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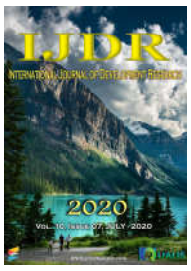

RESEARCH ARTICLE OPEN ACCESS

QUALIFICATION OF THE PROFESSIONALS OF THE FAMILY HEALTH TEAMS FROM THE VIEW OF THE PMAQ IN THE SECOND CYCLE - CASE STUDY IN THE CITY OF RECIFE, PERNAMBUCO, BRAZIL

[1]Adriana da Silva Baltar Maia Lins, [2]Eduardo Antonio Maia Lins, [3]Regina Flavia Praxedes Rodrigues and [3]Anna Karolina da Silva Pereira

[1]Universidade Federal da Paraíba – UFPB; [2]Instituto Federal de Pernambuco- IFPE e Universidade Católica de Pernambuco – UNICAP; [3]Instituto Materno Infantil de Pernambuco - IMIP

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****Corresponding author: Adriana da Silva Baltar Maia Lins,***

ABSTRACT

As a guideline and principle of the Unified Health System (SUS), access and quality of health services are priorities that include the agenda of the Ministry of Health (MS), as well as the National Policy for Permanent Education in Health (PNEPS). Permanent Health Education (EPS) is the process by which teams seek to improve, organize, and qualify actions. The Quality Access Improvement Program (PMAQ) was launched in 2011, aiming to qualify Primary Care (AB). It brings the proposal for the evaluation and coordination of actions to improve the standard of care quality in public health services through the AB teams. In this sense, the present study aimed to analyze the qualification process of the professionals of family health teams, due to the implementation of the PMAQ for the second cycle of the city of Recife. As a methodology, an exploratory research, of the documentary type, with a quantitative approach was carried out, where the data were collected through the MS database. It was observed that there is a predominance of non-public employees (58%), and, due to a change in management, there is the possibility of removal, especially in positions of trust, with no interest on the part of the employees to qualify. It is concluded that the PMAQ-AB was configured as a powerful device for the process of Permanent Education (EP), however, measures such as the most suitable types of employment contracts and implementation of the job and career plan are essential for the success of the program.

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INTRODUCTION

Care (AB) is the preferred gateway to the public health system in Brazil, within the scope of the Unified Health System (SUS). The AB is composed of actions for the prevention of diseases, promotion, diagnosis, treatment and rehabilitation, which take place in the Basic Health Units (UBS), and in the territories assigned to them, and proposes that such actions are geared to the reality of the local population. and materialize SUS principles and guidelines (Brasil, 2017). It is in this scenario that the evaluation of the results and the quality of the services offered by AB emerges as an important resource to support decisions and improve the service to the population, as its operation is permeated by political issues and intrinsic values to the service and the people who work in it and it demands the use of well-designed instruments appropriate to the local reality.

In addition, this service requires the involvement of all professionals, to make the decisions made feasible and use the results to improve work processes. In Brazil, there are serious difficulties in the infrastructure conditions of the Family Health Strategy (FHS), such as inadequate physical spaces, material deficits, incomplete teams, fragmentation of care and health services, which has compromised access and quality of care provided (Souza et al. 2013). The evaluation and use of strategies that improve the quality of primary care services is a concern in several countries around the world (Bowie et al., 2016). Considering the need to expand access to the health system in Brazil, the National Program for Improving Access and Quality in Primary Care (PMAQ-AB) has contributed to the identification of needs and the implementation of improvements (Bailie et al., 2013; Papp et al., 2014). The PMAQ was the product of an important process of negotiation and agreement between the three spheres of SUS management

