Revista Brasileira em Promoção da Saúde
Universidade de Fortaleza
Experience Description
e-ISSN:1806-1230
DOI: 10.5020/18061230.2024.14837

Interdisciplinary approach in the development of the state pharmaceutical care policy of Ceará: An experience report

Interdisciplinaridade na construção da política estadual de assistência farmacêutica do Ceará: Um relato de experiência

Perspectiva interdisciplinar en el desarrollo de la política estatal de asistencia farmacéutica de Ceará: Un informe de experiencia

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ABSTRACT

Objective: To describe the interdisciplinary experience in the collective development of the Política Estadual de Assistência Farmacêutica (PEAF) of Ceará. **Data synthesis:** This is a descriptive experience report based on workshops conducted by the Coordenadoria de Políticas de Assistência Farmacêutica (COPAF) at Secretaria da Saúde do Estado do Ceará. Strengths, weaknesses, threats, and opportunities were identified in the following areas: universal access, human resources, management of pharmaceutical care, financing, and pharmaceutical care. These workshops were conducted in three phases, beginning in January and ending in December 2021. In the first phase, a workshop was held to develop the PEAF of Ceará, with the participation of health care workers, health council members, health care residents, and health managers. The aim was to discuss strategic processes, support processes and key processes of pharmaceutical care. In the second phase, the technical team of the COPAF analyzed the information collected during the workshops, focusing on strategies and actions related to the priority issues identified in each area. In the third phase, the official decree of the PEAF was drafted, approved by the Comissão Intergestora Bipartite, and published in Diário Oficial do Estado in December 2021. **Conclusion:** Workshops facilitated the engagement of different health managers in reflection and discussion to support decision-making and the development of new policies related to pharmaceutical care. This experience contributed to the exchange of knowledge and practices between health care workers, resulting in the drafting of the decree and the subsequent publication of the PEAF of Ceará.

Descriptors: Health Services Accessibility; Health Management; National Policy of Pharmaceutical Assistance; Unified Health System.

RESUMO

Objetivo: *Descrever a experiência interdisciplinar para construção coletiva da Política Estadual de Assistência Farmacêutica (PEAF) do Ceará.* ***Síntese dos dados:*** *Trata-se de um relato de experiência, de natureza descritiva, por meio de oficinas realizadas pela Coordenadoria de Políticas de Assistência Farmacêutica (COPAF) da Secretaria da Saúde do Estado do Ceará. Identificaram-se fortalezas, fragilidades, ameaças e oportunidades nos eixos: acesso universal, recursos humanos, gestão da assistência farmacêutica, financiamento e cuidado farmacêutico. Foram realizadas em três etapas, iniciadas em janeiro e finalizadas em dezembro de 2021. Na primeira etapa, foi realizada a oficina para a construção da PEAF com participação dos profissionais de saúde, conselheiros de saúde, residentes e gestores a fim de discutir os processos estratégicos, processos de apoio e os processos-chave da assistência farmacêutica. No segundo momento, a equipe técnica da COPAF analisou as informações coletadas durante as oficinas relacionadas às estratégias e ações frente aos problemas prioritários identificados por cada eixo. No terceiro momento, teve-se a construção da portaria da PEAF aprovada pela Comissão Intergestora Bipartite e publicada no*

Received on: *12/05/2023*
Accepted on: *08/07/2024*

diário oficial do Estado em dezembro de 2021. ***Conclusão:*** *As oficinas proporcionaram o engajamento de diversos gestores na reflexão e discussão, cujo propósito foi auxiliar na tomada de decisão e no desenvolvimento de novas ações relacionadas à assistência farmacêutica. Essa vivência contribuiu para a troca de saberes e práticas entre os profissionais de saúde, que resultou na elaboração de uma minuta da portaria e, posteriormente, na publicação da PEAF do Ceará.*

Descritores: *Acesso a Medicamentos; Gestão em Saúde; Política Nacional de Assistência Farmacêutica; Sistema Único de Saúde.*

