Chapter 65

Institutionalization of pharmaceutical assistance in the municipality of Augusto Corrêa, State of Pará, Brazil

https://doi.org/10.56238/colleinternhealthscienv1-065

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ABSTRACT
Objective: To investigate the institutionalization of pharmaceutical assistance in the municipality of Augusto Corrêa, Pará. Method: Exploratory, retrospective and descriptive research, conducted in 2021. To obtain socioeconomic, demographic, epidemiological, health services, total health expenditure indicators, we used data from the Cadastro de Estabelecimentos de Saúde do Departamento de Informática do SUS, the Instituto Brasileiro de Geografia e Estatística, the Instituto de Pesquisa Econômica Aplicada and the Sistema de Informação de Atenção Básica. ®For the information on governance practices, planning, management, technical-managerial and technical-assistance components of Pharmaceutical Assistance, structured forms were used, applied through the tool Survey Monkey Monkey, via Internet® , to the Pharmaceutical Assistance coordination of the Municipal Health Secretariat of the municipality of Augusto Corrêa, Pará. Results: Augusto Corrêa has an Estimated Population of 46,937 inhabitants in 2021 and Demographic Density of 37.10 inhabitants/km² in 2010. Territorial Area of 1.099,619 km² in 2020. It is part of the Amazon Biome, the Northeast Paraense Mesoregion, Bragantine Microregion. 0.520 Municipal Human Development Index in 2010. 0.4145 Gini Index of Percapita Household Income in 2010. Does not fully comply with governance practices at the pharmaceutical care technical coordination level; in particular, staffing and competencies, principles and behaviors, organizational leadership, stakeholder relations, organizational strategy, cross-organizational alignment, governance structure, risk management and internal control, internal audit, accountability, and transparency. Also, it did not meet all the components for Technical Management of Pharmaceutical Care and Clinical Management of Medication. Conclusion: It was found that there was not full compliance with the components of technical management of pharmaceutical assistance and clinical management of the drug; as well as, governance practices at the level of technical coordination of pharmaceutical assistance need to be improved; in particular, personnel and competencies, principles and behaviors, organizational leadership, relationship with stakeholders, organizational strategy, trans-organizational alignment, governance structure, risk management and internal control, internal audit, accountability and transparency.

Keywords: Governance, Health management, Health information, Pharmaceutical assistance, Medication.

1 INTRODUCTION

The political-administrative decentralization in health provides municipalities not only with the transfer of the management of public services, but also expands their responsibility and decision-making power over the set of providers of the Unified Health System (SUS) and financial resources (Preuss, 2011;

2018). Therefore, it was intended that this, added to universality, would allow the expansion of the population's access to therapeutic assistance, including pharmaceuticals (Brazil, 1990; Brazil, 2011; Silva et al., 2016).

The Constitution of the Federative Republic of Brazil, published on October 5, 1988, brings a new scenario for the public health management system, changing what was previously part of a tradition of centralized social policies. In this context, Law No. 8.080, of September 19, 1990, which regulates the Unified Health System (SUS), establishes in its 6th article "[...] health as a field of comprehensive care, including pharmaceuticals, with universal access, equity, integrality, social control, hierarchization, decentralization, regionalization, and single direction as principles and guidelines. With the health decentralization, the municipalities now have a series of responsibilities that require mobilization of knowledge, as well as technical, managerial and political skills, regarding Pharmaceutical Assistance (Brasil, 1990; Barreto & Guimarães, 2010; Wopereis & Colossi, 2015; Preuss, 2018).

The Organic Health Law - Law No. 8,080 of September 19, 1990 - established as part of the political-administrative decentralization process the regionalization and hierarchization of the health care network. Moreover, according to the Presidential Decree No. 7508, of June 28, 2011, establishes in its normative, the constitutional determination that the Unified Health System (SUS) should be structured and organized by a regionalized and hierarchical network; where the health regions should organize themselves to offer actions and health services of primary care, urgency and emergency, psychosocial care, among others. Thus, it is the result of this integration, which in turn is not optional, but rather a mandatory requirement by being constitutional that must be met (Carvalho et al., 2017; Santos, 2017).

The organization and structuring of Pharmaceutical Assistance are the responsibility of the three managerial instances (municipal, state and federal). In this sense, it is essential that actors are in charge of planning the forecasting of budget resources for Pharmaceutical Care, according to their priorities (Nora, 2019). The planning of Pharmaceutical Assistance should rely on the SUS management instruments, such as the Municipal Health Plan (PMS), the Annual Health Programming (PAS) and the Annual Management Report (RAG) (Nora, 2016). However, it is still observed, at the current juncture, that municipalities have not been able to provide the guarantee of safety, efficacy and quality for the promotion of rational use and user access to essential medicines (Barreto & Guimarães, 2010; Ferreira & Soler, 2021).

