DOI: 10.1590/1413-81232018246.08312019

Advancements and achievements in the Brazilian Federal District public health: an essential contribution by family and community medicine

Guilherme Nabuco (https://orcid.org/0000-0002-3289-2109) [1]
Berardo Augusto Nunan (https://orcid.org/0000-0003-0870-9113) [1]
Juliana Oliveira Soares (https://orcid.org/0000-0003-3699-2622) [1]
Luisa Portugal Marques (https://orcid.org/0000-0003-3071-076X) [1]
Patrícia Taira Nakanishi (https://orcid.org/0000-0002-7756-3675) [2]
Raquel Vaz Cardoso (https://orcid.org/0000-0001-7952-8585) [1]
Tiago Sousa Neiva (https://orcid.org/0000-0002-6248-4165) [1]
Marcelo Pellizzaro Dias Afonso (https://orcid.org/0000-0003-2331-6027) [3]

Abstract *The history of Primary Health Care (PHC) in the Federal District (DF) is as old as the history of the Federative Unit. The history of Family and Community Medicine (MFC), however, is relatively recent, both locally and nationally. This paper proposes to focus on the fundamental contribution of MFC to advances in Public Health in the Federal District, especially in the last 10 years, after the founding of the Family and Community Medicine Association of Brasília (ABMFC). In order to do so, the most relevant historical events and contexts related to Health Care, Management, Social Control and Medical Education – including Undergraduate course and Residency – were documented, which support this position, in parallel with the evolution of the specialty in the Federal District. Therefore, its organization was divided into four historical stages: until 2008, from 2008 to 2011, from 2011 to 2016, and from 2016 to 2018.*

Key words *Public health, Primary health care, Family and community medicine, History*

[1] Secretaria de Estado de Saúde do Distrito Federal. STN, Asa Norte. 70086-900 Brasília DF Brasil. guilherme.nabuco@gmail.com
[2] Médica de Família e Comunidade. Brasília DF Brasil.
[3] Departamento de Medicina Preventiva e Social, Faculdade de Medicina, Universidade Federal de Minas Gerais. Belo Horizonte MG Brasil.

Introduction

Several health care plans and PHC organization initiatives have been in place for several decades. Some works have already told, with great detail, this relevant history[1]. The history of Family and Community Medicine (MFC), however, is relatively recent, both locally and nationally. Although initiatives outside the country date back to the 1940s and 1950s, that their first medical residency programs were established in Brazil only in 1976 (then called General and Community Medicine – MGC). The formalization of these programs, as well as those of other specialties, occurred later in 1981, through Resolution Nº 07/81 of the National Commission of Medical Residency (CNRM).

In 1986, the Federal Medical Council (CFM) recognized the MGC as a medical specialty. The Brazilian Medical Association (AMB) did so only in 2002, one year after changing from the current nomenclature (SBMFC)[2]. The period was marked by intense debates and enormous difficulty for the specialty to be duly recognized by its peers, which persists to some extent. Only in the 2000s, and more so in the last decade, family and community doctors with degrees or postgraduate courses in the field have achieved a higher number and a significant recognition by the other specialties[3].

Given this, this paper does not intend to recount the entire history of PHC in the DF, already very competently done by the mentioned references, but to highlight the contributions left by the MFC in this scenario. These contributions were a *sine qua non* for many of the essential qualitative advances observed in this period, especially in the last ten years, for both PHC and general public health, which was evident after the founding of the Brazilian Association of Family and Community Medicine (ABMFC) (Chart 1).

Until 2008

Ground preparation: the early days of Family and Community Medicine in the Federal District

As mentioned, PHC history precedes by a few decades the emergence of MFC in the DF. Despite the various initiatives to organize this care level until the end of the twentieth century, at the turn of the millennium, the DF health system still had an eminently hospital-centered model focused on the super-specialized medical professional; with evident lack of prestige at the primary level of health; fragmented in curative and rehabilitative actions by the primary specialties (obstetrical gynecology, general practice and pediatrics), in Health Centers and in promotion and prevention activities by very few health posts, under the Community Health Workers Program (PACS) rationale.

At the national level, the Family Health Program (PSF) was launched in 1994, the essential staff of which consisted of Community Health Workers (ACS), one nursing technician, one nurse practitioner and one general practitioner. Due to the good results, the program was promoted to the Family Health Strategy (ESF), a priority model for the organization of Brazilian PHC, showing a rapid evolution of coverage in the country, starting in 2000.

In spite of this, in that period, PHC in the DF functioned predominantly in the so-called conventional (or Soviet) model, in which primary specialty medical professionals were responsible for the outpatient care of a large area (about 30,000 people), however, with little involvement with the territory, with its population and its leadership in general, thus ignoring, in most cases, the context of life and the needs of the local community. Initiatives to implement ESF teams, through public-private partnerships, reached significant coverage, but were fleeting in the Federal District, not persisting for more than four years each.

