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THE RIGHT TO HEALTH IN PRIMARY CARE: BETWEEN LAW AND REALITY IN THE BASIC HEALTH UNITS OF JUAZEIRO DO NORTE - CE

Izaac Lobo de Mesquita

Natália Hegla Cruz Lobo Mesquita

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Abstract: This study investigated the structural and administrative challenges faced by the Basic Health Units (UBSs) in Juazeiro do Norte - CE in providing quality public healthcare, a fundamental right guaranteed by the 1988 Federal Constitution. The research adopted a qualitative, exploratory and descriptive approach, using a literature review, documentary research and empirical observation in ten selected UBSs. The results showed deficiencies in physical infrastructure, a shortage of supplies and medicines, an overload of health professionals, difficulties in administrative management and failures in integration between the levels of care. The conclusion is that, despite the normative guidelines governing Primary Care, the reality of the UBSs analyzed reveals significant obstacles to guaranteeing the right to health, requiring structural investments, greater training of professionals and improved management to improve the quality of services provided to the population.
Keywords: Right to health; Primary care; Basic health units; SUS; Health management.

INTRODUCTION

The right to health is one of the fundamental pillars of the Democratic State of Law, enshrined in the 1988 Constitution of the Federative Republic of Brazil (CRFB/1988) as a duty of the state and a right of all. The Unified Health System (SUS) was designed to guarantee universal, comprehensive and equitable access to health services, with special attention to Primary Care, which acts as the system's main gateway. However, the realization of this right still faces numerous challenges, especially in regions with greater social vulnerability, where Basic Health Units (UBSs) play an essential role in providing preventive and curative medical services.

In Juazeiro do Norte - CE, the UBSs are the main alternative for providing care to the poorest population, but they face structural and administrative difficulties that compromise the quality of the services provided. For this reason, the following research problem arose: What are the main structural and administrative challenges faced by the Basic Health Units (UBSs) in Juazeiro do Norte - CE in order to guarantee the adequate provision of health services to the needy population?

In this sense, the general objective of this research is to "map the main challenges that jeopardize the realization of the right to health in the UBSs of Juazeiro do Norte - CE, with an emphasis on the obstacles that impact on the quality of care provided to the population in need". In order to achieve this objective, it was decided to first analyze the legal framework of the right to health in Brazil, focusing on the principles of the Unified Health System (SUS) and the guidelines governing Primary Care. We then identified the main structural challenges faced by UBSs, collecting data on infrastructure, including physical facilities, availability of professionals, equipment, essential medical supplies and services offered.

Based on this, it was possible to compare the reality of the UBSs in Juazeiro do Norte with the guidelines and standards established by the Ministry of Health, pointing out possible gaps in the implementation of the right to health; as well as proposing recommendations and strategies to minimize the challenges identified, contributing to the strengthening of Primary Care and improving the quality of the services provided to the population in need.

In order to achieve the proposed objectives and answer the central question of the study, the research adopted a qualitative approach, with an exploratory nature, seeking new information and understanding the complexity of the subject, and a descriptive nature, detailing and analyzing the reality of the UBSs in Juazeiro do Norte. To this end, bibliographical, documentary and empirical research were combined.

The first stage of the research therefore consisted of a literature review on the right to health in Brazil, focusing on the legal framework of the Unified Health System (SUS), its guidelines and principles. Documentary research was conducted by analyzing a series of official documents that establish guidelines and regulations for the organization and operation of the Unified Health System (SUS). The main documents examined include the Federal Constitution (BRASIL, 1988), which enshrines health as a fundamental right; the Organic Health Law (Law No. 8.080/1990) (BRASIL, 1990), which regulates the SUS and defines its organizational principles; and the National Primary Care Policy (PNAB) (BRASIL, 2017), which guides the structure and functioning of Primary Health Care in the country.