to enable the design of the program that could allow the expansion of access and improvement of the quality of AB throughout Brazil. It is the main strategy to induce changes in the conditions and modes of operation of AB, aiming at the permanent and progressive expansion of access and quality of management practices, care and participation of the population to health services (Pinto et al., 2012). In order for the dissemination, monitoring and evaluation of results to occur in terms of the quality provided in health, the PMAQ sought to induce advances to rethink work, teaching, management and social control practices, and with this aim to promote quality and management innovation, strengthening the processes of (I) self-assessment, (II) monitoring and evaluation, (III) institutional support and (IV) permanent education in the three spheres of government (Brasil, 2012a). Permanent Education in Health (EPS) is the transformative plan of work capable of analyzing all the processes that involve the different daily lives of BA, recognizing the contexts and life stories, enabling the reception and accountability for people [8]. Through its phases, the PMAQ also has the task of ascertaining the successes and weaknesses found in the AB, during the course of the evaluation, which can contribute to the construction of collective spaces for discussion and reflection on health planning [9]. The PMAQ has in EPS one of its main bets, both to produce local movements and for the singularization, support, qualification, and reinvention in the movement to change the practices of attention, management, education, and participation (Brasil, 2012b). The offer of Permanent Education (PE) to health professionals is a powerful tool for work management, which contributes not only to the appreciation and satisfaction of the worker, but also to better qualification of the work process (Seidl et al., 2014). The PMAQ's analysis effort on PE health issues in AB can be a contribution to the search for greater potential for transforming health practices. Studies should be used to deepen this issue, in addition to providing information on more unique offers of PE practices and the assessment that professionals make of them (Pinto et al., 2014). In this perspective, this study aimed to analyze the qualification process of the professionals of the family health teams, due to the implementation of the PMAQ in the second cycle in the city of Recife, Pernambuco, Brazil.

MATERIALS AND METHODS

Choice of Location: The capital of Pernambuco, Recife, was chosen considering that it is the municipality with the highest income generation and population density and the largest number of family health teams in the state, however, not having full coverage. According to the Brazilian Institute of Geography and Statistics (IBGE), the municipality has an estimated population of 1,645,727 people, with approximately 272 family health teams with a coverage rate of 65.37% (Brasil, 2020). Brasil (2020) also states that the average monthly salary for the population of Recife was 3.2 minimum wages. The proportion of employed persons in relation to the total population was 43.9%. In comparison with the other municipalities in the state, it occupied positions 2 of 185 and 3 of 185, respectively. In comparison with cities across the country, it ranked 109 out of 5570 and 116 out of 5570, respectively.

Research Type, Data Collection and Approach: This is an exploratory, documentary research, with a quantitative approach where data were collected through the Ministry of Health (MS) database, referring to the second phase of the Access and Quality Improvement Program (PMAQ), which is external evaluation, in order to access information related to quality standards established in accordance with norms, protocols, principles and guidelines that organize actions and practices, current technical and scientific knowledge, considering the competence of the actors involved. The external evaluation instrument consisted of 903 questions, which contained items of answers related to quality standards. It is noteworthy that part of these questions was used for the certification of information teams to guide the improvement of public health policies, in the period between 2013 and 2014, which refers to the second cycle of that program. The external evaluation makes up the second phase of the PMAQ-AB. For its accomplishment, the MS had the support of Teaching and Research Institutions (IEP), which were in each Basic Health Unit (UBS) participating in the program and interviewed the AB health teams using assessment instruments (Brasil, 2017). For the certification of the teams, a scoring matrix was created, which aggregated the quality standards contained in the external evaluation instrument and in the electronic module, consisting of 532 standards directed to the AB teams and 720 standards for the AB / SB teams. The external evaluation instrument for AB teams was organized in three modules and for AB / SB teams the external evaluation instrument was organized in five modules. Complementary information to modules I, II, III, IV and V, referring to teams AB and AB / SB, were collected from the electronic module, which should be filled out by the municipal manager. This module was composed of issues related to the guarantee of labor and social security rights, the prospect of continuing the relationship, career plan and performance remuneration for AB workers. In the scoring matrix, external evaluation questions were organized into three categories with different certification functions (general, essential, and strategic standards), as shown in Chart 1.

QUALITY STANDARDS		
General	**Essentials**	**Strategy***
They scored in the team certification.	They are related to the minimum conditions of access and quality. If the team has not achieved at least 90% of the essential standards, it has been automatically certified with poor performance.	These are offers and actions of high standards of access and quality in AB. For the team to be classified with the optimum performance, in addition to obtaining a score higher than 8.0, it had to reach at least 50% of standards considered strategic.

Source: Brasil (2019).

Chart 1. Description of the three categories of quality standards

The Matrix was organized into dimensions, subdimensions and quality standards. Quality standards are the questions asked in the external evaluation. The five dimensions of the AB teams (Chart 2) were composed of 33 subdimensions, where each has a set of questions that received a value between 1 and 3, defined according to the technical, strategic and political relevance in a tripartite manner. The value 1 equals the least relevance and the value 3, the highest relevance. Equally for the AB / SB teams, relevance was attributed to the questions, and for these teams, the matrix was composed of 7 dimensions containing 42 subdimensions Brasil (2019).