The National Drug Policy (PNM) - Ordinance GM/MS no. 3916, of October 30, 1998 - presents as one of its guidelines the reorientation of Pharmaceutical Assistance, not restricted only to the acquisition and distribution of drugs. The reorientation of Pharmaceutical Assistance has as a premise the implementation of activities related to the promotion of the population's access to essential medicines and their rational use, having as one of its foundations the decentralization of municipal management (Brazil, 1990; Brazil, 2011; Silva et al., 2016).

To regulate the process of reorienting Pharmaceutical Assistance, the National Health Council (CNS) and the Ministry of Health (MS) approved Resolution CNS/MS No. 338 of May 6, 2004, which approved the National Pharmaceutical Assistance Policy (PNAF), establishing in one of its principles that "[...] Pharmaceutical Assistance is a set of actions aimed at promoting, protecting, and recovering individual and collective health, with medication as an essential input and aiming at access and rational use. Furthermore, it also involves research, development, and production of medicines and inputs, as well as their selection, programming, acquisition, distribution, and dispensation, which make up the cycle of pharmaceutical assistance" (Brazil, 2004).

Pharmaceutical Assistance contemplates the adoption of the National List of Essential Medicines (Rename), adequate and timely planning, and the redefinition of the attributions of the three instances of management (Nora et al., 2019). Decentralization contributes to the efficiency of the distribution system in the public sector and the reduction of product prices, placing local managers as responsible for the Pharmaceutical Assistance agenda in the municipalities (Silva et al., 2016).

In this context, the absence of data and information about the Institutionalization of Pharmaceutical Assistance in the municipality of Augusto Corrêa is a gap to be solved. Thus, it is believed that a Health Situation Room, focusing on the process of governance, planning and management of pharmaceutical assistance at the municipal level is important for public health. The objective of this work was to investigate the institutionalization of pharmaceutical assistance in the municipality of Augusto Corrêa, Pará.

2 METHODOLOGY

Exploratory, retrospective and descriptive research, conducted in 2021 (Mallmann, 2015; Yin, 2015; Mucci & Mafra, 2016; Minayo, 2018). To obtain socioeconomic, demographic, epidemiological, health services, and total health expenditure indicators, we used data from the Cadastro de Estabelecimentos de Saúde do Departamento de Informática do Sistema Único de Saúde (CNES/DATASUS), the Instituto Brasileiro de Geografia e Estatística (IBGE), the Instituto de Pesquisa Econômica Aplicada (IPEADATA), and the Sistema de Informação de Atenção Básica do Departamento de Informática do Sistema Único de Saúde (SIAB/DATASUS). For information on governance practices, planning, management, technical-managerial and technical-assistance aspects of Pharmaceutical Assistance, we used structured forms (Souza et al., 2017; Soler et al., 2018; Ferreira & Soler, 2021), applied by means of the Survey Monkey tool® , via Internet® , to the Pharmaceutical Assistance coordination of the Municipal Health Secretariat (SEMSA) of the municipality of Augusto Corrêa, Pará.

The structured forms were elaborated based on current regulatory frameworks, such as Portaria GM/MS nº 3.916, of October 30, 1998, which regulates the National Drug Policy (Brazil, 1998); CNS Resolution No. 338 of May 6, 2004, which approves the National Pharmaceutical Assistance Policy (2004); GM/MS Ordinance No. 971, of May 3, 2006, which establishes the National Policy for Integrative and

Complementary Practices (Brazil, 2006) and GM/MS Ordinance No. 849, of March 27, 2017, which updates the Integrative and Complementary Health Practices; GM/MS Ordinance No. 2.979, November 12, 2019, establishing the Previne Brazil Program, which establishes a new funding model for the costing of Primary Health Care within the Unified Health System; Decree no. 7.508, of June 28, 2011, which regulates Law no. 8.080, of September 19, 1990, providing for the organization of the Unified Health System (SUS), health planning, health care, and interfederative articulation, among other provisions (Brazil, 2011); Complementary Law No. 141, of January 13, 2012, which provides for the minimum amounts to be applied annually by the Union, states, Federal District, and municipalities in public health actions and services, among other provisions (Brazil, 2012); Ordinance GM No. 2.135, of September 25, 2013, which establishes guidelines for the planning process within the Unified Health System (SUS) (Brazil, 2013a); and Basic governance benchmark of the Federal Audit Court (Brazil, 2013b).

The results are presented by means of tables, charts, and narrative synthesis. These findings are byproducts of the research registered in Plataforma Brasil (SISNEP) under CAAE nº 32819220.7.0000.0018 and Opinion nº 4.154.970, complying with the guidelines and regulatory standards for research involving human subjects in Brazil (Brazil, 2012; 2016).

