Original Article

AVALIAÇÃO DA ATENÇÃO PRIMÁRIA: COMPARATIVO ENTRE O DESEMPENHO GLOBAL E AS AÇÕES DE HANSENÍASE

EVALUATION OF PRIMARY ATTENTION: A COMPARATIVE BETWEEN GLOBAL PERFORMANCE AND LEPROSY ACTIONS

EVALUACIÓN DE LA ATENCIÓN PRIMARIA: COMPARATIVO ENTRE EL DESEMPEÑO GLOBAL Y LAS ACCIONES DE LA LEPRA

Nayara Figueiredo Vieira[1], Rayssa Nogueira Rodrigues[2], Eyleen Nabyla Alvarenga Niitsuma[3], Fernanda Moura Lanza[4], Francisco Carlos Félix Lana[5]

RESUMO

Objetivo: comparar a presença e extensão dos atributos da atenção primária no geral e no desempenho da hanseníase. **Métodos**: estudo transversal e avaliativo, realizado em um município de Minas Gerais, com 28 profissionais da Estratégia Saúde da Família, sendo composto por médicos e enfermeiros. Para a coleta de dados foram aplicados o *Primary Care Assessment Tool* e o Instrumento de Avaliação de Desempenho da Atenção Primária nas Ações de Controle da Hanseníase. Utilizou-se os testes estatísticos *Wilcoxon* e *t* de Student com significância p<0,05. **Resultados**: A atenção primária, no global, apresentou alta orientação no escore geral e derivado. Nas ações de hanseníase, apenas o escore essencial alcançou alta orientação. Encontrou-se diferença significativa no escore essencial, atributos acesso e integralidade dos serviços disponíveis, e no escore derivado, atributo orientação comunitária. **Conclusão:** o desempenho da atenção primária no geral é melhor, o que demonstra fragilidades na integração das ações de controle da hanseníase e necessidade de fortalecimento das estratégias de enfrentamento da endemia no que concerne à Estratégia de Saúde da Família.
Descritores: Pesquisa sobre Serviços de Saúde; Atenção Primária à Saúde; Hanseníase; Enfermagem.

ABSTRACT

Objective: to compare the presence and extent of primary care attributes in general and in leprosy performance. **Methods:** cross-sectional and evaluative study, carried out in a city of Minas Gerais, with 28 professionals from the Family Health Strategy, consisting of doctors and nurses. The Primary Care Assessment Tool and the Primary Care Performance Assessment Instrument for Leprosy Control Actions were applied for data collection. Wilcoxon statistical test and Student's t test were used with p <0.05. **Results:** Primary care, overall, showed high orientation in the general and derived score. In leprosy actions, only the essential score reached high orientation. There was significant difference in the essential score, access and integrality attributes of the available services, and in the derived score, attribute community orientation. **Conclusion**: the primary care general performance is better, which demonstrates weaknesses in the integration of leprosy control actions and the need to strengthen the endemic coping strategies in relation to the Family Health Strategy.
Descriptors: Health Services Research; Primary Health Care; Leprosy; Nursing.

RESUMEN

Objetivo: comparar la presencia y extensión de los atributos de la atención primaria en general y en el desempeño de la lepra. **Métodos:** estudio transversal y evaluativo, realizado en un municipio de Minas Gerais, con 28 profesionales de la Estrategia Salud de la Familia, compuesto por médicos y enfermeros. Para la recolección de datos, se aplicaron el *Primary Care Assessment Tool* y el Instrumento de Evaluación de Desempeño de la Atención Primaria en las Acciones de Control de la Lepra. Se utilizaron las pruebas estadísticas de Wilcoxon y t de Student con significancia p <0,05. **Resultados:** La atención primaria, en general, presentó alta orientación en el puntaje general y derivado. En las acciones de lepra, sólo el puntaje esencial alcanzó alta orientación. Se encontró diferencia significativa en el score esencial, atributos acceso e integralidad de los servicios disponibles, y en el puntaje derivado, atributo orientación comunitaria. **Conclusión:** el desempeño de la atención primaria en general es mejor, lo que demuestra fragilidades en la integración de las acciones de control de la lepra y necesidad de fortalecer las estrategias de enfrentamiento de la endemia en lo que concierne a la Estrategia de Salud de la Familia.
Descriptores: Investigación en Servicios de Salud; Atención Primaria de Salud; Lepra; Enfermería.