RESULTS AND DISCUSSION

The following analyzes served as a basis for the discussion regarding the possible influence of the PMAQ-AB on the

qualification of the professionals of family health teams in the city of Recife. However, initially, surveys of the profiles on the professionals of the area were carried out, as well as the way of hiring the employees to understand the possible influence with the professional qualification. According to Bezerra& Medeiros (2018), it is known that working conditions, processes of professional training and qualification are dimensions that interfere daily in the way workers develop the production of health care, thus being considered transversal and guiding primary care (AB).

Chart 2. Description of the dimensions of the AB teams

TEAMS AB/SB	
DIMENSION	DESCRIPTION
DI	Municipal management for the development of Primary Care.
DII	Structure and operating conditions of the BHU.
DIII	Valuingtheworker.
DIV	Access and quality of care and organization of the work process.
DV	Access, use, participation, and user satisfaction.
DVI (oral health)	Structure and operating conditions of the BHU.
DVII (oral health)	Access and quality of care and organization of the work process and municipal management for the development of primary care

Source: Brasil (2019).

RESULTS AND DISCUSSION

The following analyzes served as a basis for the discussion regarding the possible influence of the PMAQ-AB on the qualification of the professionals of family health teams in the city of Recife. However, initially, surveys of the profiles on the professionals of the area were carried out, as well as the way of hiring the employees to understand the possible influence with the professional qualification. According to Bezerra& Medeiros (2018), it is known that working conditions, processes of professional training and qualification are dimensions that interfere daily in the way workers develop the production of health care, thus being considered transversal and guiding primary care (AB). It was observed that the professional staff is predominantly made up of nurses and an extremely low percentage of doctors. According to Brasil (2017), the team must be composed of a multi-professional team with, at least, general practitioner or family health specialist or family and community doctor, general practitioner, or family health specialist, auxiliary or health technician. nursing and community health agents (CHA). The constituted teams have, for people from different areas, exchange information, develop new ideas and solve problems (OPAS, 2011). The work relationship must be based on interdisciplinarity, with approaches that question professional certainties, stimulating horizontal and permanent communication, among the components (Brasil, 2000). According to Beinner&Beinner (2004), with the personal, human, and interdisciplinary characteristics of the training of professionals working in the area, a broad information about the health of the community is obtained. In general, during the initial 5 years, professionals tend to remain in the work environment, still adapting, as well as acquiring necessary experiences for future work or even other public tenders. According to Sá & Azevedo (2010), constant situations such as the lack of ethics, respect, and solidarity in the relationships between health professionals, can provide a conflicting, unmotivated work environment, which can generate voluntary dismissals. Another factor that may be related to the temporary reduction of employees may be associated with the electoral period. Figure 1 shows the type of employment relationship for a better understanding. It is observed that there is a predominance of non-public employees (58%), and, due to change in management, there is the possibility of dismissal, especially in positions of trust. The type of contract is predominantly of the statutory type, however, when added to the other types, temporary positions prevail that can generate difficulty in establishing the professional's link with the service and the population served. According to OPAS (2003) the easiness of political use in the granting of these positions, allows for this form of contract, a tradition of political party bargaining.

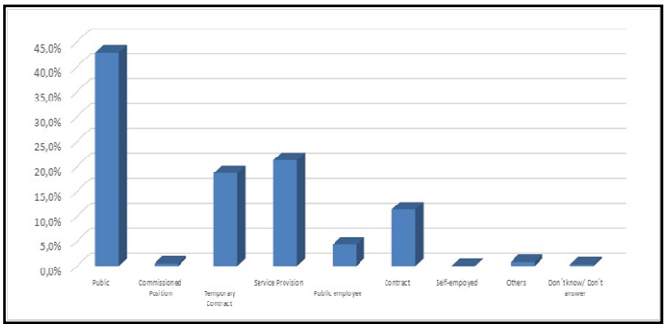

Figure 1. Type of link. Source: Adapted from Brasil (2019)

Another factor that can influence the quality of access and primary care may be related to the job and career plan. As shown in Figure 2, about 67.5% of employees do not have a job and career plan, which may generate total disincentive to improve, considering that financially they will not receive a counterpart.

