment of the visit, it was not found these wastes kept in impermeable

plastic bags and they were not identified. In SSA, two unities were found in the same situation.

Discussion regarding solid waste management have been and still incipient, nevertheless it is necessary to think about the attention regarding wastes and over the inherent risks of its disposal.

### *Furniture, equipment and instruments*

Regarding furniture, equipment and instruments that are part of the family health unities and that are indispensable for its regular operation, it is important to highlight that all USF's from both municipalities have reception room with patient chart filed by family. It was possible to identify that the waiting room, in most of the unities, have more than 10 seats for accommodating the users and just one of the unities in both cities have 50 or more seats. In three of SAJ USF's there are no drinking fountains, while all unities in SSA have one.

In relation to the area designated for the administration activities, none of the eight unities of SAJ have it available, on the other hand, in SSA, only one out of 15 does not have it. Regarding to the meeting room, in both realities, most of unities have this space and have it as well as a room used by the Community Health Agents. Concerning the stockroom, all unities in SSA have shelves, with limited access to workers. While in SAJ, two out of eight do not have any.

In relation to availability of equipment and material for communication and information, this study verified the differences between the realities of both cities. In SSA, all unities have computers and seven also have printers, while in SAJ, none of the unities have this equipment available at the reception. In Niterói, state of Rio de Janeiro, the reality is similar to the results found in SSA. There the majority of the unities were found with computers with conditions for using, and half of them had access to the internet<sup>(13)</sup>. In relation to telephone availability, 7 out of 15 USF's in SSA have telephone, and in SAJ, 5 out of 8 USF's. Also, television availability: in SSA most unities have television, on the other hand, the unities in SAJ do not have it. In both

realities, most unities uses the bulletin board as the way to publicize reports and services.

Concerning the availability of the equipment and materials for performing care and procedures, by the health professionals in the family health unities of both studied municipalities, Table presents some of the results.

Regarding the pharmacy, 3 out of 8 unities visited in SAJ have space for pharmacy operation; all the others store and distribute medicines in the reception. In SSA, there are pharmacies in all 15 unities investigated, computer, air-conditioner and proper storage of the medicines, also three of those have minibars and only one does not have an independent access. In SAJ, the three unities' pharmacies have independent access, but have no air conditioner, computer and/or refrigerator or minibar available.

#### *Clinical and dental practice and support premises conditions*

Regarding the clinical practice conditions, it was verified that none of the visited unities in SAJ have gynecological office, what makes possible to assume that preventive gynecological examinations are performed in a nurse or medical office, however, it is noteworthy that only

in four out of eight investigated unities folding screens were found. In the SSA case, there are gynecological office in 10 out of 15 visited unities, with private toilet attached, gynecological table and instruments (speculum, cover glass etc.) available. In relation to the equipment condition, it is important to stress that in both cities, equipment were not being used as they were broken, lacking preventive and reparative/corrective maintenance.

Deficiencies in clinical and dental care installations were verified in different studies<sup>(12-15)</sup> in which was confirmed the inadequacy of such installations and even inexistence of some areas such as: purge, meeting room, sterilization room, pharmacy, which compromise the health care for the individual.

Besides the physical structure and restrict availability of resources and materials, there are possible difficulties in the acquisition and availability of clinical and dental care equipment, and the lack of preventive and/or reparative/corrective maintenance, situations that limit the problem-solving capacity of the services provided in the AB/APS.

Contrary to the necessary investment that should be directed to Basic Care, which should be prioritized and improved with the purpose

**Table** – Availability of the equipment and materials for providing care in the family health unities. Salvador and Santo Antônio de Jesus, BA, Brazil, 2014 (N = 23)

<b>Equipment Description and Material Available in the Immunization Room</b>	<b>SSA</b>	<b>SAJ</b>
Sink	14	7
Hands-free Faucet	7	0
Barrier for users, avoiding transit in the USF premises	10	1
260 liters Refrigerator	15	6
Thermal Box	15	8
<b>Equipment Description and Material Available in the Dressing Room</b>	<b>SSA</b>	<b>SAJ</b>
Sink	14	8
Hands-free Faucet	7	0
Barrier for users, avoiding transit in the USF premises	9	1
Feet Washing Basin	7	0
Area Close to Washing and Decontamination Room	1	0
<b>Equipment Description and Material Available in the Dental Room</b>	<b>SSA</b>	<b>SAJ</b>
Bench with sink for material and instrument processing	14	7
Hands-free Faucet	10	0
X-Ray	10	0
Autoclave (or use of equipment shared by the team)	7	7
Compressor with Safety Valve	12	7

of changing the model based on health promotion, what is perceived is that efforts have been directed to the building and expansion of the emergency unities to the point that is possible to solve health problems which are of a particular and ephemeral nature<sup>(3)</sup>.