3 RESULTS AND DISCUSSION

It is recognized that a Health Situation Room is a physical and/or virtual space where health data and information related to a given geographical area, with a defined population and a specific time frame, are presented through narrative synthesis, tables and graphs (Brazil, 2010; Bueno, 2010; Moya, 2010; Pan American Health Organization, 2010; Lucena et al., 2014). Thus, the Health Information Systems (HIS) play a relevant role for the organization of services, because the states and municipalities in possession of information are able to quickly adopt measures of intervention and control of diseases, through the planning of actions for the promotion, protection and recovery of health, supporting decision making (Bueno, 2010; Lucena et al., 2014). Providing the integration of such information, with dynamic and updated diagnoses, enables the development of programs and actions compatible with the real needs detected in the field of public health.

Socioeconomic and Demographic Indicators

Augusto Corrêa (County Code: 1500909) had an Estimated Population of 46,937 inhabitants in 2021, a Demographic Density of 37.10 inhabitants/km² in 2010 and a Territorial Area of 1,099.619 km² in 2020. It is part of the Amazon Biome, the Northeast Paraense Mesoregion, Microregion Bragantina. 24.8% of Sanitary Sewage Adequate in 2010. 13.9% of Tree-planting in Public Streets in 2010. 0.6% of Urbanization of Public Streets in 2010. 18 SUS Health Establishments in 2009. 93.6% School Enrollment Rate from 6 to 14 Years of Age in 2010. Elementary School Early Years of 4.2 years in 2019 (IDEB -

Public School). 9,521 Primary School Enrollments in 2020. 2,291 High School Enrollments in 2020. 414 Primary School teachers in 2020. 69 High School teachers in 2020. 73 Primary Schools in 2020 and 4 High Schools in 2020. 2.0 Minimum Wage was the Average Monthly Wage of Formal Workers in 2019. 5.7% of the Occupied Population in 2019, 58.4% of the Population with Percapta Nominal Monthly Income of up to 1/2 Minimum Wage in 2010. Percapta GDP of R$7,097.33 in 2019. 96.1% of Revenues from External Sources in 2015. 0.520 of Municipal Human Development Index (IDHM) in 2010. 0.4145 of Gini Index of Percapta Household Income in 2010. R$ 92,714.54 (×1000) of Total Revenues realized in 2017, R$ 104,578.64 (×1000) of Total Expenditures committed in 2017 (Brazilian Institute of Geography and Statistics, 2021).

Garnelo et al., (2017), in the study "Regionalization in Health in Amazonas: advances and challenges", points out socioeconomic inequalities in the health region around the city of Manaus, Amazonas. In the study, a large difference is noted between the per capita GDP of Manaus, which is about R$ 32,300.56, compared to other regions, such as Santa Isabel do Rio Negro, Barcelos Careiro, Manaquiri and Nova Olinda, which have per capita GDP in the range of R$ 3,077.14 and R$ 5,000.00. Such conditions influence the organization and offer of health services, the dynamics of regionalization, and these differences represent structural inequities, associated with low management and collection capacity by the administration of the smaller municipalities; this also makes it impossible to incorporate technology in their services, perpetuates the low resolution and precarious levels of health. Among the main obstacles to achieving universality in the Unified Health System (SUS) are the socioeconomic and health inequalities in the country, aggravated by the limited governance of health authorities in the least favored municipalities and regions, especially in the North.

The Municipal Human Development Index (IDHM) of Augusto Corrêa is 0.520, considered low, according to the classification of the Atlas of Human Development, which establishes that this indicator is a number that varies between 0.000 and 1.000. The closer to 1,000, the greater the human development of a federative unit, municipality, or metropolitan region. Garnelo et al., (2017) reports that there are great inequalities between health regions in the country, especially in the North region, where 46% of the municipalities in the health regions have low HDIM. Furthermore, in the smaller municipalities, insufficient health services and problems in fixing human resources are pointed out. The authors also point out that the medium and high complexity services are concentrated in the capital cities, leaving the population living in more remote areas at a disadvantage. The transfer of federal resources is much lower than the national percapita average and there is an insufficient health infrastructure that barely meets the regional needs. In the policies of the federal government the institutionality is ignored and the regional needs are not met, having a low management capacity at the municipal level.

According to Uchimura et al., (2017), variables such as life expectancy at birth, mortality rate, and infant mortality rate are considered important indicators in evaluating the results of a health system, and

variables such as percapita GDP, despite the importance of its use in evaluating the performance of health systems, cannot be analyzed in isolation, as it does not represent environmental sustainability, nor social inclusion as determinants in the population.

Epidemiological indicators

The Infant Mortality Rate (IMR) is an indicator that evaluates the frequency of deaths of children under one year of age per 1,000 live births. The IMR for the municipality of Augusto Corrêa, Pará, in 2017 was 17.11 deaths per thousand live births (Table 1). Analyzing data taken from the Atlas Brazil, it can be seen that there was a considerable increase in the IMR in 2017, compared to 2015 and 2016, when the rates were 10.48 and 11.53, respectively. Infant Mortality Rate (IMR) is also considered one of the most sensitive indicators of the health situation and living conditions of the population (Martins et al., 2018). The IMR is directly related to the degree of development of countries, regions, states and municipalities; where high infant mortality rates reflect the low socioeconomic levels of the population, represented by deprivation of access to basic services, such as: sanitation, drinking water, education, income, among others (Pereira et al., 2021).