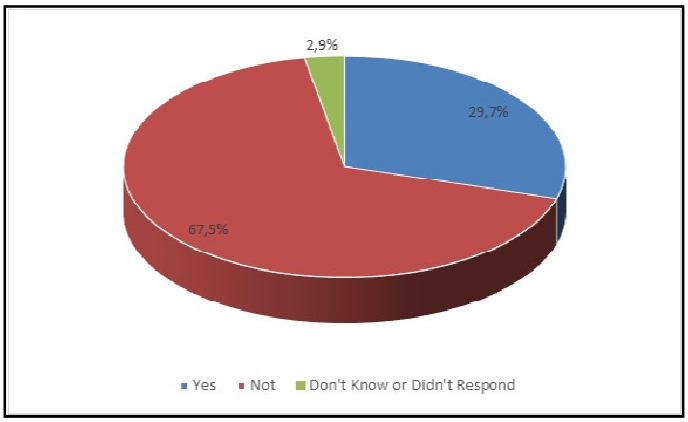

Figure 2. Positions and Careers Plan. Source: Adapted from Brasil (2019)

As seen in the Figure 2, about 67.5% of employees do not have a job and career plan, which can generate total disincentive to improve, considering that financially they will not receive a counterpart. Figure 3 shows an indication that the absence of a job and career plan creates a disincentive for professional improvement. In general, the percentage of employees in the health sector linked to primary care who did not or did not complete a specialization course, master's, or doctorate in the area in which they work is 63.3% and 1.7%, respectively. For the statutory employees of the city of Recife, the entire Job, Career and Salary Plan (PCCS) is based on Recife (1988), which is the system for classifying jobs and jobs in Organs executive bodies. In articles 18 to 20 of the Law, there are guidelines for ascension that may be of seniority in class or on

merit. The percentages of employees benefited by working time are as follows in the Figure 4. It is observed that employees who have a 71.5% job and career plan predominantly receive benefits based on progression by seniority, that is, length of service, not including temporary employees.

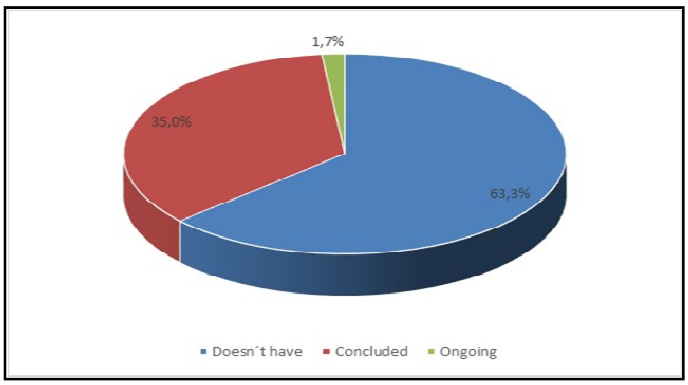

Figure 3. Complementary Training. Source: Adapted fromBrasil (2019)

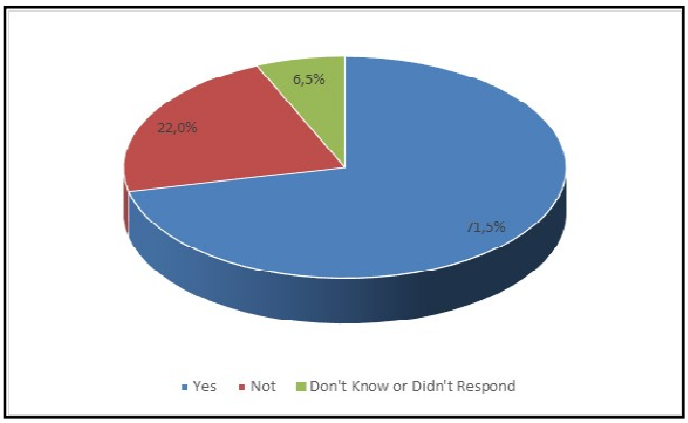

Figure 4: Percentage of employees benefited from progression by seniority. Source: Adapted from Brasil (2019)

Figure 5 shows the percentages arranged by merit. It is noted that, predominantly, 85.5% of employees receive the benefit related to merit, 11.3% do not have a degree, so they are not considered in this aspect and 3.2% do not know or did not answer.