In two unities in SAJ did not have their immunization room working, the unity located in the rural area does not have this kind of room and in other unity, although there is an immunization room, the vaccine offered were kept in thermal boxes, as the 260 liters refrigerator was broken. In only one unity, in both municipalities, the immunization room did not have sink. In SSA case, the immunization room of the fifteen unities were working. In these rooms, the thermal boxes and the disposal box for the sharps material used were available in both municipalities.

A room for material collection (e.g., blood) was identified in three out of fifteen visited unities in SSA, and in none of the unities in SAJ, however, this procedure happens in another room in five of the USF's in SSA, and in seven USF's in SAJ. Such reality demonstrates the improvisation in the unities for the inadequacies in the physical structure of these services.

In relation to the nebulization room, the visited unities in SAJ did not have this space reserved. Moreover, in SSA case, only one USF presents it, therefore this procedure is carried out in another space/room of the unities. In the capital, six unities have a central nebulizer with filters and outlets, and eight have a portable nebulizer. In SAJ, one has the central nebulizer and six have portable nebulizer.

Regarding the wound dressing room, one of the visited unities in SAJ have one – highlighting that the room has an identification plate as wound dressing room – however, this room is not for exclusive use for this procedure, and do not have a hands-free faucet, feet washing basin and folding screen. In Salvador's reality, 14 unities have sink, and seven have adequate tap and feet washing basin. In relation to the access to this service, which must be of spontaneous demand, in all unities of SAJ it is necessary to

circulate inside the unities, on the other hand, in SSA, six unities this circulation is not necessary.

Concerning dental care, all visited unities in SSA have offices working, however in SAJ one out of eight do not have dental care. The Dental office in the USF's of SAJ, does not have x-ray machine, darkroom, ultrasonic scaler, does not have hands-free faucet, and do not comply with the minimum area required of 12 m<sup>2</sup> for the installation of a dental chair. In SSA, most unities have the minimum area required of 12 m<sup>2</sup> for installing the dental chair, adequate faucet, lightning, x-ray, darkroom, compressor, amalgamator, curing light, and in 11 out of 15 have the ultrasonic scaler with bicarbonate air polisher.

In agreement with the results presented here, a study carried out in the city of Recife, about the evaluation of the Hypertension Care implementation by the Family Health teams, indicates difficulties in relation to the acquisition of supplies and equipment, as well as in relation to their maintenance. Therefore, stating that such problems generates in the professional a frustration feeling related to the difficulty of solving issues, justified by constant requests for maintenance and/or replacement of these equipment, thus such issues tend to compromise the quality in the assistance<sup>(23)</sup>.

None of the visited unities in SAJ have a brush learning sink, while in SSA, three out 15 USF, have it with three or four faucets and in one of them there are mirror place at an adequate height for child, teenagers and adult use. In 4 SAJ unities there is an area for the compressor and pump, however in only one of them comply with the maximum distance of 7 meters from the compressor to the office, and 3 of them are located outside the building without acoustic treatment for reducing noise emission. In SSA, 14 unities have a reserved area, most of them located outside the building and complying with the maximum distance of 7 meters, but only six of them have acoustic treatment for reducing noise emission.

Other services are also restricted, especially in SAJ reality, which may be connected to the structural limitations of the buildings in which the family

health unities operate. For instance, in relation to dental care, the availability of brush learning sink and adequate distance of the compressor area.

Regarding the physical structure limitations, sharing of rooms to perform some procedures such as nebulization, dressing and sterilization room was cited in Ribeiro's study<sup>(12)</sup>. However, it is important to highlight that the improvisations and adaptations utilized may seriously compromise the professional's work dynamics, incurring in health risks<sup>(15)</sup>.

About other spaces, classified as support areas, stand out the toilets, kitchen/pantry, service area, material and cleaning storage (DML) and sterilization central. In relation to toilets, 14 USF's in SSA have them separated by gender, being 11 unities with at least one handicap toilet and with exclusive toilets for employees. In SAJ, none of the visited unities have gender separated toilets, nor handicap toilets. All unities in SSA have kitchen/pantry with restricted to employees access and three out of 8 in SAJ have it, being only two with restricted access.

About the DML, the reality between the two municipalities are very distinctive. Only one unity in SSA does not have DML and the majority of them have ceramic or steel washing tank and a minimum area of 3m<sup>2</sup>; on the other hand, only two unities in SAJ have DML, and only one of those have adequate washing tank and minimum area.

