

# National Program for Improving Access and Quality of Primary Care: Implications of its Implementation in the Brazilian Northeast

ORIGINAL

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## Abstract

**Introduction:** The Ministry of Health has been very interested in initiative to maintain and/or improve the quality of population health, among which the National Program for Improving Access and Quality of Basic Care (PMAQ) stands out.

**Objective:** To analyze the changes in the area of work management of the basic care teams after the implementation of the Program of Improvement of Access and Quality of Primary Care (PMAQ) from the perspective of professionals inserted in Primary Care.

**Method:** This is a descriptive study with a qualitative approach, carried out in the city of Santa Cruz, in the county of the PMAQ implementation in the Trairi region, in the state of Rio Grande do Norte, from September to November 2016. Two techniques were used for data collection: the semi-structured interview with the secretary of health and coordinator of basic care of the county, and the technique of focus group with the graduated professionals who work in the Basic Units that joined the PMAQ.

**Results:** From this analysis emerged 3 categories: Implementation of the National Program for Improving Access and Quality of Primary

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Care, PMAQ encouraging changes in the health work process, and Evaluation on the PMAQ.

**Conclusion:** The main change made by the PMAQ in the work process of Primary Care professionals was their organization.

**Keywords**

Primary Health Care; Unified Health System; Human Resources.

## Introduction

Since the 1960s, Primary Health Care (APS) has been adopted by several countries to provide greater and more effective access to the health system, as well as in the attempt to revert the curative, individual and hospital approaches, to a preventive, collective, territorialized and democratic model. In Brazil, the APS is the reflection of the Sanitary Reform's principles, with this, the Unified Health System (SUS) adopted the Primary Health Care to emphasize the change of the care model [1].

Developed with the highest degree of decentralization and capillarity, the Primary Care develops in the place closest to the people's lives. It should be the preferred contact of users, the main entrance door of the SUS and communication center with the entire Health Care Network [2].

The Ministry of Health (MS) has as one of the main guidelines the implementation of public management based on the induction, monitoring and evaluation of processes and measurable results, guaranteeing access and quality of health care for the entire population [3]. The organization and management of health work, especially the work of a primary health care team in the public sector, is one of the central axes in the reordering of health care in SUS [4].

Thus, the creation of initiatives to maintain and/or improve the quality of population health is considered as the highest priority of the Ministry of Health. These initiatives include the National Program for Improving Access and Quality of Primary

Care (PMAQ), which aims to ensure that APS is the preferred access door for the health system [5]. The implementation of the PMAQ aims at changing the conditions of access to quality without care and a qualification of management practices, care and participation in Primary Care [6].

The PMAQ is organized into four phases: Adherence and contracting, development, external evaluation and re-contracting. These are dependent, forming a consecutive cycle [7].

The quality of care and management is considered one of the SUS's most challenging practices, since they must follow the principles of integrality, universality, equity and social participation. Inserted in this context, the organization of the work process in the APS is important for advancing the quality of care and management, preserving the universality of access to the integral care and improvement of the welfare of the worker and the user of APS [5].

In view of the foregoing and with a view to developing incentives for the induction of strategies for policies in the field of work management and health education, as well as strengthening the valorization of the health worker, some questions deserve to be investigated: the implantation of the PMAQ in health institutions is a mechanism that induces improvements in the field of labor management? What changes have been identified in the work processes of primary health care professionals?

In this context, this research had as its main objective: to analyze the changes in the area of work

management of basic care teams after the implementation of the Program for Improving Access and Quality of Basic Care (PMAQ) from the perspective of health managers and Professionals inserted in Primary Care.

## Methods

This research is a descriptive study with a qualitative approach. The study was carried out in the city of Santa Cruz, the county of the PMAQ implementation in the Trairi region of the state of Rio Grande do Norte, from September to November 2016. Participated in the survey, the graduated professionals of the various UBS of the county who experienced all phases of implementation of the PMAQ, besides the secretary of health and the coordinator of basic attention of the county. Totalling a sample of eight (8) professionals, being this sample sufficient for the realization of the chosen techniques.