[1]Graduada em Enfermagem. Doutoranda em Enfermagem pela Universidade Federal de Minas Gerais. Professora da Faculdade de Ciências da Saúde de Unaí. [2]Graduada em Enfermagem. Doutoranda em Enfermagem pela Universidade Federal de Minas Gerais. Professora Substituta da Universidade Federal de São João del Rei. [3]Graduada em Enfermagem. Doutoranda em Enfermagem pela Universidade Federal de Minas Gerais. Docente no Instituto Federal de Educação do Norte de Minas Gerais. [4]Graduada em Enfermagem. Doutora em Enfermagem pela Universidade Federal de Minas Gerais. Docente na Universidade Federal de São João del-Rei. [5]Graduado em Enfermagem. Doutor em Enfermagem Interunidades pela Universidade de São Paulo/Ribeirão Preto. Docente na Universidade Federal de Minas Gerais.

INTRODUCTION

Primary Health Care (PHC) services are preferred entry port of the user in the Unified Health System (UHS), offering, by a multidisciplinary team, actions for health promotion, disease prevention, protection, diagnosis, treatment, rehabilitation, harm reduction, palliative care and health surveillance[1].

To carry out these health actions, PHC services, which, in Brazil, have the Family Health Strategy (FHS) as a priority for the consolidation of this point of attention in the network[1], need to implement, in the daily work, PHC structural elements[2]. Structural elements are attributes, divided into: essential attributes - attention to the first contact (port of entry/access), continuing longitudinality/assistance, integrality and coordination - and the derivatives - family, community guidance and cultural competence I[2].

Studies that have evaluated the structural characteristics of the PHC in Brazilian municipalities, from professionals' point of view, demonstrated poor guidance on first-contact access[3-5] and longitudinality[3]. However, the FHS expansion allowed advances in access to health services and increased quality of care, consequently reflecting positively on health indicators.

Among infectious diseases, leprosy still remains as a challenge for public health with 26,395 new cases in 2015, of these, 67.9% were multibacillary clinical forms, 6.6% with physical incapacity grade 2 and 7.3% in patients under 15 years[6]. The magnitude and transcendence of the disease, as well as its epidemiological and operational behavior, led to the indication of leprosy elimination as a strategic area of the PHC[7-8], in which actions should be developed by municipalities through the principle of integrality[1] and the guidelines on decentralization and regionalization of health care; care centered on the person; longitudinality and resolubility[1,8].

Facing the need for strengthening leprosy control actions (LCA), the Ministry of Health reinforces the recommendation that the PHC shall provide a continuing and integral attention to cases, contacts and families, coordinating the network, according to the needs, performing actions of mobilization to facilitate the diagnosis and reducing stigma[7]. A research that assessed the presence and extent of PHC attributes in the realization of the LCA showed weak orientation of PHC in access and community orientation[9].

To evaluate the PHC performance in the realization of LCA means identifying weaknesses and potentialities of the first point of attention of the UHS. In this context, the Primary Care Assessment Tool (PCATool - Brazil)[10] provides for the evaluation of PHC attributes and the Primary Care Performance Assessment Instrument for Leprosy Control Actions (PCAT - leprosy)" [9] allows assessing the degree of orientation of the PHC in the realization of the LCA[9]. Both evaluation instruments have the same theoretical framework[2] and equivalence in the analysis methodology.