However, the constant evolution and strengthening of the ESF throughout the national territory has made the PHC in the Federal District progressively gain greater visibility. Between 1999 and 2007, it became the center of health policy transformations in the Federal District and a natural object of political-party disputes. Then, about 30 urban Primary Care Facilities (UBS) were built exclusively for the work of ESF teams, who obtained, as an affirmative policy, a specific work bonus. On the other hand, MFC expert physicians were still scarce in the Federal District, with obvious limitation of the work processes and teams' resolution.

In order to overcome these imposed limitations, Notice Nº 11 was issued on 17/06/05, which definitively incorporated the Family and Community Doctors into the medical staff of the State Health Secretariat of the Federal District (SES-DF). However, the specialty was included as a distinct medical career only on 04/12/07 by District Law Nº 4.048.

Ciência & Saúde Coletiva, 24(6):2221-2232, 2019

Chart 1. PHC/MFC Timeline in the DF.

Axes	Family and Community Medicine Specialty	Management	Care	Education
Dates				
1976	Establishment of the first Medical Residency Programs in General and Community Medicine			
1981	Regulation of PRMs in Brazil (CNRM)			
1991		Establishment of the Community Health Workers Program (PACS)		
1994		Establishment of the Family Health Program (PSF)		
2000s	(2001) Changing the nomenclature of General and Community Medicine (GCM) to Family and Community Medicine (FCM)	Elevating PSF to the level of Strategy (ESF) PHC incentive policies: Pró-Saúde (2005) and Pró-Residência (2009)		(2000) Establishment of the first PRM-MFC, SAMED-HRS (first graduate is Dr. Ruth Helena Aben Athar, also first FCM lecturer at ESCS)
August 8, 2008	**Establishment of Brasília's FCM Association, at the III National Exhibition of Family Health Production**			
2010		Incorporation of the first FCDs in posts of greater relevance in SES-DF management Establishment of SAPS, under the direction of Family and Community Doctor Berardo Augusto Nunan		Onset of the discussion about expanding RMMFC vacancies and the establishment of central COREME 1st contest for FM-UnB teacher in PHC
June 23-26, 2011	**11th Brazilian Congress of Family and Community Medicine**			
2011		Establishment of PROVAB by the MoH (Sep/11) Establishment of DRAPS in the SES-DF (Dec/11)		
2013		Law of the Mais Médicos ("More Doctors") for Brazil (Law No. 12.871, of October 22, 2013 / Conversion of Provisional Measure No. 621, of 2013)		

it contines

The First Family and Community Medicine Medical Residency Program in the DF

SES-DF's first MFC Medical Residency Program (PRM-MFC) began in 2000, integrating the Multidisciplinary Home Care Service (SAMED) at Sobradinho Regional Hospital (HRS), founded in 1994. Ruth Helena Aben Athar Gutierrez was the first resident of the program and later the first MFC faculty member of the Higher School of Health Sciences (ESCS).

In this unfavorable scenario, the PRM-MFC faced challenges to survive in its early years. With only two vacancies a year, only 15 students graduated from 2000 to 2015, mostly SES-DF employees. Faced with the shortage of preceptors in MFC, the program's internships were predominantly secondary and tertiary.

Chart 1. PHC/MFC Timeline in the DF.

Axes	Family and Community Medicine Specialty	Management	Care	Education
2014	Poor availability of FCDs with degree in the SES-DF network, little recognition and many confrontations with hegemonic model. A gradual occupation of spaces by the few FCDs.	Last public examination for FCM without the requirement of specialization course.		
2015	Onset of the call for new Family and Community Doctors at SES-DF	Computerization of services and revision of GSAP as territory management	Expansion of the service portfolio and start of adjustments in the work process of ESF teams	15 residents graduated during the 2000-2015 period, mostly SES-DF servants
March 2016		**Appointment MFC Humberto Lucena as Secretary of Health (SES-DF)**		
2016-2017	Arrival of many fellow graduates of other States with public examination appointment	District Health Plan 2016-2019, with planned expansion of the ESF	Substantial increase of ESF coverage in the DF	Creation of PRM in the FCM Network of SES-DF and PRM-MFC of HUB/UnB, with significant expansion of residency vacancies in the specialty. At UnB, a PHC appreciation movement, culminating in the change of the curriculum in 2016
2018	First public examination with FCM degree requirement for SES-DF	First public examination with FCM degree requirement. Establishment of the Family and Community Nurse career.		Maintenance of job vacancies in PRM-MFC Greater integration between the two PRM-MFC of the DF

Launching the seeds: the foundation of the Brazilian Association of Family and Community Medicine

Under this unstable and uncertain atmosphere of PHC in the DF, a small group of Family and Community Doctors and residents of the program of this specialty met informally, on 08/08/08, the last day of the III National Exhibition of Family Health Production. A commitment was then made to legally establish the Brazilian Association of Family and Community Medicine (ABMFC, ABrMFC at the time) (Figure 1), which took place in the Foundation for Education and Research in Health Sciences (FEPECS) on 23/10/08 at 7:00 p.m., and whose first president was Tiago Sousa Neiva, the leading representative of MFC in social control arenas.