The relevance of this documentary analysis lies in the need to compare the normative guidelines with the concrete reality of the UBSs in Juazeiro do Norte - CE, allowing us to identify any gaps between what is recommended by the regulatory frameworks and the daily practice of health services. As Rodrigues et al. (2019, p. 72) point out, *"the power of the protocols to strengthen primary care and guarantee the right to health will depend on how they are used in the day-to-day practices of the SUS"*. Thus, the research sought to understand to what extent the municipality's UBSs effectively incorporate the normative guidelines into their routines and what structural, administrative and socioeconomic challenges impact the provision of services to the population.

Furthermore, in order to understand the reality of the Basic Health Units (UBSs) in Juazeiro do Norte, an empirical investigation was carried out based on direct observation and semi-structured interviews.

According to Prodanov and Freitas (2013, p. 37), most research must resort, at different times, to observational procedures, which can be used alone or in conjunction with other methods. This is the case with this research, which included visits to ten UBSs in the municipality, selected with priority for those located in poor neighborhoods.

It should be noted that, according to official data, the city currently has 67 health units focused on Primary Care (PREFEITURA MUNICIPAL DE JUAZEIRO DO NORTE, 2025). However, the choice of these ten units was based on the fact that, in these places, the need for public health is more pronounced, since there is greater demand and difficulties in accessing private health care. The selection of the UBSs was based on the professional experience of one of the authors of the article, who works as a doctor at the Frei Damião II UBS, which allowed for a more precise direction in the choice of the units analyzed.

During the visits, the structural and administrative conditions of the units were observed, taking into account aspects such as physical facilities, the number of professionals available, waiting times for care, hygiene conditions and access to essential medical supplies. In addition to direct observation, interviews were conducted with health professionals - including doctors, nurses, community health workers and managers - from the ten selected units. In total, twenty-five professionals agreed to take part in the research, answering structured questionnaires. The questionnaire applied was developed specifically for this research, with open-ended questions that allowed for in-depth answers.

Given the modest scope of the study and the small number of participants, it was not possible to assess any disparity in participation by professional category. Furthermore, considering that some of the professionals interviewed do not have job stability, there was a need to adapt the research approach. In order to guarantee the safety and anonymity of the participants, it was decided not to identify the UBSs visited, thus making it impossible to link the responses to specific locations or individuals.

THEORETICAL AND LEGAL FRAMEWORK OF THE RIGHT TO HEALTH IN BRAZIL

The Federal Constitution (BRASIL, 1988) represented a milestone in the consolidation of the right to health in Brazil, establishing essential foundations for the organization and provision of health services in the country.

Article 196 of the Federal Constitution (BRASIL, 1988) states that health is a right of all and a duty of the State, and must be guaranteed through social and economic policies that reduce the risk of disease and illness, ensuring universal and equal access to actions and services for its promotion, protection and recovery. According to Barroso (2018), as well as Sarlet and Figueiredo (2014), Gomes (2020), Pierdoná (2019), this concept broadens the traditional notion of health, not restricting it to the mere absence of disease, but considering it a result of social, economic and environmental conditions. The constitutional text highlights the need for intersectoral actions that promote healthy living conditions, recognizing that factors such as education, basic sanitation, housing, food, work and the environment are social determinants of health and should be considered in the formulation of public policies.

This integrative approach is reinforced by the Organic Health Law (BRASIL, 1990), which establishes the importance of a health system that is not limited to the treatment of illnesses, but which also works to promote health and prevent diseases, considering the multiple factors that impact the well-being of the population. Rodrigues et al. (2019, p. 76) state that "the use of a protocol, however, only makes sense if it involves the team in a multi- and interdisciplinary way and users, in a dialogical way, in the search for consensus".

For example, art. 3 of Law no. 8.080/1990:

> Article 3. Health levels express the country's social and economic organization, with food, housing, basic sanitation, the environment, work, income, education, physical activity, transport, leisure and access to essential goods and services being determinants and conditioning factors of health.
> Sole paragraph. Actions which, by virtue of the provisions of the previous article, are intended to guarantee people and the community conditions of physical, mental and social well-being are also related to health (BRASIL, 1990).

The Federal Constitution and the Organic Health Law, therefore, enshrine a broader vision of health and emphasize the need for public policies that go beyond medical care, encompassing preventive actions and the promotion of well-being. The concept of health as a fundamental right and a duty of the state imposes a continuous commitment to reducing inequalities and guaranteeing universal and equal access to quality services.