It is opportune to ask: how is the behavior of the PHC attributes when evaluating the services in general and in the realization of the LCA? The objective of this study was to compare the presence and extent of the PHC attributes in general and in the performance of LCA.

METHODS

This is an evaluative research with cross-sectional design, held in the municipality of Lagoa Santa, situated in the metropolitan region of Belo Horizonte/Minas Gerais, in the period from February to March 2014. The municipality, in 2014, presented detection rate of 5.11 new cases/100 thousand inhabitants, which characterizes it as medium endemicity, among the operational indicators, examination of contacts and healing (good)[11].

The study scenario consisted of all PHC services, and, at the time of data collection, the city had 17 FHS. All doctors and nurses who worked in these teams were invited to participate in the study.

The PCATool-Brazil and the PCAT-leprosy were used, both in the doctors/nurses versions, because they allow assessing the presence and extent of the PHC attributes[9-10]. The PCATool-Brazil is based on the essential attributes (first-contact access - accessibility, longitudinality, coordination, integrality of services provided and available) and derivatives (family and community orientation)[10].

The PCAT-leprosy consists of essential attributes (port of entry, access, coordination, continuing assistance, integrality of services provided and available) and derivatives (family, community and professional guidance)[9].

The instruments were applied by two trained researchers and through previously scheduled interview, carried out individually in the work environment, after signing the Informed Consent Form. The participants answered the first PCATool-Brazil and, after 30 days, the PCAT-leprosy. The responses of the two instruments were granted through the Likert scale[9-10].

The calculation of the score of each attribute was based on the average, sum of the values of response in the items that compose each attribute divided by the number of items. The interviewees who had 50% or more of responses "9" ("I don't know/I can't remember") did not have their scores calculated. Attributes with less than 50% of responses "9" had these values converted into "2" ("probably not") in order to score in a negative manner the unknown service characteristics[12]. Later, it became a scale from 0 to 10 through the formula:

$$\frac{[obtained\ score - 1(minimum\ value)]\ x\ 10}{4\ (maximum\ value)-1(minimum\ value)}$$

The essential and derived scores were obtained by the average of their respective components. The overall score was calculated, consisting of the sum of the mean score of the components of the essential attributes added to the derivatives and divided by the number of attributes. This results in the scores for each attribute and the essential, derived and general scores, which characterize the degree of orientation of the PHC and the degree of orientation for LCA. A PHC was considered strongly orientated when the mean score was ≥6.6[10].

The data were analyzed by the software Statistical Package for Social Sciences (SPSS) (version 19) by means of the Wilcoxon test for nonparametric variables and the paired Student t-test for variables with normal distribution, with a significance level ($p<0.05$). The research meets the standards set out in Resolution 466/2012 of the National Health Council, and was approved in the Research Ethics Committee under CAAE 24578213.2.0000.5149 and funded by the Health Surveillance Department (MS) - Notice 197/2012 and Research Support Foundation of the State of Minas Gerais - Notice 03/2014.

RESULTS AND DISCUSSION

Table 1 shows the participants' characterization (n=28). All nurses (100%, n=17) accepted to participate in the research and, in relation to the doctors, there was loss of three participants due to the difficulty scheduling the interview and three of FHS teams that lacked this professional.

Table 1- Description of the study participants according to professional category. Lagoa Santa, MG, Brazil, 2014.

Variables	Doctor		Nurse	
	n	%	N	%
Post-graduation				
Yes	2	18.2	8	47.1
No	9	81.8	9	52.9
Working time in the unit				
<12 months	3	27.3	9	52.9
12 - 36 months	6	54.5	7	41.2
>36 months	2	18.2	1	5. 9
Time working in the primary health care				
<12 months	2	18.2	4	23.5
12 - 36 months	4	36.4	6	35.3
>36 months	5	45.5	7	41.2
Number of trainings in leprosy control actions				
None	7	63.6	11	64.7
One	2	18.2	5	29.4
>Two	2	18.2	1	5.9
Participation in leprosy control actions				
Yes	4	36.4	7	41.2

No	7	63.6	10	58.8
Attended to leprosy case				
Yes	1	9.1	2	11.8
No	10	90.9	15	88.2

Source: Prepared by the authors based on the performed interviews.