The founding statute of the ABMFC defined as a priority the proposal to promote the development of this medical specialty and the scien-

Ciência & Saúde Coletiva, 24(6):2221-2232, 2019

tific, technical, cultural and social exchange between its specialists and those of related areas, whether medical or not. Thus, from its early days, the association sought to identify strengths and vulnerabilities of the PHC policy in the Federal District, contributing to the construction of a strategy of management of high-performance promotion of primary health care and continuing education of the physicians involved. Even with the initial shortage of MFC expert doctors and the various confrontations and difficulties of the context, the movement grew slowly, with the conscious political strategy of "occupation of spaces" among the working colleagues in the DF. Committed to these principles, the group closely operated with the SES-DF, medical entities, the media, social control and control bodies.

From 2008 to 2011

Strong branches: Visibility to Family and Community Medicine in the Federal District

The inclusion of the Family and Community Doctor in the management of public health in the Federal District, in positions of greater relevance, started to occur on 21/06/10, with the occupation of the highest position of the Directorate of Primary Health Care (DIAPS) by Berardo Augusto Nunan, who assumed the Primary Health Care Sub-Secretariat (SAPS) on 24/08/10. At the time, following unstable and discontinued initiatives to implement the Family Health Strategy (ESF) as a model of PHC organization in the Federal District, the population coverage by its teams was meager, at about 5.5%, with 41 ESFs.

The MFC was hardly known as a medical specialty. Managers and other professionals lacked an understanding of their complexity and coverage, as well as the set of light and light-hard technologies that integrate their practice and make it highly resolutive. Also, the number of licensed Family and Community Doctors was still negligible (Graph 1). Few advances in the structuring and strengthening of PHC in the DF were observed at the time, which resulted from short-sighted political and media interests.

Thus, the incorporation of MFC into management was fundamental to several advances. The creation of SAPS and the appointment of a Family and Community Physician for its spearheading in August 2010 were essential to minimize the imbalance of hegemonic power and gain political space in SES-DF's internal disputes. From this moment on, a more robust, albeit slow, expansion of the ESF is witnessed in the DF.

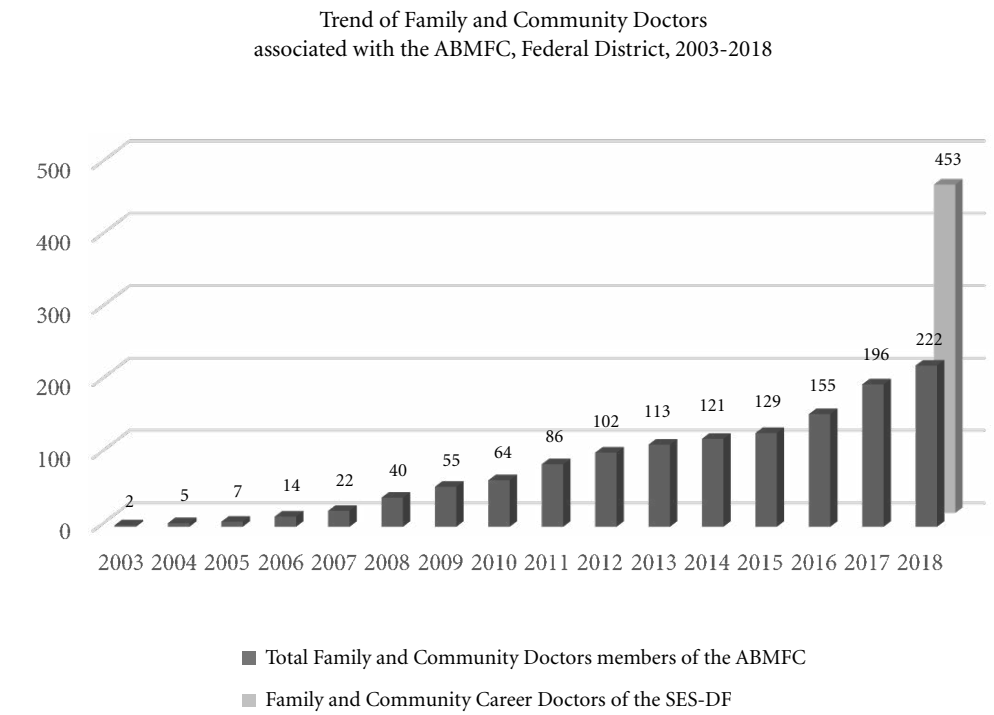
Also in 2010, on the initiative of SAPS, a discussion began on the expansion of PRM-MFC vacancies, the opening of vacancies in different administrative regional offices, the creation of a central Medical Residency Commission (COREME), and reorientation of the incorporation of residents, privileging the spaces in the PHC services.

In that same year, the first public examination for the position of professor in the Faculty of Medicine of the University of Brasília (UnB) was opened in the Primary Care area, but without a clear objective, because of the non-requirement of MFC or other PHC specialization.