In the same vein, Article 6 of the Organic Health Law (BRASIL, 1990) defines the field of action of the Unified Health System (SUS), including epidemiological and health surveillance actions, workers' health and comprehensive therapeutic care. Pierdoná (2019) explains that these guidelines are part of the strategies implemented in Primary Care to ensure a preventive and health-promoting approach.

Article 198 of the Constitution (BRASIL, 1988) establishes the guidelines for the organization of public health services, structured in a regionalized and hierarchical network that constitutes the SUS. This organization is based on the principles of decentralization, guaranteeing a single directorate in each sphere of government; comprehensive care, prioritizing preventive activities without prejudice to care services; and community participation, ensuring the involvement of the population in the formulation, monitoring and inspection of health policies.

According to Gomes (2020), comprehensive care aims to ensure that each individual receives a complete set of actions and services necessary to meet their health needs, emphasizing prevention without neglecting curative care. Social participation, regulated by Law No. 8.142/90, establishes the creation of Health Councils and Conferences in the three spheres of government. These mechanisms ensure that civil society has a voice in defining and implementing public policies, allowing historically excluded groups to influence government decisions in the health sector.

Primary Care plays an essential role in the SUS, being the preferred gateway to the system. According to Marques, Piola and Carrillo Roa (2016), its central function is to promote health, prevent disease and coordinate care, ensuring continuous monitoring of patients and their coordination with other levels of care. As a constitutional principle, comprehensiveness reinforces the need for Primary Care to offer a broad set of actions that respond to the needs of the population, promoting continuity of care and ensuring a holistic approach to health.

Community participation is fundamental to the effectiveness of Primary Care. Through Health Councils and Conferences, the population contributes to defining priorities, implementing and evaluating health policies, ensuring that actions are appropriate to local realities and promoting co-responsibility in the management of the health system.

The Organic Health Law (BRASIL, 1990) establishes guidelines and norms for implementing the constitutional principles of health, defining the central strategy for health promotion, prevention and care. In addition, the law states that Primary Care should be the citizen's first level of contact with the health system, guaranteeing promotion, prevention and recovery actions. The Family Health Strategy (ESF) reinforces this guideline by expanding coverage and strengthening the link between health professionals and the population, ensuring closer and more continuous care.

In addition, the law states that Primary Care should be the citizen's first level of contact with the health system, guaranteeing promotion, prevention and recovery actions. The implementation of the Family Health Strategy (ESF) reinforces the importance of Primary Care, aiming to expand coverage and strengthen the bond between health professionals and the population.

In order to organize Primary Care in the Unified Health System, the Brazilian Ministry of Health established a set of guidelines called the National Primary Care Policy (PNAB) (BRASIL, 2017). Thus, Primary Care is characterized by a set of individual, family and collective health actions that involve promotion, prevention, diagnosis, treatment, rehabilitation and health surveillance, developed through integrated care practices and qualified management, carried out by multi-professional teams and aimed at the population in a defined territory, over which the teams assume health responsibility.

The National Primary Care Policy (PNAB) was first instituted in 2006, in the context of the Pact for Health, reaffirming the Family Health Strategy (ESF) as the priority model for reorganizing primary care in Brazil. This strategy aims to reorganize basic care in the country, in accordance with the precepts of the SUS, and is seen by the Ministry of Health and state and municipal managers as a strategy for expanding, qualifying and consolidating basic care, as it favours a reorientation of the work process with greater potential for deepening the principles, guidelines and foundations of basic care, increasing resolutiveness and impact on the health situation of people and communities, as well as providing an important cost-effectiveness ratio.

In 2017, the National Primary Care Policy (PNAB) underwent a significant update, introducing changes that directly impacted the organization of Primary Health Care services. Among the changes, we highlight the expansion of the duties of Community Health Agents (ACS), allowing them to work more comprehensively in monitoring families, and the reduction in the number of these professionals per team, which generated debate about the possible impacts on coverage and quality of care.