For material washing and decontamination within the unity, the proper area is the Material and Sterilization Center (CME), which is available in most unities in both municipalities. An CME exists in 14 unities in SSA, in some of them, it is located distant from the wound dressing room, although having reception, washing and decontamination room, 12 of those have a counter for communication with the sterilization area and autoclave on the bench, and nine of them have an exhaust fan. In SAJ, the CME does not exist only in a unity located in the rural area. Four of them have reception, washing and decontamination room, three of them have autoclave on the bench, two have counter for communication with the sterilization area and only one has an exhaust fan. Distance between washing and

decontamination room and the wound dressing room, is noteworthy, as such areas are separated by floor in many of the visited unities in Salvador, placing in risk the people circulating in the unity (workers and users) and the contamination of the environment by the infected material generated in some procedures.

Improvisation and adaptation due to non-conformities of the physical structure was confirmed during the visits to the unities' premises and in learning about availability and disposition of services and equipment. Findings demonstrated in this study through the checklist application in family health unities are coherent with the perception of managers, health professionals and users regarding the sanitary conditions of the unities they work or attend.

Barreto, Souza e Silva's<sup>(24)</sup> study, developed in the same USF's of Santo Antônio de Jesus – Bahia, where the checklist was applied, searched to answer if there is any relation between the Health Care Network operationalization, and the sanitary conditions of the family health unities. The study pointed out that the majority of professionals and managers stated that the deficiencies in the sanitary conditions were almost always related to the ambience, physical structure and lack of supplies, in accordance with the users perception, which highlighted the lack of medicines and equipment. Such study concluded that the structure to attend the population health necessities may, at some level, compromise the APS problem solving capacity, as may alter the other health care levels flow, by overloading secondary and tertiary care services.

Another article<sup>(25)</sup> about the USF sanitary conditions which has taken as reference for the analysis of constitutive elements of work process in health pointed – from the testimonies of managers and health professionals in the unities in Salvador-Bahia – to infrastructure problems and access conditions. It is coherent with the findings of the checklist application, concluding, therefore, that the work agent's actions are made difficult by the limitation of means and instruments, which compromises, at a certain level, the work's objective.



Based on the presentation, analysis and discussion of the findings, it is possible to state that the non-conformities identified in the USF's in many of the country's realities, bring different consequences, requiring from the managers effort and financial investments for providing the effective services, in order to ensure the integrality principle. It is worth mentioning that some initiatives may be developed by managers, such as: expansion and/or construction of health unities, as well as structural reforms, provision of supplies and the preventive maintenance, among others. However, the panorama of reform restricted to painting and electric and plumbing repairs, and the lack or discontinuity of preventive maintenance haven't been enough to correct many non-conformities presented and discussed here.

## Conclusion

Non-conformities revealed by the structural conditions limitations and adaptations to the health establishment operation, reverberates at some level, in the quality of the offered services. It indicates, somehow, to the lack of priority in organizing and structure the AB/APS, which may compromise the change in the care model, provided by the national policy.

Findings in this study, indicates the necessity to re-structure the AB/APS, which includes adequate conditions to the unities operation, satisfactory structure and acquisition of equipment and enough supplies, in order to guarantee the access and the offer of quality care. In this perspective, it is necessary to re-think the Public Health paths in Brazil, highlighting the prioritization of resources and political efforts in the scope of AB/APS, so it does not incur, as well in the reversion of the innumerable achievements.

Results presented and discussed here may contribute for the reflection and creation of strategies for the improvement of the health care and services conditions, aiming the implementation of models that provide centrality to the APS, to the professionals and their work situation

and to the population to which the right to quality health and safety must be guaranteed. That this study does not include all unities from both municipalities is noteworthy. And that the situation revealed correspond to the period, in which the unities were visited, allowing, therefore, the continuity of studies in the research segment – sanitary conditions of the health services – which may increase the results presented and discussed here for these municipalities and for other realities within the Brazilian territory. Including indicating initiatives, limits and possibilities for changing the reality of health services and putting into effect a quality public health system.

## Collaborations

1. design, project, analysis and interpretation of the data: Mariluce, Leidiane, Elaine;
2. article writing and critical review of the intellectual content: Mariluce, Leidiane e Elaine;
3. final approval of the version to be published: Mariluce, Leidiane e Elaine.

## Funding

Financial support provided by Bahia Research Foundation (Fapesb), under process n. 020/2013.

## References

1. 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 á saúde no Brasil. *Rev Cien Saude Colet*. 2009;14(3):794-83.
2. Escorel S, Giovanella L, Mendonça MHM, Senna MCM. O Programa de saúde da família e a construção de um novo modelo para a atenção básica no Brasil. *Rev Panam Salud Publica*. 2007;21(2):176-64.
3. Ministério da Saúde (BR). Portaria Nº 2.488, de 21 de outubro de 2011. Aprova a Política Nacional da Atenção Básica. *Diário Oficial União*. 24 out 2011.
4. Pedrosa ICM, Corrêa ACP, Mandú ENT. Influências da infraestrutura de centros de saúde nas práticas profissionais: percepções de enfermeiros. *Rev Cien Cuid Saúde*. 2011;10(1):58-65.