In parallel, essential programs were established at the national level, such as Pró-Saúde[4] – which promoted the improvement of undergraduate health education, strongly oriented to PHC – and Pró-Residência[5] – which urged the opening of residency vacancies in medical specialties required by the SUS, including MFC.

With the slow, but progressive expansion and organization of the ABMFC, the demand for a national MFC event held in the Federal District emerged to strengthen the incipient local movement, spur students' interest in the area and explain to managers the fundamental role of the specialty in a resolutive PHC.

Figure 1. Former logo of the Family and Community Medicine Association of Brasília.



Graph 1. Trend of Family and Community Doctors associated with the ABMFC, Federal District, 2003-2018.

Source: Family and Community Medicine Association of Brasília, June 2018.

From 2011 to 2016

First produce: the 11th Brazilian Family and Community Medicine Congress and its immediate repercussions

The 11th Brazilian Family and Community Medicine Congress (11th CBMFC) was an important milestone for the development of MFC in the DF. The first major MFC event in the capital was held in Brasilia in the period 23-26/06/2011, at the Ulysses Guimarães Convention Center, with almost 3,500 registered members and 232 speakers, 26 of whom were foreigners.

For that edition, the motto chosen was "Family and Community Medicine – Now more than Ever". In this context, the "Manifesto against Over-Prevention", called pornoprevention, was chosen as the theme for the opening session, which brought to the debate the role of the Family and Community Doctor in the face of the issue.

The apex of the Congress was spearheaded by Spaniards Juan Gérvas and Mercedes Perez who, through the manifesto against pornoprevention, reinforced Medicine principle *primum non nocere* (which means first do no harm). Along with other international celebrities, such as Iona Heath (England), Marc Jamoulle (Belgium) and João Sequeira Carlos (Portugal), Gérvas and Perez raised the need to avoid extreme preventive measures (exams or medication). Today, six years into this emblematic Congress, the concern about over-prevention has been widely disseminated and several other movements and concepts have been created, reinforcing a less interventionist view of medicine to consider: Quaternary Prevention, Polypharmacy, Choosing Wisely[6-8].

With a robust scientific program coupled with the varied offer of cultural and complementary activities, the Congress was fundamental for more doctors and other professionals to become

Ciência & Saúde Coletiva, 24(6):2221-2232, 2019

interested in PHC work, as well as convincing local managers of the importance of MFC for effective resolution of this level of care. This was a strong impetus for new advances in the structuring of PHC in the DF.

Entrenching the roots: the early structuring of PHC in the DF

With a reinforced management team consisting of more Family and Community Doctors and other professionals adequately geared to PHC, besides political alignment with the then State Health Secretary Rafael Barbosa, the SAPS advanced during 2011. With the elaboration of projects for the structural adaptation of the PHC in the Federal District, it considered the renovation and construction of UBS, to offer spaces, furniture and equipment compatible with the activities that would be developed in the services, as well as an adequate environment for the well-being of workers and users. The projects resulted in the construction of Family Clinics, which enabled, in part, the expansion of ESF that occurred in the following years.

MFC and PHC have progressively gained more space in the political dispute against the hegemonic hospital-centered and overspecialized model prevailing in SES-DF. The increased valuing of PHC in management has led to significant advances in the work processes of the Health Centers, with the parameterization of these services – as per Administrative Rule no. 576, of 19/09/11 – and towards an organization of processes guided by PHC principles described in the National Primary Healthcare Policy (PNAB) in force – Administrative Rule GM/MS No. 648 of 28/03/06.

At the end of 2011 (DODF no. 232 dated 06/12/11)[9], PHC structuring in the DF achieved one more important gain: the creation of the Regional Directorates of Primary Health Care (DRAPS) and the Family Health Management Offices (GESF), within Regional Health Administrative Offices. The new organizational structure of the SES-DF was fundamental for the strengthening of PHC management at the local level, eliminating the hierarchy that conferred more prestige to the Health Centers Management (GCS), in a mostly conventional model, to the detriment of Family Health leadership (NAPESF and GAPESF).

Consolidation of the Medical Residency Program in Family and Community Medicine in the Federal District

Based on the need to foster the expansion, reorganization and qualification of PHC in the Federal District, as per the rationale of the ESF, besides attracting and securing medical specialists in the area, a new PRM-MFC was designed by SAPS, together with a group of Family and Community Doctors, under the leadership of Juliana Oliveira Soares, responsible for the approximation that would result in the unification of the programs. With the encouragement of Pró-Residência, still in force by the Federal Government, the efforts of several MFC experts from DF were mobilized, with the support of the Conceição Hospital Group of Rio Grande do Sul, a national reference in the area.

Thus, as opposed to the medical residency program of Sobradinho/DF – until then the only one in MFC of the DF, whose distribution of stages significantly valued secondary and tertiary levels, sacrificing training to a healthcare network – the PRM-MFC of Planaltina/DF was inaugurated in 2012, with three yearly vacancies. Despite its advanced proposal, the new PRM-MFC has suffered various problems from the outset, such as a lack of infrastructure, adequate training camps and collaboration by local management. As a result, until 2014, the DF had two extremely fragile PRM-MFCs, with few annual vacancies.