Subsequently, in 2019, the Previne Brasil Program was established, which reformulated the Primary Health Care financing model, replacing the Primary Health Care Floor (PAB) with new criteria for financial transfers to municipalities. The new model now considers three main axes: weighted funding, which defines resources based on the number of registered users and their socio-economic characteristics; payment for performance, which evaluates quality indicators of the services provided; and incentives for strategic actions, aimed at specific policies defined by the Ministry of Health. These changes were aimed at improving the efficiency of financial transfers and encouraging the continuous improvement of care for the population.

However, the effectiveness of these policies depends directly on the physical and organizational structure of the Basic Health Units (BHUs). The National Primary Care Policy (PNAB) pays special attention to the need for adequate infrastructure for these units to function, establishing minimum requirements to guarantee a safe and efficient environment for care. These requirements include the presence of doctors' and nurses' offices, vaccination rooms, adequate storage space for medicines and essential medical equipment.

The importance of infrastructure and the organization of services is also reflected in the adoption of care protocols, which guide the practices of health professionals. As Rodrigues states:

> *"protocols can be used as care management technologies to support the professional practice of primary care workers and strengthen the policies developed in the SUS by encouraging interdisciplinary and multiprofessional work, but their use will depend on the political will of local managers and workers to adhere to and implement them"* (Rodrigues et al., 2019, p. 77).

Thus, the effective implementation of the guidelines established by the National Primary Care Policy (PNAB) and Previne Brasil requires not only structural investments, but also the commitment of municipal managers to ensure that UBSs fulfill their role as the gateway to the SUS.

The National Primary Care Policy (PNAB) (BRASIL, 2017, p. 35) also specifies that UBSs should be built in accordance with health standards and the guidelines of the infrastructure manual of the Primary Care Department/SAS/MS. In addition, it is recommended that the units have medical and nursing offices, a dental office with a toilet, a multi-professional room for receiving spontaneous demand, an administration and management room and a room for collective activities for use by Primary Care professionals. These criteria aim to guarantee efficient and humanized care, providing a suitable environment for both professionals and users of the health system.

The Manual for the Physical Structure of Basic Health Units (BRASIL, 2006), drawn up by the Department of Primary Care/SAS/MS, establishes guidelines for the construction, renovation, expansion and selection of buildings for UBSs, ensuring that infrastructure is not a limiting factor in the adequate provision of health services.

The manual (BRASIL, 2006) emphasizes that the structure of UBSs should be planned according to the population served and their specific needs. The physical space should

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allow for both individual care and collective health promotion actions. Among the essential components are the offices for medical and nursing care, the dental office equipped with dental chairs and brushing areas, as well as the vaccination room, strategically positioned to avoid cross-contamination. There is also a procedure room for dressings and administering medicines, a nebulizer room for respiratory therapies, a sterilization and materials storage room, an area for dispensing medicines, which can function as a basic pharmacy, as well as a reception and waiting room, designed to ensure comfort and accessibility. The manual also provides for an administrative area, including a meeting room for the family health teams.

In addition to the distribution of spaces, the manual (BRASIL, 2006) emphasizes the need to follow sanitary standards and ensure accessibility. The construction of UBSs must include adequate ventilation, natural lighting and accessibility for people with disabilities, as well as internal flows that avoid cross-contamination. The use of suitable materials is also a concern. Floors and walls should be washable, avoiding rough or textured surfaces that make cleaning difficult. Furniture should be planned to allow for efficient organization of care and procedures.

Another aspect addressed in the manual is the concern with the location of the UBSs, recommending that the choice of location take into account social impacts, carrying out a prior study on accessibility and road structure to facilitate the population's access to the health service.

Neither the National Primary Care Policy (PNAB) (BRASIL, 2017) nor the Manual for the Physical Structure of Basic Health Units (BRASIL, 2006) specify the need for an exclusive room for urgent and emergency care within UBSs. However, these documents do mention that Family Health teams should be prepared to provide basic emergency care.