RESUMEN

Objetivo: *Describir la experiencia interdisciplinaria en el desarrollo colectivo de la Política Estadual de Assistência Farmacêutica (PEAF) de Ceará.* ***Síntesis de los dados:*** *Este es un informe descriptivo de experiencia basado en talleres realizados por la Coordenadoria de Políticas de Assistência Farmacêutica (COPAF) de la Secretaria da Saúde do Estado do Ceará. Se identificaron fortalezas, debilidades, amenazas y oportunidades en las siguientes áreas: acceso universal, recursos humanos, gestión de la asistencia farmacéutica, financiamiento y atención farmacéutica. Estos talleres se llevaron a cabo en tres fases, comenzando en enero y finalizando en diciembre de 2021. En la primera fase, se realizó un taller para desarrollar la PEAF de Ceará, con la participación de trabajadores de la salud, miembros de consejos de salud, residentes de salud y gestores de salud. El objetivo era discutir los procesos estratégicos, de apoyo y clave de la asistencia farmacéutica. En la segunda fase, el equipo técnico de la COPAF analizó la información recopilada durante los talleres, centrándose en las estrategias y acciones relacionadas con los temas prioritarios identificados en cada área. En la tercera fase, se redactó el decreto oficial de la PEAF, el cual fue aprobado por la Comissão Intergestora Bipartite y publicado en el Diário Oficial do Estado en diciembre de 2021.* ***Conclusión:*** *Los talleres facilitaron la participación de diferentes gestores en la reflexión y discusión para apoyar la toma de decisiones y el desarrollo de nuevas políticas relacionadas con la asistencia farmacéutica. Esta experiencia contribuyó al intercambio de conocimientos y prácticas entre los profesionales de la salud, resultando en la redacción del decreto y la posterior publicación de la PEAF de Ceará.*

Descriptores: *Acceso a medicamentos; Gestión en salud; Política Nacional de Asistencia Farmacéutica; Sistema Único de Salud.*

INTRODUCTION

The 1988 Constitution of Brazil established the right to health as a fundamental right. Consequently, the State was charged with the fundamental duty of developing social and economic policies to implement actions and services that guarantee a universal and equitable system of access to public health services. The fundamental right to health, as established in the text of the Constitution, is embodied in the right to universal and equal access to public health care policies defined by the legislature and implemented by the executive. In order to realize the right to health, the constituent legislator established that public services would form a regionalized and hierarchical network, constituting a unified system[1].

Public policies represent guidelines, principles for action, rules, and procedures that govern the relationship between the public sector and society, mediated by social actors and the state. They are explicit, systematic, or formalized policies documented in laws, programs, and funding lines that guide actions that typically involve the use of public resources. In addition, health promotion involves the formulation and implementation of public policies that reorient health services to ensure not only access, but also the quality and effectiveness of care provided to the population[2].

Starting from the premise that the right to access to medicines is guaranteed by the 1988 Constitution of Brazil, and that the implementation of “comprehensive therapeutic assistance, including pharmaceuticals” is one of the areas of action of the Sistema Único de Saúde (SUS), policies related to pharmaceutical care are of great relevance in guaranteeing the right to health and in implementing actions capable of improving the health conditions of the population[3].

The Política Nacional de Assistência Farmacêutica (PNAF), approved by Resolution No. 338 of May 6, 2004, guides the formulation of sectoral policies and actions, some of its strategic axes being the maintenance and qualification of pharmaceutical care services within the public health network, the qualification of human resources and the decentralization of actions[4].

Furthermore, the Política Nacional de Medicamentos (PNM), established by Office of the Minister/Ministry of Health (GM/MS) Ordinance No. 3.916 of October 30, 1998, complements the PNAF by establishing guidelines to ensure the safety, efficacy, and quality of drugs available in Brazil as well as promoting rational use and ensuring public access to these drugs. The PNM emphasizes the importance of an effective pharmaceutical care integrated into health policies, which contributes to the sustainability of the SUS and the improvement of public health indicators[5].

These historic milestones call for a special focus on pharmaceutical care to improve its integration with the epidemiological situation in Ceará, Brazil, and globally. Several factors, such as the aging of the population, the increase in chronic noncommunicable diseases (NCDs), violence, environmental disasters, the emergence of infectious diseases as well as the increased coverage of services, the use of high technology, and greater user demands, contribute to the escalation of health and pharmaceutical costs to levels that challenge the sustainability of health care systems[6,7]. In addition, GM/MS Ordinance No. 4.279/2010, which established the Redes de Atenção à Saúde (RAS) within the SUS, requires that pharmaceutical care processes be effectively integrated into the RAS[8].

This integration should be understood not only as a support system (supply services: selection, programming, procurement, storage, and distribution) but also as a point of care (pharmaceutical care services)[8].