Hardships faced by both PRM-MFCs, in a national context of intense promotion of increasing residency vacancies in priority areas of the SUS, including MFC, through the More Doctors Program – Law nº 12.871, dated 22/10/13, Conversion of Provisional Measure No. 621, of 2013 – prompted a radical and structuring transformation of MFC medical residency in the DF in 2016.

New steps for the structuring of Primary Health Care in the Federal District

Between 2012 and 2015, despite the lack of family and community doctors in significant posts in the central management of the SES-DF, the population coverage by established ESF teams (minimum teams) increased significantly (Graph 2). Nevertheless, difficulties persisted in the work process of a significant lot, besides the dichotomy between ESF teams and regular care provided by Health Centers, generating conflicts between managers and professionals, and disinformation to the population served.

As of 2015, the return of the Family and Community Doctors to the strategic management positions has propelled a new period of structuring and organization of the PHC in the DF. Returning to the post of undersecretary of SAPS, Berardo Augusto Nunan carried out a large project of computerization and implementation of electronic medical records for all Primary Care Facilities (UBS), including ESF and conventional Health Centers.

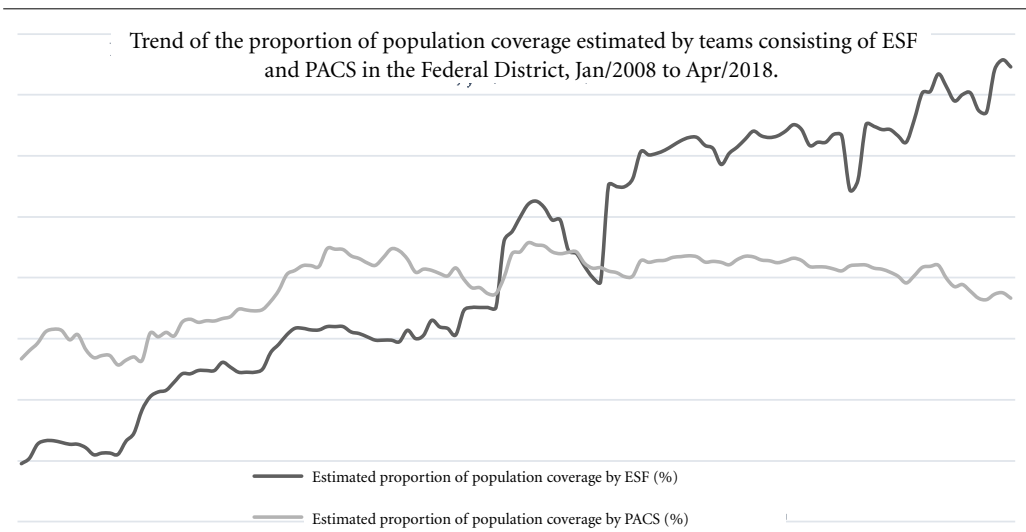
At the end of the same year, PHC management positions were once again restructured at the local level, with the termination of Health Center Management (GCS) and ESF Management (GESF), unified under Primary Care Services Management (GSAPS) – DODF No. 228, 27/11/15[10]. The restructuring was of paramount importance for the organization of PHC services since besides replacing the Health Centers model, it broke with the idea that the manager would only have internal responsibility for the service. This was a visible sign of progress in the concept of sanitary responsibility, which was provided by the PHC in defined territories. Intersectoriality and integration of the UBS with the other services of the health and intersectoral network were then introduced.

From 2016 to 2018

The first Family and Community Doctor as Secretary of State of the Federal District

In 2015, the expanded ESF coverage was limited by financial constraints (fiscal responsibility cap), significantly reducing the appointment of new staff. As an alternative to the extension and qualification of PHC coverage, the proposed reorganization of the conventional model in PHC Teams (EAB), consisting of clinicians, pediatricians and gynecologists, was presented, whose work process followed, however, the principles of the National Primary Healthcare Policy (PNAB). Faced with the enormous resistance found for the necessary reorganization, Decree Nº 02 of 02/03/16 (DODF Nº 4, of 03/02/16)[11] named the first Family and Community Doctor State Health Secretary of the DF, Humberto Lucena Pereira da Fonseca.

Despite the slower pace, successive appointments to the MFC position at SES-DF allowed the entry of several colleagues with expertise in the area – many of them essential references in MFC from other states – although, in the past, it was not a requirement for the career. This reinforcement was essential for the ongoing qualification of management, teaching and care spaces.



Graph 2. Trend of the proportion of population coverage estimated by teams consisting of ESF and PACS in the Federal District, Jan/2008 to Apr/2018.

Source: Primary Care Department/Ministry of Health, June 2018.