For the United Nations (UN), infant mortality is a health priority in national and international pacts; indicator present in the Millennium Development Goals (MDGs) for the year 2015 and, later, in the Sustainable Development Goals (SDGs) for the year 2030 (Moraes, 2020; Pereira et al., 2021). In this context, in 2015 the municipality of Augusto Correa, Pará, met the target set by the Millennium Development Goals; that is, that infant mortality should be below 17.9 deaths per thousand live births. The municipality of Augusto Corrêa, Pará, now has to meet the goals of the Sustainable Development Goals (SDGs); that is, to end preventable deaths of newborns and children under 5 years old by 2030. Governments must be committed to reducing neonatal mortality to at least 12 per 1,000 live births and under-five mortality to at least 25 per 1,000 live births (United Nations, 2021).

As for Life Expectancy at Birth, the municipality obtained an average of 71.3 years for the year 2017, which is below the average for Brazil according to Atlas Brazil (2021), which is around 73.94 years (Table 1). Life Expectancy or Life Expectancy at Birth represents the average number of years that a child born today is expected to live, if current mortality rates are maintained. Age-specific mortality rates are used to determine the probability of reaching the next age (Beojone et al., 2016).

Table 1 - Epidemiological data from the municipality of Augusto Corrêa, Pará.

INDICATORS	DATA
Life Expectancy at Birth (2010)	71.3 years
Infant mortality rate (2017)	17.11 per thousand live births
Elderly mortality rate (2018)	73 over 65 years old
Top five prevalent morbidities (2019)	Pneumonia (180109.53) Heart Failure (109962.56) Renal Failure (75230.11) Diabetes mellitus (56064.69) Leukemia (42675.02)
Top five prevalent mortalities (2018)	Diabetes mellitus (23) Neoplasms (8) Acute Myocardial Infarction (6) Alcoholic Liver Disease (4) Pneumonia (3)
Top five prevalent endemics (2019)	Influenza [flu] (224,534.41) Congenital syphilis (12,252.68) Dengue [classic dengue] (7,753.76) Meningococcal infection (865.91) Leptospirosis unspecified (734.7)

Source: Institutionalization of pharmaceutical assistance in the municipality of Augusto Corrêa (2021).

Among the main causes of mortality in the municipality of Augusto Corrêa, diabetes mellitus, neoplasms, acute myocardial infarction, alcoholic liver disease, and pneumonia stand out. Among the main prevalent morbidities in the municipality, pneumonia, heart failure, renal failure, diabetes mellitus, and leukemia stand out (Chart 1).

Efficient indicators of mortality by cause of death are relevant because they subsidize the planning of health actions and their evaluation; being, therefore, important in the analysis of the health situation to direct public policies (França et al., 2014; Corrêa & Miranda-Ribeiro, 2017).

Corrêa and Miranda-Ribeiro (2017), in the study "Gains in life expectancy at birth in Brazil in the 2000s: impact of variations in mortality by age and causes of death," measure the contribution of age groups and causes of death in the variation of life expectancy at birth. The study shows that the reduction in mortality from some comorbidities such as infectious diseases, circulatory and respiratory system diseases, among others, contributed to the increase in life expectancy at birth for Brazilians, and that this is due to health policy actions such as control and prevention of comorbidities, vaccination of risk groups against influenza and pneumonia, and continuous improvements in the health area, etc.

Therefore, it is essential that health managers in the municipality of Augusto Corrêa, Pará, adopt action plans to combat the comorbidities that most affect the inhabitants, especially with regard to circulatory and respiratory diseases, so that the population gets better results in relation to their life expectancy and for the municipality to achieve the goals of the Sustainable Development Goals by 2030.

It is known that the progress of countries and the distribution of public resources for health rely on the estimates of health indicators, both global, national and regional, for their evaluation and guidance (Abouzahr, 2001; Prata, 2011; Silva et al., 2018). The fact that Brazil has a history of quite striking social inequalities is reflected in the health of its population, being of great importance the social determinants for

health. Therefore, for the adequacy of public policies it becomes essential to present and value the evidence of health inequalities (Paim, 2011; Kleinert, 2011; Landmann, 2016; Silva et al., 2018).

Health service indicators

The Total Number of Health Professionals has been increasing over the years (294 in 2017; 283 in 2018; 331 in 2019). As for the Number of Health Establishments, there was a decrease in the number of Family Health Strategy (FHS) teams (Table 2). It is recognized, to be important for the effectiveness of health services, a good correlation of health professionals (Silva et al., 2018).