The documents also provide for the existence of procedure rooms, where actions such as dressings, administration of injectable medication, drainage of abscesses and sutures, as well as oral rehydration therapy, are carried out. These rooms can be used to stabilize patients before they are referred to more complex services.

In this way, the UBSs must guarantee resolutive care and the appropriate referral of more complex cases to other levels of care, including urgent and emergency care when necessary. This indicates that UBSs play an essential role in the triage and initial care of urgent situations, but that more serious cases should be referred to more complex units.

The National Primary Care Policy (PNAB) (BRASIL, 2017, p. 36) even takes care to detail the dimensions and characteristics of the reception area and the place for files and records, the procedure room, the vaccine room, the medication dispensing and storage area, the collective inhalation room, the collection and dressing room, as well as an observation room. The document (BRASIL, 2017, p. 37) also addresses the need for regular maintenance of the infrastructure and equipment of UBSs, as well as the requirement to maintain regular stocks of essential supplies and medicines to ensure continuous and efficient care for the population.

THE REALITY IN THE BASIC HEALTH UNITS OF JUAZEIRO DO NORTE - CE

As previously detailed, the research into the Basic Health Units (UBSs) of Juazeiro do Norte used direct observation of 10 UBSs and semi-structured interviews with health professionals to understand their reality. The UBSs were selected with priority given to those in deprived areas due to the greater demand and difficulties in accessing private healthcare.

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During the visits, structural conditions, number of professionals, waiting times, hygiene and availability of supplies were analyzed. Twenty-five health professionals were interviewed, including doctors, nurses, community workers and managers, using structured questionnaires with open-ended questions.

Asked about previous experiences in other UBSs and possible differences between the UBSs in Juazeiro do Norte, 64% of the interviewees said they had already worked in other units. However, 84% pointed out that the UBSs in Juazeiro do Norte show significant structural differences, despite the architectural standard adopted in the public buildings. While some units operate in newly-built buildings, others are housed in old, poorly-maintained buildings.

In addition, some interviewees reported that, in cases of urgent need for renovation, UBSs are temporarily transferred to properties rented by the city, which do not follow the criteria established in the *Manual for the Physical Structure of Basic Health Units*.

When asked about the services offered by the units, the interviewees said that the UBSs provide medical care, nursing care, dental care, psychological care (usually once a week), vaccinations, simple injectable medication (when available, such as injectable contraceptives and dipyrone), dressings and home visits.

In addition, the second biggest complaint from the professionals interviewed in relation to the services offered was the existence of uncovered areas, i.e. without Community Health Agent (CHA) coverage. This absence makes it difficult for the unit's professionals to access essential information about the population they serve, compromising the continuity of follow-up and hindering users' access to health services.

However, the main problem pointed out by the interviewees in relation to the services offered was the long waiting time for care at the unit. The interviewees unanimously reported that, even with the weekly scheduling system and the daily distribution of forms for spontaneous demand, users often have to return several times to get an appointment.

The interviewees acknowledged, however, that the implementation of these mechanisms by the municipal administration was a success, since before this organization the situation was even more chaotic. According to some interviewees, the lack of a structured system resulted in long queues and unpredictable service, which caused even more frustration among users.

Even so, the situation remains critical, especially because the unit serves a densely populated urban area, where a large part of the population lives in conditions of socio-economic vulnerability and depends exclusively on the UBS for medical care. Many users, as well as facing difficulties in getting appointments at the unit, don't have the financial resources to travel to specialists or emergency services, which further compromises access to healthcare.

The infrastructure and physical conditions of the units were analyzed using observational procedures, which were of great relevance to the research and were combined with the data obtained from the interviews. From this analysis, it was concluded that none of the 10 units visited are in perfect condition and that 6 of them are in a poor or very poor state of repair.

The staff interviewed reported that they had recently received visits from municipal secretaries and had been informed about an ongoing renovation project for these units. Among the main problems observed and mentioned in the interviews were the presence of mold on the walls, especially in the service rooms and reception areas of three units, structural problems in the ceiling beams, leaks, infiltrations, poor air circulation, dirty and inefficient fans, air-conditioning units that were not working or needed maintenan-

ce, bathrooms that were unmarked and, in some cases, in poor hygiene conditions.