These actions seek to provide pharmacotherapeutic monitoring, rational use and access to medicines in an integrated, continuous, safe, effective manner for individuals, families, and communities, with a focus on achieving concrete therapeutic outcomes. The aim is to optimize health benefits by making better use of available resources, thereby increasing the efficiency of the health care system[9].

To do so, the proposed objectives must be achieved for the benefit of the population, while considering the results of the experience of pharmaceutical care management, which can improve the implementation of this policy and serve as a resource for other managers. In this regard, this study aimed to report the experience of Ceará in the development of the Política Estadual de Assistência Farmacêutica (PEAF).

DATA SYNTHESIS

This is an experience report of a descriptive nature, using a retrospective approach to the implementation of pharmaceutical care policies in the state of Ceará. In the case described, the process was divided into three phases during the year 2021, comprising eight meetings held in August, September, October, and November. Each meeting lasted about eight hours. The objective was to develop effective guidelines and strategies for the PEAF, involving various representatives and sectors within and outside the Secretaria da Saúde do Estado do Ceará (SES-CE), as detailed below.

First stage: A technical steering group was established by Ordinance No. 1044/2021/SESA, published in the Diário Oficial do Estado (DOE), Series 3, Year XIII, No. 202, in September 2021. The group included representatives from the following organizations: Conselho Regional de Saúde (CESAU); Universidade Federal do Ceará (UFC); Conselho Regional de Farmácia (CRF); Escola de Saúde Pública do Ceará (ESP/CE); Conselho das Secretarias Municipais de Saúde do Ceará (COSEMS); Secretaria Executiva de Políticas de Saúde (SEPOS); Coordenadoria de Políticas de Assistência Farmacêutica (COPAF); Coordenadoria de Políticas de Saúde Mental, Álcool e outras Drogas (COPOM); Coordenadoria de Políticas em Gestão do Cuidado (COGEC); Coordenadoria de Políticas Intersetoriais (COPIS); Secretaria Executiva de Atenção à Saúde e Desenvolvimento Regional (SEADE); Coordenadoria de Atenção à Saúde (COASA); Superintendências Regionais (SRFOR/SRNOR/SRSUL/SRLES/SRCEN); Secretaria Executiva de Vigilância e Regulação (SEVIR); Vigilância Sanitária (VISA/SEVIR); Célula de Fiscalização e Inspeção de Tecnologias e Ambientes (CEFIT/VISA/SEVIR); Célula de Gestão de Resultados do Sistema de Saúde (CEGRS/CORAC/SEVIR); Célula de Avaliação da Qualidade em Saúde (CEQUA/CORAC/SEVIR); Célula de Execução de Compras de Recursos Biomédicos (CECOB) and Célula de Gestão de Logística de Recursos Biomédicos (CELOB/SEAFI) at Secretaria Executiva Administrativa Financeira (SEAFI); Secretaria Executiva de Planejamento e Gestão Interna (SEPGI); and Coordenadoria de Planejamento e Gestão Orçamentária (COPGO/SEPGI)[10].

The formation of this technical lead group was crucial for the development of PEAF. Comprising representatives from various relevant institutions and bodies, it facilitated a multidisciplinary and cross-sectoral approach. The participation of entities such as CESAU, UFC, and SEPOS ensured that decisions were informed by a wide range of integrated perspectives and expertise.

In addition, coordination between different levels of government and sectors was strengthened through the involvement of representatives from executive secretariats, regional superintendencies and specific coordination bodies such as SEVIR and COASA. This coordination was aimed at enabling the programmatic implementation of the policy in all the regions of Ceará, ensuring the actions were continuously monitored and evaluated, particularly through the units focused on the management of health outcomes and quality assessment (CEGRS and CEQUA).

The involvement of specialized cells such as CEFIT, CECOB, and CELOB has facilitated the management of technical and operational aspects of pharmaceutical care. The collaboration and exchange of knowledge promoted by the leading technical group in the development of the policy aim to benefit the health and well-being of the population.