Ciência & Saúde Coletiva, 24(6):2221-2232, 2019

With the modified correlation of political forces, a more significant number of Family and Community Doctors has taken up management positions at the senior level of the central level or in service management positions, PHC boards and other regional offices. More structural changes in the PHC model of the DF were implemented, concomitantly with the consolidation of the presence of Family and Community Doctors as professors in undergraduate courses and the reorganization and expansion of the medical residency vacancies of the specialty.

The creation of new Residency Programs in Family and Community Medicine: consolidation of training in the Federal District

Multiple factors contributed to a significant reorganization of medical residency in MFC in the DF. On the one hand were the already reported difficulties faced by the two existing programs (Sobradinho/DF and Planaltina/DF). On the other, a large window of opportunity with the presence of more MFC specialists on the civil servant cadres throughout the DF, within a national context of stimulating the expansion of residency vacancies in the specialty. Also, the Competence-Based Curriculum of the Brazilian Society of Family and Community Medicine (SBMFC)[12] and Resolution N° 1 of May 25, 2015 CNRM/MEC[13] were published, which supported the proposal to open a new PRM-MFC that would rescue the initial governmental focus: strengthening PHC in the DF.

With the strategy of using the entire PHC network in the DF in its various regions, through the creation of small nuclei of potential gradual expansion of residency vacancies, the PRM was created in the MFC Network of SES-DF (Administrative Rule Nº 37, dated 24/03/16, DODF nº 58, dated 28/03/16)[14]. Thus, the two residency programs then in effect were absorbed by the new proposal, which was in total harmony with the national movement of improvement, expansion and consolidation of the specialty. Therefore, a harmonious partnership was started between SES-DF, FEPECS and some preceptors and residents of existing residency programs, who built a new project. Seeking the success of the strategy, a new Regional Medical Residency Commission (COREME) was opened, namely, COREME Rede SES/DF.

The vacancies offered for the specialty in the DF hiked from 14 (6 for Planaltina/DF and eight from Sobradinho/DF) to 48 vacancies (24 R1 and 24 R2), with scenarios distributed in 7 of the 31 Administrative Regions (AR). In 2018, a new increase was recorded, reaching 60 residency vacancies, with a structure of almost 30 preceptors, all MFC specialists, distributed in more than 20 UBS, 10 ARs, with an occupancy rate above 50%, surpassing the national average[15].

The PRM-MFC of the University Hospital of Brasília (University of Brasília) was born in the same year as the PRM in MFC Network of SES-DF. Currently holding three vacancies, the program is notable for its effective integration into the Multidisciplinary Residency Program for Primary Care of the same institution, with the UBS of the Eastern Health Region (AR Paranoá, Itapoã and São Sebastião) as a practice scenario. The integration between the two initially fragile PRMs has been strengthened over the years, especially from 2018, when programs have come to meet for regular theoretical activities.

The key turn of Primary Health Care in the Federal District

On 04/10/16, after heated clashes/debates in the Health Council of DF, with the effective participation of the ABMFC representative, Tiago Sousa Neiva, Resolution Nº 465 was born and laid the foundation for the PHC reform in the Federal District, as embodied in SES-DF Ordinance Nº 77, dated 14/02/17. DF's new PHC policy was established, and the ESF became its exclusive model of organization, aligned with the substantial evidence of the multiple positive health outcomes associated with this model. Thus, similar to other capitals in the last decade, all PHC medical professionals who worked in Health Centers in the primary specialties, as per the conventional model, were provided the alternatives of converting to the career of Family and Community Doctors. These would be incorporated into the ESF model, after specific training, or would compose other levels of care, particularly secondary care, in their specialties of origin, an urgent need for adequate back-end in the restructuring process from the organization of PHC needs. A substantial increase in PHC coverage was observed with approximately 33% of these professionals joining, up from 34.9% in June 2017 to 66.6% in July 2018 (counting also the teams not consisting of the Ministry of Health, mainly for lack of ACS professionals)[16].

Ordinance No. 77/2017 was widely advocated by the ABMFC, however, questioning some specific points of the new policy. Concerned with increased PHC resolution, the ABMFC consid-

ered the best effectiveness in the use of the doctors of the primary specialties that opted for the non-conversion in Family Health Support Center (NASF) teams. However, given the incipient structuring of the secondary and tertiary care levels in the Federal District, and the challenges and gaps in NASF's performance in several municipalities around the country, the association began to recognize the establishment of Polyclinics (secondary level specialties centers) for qualified secondary care as strategic for strengthening the health network, in order to provide effective back-end for PHC.

Consolidation of the Primary Health Care Reform in the DF

The publication of Ordinance Nº 77/2017 SES-DF allowed fundamental advances for the so-called Primary Health Care Reform in the Federal District and indeed was the most exceptional historical opportunity for the organization of local public health. With a view to consolidation, it was followed by other structuring actions, for example, the establishment of the District Technical Reference (RTD) in MFC (Ordinance Nº 642 of 01/11/17, DODF nº 218, of 14/11/17)[17], another milestone for the qualification of PHC in the DF, through the strengthening of MFC. RTD is responsible for developing activities related to the management of the clinic, in line with the reformulated representation of several medical and health specialties at the SES-DF.