Mold on the walls, as shown in the photograph above, is one of the most serious and recurring problems in healthcare facilities. As well as compromising the quality of care provided, it also makes the working environment unhealthy for staff, posing a health risk to professionals and patients, especially those with respiratory diseases such as asthma and allergic rhinitis. In some of the offices visited, the walls were completely covered in mold, highlighting the urgent need for maintenance and improvements to the infrastructure.

In this sense, it would be advisable to invest in waterproofing walls, repairing roofs and drainage systems to prevent the accumulation of damp, as well as applying antifungal paints and coatings to prevent the reappearance of mold. At the same time, improving the natural and artificial ventilation of the rooms should be prioritized, either by installing larger windows, exhaust fans or suitable air conditioning systems. It would also be essential to implement an ongoing building maintenance program, ensuring that structural problems are identified and corrected before they become critical.

On the other hand, the reception rooms were generally spacious and well lit. Accessibility for people with disabilities or reduced mobility was also a positive point, as all the units analyzed have easy access, rooms that accommodate wheelchairs, a ground-floor structure with no steps and wide doors, ensuring better movement conditions for these users.

With regard to the upkeep of the furniture and equipment used in the unit, it was observed that the furniture, although old, was still functional. However, the chairs used by receptionists and health professionals were unsuitable for long working hours, offering little comfort and lacking proper back support, which can compromise ergonomics and workers' health.

On the other hand, the stretchers were considered suitable for use, the computers were in full working order and the printers operated normally, guaranteeing the necessary support for administrative and care activities.

However, in two of the units visited, there were no functioning drinking fountains, which represents a serious deficiency in the infrastructure, compromising the comfort and well-being of both professionals and users. According to the staff at this unit, the lack of this essential item creates discomfort while in the unit, especially on hot days, highlighting the urgent need for adequate maintenance and replacement to guarantee minimum conditions for care and permanence in the UBSs.

With regard to the availability of basic hygiene materials, such as toilet paper, soap and towels, 80% of those interviewed said that these items are never in short supply, 12% reported that they are rarely in short supply and only 8% mentioned that they are occasionally in short supply. These figures indicate that hygiene products are generally replenished efficiently, helping to maintain the cleanliness and well-being of both staff and users of the unit.

There are specific rooms and areas for vaccinations, medical care, nursing care and dental care. There are no specific rooms for emergency care or consultations with specialists, as these services are not offered by the units. In two units, there is no room for the psychologist's weekly appointments, so another room has to be provided.

It was also reported that there are often power outages in the poor neighborhoods where the units are located, which has a direct impact on service, which has to be suspended until the supply is restored. The situation is exacerbated by the condition of the rooms, which have small windows with little natural light or, in some cases, no windows at all. In addition, computers are essential for carrying out and recording appointments, making it impossible for the unit to function in the absence of electricity. This problem jeopardizes the continuity of services and reinforces the need for measures to ensure greater stability in the power supply, such as the installation of generators or other emergency alternatives.

With regard to the security of the units, three of them do not have any kind of surveillance, while in another four the security is only present for part of the opening hours. This deficit in the protection of the units has a direct impact on the working environment and the service provided to users.

In addition, 92% of those interviewed reported that there had been fights between patients inside the unit, which had to be contained by the staff themselves, without the help of security agents. This scenario not only exposes professionals to risky situations, but also compromises the quality of care. In addition, 48% of those interviewed said that these conflicts had already resulted in damage to the unit's property, highlighting the urgent need to reinforce security to guarantee the physical integrity of staff and users, as well as the preservation of the structure and equipment.

As for the disposal of hospital waste, it was observed that sharps are properly disposed of in appropriate garbage cans, and each room has identified garbage cans for separating contaminated waste from ordinary waste.

This control contributes to the safety of health professionals and patients, minimizing the risk of contamination. In addition, 88% of those interviewed said that the collection of this waste is carried out regularly by an outsourced company contracted by the municipality, guaranteeing the correct disposal of discarded materials.