Second stage: In this phase of PEAF development, key questions were used to identify contributing and constraining factors within the axes of universal access, human resources, management of pharmaceutical care, financing, and pharmaceutical care. These were considered critical issues to which the policy would seek to provide solutions. The "problem tree" tool was used with the following keywords/descriptors: "access to medicines," "rational use of medicines," "infrastructure," "process management," "outcomes," "accessibility," and "care." This process was conducted through the Figma board activity application, a free web-based design tool that allows projects to be saved in the cloud and worked on from anywhere. The tool was used during workshops conducted by COPAF and intersectoral representatives, who comprised the leading group. Strengths, weaknesses, threats, and opportunities were identified within the following axes: "universal access," "human resources," "pharmaceutical assistance management," "financing," and "pharmaceutical care." Workshops facilitated the engagement of various managers in reflection and discussion to support decision-making and the development of new policies related to pharmaceutical care. This experience contributed to the exchange of knowledge and practices among health care workers and led to the drafting of a preliminary regulation. During the meetings, a designated secretary was responsible for documenting the discussions using Microsoft Word. At the end of each meeting, the document was read aloud to verify participants' agreement with the recorded content or to identify the need for corrections. Of note, the meetings were conducted with a minimum quorum of 51% of the participants.

Third stage: The final stage was the drafting of the PEAF regulation, which was approved by the Comissão Intergestora Bipartite (CIB). The document was approved by CESAU Resolution No. 55/2021 and published in DOE, Series 3, Year XIII, No. 269, in December 2021[11].

Following the formation of the technical lead group in the first phase, members defined strategies and guidelines for designing the PEAF, monitoring and evaluating implementation results, supporting professional training and development processes, proposing standards, procedures, and measures to qualify and improve the PEAF, and collaborating with and supporting COPAF on matters related to the PEAF.

The study by Bermudez et al.[12], titled "Assistência Farmacêutica nos 30 anos do SUS na perspectiva da integralidade," confirms that pharmaceutical care is a broad, central issue with intersectoral implications. Over the past 30 years, Brazil—a country of continental dimensions, inequalities, and complexity—has undergone various political, economic and social changes. Existing legal acts express efforts towards implementation, but do not necessarily guarantee that implementation has been complete or successful, highlighting concerns about current policies and the dismantling of solid structures that represented social progress[12].

In the second phase, eight workshops were held (Table 1). Subsequently, the COPAF technical team analyzed the information collected in terms of strategies and actions to address the priority problems identified in each axis. These workshops were also characterized by the promotion of integration between different levels of management and health care workers, thereby strengthening the network of services in an articulated, effective way.

Table I. Schedule of activities for the development of State Policy on Pharmaceutical Services (Política Estadual de Assistência Farmacêutica). Ceará, Brazil, 2023.

Date	Program	Outcome
08/17/2021	1st workshop on the development of PEAF	Conceptual alignment and work schedule
08/31/2021	Brainstorming workshop on major issues (Part 1)	Problem tree
09/14/2021	Brainstorming workshop on major issues (Part 2)	Problem tree
09/28/2021	Start of the development of the PEAF base document	PEAF base document
10/18/2021	Presentation of the final draft proposal	Final draft of PEAF
10/27/2021	Presentation of the draft to CTAF	Draft validated by CTAF
11/12/2021	Presentation of the draft to CIB	Draft approved by CIB Resolution
11/20/2021	Presentation of the draft to CESAU	Draft approved by CESAU

ACRONYMS: CESAU: Conselho Estadual de Saúde; CIB: Comissão Intergestora Bipartite; CTAF: Câmara Técnica da Assistência Farmacêutica; PEAF: Política Estadual de Assistência Farmacêutica.
Source: Prepared by the authors (2023).

Based on the analysis of the collected information, seven keywords were identified as the starting point for constructing problem trees. This methodology, which includes a graphical representation, aims to analyze an issue by identifying its causes and effects. This approach was proposed in the work of Welter et al. and includes the following keywords: accessibility, access to medicines, care, process management, infrastructure, outcomes and rational use of medicines[13]. Table 2 shows the consolidation of the data collected during the workshops.

Quadro 2. Results of the problem tree built by the technical group conducting the state policy of pharmaceutical assistance. Ceará, Brazil 2023.

Refined problems	ACCESS TO DRUGS	
Causes	Financing	Difficulties in financing; insufficient resources.
	Access to Information	Lack of information and guidance; access depends on proper drug selection, programming, acquisition, and information system.
	Logistics	Lack of incorporation and standardization; limitations in the national/state/local pharmaceutical market restricting drug supply; lack of raw materials; currency fluctuations complicating execution; deficient human resources and logistics at all levels; logistics issues in receiving medications from the ministry; lack of uniformity in information provided to patients; supplier delays; access depends on rational use policy; users' lack of knowledge about the acquisition process, logistics problems (transport, proper storage, timely receipt); drug shortages; technologies not covered by SUS.
Consequences	Financing	Difficulty in fulfilling the programming.
	Access to Information	Difficulty in guiding prescribers within the components of pharmaceutical care.
	Logistics	Lack or discontinuity in the supply of specialized items; drug shortages; inaccurate drug forecasting; absence or insufficiency of items in basic and secondary PPI; delays in receiving compulsory notification drugs.