The recognition of the PHC as an entry port does not mean that actions are actually performed; 60.7% of the interviewees reported not performing LCA and 89.3% did not attend to cases. These conditions should be referred to the medium-complexity specialized service; barriers to access are determinants for the use of PHC as entrance door and imply choosing the first point of care[9].

When analyzing Table 2, in relation to the essential attributes, Lagoa Santa PHC presents high orientation (≥6.6) of services both in the PHC in general as in the performance of LCA in the attributes coordination and integrality of provided services.

Table 2- Comparison of the presence and extent of primary care attributes in general and in the leprosy performance in the point of view of doctors and nurses. Lagoa Santa, MG, Brazil, 2014.

Instruments Variables	PCATool-Brazil			PCAT-leprosy			Difference	p-value
	Mean/ Median	Standard Deviation / Interquartile range	% High Score (≥6.6)	Mean/ Median	Standard Deviation / Interquartile range	% High Score (≥6.6)		
Entrance door	†	†	†	7.6/7.5	±1.4/0.8	78.6	†	†
Accessibility/ Access	3.8/3.7	±1.0/1.4	3.6	5.7/5.5	±1.3/1.5	10.7	1.9	0.001[a]
Longitudinality	6.9/6.9	±1.1/1.2	67.9	*	*	*	†	†
Coordination	7.8/7.8	±1.0/0.7	60.7	7.2/8.3	±4.9/7.9	‡	-0.5	0.56[b]
Integrality: provided services	7.6/7.7	±1.1/1.5	82.1	7.3/7.5	±2.1/3.3	64.3	-0.2	0.05[b]
Integrality: available services	6.6/6.6	±1.6/2.5	50	8.9/8.9	±0.7/1.0	100	2.3	0.001[a]
Family guidance	8.6/8.9	±1.3/2.2	96.4	*	*	*	†	†
Community guidance	6.5/6.7	±1.4/2.1	53.6	3.5/4.0	±2.3/2.7	10.7	-3	0.001[a]
Professional guidance	†	†	†	4.3/4.4	±2.2/3.1	25	†	†
Essential	6.5/6.7	±0.8/1.2	75	7.2/7.6	±1.4/2.6	67.9	0.9	0.005[b]
Derivative	7.6/7.8	±1.2/2.4	67.9	3.9/4.0	±1.8/3.1	10.7	-3.8	0.001[b]
General	6.8/6.9	±0.9/1.4	75	6.1/6.3	±1.2/2.2	53.6	-0.7	0.08[a]

Source: Prepared by the authors based on the performed interviews.
a) Statistical significance by *t Student* test for paired samples; b) Statistical significance by Wilcoxon test for paired samples.
*The scores of continuing service and family guidance could not be calculated, since these are dimensions responded by professionals who attended to cases of the disease, three study participants met the criterion, which represents <50%; † Non-comparable attributes; ‡ Percentage of *missings* greater than or equal to 50%.

The comparable attributes involve access/accessibility, coordination, integrality of services provided and available, community guidance and the overall, essential and derivative scores. The PCAT-leprosy is based on the theoretical framework of the PHC[9] and on the LCA recommended in the national guideline, and "professional guidance" is not contemplated in the PCATool-Brazil[10], but recommended in another study since the UHS offers

capacitation[12]. In addition, "family guidance" and "longitudinality" attributes were not calculated for the PCAT-leprosy, because 80% of the participants did not follow cases, a criterion for the interviewee to respond to items.