The World Health Organization (WHO) guides the strengthening of Primary Health Care (PHC) for all countries as the main strategy for reorienting health systems, aiming to overcome inequalities in access, reduce costs, and achieve results in health policies. Primary Health Care (PHC) is the gateway to health care for the population (Venâncio et al., 2016). The World Health Organization (WHO) and the Pan American Health Organization (PAHO) guides consider human resources and good infrastructure and organizational conditions as key components for a health policy, especially for drug policy and pharmaceutical assistance (Barbosa et al., 2017; Bermudez et al., 2018).

Table 2 - Structure and organization of health services in Augusto Corrêa, Pará.

INDICATOR	YEAR
Total number of health professionals	
294 Health Professionals	2017
283 Health Professionals	2018
331 Health Professionals	2019
Number of health facility	
2 ESF Units	2017/2018/2019
20 Municipal Health Units	2017/2018
22 Municipal Health Units	2019
2 Polyclinics	2017/2018
0 Hospital	2019
1 Hospital	
Number of Family Health Strategy teams	
111 ESF - Agents	2017
108 ESF - Agents	2018
63 ESF - Agents	2019
11 ESF-M1 General	2017/2018
10 ESF-M1 General	2019
17 ESF - General	2017/2018
11 ESF - General	2019

Source: Institutionalization of pharmaceutical assistance in the municipality of Augusto Corrêa (2021).

The Family Health Strategy (FHS) is a state policy prioritized by the Ministry of Health (MH). It has been implemented since 1994 and, in 2015, reached coverage of approximately 67% of the Brazilian population (Venâncio et al., 2016). Importantly, the ESF plays a key role in first contact, longitudinality, and care coordination, and should operate as the basis for structuring the Health Care Networks (RAS), as a support for diagnostic support services, specialized and hospital care (Malta et al, 2016). In the

municipality of Augusto Corrêa, Pará, the number of teams has remained the same in recent years. There is a need for expansion to provide greater coverage in the care process of the population.

Health services in a given territory - health regions - need to be planned in terms of infrastructure and organization. Health actions and services must be ascending, continuous, and articulated among the federal, state, and municipal spheres. They must have priority on the government's agenda. In this context, interventions at local, regional, and national levels should be based on the health needs of the population and founded on epidemiological, socioeconomic, and demographic criteria (Pereira & Tomasi, 2016). The Unified Health System (SUS), with an orientation towards primary care and regionalized, must be able to respond to the needs of the population and act on all the determinants of the health-disease process (Macinko & Mendonça, 2018).

Total Health Expenditures

It is observed that the resources applied to health are always increasing, going from R$ 13,757,008.17 in 2017 to R$ 17,607,110.57 in 2019 (Table 1). In order to have an efficient application of financial resources, it is crucial that the municipality performs quality management, applying the concepts of governance, management by results, situational strategic planning, transparency, and sustainability (Soler et al., 2017; Silva et al., 2018).

Table 1 - Health expenditures in the municipality of Augusto Corrêa, Pará.

CATEGORY	2017 (R$)	2018 (R$)	2019 (R$)
Expenditure with medicines in health units	917.399,12	612.009,90	1.119.561,00
Spending on Primary Care	8.275.010,12	13.350.280,04	15.371.377,84
Spending on inpatient and outpatient care	849.631,22	1.362.355,91	1.062.878,07
Expenditure as prophylactic and therapeutic support	0	0	0
Expenditure in health surveillance	753.922,72	787.233,11	1.029.767,20
Expenditure in epidemiological surveillance	0	0	0
Expenditure in other sub-functions	3.878.444,11	1.144.258,08	143.087,46
Total	13.757.008,17	16.644.127,14	17.607.110,57

Source: Institutionalization of pharmaceutical assistance in the municipality of Augusto Corrêan (2021).

The Information System on Public Health Budgets (SIOPS) was designed to enable the monitoring of spending in the sector, becoming a tool for monitoring the minimum application in Public Health Actions and Services (PHA) by the states, Federal District, and municipalities (Vieira, 2018). It is recognized that the financial transfers to the federative entities are not sufficient for the demands of actions and services in health. In this context, while it becomes necessary to evaluate the health system, it also highlights the need for dialogue about the underfunding of the Unified Health System (SUS). Health financing in Brazil has been insufficient to ensure the universality, integrity, and quality of public health. The low federal funding

reaches the three levels of care in an unequal way, affecting mainly Primary Health Care (PHC), which is around 20% of the total applied to health (Costa & Morimoto, 2017). It can be inferred that part of the structural problems that currently plague the SUS is the funding factor (Neto et al., 2017).