Refined problems	RATIONAL USE OF DRUGS	
Causes	Health care workers	Lack of clinical pharmacists; inadequate continuing education; limited human resources; lack of knowledge about standardization; insufficient information for professionals and patients.
	Managers	Pharmaceutical services focused on logistics rather than on the user; logistical failures in pharmaceutical assistance (AF); non-compliance with essential drug lists; insufficient pharmaceutical care services in primary and specialized care; clinical decisions driven by prescriber preference; market unavailability/discontinuity; lack of pharmacy and therapeutic committees.
	Citizens	Indiscriminate use/self-medication; lack of patient information about the medication in use; inadequate drug selection; inappropriate prescription; lack of medication reconciliation; absence of clinical pharmacist follow-up; problems at any stage of pharmaceutical care logistics; lack of continuity in patient follow-up; difficulty in conducting health education activities for medication users.
Consequences	Health care workers	Lack of access to workers; overburdened staff responsible for all pharmaceutical care actions within the service; professionals with service roles centered on logistics.
	Managers	Drug shortages; lack of dispensing control; increased resource usage; polypharmacy; inability to implement antimicrobial therapy management programs; lack of managerial sensitivity to implement clinical services.
	Citizens	Culture of inappropriate medication use; increased rates of hospitalization, morbidity, and mortality; inappropriate prescriptions; patients not using medications correctly; compromised patient safety.

Refined problems	INCIPIENT PHARMACEUTICAL CARE	
Causes	Human resources	Lack of active multidisciplinary teams; insufficient pharmacist qualifications; inadequate allocation of available professionals; lack of a well-coordinated multidisciplinary team; absence of a permanent training program; insufficient number of clinical pharmacists to meet demand; lack of health team integration; limited availability of clinical pharmacy services; no established collaboration between primary and specialized care for patient evaluation and follow-up; lack of interaction between medical and pharmaceutical professionals and patients; lack of interprofessional collaboration for implementing pharmaceutical care in services.
	Infrastructure	Reduced availability of care access points; inadequate health equipment.
	Communication	Lack of accessibility and availability of services and products to users; absence of health education programs; managers' lack of understanding of the pharmacist's role in clinical settings; lack of visibility and appreciation of the pharmaceutical profession.
Consequences	Human resources	Insufficient number of clinical pharmacists to meet demand; lack of adequate workforce to meet patient needs; difficulty in understanding and using evidence-based guides and other support tools; absence of direct supervision of treatment by a pharmaceutical professional.
	Infrastructure	Compromised patient safety.

	Communication	Lack of guidance for users regarding medication; inadequate health care information; lack of patient involvement in their treatment; absence of health education for proper medication use, self-care, health promotion actions, and treatment adherence; low treatment adherence; lack of guidance and referrals to health services, and inadequate health information.

Refined problems	INFRASTRUCTURE: Inadequate physical space in size and structural conditions for proper storage of medications, supplies, immunobiological substances, and qualified human resources	
Causes	Planning	Lack of planning and projects for implementing pharmaceutical care services; inadequate planning of spaces designated for the pharmacy sector; lack of funding; inadequacy, and under sizing for the type of care provided; compromised logistics quality; patient safety concerns; lack of managerial sensitivity.
	Human resources	Absence of workforce dimensioning.
	Financial resources	Lack of investment and noncompliance with good storage practices; insufficient funding for the structuring of pharmacies and CAF.
	Physical structure	CAFs established without adequate physical infrastructure; difficulty in acquiring and maintaining public buildings; architectural designs not aligned with ANVISA RDC No. 51, 2010; lack of adequate space for structuring.
	Equipment	Lack of functional equipment (computers and software); insufficient equipment for AF activities; inadequate equipment, such as lack of climate control and ventilation; outdated and defective equipment; lack of equipment maintenance.
Consequences	Financial resources	Resource losses; medication loss..
	Human resources	Insufficient staff to meet demands; inefficient product management.
	Physical structure	Difficulty in properly storing medications; challenges in adjusting activities to available spaces; inadequate or insufficient transportation for the volume of items to be moved; unsatisfactory storage of thermolabile products; inadequate and precarious structures; non-compliance with good storage practices.
	Citizens	Patient safety concerns.
	Equipment	Thefts/robberies.