Another critical step was given on 05/03/18, with the launch of the public tender announcement for a Family and Community Doctor career (Public Tender N° 06, of 02/03/18, DODF Nº 43 of 05/03/18)[18]. In compliance with Ordinance Nº 74 of 14/12/17 (DODF Nº 55, Extra Edition of 15/12/17)[19], for the first time, the SES-DF began to require specialization in MFC for the career, as in leading cities in PHC, such as Florianópolis and Curitiba. The specialty can be proven with the residency in the field or a specialist title by the Brazilian Medical Association (AMB). It should be noted that Joint Ordinance Nº 74 of 14/12/17 established the Family and Community Nursing career, another essential step towards strengthening PHC and building qualified teams.

The spring of Family Medicine and Community in the Federal District and the blossoming of the Brazilian Association of Family and Community Medicine

With the increasing demand and occupation of the residency vacancies in MFC in the DF, the more significant role of the PHC in the new DCNs of the undergraduate courses in Medicine, the increased coverage of ESF in the DF, and also with the arrival of many Family and Community Doctors from other cities, it became imperative to strengthen its primary entity. Thus, within a set of actions, the board of the Brazilian Association of Family and Community Medicine proposed to change the old acronym ABrMFC, to make it simpler and sonorous. Thus, from March to April 2018, by online voting, its members chose the new acronym of ABMFC.

Likewise, the logo was also modernized, with the partnership of designer Gustavo Pozzobon, guiding the creative brainstorming, signing and drawing the final product. Since Family and Community Doctors are first-level care experts, the Dawson Study[20] emerged as an illustrative option, whose diagram shows a network in which PHC plays a fundamental role. The Cerrado and linkages in this biome were evoked to represent Brasilia. Merging these ideas and considering the blossoming of Family and Community Medicine in these lands, Palipalan, one of the main Cerrado flowers, was chosen to represent the brand (Figure 2).

National Forum on Primary Health Care: looking at the future

Recently, ABMFC's primary work focus was the organization of the National Forum on Primary Health Care, in partnership with the SBMFC. This was the largest and most important meeting held by MFC in the DF since the 11th CBMFC in 2011. The event was held in 2018, to also celebrate the 10 years of ABMFC, 30 years of the SUS and 40 years of the Declaration of Alma-Ata. Moreover, under the national climate of political instability, a crisis of representativeness and denunciation of arbitrariness among the Three Powers, it is urgent to position both the technical and political specialty, remembering that this was an election year[21]. The social setbacks and threats to fundamental rights observed today are a matter of grave concern, especially the Constitutional Amendment No. 95 of 15/12/16 – which froze health resources for the next 20 years – and its disastrous consequences[22].

Given this context, it has become essential to discuss the future, not only of MFC but of the SUS. The event held at the Medical Association of Brasília (AMBr), from June 14 to 16, aimed to create another safe venue for a fundamentally political debate to advocate for the SUS. The role

of PHC in the strengthening of the SUS was discussed then, as well as the importance of MFC. The event was backed by essential institutions such as the Pan-American Health Organization/ World Health Organization (PAHO/WHO), the Primary Care Department of the Ministry of Health (DAB/MS), the State Health Secretariat of the Federal District (SES-DF).

The main final product of this forum was the writing of the Charter of Brasília[23]. This document will be presented to the different candidates to be incorporated into their government plans, with the expectation that it will be a reference in the conduct of public health by the elected officials in Brasilia and the states.

Conclusion

At the end of this paper, it became clear that although mishaps marked the history of MFC and PHC, large windows of opportunity were used, always with the result of proactivity and leadership of the right people, in the right spaces and times.

We must emphasize that the Family and Community Doctor is always an advocate of teamwork, respect for the duties of each professional and the recognition of the clinical performance of other professionals, especially the nurse practitioner in the care practice. This does not allow the criticism of the traditional, doctor-centered model to transform it into a model centered on the nurse, community health worker or staff. It should focus on users, their needs, through democratic management practices in a qualified, humanized and respectful clinic.

Similarly, it is evident that all the advances mentioned here have received an equivalent contribution from other categories, associated to the MFC in the construction of a fair, universal, equitable, qualified and resolutive SUS. This paper aims, therefore, to emphasize the indispensability and leadership of the MFC for the construction and qualification of the care network and training of human resources in health, without erasing the relevance of the other categories.

Many challenges have already been overcome, but so many others arise at this time or in the short-term. Attempts to dismantle services and withdraw rights from Brazilian citizens are ongoing. The ghost of the restriction and the annulment of democracy traverses the Country once again. Family and Community Medicine is not afraid of challenges; it will always be present to protect and build an effective Health System and a fair Brazil.

Figure 2. New logo of the Family and Community Medicine Association of Brasília.