There were differences in the evaluation of the PHC in general (6.8) and in leprosy (6.1), which highlights the difficulties in the performance of actions of the disease when compared to general activities carried out in the PHC. Factors such as unprepared professionals, decreased incidence, stigma of patients in treating close to residences, difficult access to the service and resolubility of the PHC are aspects that hinder the integration of LCA in the PHC [9]. Nevertheless, strong orientation for PHC in general shows approximation with the organizational and ideological precepts of the UHS; similar results were found in Cascavel[13], demonstrating the potential of the PHC to assume the leading role in the development of LCA.

The access/accessibility had a low percentage of guidance in both instruments, although the average was statistically lower for the PHC in general. Accessibility is the use of the service as a source of care to each new problem and access comprises the geographical issue, i.e., how people arrive at the service[2]. A systematic review found inadequate access/accessibility in most of the studies that used the PCATool-Brazil[14]. Geographic and organizational barriers of PHC, as reduced hours of operation, difficulties scheduling appointments and waiting time for care, contribute to worse evaluation[14]. These obstacles are reflected in leprosy, because the user with suspicion of the disease can have difficulty, thus delaying the early diagnosis and monitoring of the case. In particular, in leprosy, access is determined by prioritizing in municipal policy, the presence of trained professionals, instruments that allow skin-neurological evaluation and the knowledge of the population about the disease[15].

There were significant differences in the integrality of services provided and available; in the latter, there was a high percentage of higher scores for the LCA when compared to the PHC in general. The integrality of services refers to items addressed by the professional interviewed during the care[10]. There was a strong guidance in both tools and a significant difference, but the PHC received worse evaluation. Regarding PCAT-leprosy, the recommended actions are: suspicion of cases, diagnosis, general guidelines, administration of the supervised dose and evaluation of contacts[7]. In the PCATool-Brazil, the integrality of services refers to health promotion policies, safety in the home environment and general guidelines regarding the rational use of drugs[10]. Studies conducted in Minas Gerais and in Pará obtained, respectively, strong and weak guidance for the LCA[9,16]. In this way, different orientations of the PHC in LCA suggest that inequalities in the performance relate to the epidemiological scenario, the level of integration of LCA, political, cultural and socioeconomic factors.

The integrality of available services are procedures and guidelines implemented in the PHC[10]. In general, a borderline score (6.6) was obtained; however, in the PCAT-leprosy, there was a strong orientation (8.9) and statistically significant difference. The PCATool-Brazil items may have contributed to the worst evaluation, because issues such as the implementation of suture, evaluation of visual problems, placement of immobilizer, removal of warts and ingrown nail and inclusion in food supplementation program are not yet routine practices of PHC. Since Lagoa Santa has only the FHS, in theory, it has features to give effect to the principles of integrality once actions are carried out in the territory, allowing the planning according to the needs and demands from the living conditions of the assigned population[1,17].

To evaluate the derived attributes, the community guidance presented, in both instruments, weaknesses in their presence and extension; however, the degree of guidance was statistically lower for the LCA. The PHC showed a heterogeneous behavior in essential, derived and general scores, with significant differences in the essential and derived scores.

Community guidance presented weaknesses in the PHC in general and in leprosy with significant difference. The community guidance consists of the recognition, by the service, of the community needs by means of epidemiological indicators and the contact with the community[2]. Difficulties performing the actions may relate to the persistence of the healing model, based mainly on the disease, far from the health surveillance model. "The integration between Health Surveillance and basic care is an essential condition to achieve results that meet the health needs of the population, in the perspective of integrality of

health care"[1]. These difficulties reflect on the worse evaluation of LCA, because the lack of professionals in relation to the disease does not translate into practices that integrate the community and impact on health problems[16].

In coordination, there was strong orientation in the PHC in general and in leprosy, but without any statistical difference. Coordination comprises the integral access to services in different points of the attention network, where there is dialog between the services[2]. In this way, a PHC strongly oriented to LCA needs to assume the role of care organizer, and medium- and high-complexity services need to work, preferably through referrals of short duration[9] and according to the criteria defined by the National Guideline[7].