Refined problems	INADEQUATE OR DEFICIENT PROCESS MANAGEMENT	
Causes	Planning	Lack of training; high staff turnover; absence of well-established and functional workflows; lack of awareness of existing workflows; work methods need to be created or improved; duplicate activities; lack of protocols; inefficient communication; absence of service quality mapping and monitoring.
	Execution	Disorganized workflows; non-institutionalization of SOPs; lack of awareness of existing workflows; inefficient communication; absence of service quality mapping and monitoring.
	Monitoring	Absence of process mapping; non-use of indicators; lack of service quality monitoring; inefficient communication.
Consequences	Planning	Poorly qualified workforce; financial budgets that are insufficient or poorly executed.
	Execution	Increased operational costs; management not centered on the user; slow task execution; long response time for compulsory notification medications; poorly qualified workforce; compromised decision-making; users not adequately served.
	Monitoring	Absence of service quality mapping and monitoring.

Refined problems	INADEQUATE results generated by inappropriate indicators; insufficient or inadequate result evaluation; inconsistent/irregular result monitoring	
Causes	Planning	Inadequate planning; lack of close monitoring of partial deliveries; absence of well-established goals; lack of appropriate systems and indicator structures.
	Execution	Non-applicability of information derived from indicators; failure to deliver what was planned; lack of team commitment; failure to complete tasks within the deadline.
Consequences	Planning	Lack of proper qualification for professionals; inadequate planning.
	Execution	Results not adequately evaluated; failure to achieve planned outcomes; difficult-to-measure indicators; inability to use results for service improvement; non-applicability of information derived from indicators; dissatisfied users; failure to deliver planned tasks; compromised patient treatment; lack of team commitment; unproductive staff.

Refined problems	ACCESSIBILITY: Lack of a culture of understanding and respect for accessibility issues	
Causes	Mobility	Difficulty in physical accessibility to pharmacies in primary care units for people with disabilities.

	Communication	Inefficient dissemination of information regarding the availability of medications and service workflows; lack of transparency about accessibility pathways; absence of pharmaceutical assistance policy for people with disabilities; lack of access to digital technology for information; users' lack of knowledge about their rights; lack of resources for users to access health services; lack of ethical and technical qualification of healthcare workers to address social issues; lack of professional training.
Consequences	Mobility	Services and facilities are not fully accessible; lack of physical accessibility (e.g., stairs, inadequate counters) for people with disabilities.
	Communication	Lack of information awareness among health care workers; inadequate guidance for users; lack of knowledge among users of their rights; lack of sensitivity among technicians in assisting users; lack of public awareness of the medicines available in the SUS; trivialization of the use of medicines in the care of socially and economically disadvantaged populations; lack of functional applications.

ACRONYMS: ANVISA: Agência Nacional de Vigilância Sanitária; CAF: Central de Abastecimento Farmacêutico; PPI: Programação Pactuada Integrada; RDC: Resolução da Diretoria Colegiada; SOP: Standard Operating Procedure; SUS: Sistema Único de Saúde.
Source: Prepared by the authors (2023).

A historical review of the progress and challenges of pharmaceutical care policy, covering issues such as the reorientation of pharmaceutical care, human resource training, technological development and industrial production, underscores the historical reasons behind the adoption of a pharmaceutical care policy in Brazil. This review highlights the multiple factors that have influenced the construction of this policy[13].

The study by Souza and Costa[14] provided a descriptive documentary approach to the implementation process of the pharmaceutical care policy in the state of Bahia, discussing and classifying the problems of pharmaceutical care into five categories in order to structure an action plan. To do so, they had to be organized around three fundamental guidelines: democratic governance, rational use of drugs, and expanding and qualifying access.

After the implementation of the policy, political, administrative and technical stability was observed in the actions that ensured the expansion and qualification of access. Access and promotion of rational use of drugs are becoming urgent needs to ensure greater effectiveness of actions and to minimize the negative impact on the health budget[14].