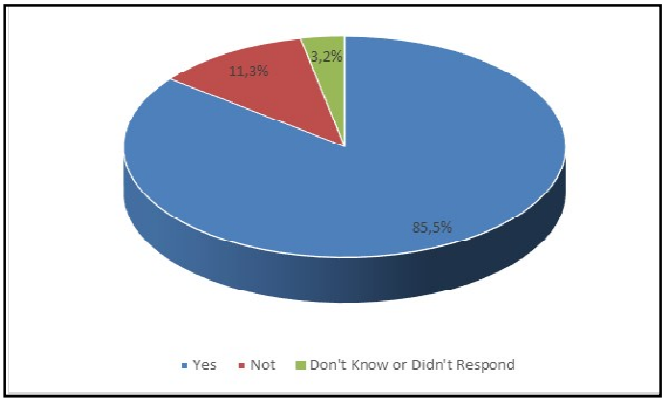

Fig. 5. Percentage of employees benefited from progression through professional qualifications and training. Source: Adapted from Brasil (2019)

The merit of the servant is assessed by observing the essential and fundamental conditions determined by assigning positive and negative points respectively, determined due to the nature of the position and included in the Merit Bulletin. The first paragraph of Recife (1988) says that one of the essential conditions of merit is - the quality and productivity of the service, as well as professional improvement. In the guidelines established in the NOB / RH-SUS, the PCCS is considered an instrument of work ordering, and must be incorporated in each level of SUS management. As an instrument of work management, the PCCS proposes to value the worker through a set of rules that guides and disciplines the worker's trajectory in his career, with the respective remuneration, favoring professional qualification (Brasil, 2006; Castro et al., 2016). With the PMAQ as an objective to encourage managers and teams to improve the quality of health services offered to citizens of the territory, it was observed that 73.7% of the professionals participated in the activities and related training, of which 93.6% carried out self-assessment through the PMAQ Instrument (AMAQ). This allows the team, and each professional, to assess the degree of adequacy of their practices to the presented quality standards and make local planning, through the construction of a matrix and intervention plan, with multi-professional, interdisciplinary and intersectoral actions, aiming to improve the organization and quality of services offered at the health unit (Brasil, 2016).

As for the aspect related to support in the organization of the work process, aiming at improving access and quality based on the PMAQ standards, it was observed in Figure 6, presented below, that 84.4% of the employees perceived the support institutional. The institution must be inserted as an agent that facilitates the process, helping teams to reflect and develop solutions in the daily activities of a health unit, in addition to seeking strategies for existing problems. For Campos et al. (2013), institutional support presupposes “pressure from outside, implies bringing something external to the group that operates the work processes or that receives goods and services. Whoever supports sustains and pushes the other”.

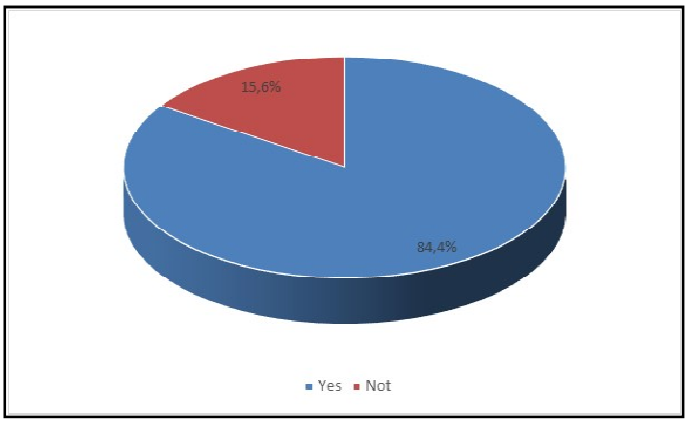

Fig. 6. Percentage of support in the organization of the work process aimed at improving access and quality based on the PMAQ standards. Source: Adapted from Brasil (2019)

The teams receive permanent institutional support from a team or person from the Municipal Health Secretariat with the objective of jointly discussing the work process, helping with the identified problems. However, most of these inductions did not receive support from the PMAQ, as shown Figure 7. It is observed in surveys carried out with employees in the area, that 78% say they have not received any type of induction from the PMAQ. According to Bezerra&Medeiros (2018), the PMAQ-AB has limits, disregarding the insertion of workers in unions or other collective bargaining spaces, taking into

account only the performance of the professional in their work and forgetting the participation or knowledge of this available collective bargaining.