There were evaluations isolated from some attributes due to conceptual issues: in PCATool-Brazil, longitudinality and family guidance attributes, and in PCAT-leprosy, entrance door and professional guidance attributes.

In essential score, there was poor guidance in PCATool-Brazil, strong guidance in PCAT-leprosy and significant difference. In the PHC in general, integrality of available services and access/accessibility contributed to worse evaluation when compared to PCAT-leprosy. A facilitated access/accessibility expands early diagnosis and contributes to reducing disability caused by the disease[9].

The essential attribute "entry door" (PCAT-leprosy) received strong orientation and demonstrates that the PHC is understood as the place of choice in case of suspicion of disease, similar results were observed by nurses[16].

In an isolated manner, assessment of "longitudinality" for the implementation of the PCATool-Brazil had as a result a borderline score (6.9), but a strongly oriented PHC. This attribute is provided for in the National Policy of Basic Care, which stimulates the bond in order to avoid loss of reference, reducing the risk of iatrogenic diseases arising from lack of knowledge and care coordination[1] built by strong interpersonal bonds that reflect the mutual cooperation between community and professionals[2]. Systematic review performed with PCATool-Brazil studies showed that the longitudinality presented the third best evaluation in studies[14]. Characteristics such as assigned population, universalization of access by the expansion of the FHS[18], organization of work and reference team

along time[19] may be variables that explain the good performance[14].

These evidences corroborate the hypothesis that PHC is conducive to establish the link between leprosy patients and teams, since the disease propaedeutic is long, six through 12 months, according to operational classification of the disease. In this way, the integration of LCA in primary care is able to increase the early detection, improve adherence to treatment, prevent disabilities and surveillance of contacts by means of health surveillance[8].

The derived score is known to increase the power of interaction between individuals and the community[10]. There was poor guidance in LCA (3.9), but strong guidance in the PHC in general (7.6) and statistically significant difference. The worst evaluation observed in leprosy portrays the weaknesses in community and professional guidance.

In the professional guidance (PCAT-leprosy), results showed weak orientation of the PHC; 64.3% of doctors/nurses did not undergo training. The trainings are important strategies for strengthening the PHC, once they sensitize professionals by the epidemiological situation. In addition to trainings, strategies such as active search and carrying out health education actions are possibilities for the early diagnosis[20]. The lack of training in LCA along with problems in the recognition of the community needs results in inadequate quality of LCA, thus, the disease persists as a public health problem.

Another derived attribute, the family guidance (PCATool-Brazil), understood as an assessment of needs considering the family context[2], had a strong orientation of PHC in general; however, other studies found different results, showing little incorporation of the family in care practices and lack of professionals to meet the life conditions of patients and their families[21-22].

A study conducted in Tamandaré/Pernambuco found that 93% of interviewees mentioned the treatment as a priority in leprosy followed by the nursing consultation (86%), prevention of disabilities (79%) and clinical control (71%)[23]. This shows inadequate insertion of the family in the disease propaedeutic, which, made in the image and likeness of technical-science and the biomedical model, is still present in professionals' healthcare practices[24]. A study that evaluated the nurses' knowledge about the treatment of leprosy in the PHC showed little

emphasis in the family as a support in cases of the disease[25].

A limitation of this study was its development in only one municipality, restricting generalizations. Therefore, future studies should be carried out with the aim of increasing the power of comparability between the assessment tools.

CONCLUSION

In relation to the comparable attributes, there was convergent behavior in the accessibility/access and community guidance, inadequately assessed, both in general as in the LCA. The essential score showed divergence, because the PHC in general was worse evaluated than in leprosy. Nevertheless, general and derived scores showed the opposite, once the PHC in general was more thoroughly evaluated than in leprosy.