Two techniques were used to collect the data: the semi-structured interview, with the secretary of health and coordinator of Primary health care of the county; And the focus group technique with graduated professionals working in the UBS who joined the PMAQ.

The focus group technique represents the process of construction of reality by certain social groups, understanding daily practices, actions and reactions to facts and events, behaviors and attitudes [8].

A focus group meeting was held, which consisted of six professionals from the county's Primary Health Care network, three of whom were nurses, two dentists and one doctor, who works in six different UBS of the city. This sample is sufficient by means of studies carried out, in which authors affirm that the ideal total participants of the focal group oscillate between a minimum of six (6) and a maximum of twelve (12) people [9].

For the interviews performed with the secretary of health who has a bachelor degree in pedagogy

and the coordinator of Primary care with a bachelor degree in nursing, the semi-structured interview technique was used, individually, on different days and times.

The semi-structured interviews and the meetings with the focus group were recorded in an electronic device type mp3, and later entirely transcribed.

After collecting and transcribing the recordings, the data were analyzed according to the Minayo method by means of categorization, to reach an objectification during the analysis [10]. Based on data analysis, three categories emerged: PMAQ Implementation, Health Work Process, and PMAQ Evaluation.

The professionals had their identities replaced by the name of a native Brazilian flower, representing the existing beauty in the perseverance found in each Brazilian. All participants signed the Informed Consent Term.

Meeting the norms of the ethical principles of Resolution 466/2012 of the Federal University of Rio Grande do Norte, regarding researches involving human beings, this study is part of a larger research, linked to the Graduate Program in Public Health Of the Faculty of Health Sciences of Trairi - FACISA, entitled "Improvement of Access and Quality of Labor Management of Primary Care Professionals", approved by the FACISA Research Ethics Committee, with the number of Opinion 1,707,601 and CAAE 58652816.6.0000.5568.

## Results

### Implementation of the National Program for Improving Access and Quality of Primary Care

In the analysis, it was possible to see a complementation of the knowledge between the managers and the professionals of the UBS about the first phase of the Program in the county:

*The implementation of the PMAQ was done by the prior managers in 2012. The first cycle came, it was when they made the mapping and they knew how many units they had. From 2013 to 2014, the 12 teams of Strategy were joined.*

Flor-de-Maio.

*By 2013, half of the teams were already participating in this program.*

Alamanda.

*In the 2nd cycle was when the Law of the PMAQ was made, there was really the participation of professionals, in the formulation of the Law, professionals were demarcating some things that worked and others did not.*

Flor-de-Maio.

Under Ordinance No. 1,654, from July 19, 2011, primary health care teams, including the oral health team, must comply with the principles of Primary Care to join the PMAQ on a voluntary basis and having an agreement between the health teams and managers of the county, this must occur prior to the formalization of the adherence of the counties by the Ministry of Health [11].

The computerized stage of adherence was described by one of the managers of the county, who had an active participation in the implementation period, being responsible for the insertion of the teams of the second cycle, as well as the meetings regarding the theme and presentation of the PMAQ for the professionals of the Units.

*Through a system, with login and password of the management of the health department, we have joined. With this adherence there were a printed Term of Commitment and a Meeting Report.*

Alamanda.

The first phase of the PMAQ, adherence and contractualisation, can be considered the most documentary and formalized phase, since it involves the commitment of the teams in the regional and federal pacts, with the participation of social control. The participation of the actors involved in this process has a fundamental importance, since it allows them, managers and professionals of Primary Care, to establish the same dialogue, aiming at reaching the goal common to the entire community. However, from the professional point of view, there is a gap between this participation in the first phase of the PMAQ:

*What happened here: in the past management was made the adherence by the old secretary without talking to anyone, they elaborated a law and sent to the city council. And today we are kind of tied to this Law, even in relation to division.*

Caliandra.

When asked about the second phase of implementation, professionals emphasized the self-assessment process, which is considered as the first point to occur the development phase, since it was based on the use of self-assessment for Improving Access and Quality of Primary Care (AMAQ) that the teams visualized how their work process was carried and what they would need to improve in order to achieve satisfactory results:

*The county provided to all the Units, which had joined, the AMAQ to carry out the self-assessment and then return it to it.*

Flor-de-Maio.