Among other regulatory milestones, Ordinance GM/MS No. 3,992, of December 28, 2017, establishes that the transfer of federal financial resources to fund health actions and services, previously transferred in five blocks, is now performed, as of January 10, 2018, to municipalities in two financial accounts: funding and infrastructure. Furthermore, in 2019, the Brazilian government launched a new policy for Primary Health Care (PHC) in the Unified Health System (SUS), through Ordinance No. 2,979, of November 12, 2019, which instituted the Previne Brazil Program, establishing a new funding model for the costing of Primary Health Care within the Unified Health System. The policy changed the financing of PHC for municipalities. Instead of inhabitants and Family Health Strategy (FHS) teams, intergovernmental transfers began to be calculated based on the number of people enrolled in PHC services and results achieved on a selected group of indicators (Araújo et al., 2018; Figueiredo et al., 2018; Brasil, 2019).

Until December 31, 2019, the financing of Primary Care was composed of Fixed and Variable PABs. The Fixed PAB was obtained by multiplying the resident population of the municipality by the per capita value that varies between R$23 and R$28. For this calculation, the 2016 population estimate of the Brazilian Institute of Geography and Statistics (IBGE) was used and the distribution of municipalities in four ranges, according to the following indicators: per capita GDP, percentage of the population with health insurance, percentage of the population with Bolsa Família, percentage of the population in extreme poverty, and demographic density (Brazil, 2019).

The Variable PAB depended on the accreditation and implementation of strategies and programs, such as Family Health Teams (FHT), Oral Health Teams (OHT) and Community Health Agents (CHA), among others. In short, the PAB funding was based on the per capita population logic and by adherence to strategies. The new PHC funding model is a mixed payment model that seeks to stimulate the achievement of results and is composed of the following components: weighted capitation, payment for performance and incentive for strategic actions (Brazil, 2019).

The financing of public health actions and services is the responsibility of the three management spheres of the Unified Health System (SUS), with due regard for the provisions of the Federal Constitution, Complementary Law No. 141 of January 13, 2012, and the Organic Health Law. The federal financial resources administered by the National Health Fund are intended to finance the public health actions and services of SUS member entities. Part of this resource is transferred to the states, the Federal District, and the municipalities so that they carry out, in a decentralized manner, health actions and services. As of January 2018, the resources of the Ministry of Health, destined for expenses with public health actions and services, to be transferred to the States, the Federal District and the Municipalities, are organized and

transferred in the form of the following financing blocks (Brazil, 2019): I. Block for the Costing of Public Health Actions and Services. II. Block of Investment in the Public Health Services Network.

The resources that make up each Block are transferred, fund-to-fund, in a regular and automatic manner, in a specific and unique current account for each Block and maintained in official federal financial institutions (Brazil, 2019). Payments made in the fund-to-fund modality are those characterized by the transfer through the decentralization of resources directly from the National Social Assistance Fund (FNAS) to state, municipal, and Federal District funds, in a regular and automatic manner. This type of payment is related to the co-financing of continuous action services (Brazil, 2015).

The Ministry of Health can only transfer resources to the state, Federal District, and municipality that have, as already provided for in Complementary Law No. 141 of January 13, 2012: I. Regular feeding and updating of the information systems that make up the SUS national information base. II. Health Council established and functioning III. Health Fund instituted by law, categorized as a public fund in operation; IV. Health Plan, annual health programming and management report submitted to the respective health council (Brazil, 2019).

Indicators related to pharmaceutical assistance planning and management tools

As for the Planning and Management Instruments of the Unified Health System (SUS), it is observed that the municipality of Augusto Corrêa, Pará, complies with the main ones, such as the Multi-Year Plan (PPA), the Municipal Health Planning (PMS), the Annual Health Planning (PAS), the Annual Management Report (RAG), the Detailed Report of the Previous Quarter (RDQA), and the General Health Actions and Services Programming (PGASS) (Chart 3).

It is known that planning in the Unified Health System (SUS) concerns the responsibilities of the managers of the three spheres of management. As recommended by the legislations of the Ministry of Health, planning should be organized as an ascending and articulated system obeying the programmatic actions and the budget forecast of the Health Plan (Fuginami et al., 2020). The planning process in public health is guided by several legal devices; such as the Constitution of the Federative Republic of Brazil, of October 5, 1988, Law No. 8,080, of September 19, 1990 and Law No. 8,142, of December 28, 1990, the Basic Operational Standards (NOB), the Operational and Health Care Standards (NOAS), the 2006 Pact for Health (Ordinance No. 399, of February 22, 2006) and Presidential Decree No. 7,508, June 28, 2011 (Ferreira et al, 2018).

The SUS Planning System (PlanejaSUS) was implemented based on the Health Pact (Ordinance No. 399 of February 22, 2006), aimed at organizing the planning process in a continuous, participatory, integrated, and articulated way among the three federative entities, giving the management instruments (Health Plan, Annual Health Programming, and Annual Management Report) a broader role in guiding and conducting the decision-making process and improving the effectiveness of actions and evaluating the

services provided (Trevisan; Junqueira, 2007; Vicentine et al., 2018; Fuginami et al., 2020). Pharmaceutical Assistance is explicit and linked to the management instruments of the System Health System (SUS); in particular, the Municipal Health Plan (PMS), Annual Health Programming (PAS) and the Annual Management Report (RAG) and the General Programming of Health Actions and Services (PGASS) (Ferreira & Soler, 2021).