5. Salvador. Secretaria Municipal de Saúde. Plano Municipal de Saúde 2014-2017. Salvador: Secretaria Municipal de Saúde; 2014.
6. Santo Antônio de Jesus. Secretaria Municipal de Saúde. Relatório Anual de Gestão 2013. Santo Antônio de Jesus: Secretaria Municipal de Saúde; 2014.
7. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, Departamento de Atenção Básica. Manual de estrutura física das unidades básicas de saúde: saúde da família. 2a ed. Brasília, DF: Ministério da Saúde; 2008.
8. Brasil. Resolução Nº 50, de 21 de fevereiro de 2002. Dispõe sobre o regulamento técnico para o planejamento, programação, elaboração e avaliação de projetos físicos de estabelecimentos assistenciais de saúde. Diário Oficial União. 4 set 2002.
9. Ministério da Saúde (BR), Conselho Nacional de Saúde. Resolução 466, de 12 de dezembro de 2012, Sobre Pesquisas envolvendo seres humanos. *Bioética*. 2013;4(2):3-12.
10. Ministério da Saúde (BR). Política Nacional de Atenção Básica. Brasília DF: Ministério da Saúde; 2012.
11. Oliveira DC, Mandú ENT, Corrêa, Tomiyoshi JT, Teixeira RC. Estrutura organizacional da atenção pós-parto na Estratégia Saúde da Família. *Esc Anna Nery*. 2013;7 (3):446-54.
12. Ribeiro PR, Mamed SN, Souza MR, Souza MM, Rosso CFW. Acessibilidade aos serviços de saúde na Atenção Básica do Estado de Goiás. *Rev Eletr. Enf*. 2015;17(3).
13. Janssen M, Fonseca SC, Alexandre GC. Avaliação da dimensão estrutura no atendimento ao pré-natal na Estratégia Saúde da Família: potencialidades do PMAQ-AB. *Rev Saúde Debate*. 2016;40(111):140-52.
14. Rocha ACD, Sousa CPC, Queiroz D, Pedraza DF. Atenção básica à saúde: avaliação de estrutura e processo. *Rev RAS*. 2012;(14)54.
15. Strehlow BR, Fontana RT. Implicações da estrutura física de Unidades de Saúde da Família na dinâmica do trabalho. *Rev Enferm UFPE on line*. 2016;10(7):2624-33.
16. Associação Brasileira de Normas Técnicas. NBR 9.050: 1994. Acessibilidade de pessoas portadoras de deficiência e edificações, espaço, mobiliário e equipamento urbano. Rio de Janeiro: Associação Brasileira de Normas Técnicas, 2001.
17. Vieira AMP, Cruz APF, Cunha UF. Assistência farmacêutica em unidades básicas de saúde do município de Panamirim-RN. *Rev Científica Esc Saúde Catussaba*. 2012;2(1):35-49.
18. Ministério da Saúde (BR), Secretaria-Executiva, Núcleo Técnico da Política Nacional de Humanização. *Humaniza SUS: ambiência*. Brasília, DF: Ministério da Saúde; 2004.
19. Trad LAB, Rocha AARM. Condições e processo de trabalho no cotidiano do programa saúde da família: coerência com processo de humanização em saúde. *Rev Cien Saude Colet*. 2011;16(3):1969-80.
20. Brasil. Portaria Nº 1.170, de 05 de junho de 2011. Habilita municípios a receber recursos referentes ao Programa de Requalificação de Unidades Básicas de Saúde (UBS), componente ampliação. Diário Oficial União. 19 set 2012.
21. Brasil. Resolução Nº 306, de 07 de dezembro de 2004. Dispõe sobre o regulamento técnico para o gerenciamento de resíduos de serviços de saúde. Diário Oficial União. 10 ago 2004.
22. Brasil. Resolução Conama Nº 358, de 29 de abril de 2005. Dispõe sobre o tratamento e a disposição final dos resíduos dos serviços de saúde e dá outras providências. Diário Oficial União. 10 set 2005.
23. Costa JMBS, Silva MRF, Carvalho EF. Avaliação da implantação da atenção à hipertensão arterial pelas equipes de saúde da família. *Rev Cienc. Saude Colet*. 2011;16(2):623-33.
24. Barreto LA, Souza MKB, Silva EAL. Rede de atenção e condições sanitárias das unidades de saúde da família: há alguma relação?. *Rev Enferm UERJ*. 2016;24(6):17440.
25. Barreto HIV; Souza MKB. Análise das condições sanitárias de Unidades de Saúde da Família com base no referencial sobre processo de trabalho. *Revista APS*. No prelo. 2017.

Received: November 6, 2016

Approved: October 06, 2017

Published on: December 20, 2017