Resolution No. 1,095 of November 14, 2018, approved the PEAF of state of Pará, Brazil. The main objective of PEAF is to guarantee the population of Pará comprehensive, qualified access to essential drugs and standardized health products, included in the Relação Nacional de Medicamentos Essenciais (RENAME), at all levels of health care. The policy also promotes rational use, continuous supply and humanized care. The implementation, monitoring, control and evaluation of the PEAF are the responsibility of the Secretaria de Estado de Saúde Pública do Pará (SES-PA), through the Departamento Estadual de Assistência Farmacêutica, and are supervised and monitored by the plenary of the Conselho Estadual de Saúde (CES) and coordinated with the Colegiado dos Secretários Municipais de Saúde (COSEMS) within their respective competencies[15].

Nevertheless, the key points highlighted by the leading group in the areas of "access to medications," "rational use of medications," and "care" find partial support in the studies by Oliveira, Nascimento, and Isabel[16] as well as Monteiro, Lacerda, and Natal[17]. These studies emphasized the importance of these aspects for improving pharmaceutical care, corroborating the observations made by the technical group.

Regarding "infrastructure," "process management," and "accessibility," these aspects were supported by the research of Leite et al.[18], who characterized the physical structure of primary care pharmacies in the SUS as a fundamental factor for the humanization of the services offered and for the working conditions of health care workers. In addition, Paula-de-França et al.[19] examined the physical structure of Unidades Dispensadoras de Medicamentos Antirretrovirais (UDM) and the conditions of care provided to people living with HIV/AIDS (PLWHA), confirming the importance of these elements for the quality of pharmaceutical care.

In the third stage, the PEAF ordinance was drafted, approved by the Bipartite Inter-managerial Commission (CIB) and published in DOE, Series 3, Year XIII, No. 269, in December 2021. The democratization of the process and access to information is a catalyst for change, as it promotes learning processes and enables a critical and reflective perspective on the current scenario[11].

Resolution No. 753, dated August 8, 2018, approved the PEAF of Pernambuco. This policy guides comprehensive, qualified access to essential medicines and standardized health products, included in the Relação Estadual de Medicamentos Essenciais (RESME), at all levels of health care. The policy focuses on rational use, continuous supply and humanized care, and is based on guidelines for democratic and participatory management. Thus, the implementation, monitoring, control and evaluation of the PEAF are the responsibility of the Secretaria de Saúde do Estado de Pernambuco (SES-PE), through the Diretoria da Assistência Farmacêutica Estadual, supervised by the

plenary of the CES and coordinated with the COSEMS collegiate within their respective competencies[20].

This work encompassed six fundamental axes necessary for building quality pharmaceutical assistance in the state of Ceará: access to drugs, rational use of drugs, care, infrastructure, democratic and participatory management, governance, and financing (Figure 1).