The PHC performance in general is better, which shows the weaknesses in the municipal health policy of the municipality in coping with the disease. Thus, it is important to integrate leprosy actions in the PHC, since, despite some weaknesses, the service is capable of performing the actions of the disease. The quality observed in the PHC can reflect on LCA through prioritization of disease in the epidemiological scenario, professional training, knowledge of the needs, health education, involvement of management and reference service.

REFERENCES

1. Ministério da Saúde (BR). Departamento de Atenção Básica. Portaria MS/GM nº 2436, de 22 de setembro de 2017. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes para a organização da Atenção Básica, no âmbito do Sistema Único de Saúde (SUS). Diário Oficial da União 2017.

2. Starfield B. Atenção primária: Equilíbrio entre necessidades de saúde, serviços e tecnologia. Brasília: UNESCO; 2002.

3. Vitória AM, Harzheim E, Takeda SP, Hauser L. Avaliação dos atributos da atenção primária à saúde em Chapecó, Brasil. Rev Bras Med Fam Comunidade 2013;8(29):285-93. DOI: 10.5712/rbmfc8(29)832

4. Silva SA, Nogueira DA, Paraizo CMS, Fracolli LA. Avaliação da Atenção Primária à Saúde: Visão dos profissionais de saúde. Rev Esc Enferm USP. 2014;48 (nesp):126-32. DOI: 10.1590/S0080-623420140000600018

5. Martins JS, Abreu SCC, Quevedo MP, Bourget MMM. Estudo comparativo entre Unidades de Saúde com e sem Estratégia Saúde da Família por meio do PCATool. Rev Bras Med Fam Comunidade 2016;11(38):1-13. DOI: 10.5712/rbmfc11(38)1252

6. World Health Organization (WHO). Global leprosy update, 2015: Time for action, accountability and inclusion. Geneva: World Health Organization; 2016.

7. Ministério da Saúde (BR). Secretaria de Vigilância em Saúde. Diretrizes para vigilância, atenção e eliminação da hanseníase como problema de Saúde Pública, com a finalidade de orientar os gestores e os profissionais dos serviços de saúde: Portaria MS/GM nº 149, de 3 de fevereiro de 2016. Brasília, DF: Ministério da Saúde; 2016.

8. Saltarelli RMF, Seixas DHT. Limites e possibilidades na atenção ao portador de hanseníase no âmbito da estratégia saúde da família. Rev APS. 2016 [citado em 20 nov 2017]; 19(4):613-22. Available in: https://aps.ufjf.emnuvens.com.br/aps/article/view/2443

9. Lanza FM. Avaliação da atenção primária no controle da hanseníase: Validação de instrumento e análise de desempenho de municípios endêmicos de Estado de Minas Gerais [tese]. Belo Horizonte (MG): Escola de Enfermagem da Universidade Federal de Minas Gerais; 2014.

10. Ministério da Saúde (BR). Secretaria de Atenção em Saúde. Manual do instrumento de avaliação da atenção primária à saúde: *Primary care assessment tool PCATOOL.* Brasília, DF: Ministério da Saúde; 2010.

11. Ministério da Saúde. Sala de Apoio a Gestão Estratégica. 2017 [citado em 12 dez 2017]; [1 tela]. Available in: http://sage.saude.gov.br

12. Organização Pan-Americana da Saúde. Validação de uma metodologia de avaliação rápida das características organizacionais e do desempenho dos serviços de atenção básica do Sistema Único de Saúde (SUS) em nível local. Brasília: Ministério da Saúde; 2006.