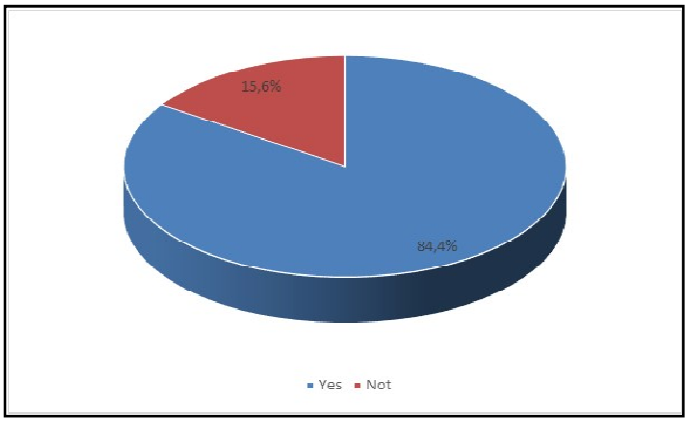

Fig. 7. Percentage of employees who received induction through the PMAQ. Source: Adapted from Brasil (2019)

Final Considerations

The qualification of health professionals is one of the ways to achieve a higher quality of health care services. However, measures such as salary increases, more suitable types of employment contracts and implementation of the PCCS are essential for the success of the program. The assessment of the process by team professionals, supporters of partner institutions and public management, in a shared and consensual way, leads to paths that need to be addressed. There was an advance in understanding the actions as a process and not just as tasks to be accomplished. EPS permeates all phases and sub-phases of PMAQ-AB, from evaluation and monitoring to re-contracting. The PMAQ-AB, however, provided debates by rethinking the possibilities of professional development, the resolutive capacity of AB, the management and community participation and the articulation with the needs of health services in the territory where they operate. In this context, EPS invades these issues, as it aims to transform the practices of doing, work, and service to better face the challenges and minimize and / or solve problems of the population and consequently of the territory. In the self-assessment, it was possible to experience, within the teams themselves, the identification and recognition of vulnerabilities and positive work products. In this stage, the reflection generated a critical thinking full of meanings that could mobilize changes to improve the assistance and resolvability of primary care. From this analysis, the EPS process could proceed. What would then allow the transformation in the functioning of services and the work process.

EPS is an ascending educational planning, starting from the collective analysis of labor processes with the identification of critical nodes to be faced in care and / or management, and which needs to be on the agenda of managers and workers in order to build strategies that promote dialogue between general policies and the peculiarities of places and individuals, with increasing encouragement in making innovative practices. The last sub-phase, institutional support, has a managerial function that focuses on the potential of work. It contributes and assists the teams in managing their difficulties, as well as helping in the planning of interventions and in the use of the necessary tools for the improvement of the teams in primary care. And yet, regarding institutional support, more specifically, as it says in the PMAQ-AB Instruction Manual:

During the performance of the external evaluation, it is possible to understand which actions, demands and priorities are considered; the meaning of EPS for workers; and what changes are noticeable by health teams. It is also at this stage that access to the concreteness of health service practices is achieved and that EPS qualifies the service through the transformation of problems / challenges and the autonomy of intervention in the field of work. Based on the development of the Program and its phases, the PMAQ-AB can enable transformations in everyday life through the evaluation, which it proposed, to rethink elements and concepts in the structural perspective of primary care, under the focus of the user and the team and manager professional . This induction was able to enhance the reflection on the part of the teams about their practices and their work processes, from the moment of self-assessment to external evaluation, producing challenges and seeking solutions to the obstacles to be faced. Although the PMAQ-AB has been characterized as the main performance-based payment program for primary care and provides for the involvement of the team from the moment of joining the program, it is necessary to think how to aggregate all the awakened competence, in the face of reality of the teams and the place where they work with the practice of EPS for moments not intended only for the evaluation. Instituting the practice of EPS is of paramount importance, as it presupposes a stimulating model for the improvement and quality of primary care, from management to users. It appears that the development of the PMAQ was closely related to the work process and its readjustment, although many of its actions went beyond the governance of the team by requiring resources for its application. For this, the PMAQ-AB and EPS would need to operate as a device that would put practices into analysis, in everyday life. What would only happen from a political determination of the different actors. However, it is necessary to move towards the construction of new research opportunities on the subject, with a view to contributing to overcoming the existing edges, so that permanent education can, in fact, contribute to the improvement of Primary Care.

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