Collaborations

G Nabuco worked on the design, organization, drafting, critical review and approval of the final version of the paper. BA Nunan worked on the design, drafting and approval of the final version of the paper. JO Soares, LP Marques, PT Nakanishi, RV Cardoso and TS Neiva worked on the drafting and approval of the final version of the paper. MPD Afonso worked on the design, organization, drafting, critical review and approval of the final version of the paper.

References

1. Gottems LBD. *Análise da política de Atenção Primária à Saúde desenvolvida no Distrito Federal: a articulação entre o contexto político, os problemas, as alterantivas e os atores na formação da política de saúde (1979 a 2009)*. Brasília: Universidade de Brasília; 2010.
2. Falk JW. A Medicina de Familia e Comunidade e sua Entidade Nacional: Histórico e Perspectivas. *Rev Bras Med Fam Comunidade* 2004; 1(1):5-10.
3. Scheffer M, Biancarelli A, Cassenote A. *Demografia médica no Brasil 2015*. São Paulo: Departamento de Medicina Preventiva da Faculdade de Medicina da USP; Conselho Regional de Medicina do Estado de São Paulo; Conselho Federal de Medicina; 2015.
4. Brasil. Ministério da Saúde (MS). Ministério da Educação (MEC). *Programa Nacional de Reorientação da Formação Profissional em Saúde - PRÓ-SAÚDE*. Brasília: Editora do Ministério da Saúde; 2007.
5. Brasil. Ministério da Saúde (MS). *Pró-Residência Médica* [Internet]. Ministério da Saúde; 2018. [acessado 2018 Jun 15]. Disponível em: http://portalms.saude.gov.br/trabalho-educacao-e-qualificacao/provisao-de-profissionais/pro-residencia-medica
6. Gérvas J, Starfield B. Heath I. Is clinical prevention better than cure? *Lancet* 2008; 372(9654):1997-1999.
7. Norman AH, Tesser CD. Prevenção quaternária na atenção primária à saúde: uma necessidade do Sistema Único de Saúde. *Cad Saude Publica* 2009; 25(9):2012-2020.
8. Cassel CK, Guest JA. Choosing Wisely: Helping Physicians and Patients Make Smart Decisions About Their Care. *JAMA* 2012; 307(17):1801-1802.
9. Distrito Federal. Decreto nº 33.384, de 05 de dezembro de 2011. *Diário Oficial do Distrito Federal* 2011; 6 dez.
10. Distrito Federal. Decreto nº 36.918, de 26 de novembro de 2015. *Diário Oficial do Distrito Federal* 2015; 27 nov.
11. Distrito Federal. Decreto nº 2, de 2 de março de 2016. *Diário Oficial do Distrito Federal* 2016; 2 mar.
12. Sociedade Brasileira de Medicina de Família e Comunidade (SBMFC). *Currículo baseado em competências para Medicina de Família e Comunidade*. Rio de Janeiro: SBMFC; 2015.
13. Brasil. Ministério da Educação (MEC). Resolução nº 1, de 25 de maio de 2015. *Diário Oficial da União* 2015; 26 maio.
14. Distrito Federal. Secretaria de Estado de Saúde (SES). Portaria nº 37, de 24 de março de 2016. *Diário Oficial do Distrito Federal* 2016; 28 março.
15. Alessio MM. *Análise da Implantação do Programa Mais Médicos*. Brasília: Universidade de Brasília; 2015.
16. Distrito Federal. Secretaria de Estado de Saúde (SES). *A reforma da saúde no Distrito Federal*. Brasília: SES; 2019.
17. Distrito Federal. Secretaria de Estado de Saúde (SES). Portaria nº 642, de 1 de novembro de 2017. *Diário Oficial do Distrito Federal* 2017; 14 nov.
18. Distrito Federal. Secretaria de Estado de Saúde (SES). Edital nº 06, de 2 de março de 2018. *Diário Oficial do Distrito Federal* 2018; 5 mar.
19. Distrito Federal. Secretaria de Estado de Planejamento, Orçamento e Gestão, Secretaria de Estado de Saúde do Distrito Federal. Portaria Conjunta nº 74, de 14 de dezembro de 2017. *Diário Oficial do Distrito Federal* 2017; 15 dez.
20. Penn LD. *Interim Report on the Future Provision of Medical and Allied Services*. London: Her Majesty's Stationery Offices; 1920.
21. Vieira FS, Benevides RPS. *Nota Tecnica nº 28 - Os impactos do novo regime fiscal para o financiamento do sistema único de saúde e para a efetivação do direito à saúde no Brasil*. Brasília: IPEA; 2016.
22. Rasella D, Basu S, Hone T, Paes-Sousa R, Ocké-Reis CO, Millett C. Child morbidity and mortality associated with alternative policy responses to the economic crisis in Brazil: A nationwide microsimulation study. *PLOS Med* 2018; 15(5):1-20.
23. Sociedade Brasileira de Medicina de Família e Comunidade (SBMFC). *Carta de Brasília*. Brasília: SBMFC; 2018.

Article submitted 15/06/2018
Approved 06/02/2019
Final version submitted 26/03/2019