Finally, 92% of respondents believe that the physical environment of the UBS does not favor humanized care, which highlights the need for structural improvements to provide greater comfort and welcome to users.

With regard to the number of health professionals (doctors, nurses, nursing technicians, community health workers, dentists and social workers), 52% of those interviewed felt that the team was sufficient to meet the demands of the UBS. Some of these professionals justified their response by saying that the number of patients per team is still within the limit recommended by the Ministry of Health.

On the other hand, the 48% who disagreed pointed above all to the population's misunderstanding of the nature of the services provided by UBSs. According to some of those interviewed, many patients still go to the unit for cases that should be dealt with in emergency services or that require hospital care. In addition, consultations with specialists belong to the secondary care network and are not part of Primary Care's remit. In these cases, there is a referral system via the Health Department, which makes the appointments after the medical request has been made at the UBS, polyclinics or specialist centers. However, patients can follow up requests for exams and referrals via the basic unit, but in order to know their place in the queue they have to go to the Health Department to follow up the appointment, which creates difficulties, especially for those in vulnerable situations.

On this point, 64% of respondents agreed that the referral system is inadequate, mainly due to the lack of control over waiting times, which can be excessively long, even in cases classified as urgent. In addition, the lack of feedback from secondary care to the UBS makes it impossible to provide continuity of care, since the electronic medical record systems are different, making it difficult to monitor patients and hindering integration between the levels of health care.

Of those interviewed, 92% said that there is no replacement of professionals during vacation periods. However, the majority pointed out that, in cases of prolonged leave, replacement can take place, although it takes several months to do so. In one of the units, it was reported that there has been no cleaning professional for months, which compromises the hygiene conditions of the place. Furthermore, in half of the units visited, cleaning is not carried out on a daily basis, but is outsourced to day laborers who come in two or three times a week to clean the rooms and bathrooms.

As for professional training, 80% of those interviewed said that UBS professionals receive training and updates, albeit sporadically and organized by other sectors of the municipality. One of the interviewees mentioned the update on leprosy promoted by the Dermatology Center, while another mentioned the training on HIV conducted by the infectolo-

gy team. In addition, it was reported that the Primary Care department frequently offers training in the use of systems and bureaucratic procedures, which demonstrates a concern for the qualification of the team, although there is still a need for greater regularity in these initiatives.

Regarding the relationship and communication between UBS professionals, 72% of those interviewed said that the internal team had a good relationship, with multi-professional work being carried out satisfactorily. However, 84% reported that communication with community health agents has been poor. While some agents are active and collaborate actively, others don't show up when asked and are not subject to effective supervision of their work, which compromises team integration and hinders coordination between professionals. There are also challenges in coordinating meetings that involve the whole team, including internal and external professionals.

Another problem identified is the lack of adequate administrative support. In 8 of the 10 units visited, there are not enough staff to deal with medical records, appointments and demand management, overloading receptionists, who end up accumulating these functions.

As for the relationship between the UBS team and the population they serve, the interviewees highlighted some positive points, such as the patients' trust in the unit for ongoing treatment, the proximity of their homes to the UBS and the fact that the population, in general, does not miss scheduled appointments. However, the main challenges mentioned were the population's high dependence on the UBS, which overloads the unit and makes it difficult to schedule appointments, as well as the low level of education on the part of users, requiring professionals to constantly repeat the same information to ensure proper understanding.

As for the medical equipment and supplies available at the UBS, it was found that they are not adequate to meet the needs of the unit. There were low-quality stethoscopes, non-functional sonars and no monitors or defibrillators. In addition, each unit has only one blood pressure device (sphygmomanometer), which is usually kept at the reception desk for screening, limiting the access of other professionals to the equipment.

Another worrying problem is the lack of provision for replacing or repairing broken equipment. There is no regular maintenance program, and it is only possible to request small or urgent repairs carried out by the unit's own professionals, which compromises the continuity of care and the quality of the assistance provided.