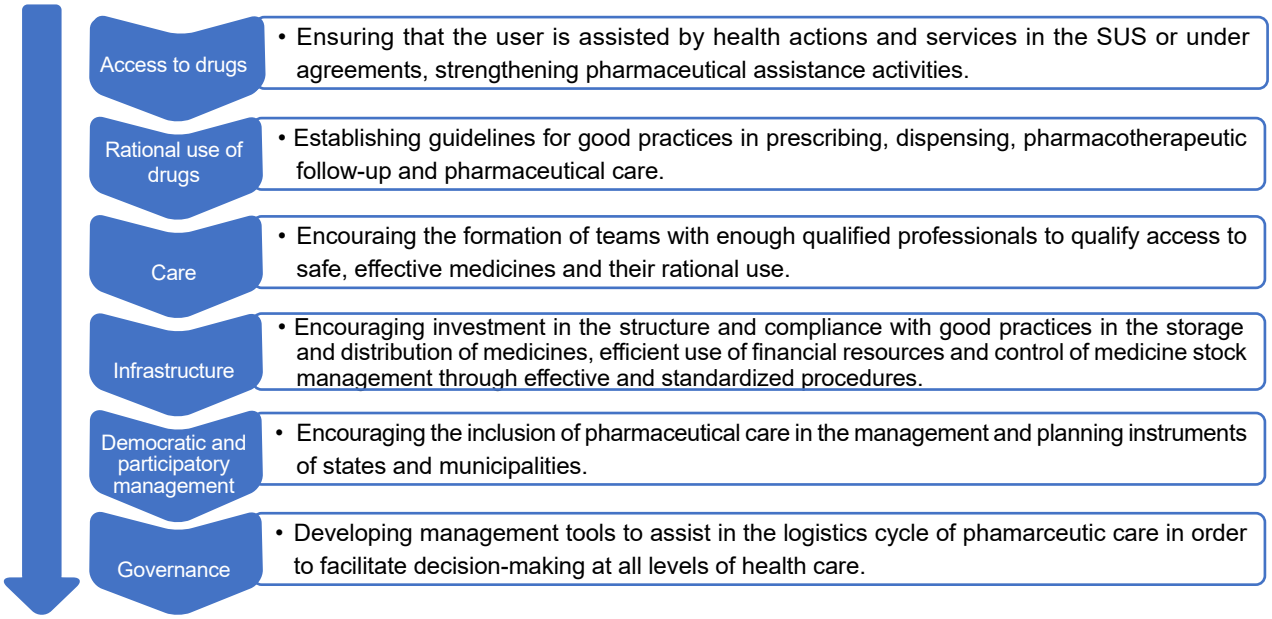

Figure 1. Guiding principles of PEAF of Ceará. Ceará, Brazil, 2023.
Source: Prepared by the authors (2023).

Improving access to medicines and ensuring their rational use by integrating pharmaceutical assistance with other health policies, optimizing financial resources, incorporating and integrating pharmacists into federal, state and municipal health systems, developing and training human resources to implement pharmaceutical care, and making management efficient through guiding principles are some of the current and future challenges in our country. Meeting these challenges requires coordinated action by health managers at all three levels of government, so that pharmaceutical assistance can be defined as a strategic public policy within the social control of the SUS and incorporated as a priority in the actions of health managers[21].

The results of the process of developing the PEAF of Ceará led to the creation of a leading group for the formulation of the policy and the subsequent approval of the PEAF. The strengthening of the PEAF at all levels of health care in the state (primary, secondary, and tertiary) should be discussed in order to expand and organize access to medicines, promote rational use, structure pharmaceutical care and improve organization, infrastructure and governance mechanisms as well as ensure adequate financing with democratic, participatory management[10].

In this context, the development of PEAF by SES-CE emphasized the importance of promoting health through public policies that ensure not only access to medicines but also their rational use and the continuous training of health professionals. This is in line with the need to reorient health services to better meet the needs of the population[22].

There is a recognized need for progress in the structuring (construction) of state pharmaceutical assistance policies that respond to the needs of the population in a determined and humanized manner, as well as the restructuring of national drug policies in response to technological advances, in harmony with other established policies. The realization of social rights requires the implementation of public policies. The transparency of these rights and policies, as well as the continuous dissemination of information, are essential for the better organization of the SUS.

However, a limitation of this work is that the meetings were not recorded, which would have allowed the audio, in addition to the written material, to be reviewed to verify the information described. For future studies, we suggest evaluating the implementation of the PEAF in Ceará. Data described in this report will hopefully motivate state and municipal pharmaceutical assistance managers to develop PEAF in their territories, thereby increasing access to medicines for the Brazilian population.

CONCLUSION

The PEAF of Ceará was one of the strategies adopted by SES-CE to consolidate actions aimed at promoting, protecting and restoring individual and collective health, with pharmaceutical care for the citizens of Ceará as a central focus. The PEAF seeks to strengthen pharmaceutical assistance at all levels of care (primary, secondary, and tertiary), focusing on organizing and expanding access to drugs, promoting their rational use, structuring pharmaceutical care, organizing infrastructure and governance mechanisms, and ensuring adequate financing with democratic and participatory management.

The implementation of this policy and its outcomes-such as improving the government's drug procurement processes, expanding access strategies, structuring and standardizing pharmaceutical services within the SUS network, and training professionals at all levels of care to ensure that health is truly universal-allow for the equitable and comprehensive restoration, protection, and promotion of health through pharmaceutical assistance. These efforts serve as a foundation that can guide managers in implementing more effective strategies to strengthen public policies.

CONFLICTS OF INTEREST AND ACKNOWLEDGMENTS

The authors declare no conflicts of interest.

CONTRIBUTIONS

Karla Deisy Morais Borges and **Joyce da Silva Almeida** contributed to the study design, data acquisition, analysis, interpretation, drafting, and revision of the manuscript. **Paulo Ricardo Merencio da Silva** contributed to the study design, data acquisition, analysis, and interpretation. **Francisco Álisson Paula de França** contributed to the drafting and revision of the manuscript.

FUNDING

No funding was received.

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How to cite: Borges KDM, Almeida J da S, Silva PRM da, França FAP da. Interdisciplinary approach in the development of the state pharmaceutical care policy of Ceará: An experience report. Rev Bras Promoç Saúde. 2024;37:14837.