*In my unit we did it with the whole team.*

Caliandra.

*It's very complex and very complete. There was a self-assessment of the physical structure, of the inputs, and of the management itself.*

Alamanda.

Facing the phases established by the MS, a correlation was made between these phases and the statements of the participating professionals, evidencing that the county of Santa Cruz/RN is in the second phase of the third cycle of the Program, waiting the external evaluation of it. Both managers and professionals demonstrated a fear attached to the evaluation, since only one unit had obtained the category of good performance, being an example for the others.

Knowing this, it was visualized a greater empowerment in this aspect by the professionals coming from an academic formation in health, being emphasized for the professionals of the Basic Units and the coordinator of the Basic Care, thus establishing a knowledge to make decisions.

### **PMAQ in the encouragement of changes in the health work process**

With a workload of 40 hours per week, the professionals, when asked about their work process, made reference to the organization of the work, after the steps of the second phase of the PMAQ, especially from the use of the AMAQ:

*Actually, we did not change the work routine, a lot of things I didn't document. After the implementation of the PMAQ, because of the demands of both the self-assessment and the external, we started to have this criterion.*

Caliandra.

*The way to meet and talk, the way to meet the quality has not changed, because we had a good quality of service in the county.*

Flor-de-Maio.

Even if PMAQ aims at a better quality care, participants positively evaluate themselves in this factor, not making changes related to the way they care. From a managerial point of view, the Program was only able to bring about changes in minimum points in the work process of the professionals, since it is already one of the principles of PNAB:

*Actually, if I speak very superficially, I might even say that we did not notice so many changes, but some small things that were not UBS routines, for example, the implementation of health education groups.*

Alamanda.

When asked about teamwork, most of the professionals presented joint work statements regarding decision-making and planning.

*There, at my post there are two teams, but it's quiet. We do the actions together, everything we plan together. There are some peculiarities, but I think there are in everywhere.*

Flor-de-Maio.

*If anyone needs help, everyone will be helped.*

Jacarandá.

In the county there is a portion of the workers that have the employment contract with the administration, including the professional responsible for the institutional support of the PMAQ. In this way, it is evidenced that the work is broken due to personnel changes, resulting in professional changing and consequent discontinuation of work. In this way it is necessary to create a civil service exam, as well as the implementation of plans of exclusive positions in the health service, in order to provide effective links and the valorization of the worker.



*We have been working, it is a person to coordinate the PMAQ [...] because we understand that this person will monitor, to evaluate and subsidize other coordination, to really improve the quality of service, which is our proposal.*

Ipê-rosa.

*Ideally, we would have a person, if possible with an effective link, so this person would be prepared and be with those teams, working, developing, implementing, supervising what was necessary, in this way, the program would get done everything that really matters.*

Alamanda.

The institutional support in health should be a managerial function that seeks the reformulation in the traditional way of coordinating, planning, supervising and evaluating health systems and services. In this way, the effort to expand the democratization, autonomy and commitment of workers and managers, are based on cooperative and ongoing relationships and between PMAQ supporter and health team, to address the demands and doubts about the Program [12].

When asked about the participation of the management in the work process, in the incentive to improve the knowledge, the professionals report about the partnership of the Municipal Health Department with an extension project of the College of Health Sciences of Trairi (FACISA), which are assisting them in the adequacy of work improvement:

*About three months ago, the professor setted up fellowships [...] We started to build the checklist and the records books [...] The checklist every Friday the scholarship holders are in my unit [...] and also other activities, which were the training, were programmed by the end of the year, were programmed for them to simulate the external evaluation.*

Flor do Pau-Brasil.

*They look at what needs improvement or what's missing from the material, basically that's what they do, they help. Because in the day-to-day, you are a little relaxing, and with them you realize, for example, that the leprosy book is missing, or a record of CeD and so they are helping us.*

Flor-de-Maio.

With this, the participation and interaction of the professionals with this partnership reinforce the direction and mutual exchange of knowledge between university and service.