With regard to the supply of supplies and medicines, 84% of professionals said that the unit faces frequent problems with shortages of essential medicines. On the other hand, 68% consider that the supply of basic supplies such as gloves, syringes, masks, dressings and cleaning materials is relatively regular. Among those who disagreed with this statement, the main complaint was the shortage of materials for dressings and cleaning wounds, which directly impacts the care of patients with wounds and specific care needs.

Regarding the management of medicines, it was explained that the unit's pharmacy is supervised by a pharmacist who comes in only once a week. However, there is a mismatch between the medication received and the actual demand from the population. According to the interviewees, antibiotics for sporadic use often arrive in large quantities, while medicines for continuous and essential use, such as ferrous sulphate - essential for anemia prophylaxis in pregnant women - are often sent in insufficient quantities, resulting in recurring shortages and compromising patient care.

On the other hand, 84% of professionals said that the stock of vaccines is generally satisfactory, storage is adequate and, in most cases, the children in the area have up-to-date vaccination cards.

In addition, 64% of those interviewed said that laboratory tests for pregnant women are easy to access, with no need for prior scheduling - all that is needed is a request from a doctor, nurse or dentist for them to be carried out immediately. However, general laboratory tests follow a different flow: they are requested via the system from the Health Department, which schedules them and then sends the appointments to the unit. The professionals reported that they have no control over the waiting time for these tests, nor do they have access to a system that allows them to follow the waiting list, which makes it difficult to monitor and ensure continuity of care.

Furthermore, 80% of those interviewed said that the computerized system contributes to efficient care and continuity of care. As well as being easy to use and containing complete information on patients, the system is constantly updated, ensuring greater precision and organization in the recording of care.

Finally, with regard to the biggest challenges faced by the UBS in terms of infrastructure and working conditions, the interviewees pointed to the following measures as priorities: renovating the building to improve its physical structure, replacing or repairing damaged equipment and hiring professionals to make up for the shortcomings in the workforce. These actions are considered essential to guarantee a more efficient and adequate service to the population.

FINAL CONSIDERATIONS

The research revealed that, despite the right to health being widely guaranteed by Brazilian legislation through the Unified Health System (SUS), the reality of the Basic Health Units (UBSs) in Juazeiro do Norte - CE still presents significant challenges that compromise the realization of this right. The difficulties encountered range from precarious infrastructure to deficiencies in resource management, security and the integration of health services, factors that directly impact on the quality of care provided to the population.

The comparative analysis between the normative guidelines and the concrete reality of the UBSs revealed discrepancies that demonstrate the urgent need for investment and strategic planning to improve the structural and operational conditions of the units. Among the main problems observed are a lack of preventive maintenance of equipment, a shortage of essential supplies and medicines, a shortage of administrative and security professionals, as well as failures in integration and communication between primary and secondary care systems.

Given this scenario, some strategies could be implemented, such as improving the infrastructure through a regular preventive maintenance program for medical equipment, improving the air conditioning and ventilation in the units, as well as increasing natural and artificial lighting in the care spaces.

Security at UBSs also deserves special attention. Hiring professionals to guard the units during all opening hours could guarantee greater protection for professionals and patients, while camera monitoring at strategic points would help inhibit fights and acts of vandalism, creating a safer environment for everyone.

Another fundamental aspect is the expansion of the team and professional training. Hiring more administrative staff would reduce

the overload on receptionists, who are often responsible for scheduling appointments and managing medical records. More effective integration between internal teams and community health agents would also be essential to improve patient follow-up and ensure greater coordination in identifying demands.

Finally, integration between UBSs and other health units needs to be strengthened. Improving the referral system for specialized consultations would enable patients to be referred more quickly and efficiently. In addition, the unification of electronic medical records between Primary and Secondary Care would prevent discontinuity in patient follow-up, ensuring more coordinated and integrated treatment.

The implementation of these measures, combined with greater coordination between public health managers and primary care professionals, could make a significant contribution to overcoming the challenges mapped out, promoting a more efficient and accessible health system. For the right to health to be fully guaranteed, it is essential that the public authorities prioritize structural and administrative actions aimed at improving the UBSs, reinforcing their essential role as the gateway to the SUS and ensuring that the population, especially the most vulnerable, has dignified and continuous access to health services.

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