SUS management is regulated by Ordinance GM/MS No. 2,135 of September 25, 2013, which defines that the Health Policy is synthesized in three main documents: Health Plan (PS), Annual Health Programming (PAS) and the Annual Management Report (RAG) (Santos, 2020). The Health Plan (HSP) is considered the central planning instrument for defining and implementing initiatives in each sphere of SUS management for a four-year period. The Annual Health Program (PAS), in turn, is considered the instrument that coordinates the intentions expressed in the Health Plan and aims to achieve its goals each year and predict the allocation of budgetary resources to be executed. The Annual Management Report (RAG) is defined as a management instrument that allows the manager to present the results achieved with the execution of the PAS and guides any necessary redirections in the PS (Brazil, 2013; Garcia & Reis, 2016).

According to Fuginami (2020), despite the recognition of the importance of management tools for health planning, it is observed that there are still many obstacles in relation to the effectiveness of management tools as the basis for health actions; for example, the lack of understanding of the basic concepts of their construction and use that leads to failures in their preparation, difficulty in integrating these instruments among themselves, and of these, with the government's Multi-Year Plan (PPA), and weaknesses in the practices of articulation, integration, and bottom-up planning.

As for the Technical Management of Pharmaceutical Assistance, it is observed that the stages of drug logistics (Selection, Programming, Acquisition, Storage, Distribution and Dispensing) are done in a standardized manner, using Standard Operating Procedures (Chart 3). However, according to information passed on by the manager, there are flaws in some of the steps.

It is observed that the municipality does not have a Pharmacy and Therapeutics Committee (CFT), which can compromise some phases of the Pharmaceutical Care Cycle, undermining its organization. The selection of medications, for example, should be carried out by a CFT, defining which medications and inputs will be made available by the SUS for the different levels of health care (Conselho Nacional de Secretários de Saúde, 2011). The purpose of the Pharmacy and Therapeutics Commission (CFT) is to select the essential drugs used in the health system. It is composed of health professionals of various backgrounds, including the pharmacist, whose main role is to carry out educational measures to promote the rational use of medicines. The CFT consists in a strategy where the manager makes more consistent decisions, based on evidence-based health (Barreto & Guimarães, 2010; Teixeira et al., 2017). In this sense, the CFT is

fundamental in this stage of Pharmaceutical Assistance and its absence implies in the reduction of the effectiveness of the selection (Reis & Perini, 2008; Pereira & Fernandes, 2017).

The municipality does not have a computerized system, such as the Horus System, that helps in the management of Pharmaceutical Assistance; that is, it may compromise the entire logistics cycle, especially the Medication Programming. According to Roque (2017), in order to carry out the programming step, it is necessary to have reliable databases for the use of information such as epidemiological profile, historical consumption, adjusted consumption, service supply, among others. Therefore, this would explain, according to the author, the need to use information systems and inventory management.

The Pharmaceutical Supply Center (CAF) is not structured and organized according to the legal frameworks established by the health surveillance, which may interfere in the quality standards related to the receipt, storage and security against physical damage, theft or robbery, and conservation may not be satisfactorily performed. According to Pinto (2016), it is common in institutions the improvisation in the facilities of their medicine storage locations, forgetting that this space should ensure quality, availability at distribution points, safety and control of stored products. The Pharmaceutical Supply Center (CAF) is the pharmaceutical assistance unit that has the purpose of storing medications and related products, where activities regarding their correct reception are performed, storage and distribution (Rosa et al., 2006; Correia, 2020). Therefore, a good CAF structure is essential to fulfill the purposes of the Storage stage and ensure proper conservation, storage and safety of medicines.

Regarding the purchase of medicines, it is observed that the Secretariat of Health of Augusto Correa does not use the Health Price Database System (BPS) of the Ministry of Health; a system that is intended for the registration and consultation of information on purchases of medicines and health products made by public and private institutions (Brazil, 2021). This system, created by the Ministry of Health, reports the prices paid nationally for medicines and health products purchased by public and private institutions registered in the bank, as it registers, stores, and makes the information available via the web. In addition, the system offers management reports that can help institutions manage their financial resources (Conselho Nacional de Secretarias de Saúde, 2011).

The Tripartite Interagency Commission (CIT), through Resolution No. 18 of June 2017, determines that states, the Federal District, and municipalities are required to use the Health Price Bank (BPS). To this end, health institutions that bid on medications and supplies must register with the BPS so that they can enter their purchasing information into the system (Brazil, 2021).

There are two pharmaceutical professionals in the municipal management, which serve a population of 46,937 inhabitants; that is, insufficient to meet the needs regarding the technical-managerial technical-assistance aspects of pharmaceutical care. The insufficiency of pharmaceutical professionals may compromise the pharmaceutical care; since this professional provides the use of medicines with quality (World Health Organization, 1993; Castro, 2004; Chemello, 2006; Teixeira & Teles, 2017; Moreira, 2017).