### Evaluation about PMAQ

According to the studies observed, it is evident in the APS that the graduated professionals delegate to the nurse the role and the authority to pass information about the work processes of the unit. Thus, it is evident that this professional is in charge of the management, coordination, supervision of community health agents, maintenance of inputs and control of services [5].

In this context, during the interviews it was noticed that many professionals of this area work overloaded and with feelings of always be retaining the greater content of responsibility and commitments of the management of the unit.

*Because you who are a nurse carry all the staff in your shoulders.*

Flor-de-Maio.

The feeling of impotence and noncompliance with the duty, due to not being able to meet the needs of the population's demand for care, was reported by all the professionals working in the UBS, there are even those who directly criticize the calculation of the population that each ESF team should meet, carried out by the MS itself:

*Demand has no end. I have always been a critic in relation to this calculation that the ministry does with the teams' performance [...] having in your responsibility 1,500 registered families is humanly impossible [...] I particularly experience this anguish that you can not cover the demand.*

*It's our name that is there in the Ministry of Health. That CBO, CNES identifies you, mainly in E-SUS now, everything is you that is being looked at, does not have a number of community health agents.*

Caliandra.

Each ESF in the county of Santa Cruz contains a multiprofessional team composed by a doctor, nurse, auxiliary or nursing technician, community health agents, and the oral health team who are the dentist surgeon with an auxiliary or oral health technician.

It was questioned if the PMAQ was motivational inducer for improvement in the aspects of the work, being it financial, or in the matter of quality improvement in the work scope. From a management perspective, the professionals had a momentary motivation that gradually disappeared after the external evaluation.

*While the external evaluation was going on, that professional really got excited and totally changed the work process for the better, but then it kind of fell asleep. I notice in that way.*

Alamanda.

*But so some of the higher level did not stay, so motivated, or did not understand what the proposal would be. The professionals at elementary and high school level were motivated more, not in the search for improvement in care, they were concerned to increase the attendance, to make the lectures, to photograph.*

Ipê-rosa.

In the view of the professionals, the demotivation starts from the distribution of this financial incentive where 50% of the value is designated for the management and the other 50% are designated to the ESF teams, as well as to those teams that have obtained satisfactory levels in the external evaluation result. This is due to one of the negative points regarding the apportionment of PMAQ resources:

*Financially it's not interesting, when you divide those 50% by a huge group of people [...] You have nothing.*

Jacarandá.

*PMAQ for me was demotivating, why? The ESF of which I am part was downgraded on the grade, it fell to 20%, so what happened? My value was greatly diminished [...] in the end my incentive decreased, that I received almost R\$400.00, now I am receiving R\$110.00.*

Caliandra.

*Here 50% is for management and the other 50% is equally divided for all the participants of the team, including the community health agents, the ASG, the pharmacy assistant, the administrator.*

Flor de Flamboiã.

The financial dissatisfaction with the increased work due to the problem's specification gains greater prominence during the focus group. It was also evidenced this financial incentive was motivational only for the professionals with basic and high school levels, due to the salary value received by them and the content of responsibility did not change.

*Because sometimes, wanting or not, the graduated professionals takes the most difficult duties [...] Because we have increased our work [...] the responsibility for them (the not graduated/high school level professionals) has not increased anything.*

Flor-de-Maio.

*I note that for the people who have the lowest salary [...] this value is very significant.*

Jacarandá.

The performance is evaluated considering the external performance evaluation of the health and management teams of the basic health, the verification of the self-assessment moment by the professionals of the teams, and the performance evaluation of the set of indicators contracted in the stage of adhesion and contractualisation [12].

In addition to the explicit challenges, the professionals and managers have expressed good knowledge about PMAQ and recognize the implications that it provides for APS. It was also evidenced that, with the financial incentive for the management, there was an improvement in the physical structure of the units, enabling better working conditions, which leads to a higher quality of service to the population.

## Discussion

The PMAQ is organized into four correlated and continuous cycle phases for its implementation: Adherence and contracting, development, external evaluation, and re-contractualization [3]. Looking at the phases described, the county of Santa Cruz is waiting for the external evaluation of the third cycle.

The adhesion to the PMAQ of the County by the Federal District was made through the completion of a specific electronic form. In the Term of Commitment signed by the unit's primary care team, it is assured with the MS that this team will follow and comply with the organizational guidelines of the PMAQ [3].