13. Carrer A, Toso BRGO, Guimarães ATB, Conterno JR, Minosso KC. Efetividade da Estratégia Saúde da Família em unidades com e sem Programa Mais Médicos em município no oeste do Paraná, Brasil. Ciênc Saúde Coletiva 2016;21(9):2849-60. DOI: 10.1590/1413-81232015219.16212016

14. Prates ML, Machado JC, Silva LS, Avelar PS, Prates LL, Mendonça ET, et al. Desempenho da

Atenção Primária à Saúde segundo o instrumento PCATool: Uma revisão sistemática. Ciênc Saúde Coletiva 2017;22(6):1881-93. DOI: 10.1590/1413-81232017226.14282016

15. Lanza FM, Lana FCF. Decentralization of leprosy control actions in the micro-region of Almenara, State of Minas Gerais. Rev Latino-Am Enfermagem 2011;19(1):187-94. DOI: 10.1590/S0104-11692011000100025

16. Sousa GS, Silva RLF, Xavier MB. Atributos da atenção primária em saúde no controle da hanseníase: Ótica do enfermeiro. Rev Baiana Enferm. 2017;31(1):1-10. DOI: 10.18471/rbe.v31i1.17251

17. Sala A, Luppi CG, Simoes Z, Marsiglia RG. Integralidade e Atenção Primária à Saúde: Avaliação na perspectiva dos usuários de unidades de saúde do município de São Paulo. Saude Soc. 2011;20(4):948-60. DOI: 10.1590/S0104-12902011000400012

18. Lima EFA, Sousa AI, Primo CC, Leite FMC, Lima RCD, Maciel ELN. An assessment of primary care attributes from the perspective of female healthcare users. Rev Latino-Am Enfermagem 2015;23(3):553-9. DOI: 10.1590/0104-1169.0496.2587

19. Pereira MJB, Abrahão-Curvo P, Fortuna CM, Coutinho SS, Queluz MC, Campos LVO, et al. Avaliação das características organizacionais e de desempenho de uma unidade de Atenção Básica à Saúde. Rev Gaúcha Enferm. 2011;32(1): 48-55. DOI: 10.1590/S1983-14472011000100006

20. Stafin I, Guedes VR, Mendes SUR. Diagnóstico precoce de Hanseníase e ações estratégicas para a sua detecção. Revista de Patologia do Tocantins 2018;5(2):67-73. DOI: 10.20873/uft.2446-6492.2018v5n2p67

21. Alencar MN, Coimbra LC, Morais APP, Silva AAM, Pinheiro SRA, Queiroz RCS. Avaliação do enfoque familiar e orientação para a comunidade na Estratégia Saúde da Família. Cien Saude Coletiva 2014;19(2):353-64. DOI: 10.1590/1413-81232014192.08522012

22. Silva NC, Giovanella L, Mainbourg EMT. A família nas práticas das equipes de Saúde da família. Ver Bras Enferm. 2014;67(2):274-81. DOI: 10.5935/0034-7167.20140037

23. Silva LSR, Silva TM, Rocha JT, Andrade WG, Lessa EC, Correia NS. A assistência de enfermagem aos portadores de hanseníase assistidos pelo programa de saúde da família. RUOL. 2016 [citado em 3 mar 2018]; 10(11):4111-17. Available in: https://periodicos.ufpe.br/revistas/revistaenfermagem/article/view/11498/13365

24. Santos SSBS, Silva LS, Carneiro EKN, Saback MAMC, Carvalho ESS. Processo de trabalho da equipe de Enfermagem em Unidades Saúde da Família em município baiano. Rev Baiana Enferm. 2013;27(2):101-7. DOI: http://dx.doi.org/10.18471/rbe.v27i2.8850

25. Ribeiro MDA, Castillo IS, Silva JCA, Oliveira SB. The nurse's view on leprosy treatment in primary health care. Rev Bras Promoc Saúde 2017 [citado em 16 jul 2018]; 30(2):221-8. Available in: https://search.proquest.com/openview/fb079e9f004efd1fdcf7195fc543579c/1?pqorigsite=gscholar&cbl=2046042

Mailing address:
Nayara Figueiredo Vieira
Street Zaida Torres, Nº 101, apt302
ZIP CODE: 38610-000 - Unaí/MG - Brazil
E-mail: nayarafv5@hotmail.com