The organizational guidelines concern about the work process, observation of the program's operating rules, implementation of access devices, co-management, self-assessment, planning and evaluation related to each of the subsequent

phases, being monitored for six months from forty seven indicators of the Primary Care Information System (SIAB); To undergo an evaluation process, including a self-assessment, and an on-site evaluation carried out by external evaluators who would visit each team in the third phase of the program [13].

With priority given to public management based on monitoring actions and evaluation of processes and results, the MS is committed with the implementation of initiatives that promote quality access to health services for the Brazilian society, thus strengthening SUS in every contexts in the country. Among these activities, the care to the population in the environment of their life is considered an inherent action to the PMAQ, a quality-inducing strategy by MS, highlighting as objective the establishment of a culture of evaluation of Basic Care in SUS [14].

Knowledge in Public Health can be considered a key point in order to obtain a better performance in any phase of the PMAQ, this one maintains a convergence with the academic formation of each professional, being a manager or not.

The attention to the health and the expansion of health policies at the municipal level, especially in the Family Health Strategy, require the insertion of workers with a specific profile for public health, this fact is currently the greatest difficulty to expand this model of care, due to the emphasis given to the assistance and specialties of the academic formation of the health professional [15].

The Primary attention should receive an operationalization through democratic and participatory management practices and care practices, in the form of teamwork. Following the principles and guidelines of SUS, this work should be directed to the populations of territories that assume specific functions and characteristics, making use of technologies of care and observation of risk and health vulnerability criteria, so that all the demand for health or suffering can be welcomed by the team [5].



In this context, the support in the organization of the work process is fundamental so that the team can advance in the improvement of the work itself, requiring of the professionals a broad knowledge and technical competence in the development of health management and care [5].

According to the Ministry of Health, in PNAB, each Family Health team should be responsible for a maximum of 4,000 people, following a recommended average of 3,000 people, respecting criteria of equity for this definition. This number should take into consideration the families' degree of vulnerability in the territory where the unit is inserted, obeying the equation of the greater the degree of vulnerability the smaller the number of people per team [2].

The Ordinance No. 1,654, dated July 19, 2011, establishes the PMAQ-AB in the SUS, and the Financial Incentive of the PMAQ-AB, under the SUS, called the Variable Basic Care Floor Component – variable PAB. This incentive deals with the cash value transferred, found to found, to the Counties and the Federal District that join the PMAQ-AB through the Variable PAB, having its value defined from the results verified in Phases 2, 3 and 4 of the PMAQ-AB [12].

The receipt of this financial incentive occurs through the certification phase, considered the moment of recognition of the effort to improve access and quality of the Primary Care developed by the participating teams and the county manager. This phase aims to recognize the teams that have achieved high quality standards, as well as those that will need to strengthen the management and work processes, trying to improve quality [3].

## Conclusion

Being Santa Cruz is a reference center for the service in the SUS of the state, both in primary care as in the medium and high complexity, having in its Health Network a University Hospital of federal

instance acting in the area of health of women and children.

In this context, it was the implementation of the PMAQ is known by the professionals and managers of the county of this study, even though a majority did not participate actively in this initial process, the professionals showed an interest in seeking information on the subject and how the process occurred in their county.

With regard to the "PMAQ Evaluation", the knowledge of the professionals is minimal, demonstrating that the workers involved in the system did not discuss the subject in the scope of work, this point was highlighted as the greatest difficulty in the study, Due to few arguments of the theme.

The main change observed in the speeches of the participants, based on the experience in the PMAQ, is the implications that the Program provided in the work process of Primary Care professionals, such as the organizational redirection, in which these professionals acquired the habit of effectively register their actions in the care of the population, bringing benefits not only in terms of external evaluation, but also legal support of their professional performance.

With a less comprehensive result, the study had as a limitation the restriction of localities to be studied, carried out only in a municipality of Rio Grande do Norte, leaving explicit the necessity of continuity in the study in the other municipalities of the PMAQ, in order to obtain a real Evaluation of the Program, by health professionals and managers

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