Table 3 - Indicators related to pharmaceutical assistance planning and management tools in the municipality of Augusto Corrêa.

CATEGORY/INDICATOR	YES	NO
Pharmaceutical assistance policy		
Is the Pharmaceutical Assistance Coordination part of the official organizational chart of the Municipal Health Secretariat?	X	
Type of employment relationship of the pharmacist in charge of the Pharmaceutical Assistance Coordination? A = Contracted	X	
Workload in the function as coordinating pharmacist of the Pharmaceutical Assistance in the municipality? A = 30 hours	X	
Is there a job and salary plan that contemplates the Pharmaceutical Assistance professionals?		X
Is there a performance evaluation mechanism for Pharmaceutical Assistance professionals with incentives related to the achievement of goals or production?		X
How many pharmacists work in the municipality's health services or total number of pharmacists?	2	
Is Pharmaceutical Assistance part of the Municipal Health Plan (PMS)?	X	
Where are pharmacists working? You can mark more than one option: (specify) A = Pharmaceutical Supply Center and Psychosocial Care Center	X	
Instruments for planning and managing pharmaceutical assistance		
Is Pharmaceutical Assistance contemplated in the Municipal Health Plan (PMS)?	X	
Is Pharmaceutical Assistance contemplated in the Annual Health Program (PAS)?	X	
Is Pharmaceutical Assistance contemplated in the Regionalization Master Plan (RDP)?	X	
Is the Pharmaceutical Assistance contemplated in the Contrato Organizativo de Ação Pública (COAP)?	X	
Is Pharmaceutical Assistance contemplated in the General Program of Actions and Health Services (PGASS)?	X	
Is Pharmaceutical Assistance contemplated in the Budget Guidelines Law (LDO)?	X	
Is Pharmaceutical Assistance contemplated in the Annual Budget Law (LOA)?	X	
Is the Pharmaceutical Assistance contemplated in the Multi-Year Plan (PPA)?	X	
Is the Pharmaceutical Assistance included in the Detailed Report of the Previous Quarter (DQRF)?	X	
Is the Pharmaceutical Assistance included in the Annual Management Report (RAG)?	X	
Is Pharmaceutical Assistance contemplated in the Integrated Regional Planning (PRI)?	X	
Does the accountability made to the Municipal Health Council (CMS) include pharmaceutical assistance?	X	
Technical management of pharmaceutical assistance		
There is a Pharmaceutical Supply Center structured and organized according to standard operating procedures regulated by the health surveillance?		X
Is there a Pharmacy and Therapeutics Committee (CFT) responsible for drug standardization?		X
Is there a standardized list of drugs or a list of essential drugs?	X	
Is there a Computerized System for Pharmaceutical Assistance Management?		X
Does the municipality use the Horus System?		X
Does the Horus System meet the municipality's needs?		X
Pharmaceutical assistance logistics		
Drug Selection		
Does the municipality use standard operating procedures for drug selection?	X	
What is the total quantity (number) of medicines included in the Municipal List of Essential Medicines (REMUME) in your municipality?	160	
What is the quantity (number) of medicines that make up the National List of Essential Medicines (RENAME) and that are included in the Municipal List of Essential Medicines (REMUME) in your municipality?	160	
What is the quantity (number) of medicines that are not part of the National List of Essential Medicines (RENAME) and that are included in the municipality's Municipal List of Essential Medicines (REMUME)?	0 (zero)	
Acquisition of medicines		
Does the municipality use standard operating procedures for the procurement of medicines?	X	
What are the predominant forms of medicine procurement used by the municipality? A = Municipal Bidding Process and Centralized Purchase	X	
Does the pharmacist participate in the elaboration of the Term of Reference (TR) for the acquisition of medicines?	X	
Does the pharmacist issue a technical opinion in the bidding process for the acquisition of medication?		X
Is the Municipality organized in the form of a consortium for the acquisition of medicines?		X
If the municipality participates in a Consortium for the Purchase of Medicines, what are the advantages observed?		X
Does the municipality use the Banco de Preçodo do Brasil tool?	X	
Does the Health Secretariat use the information available at the Price Bank to guide the drug procurement process?	X	

Does the Secretariat of Health feed the Database of Prices without Health with information about the prices practiced without its acquisitions related to Pharmaceutical Assistance?		X
Storage of medicines		
Does the municipality use standard operating procedures for the receipt and storage of medicines?	X	
Medicine Distribution		
Does the municipality use standard operating procedures for the distribution of medicines?	X	
Drug Dispensing		
Does the municipality use standard operating procedures for dispensing medicines?	X	
Governance practices at the pharmaceutical assistance technical coordination level		
Does the municipality apply governance practices at the level of the Coordination of Pharmaceutical Assistance?	X	
Does the municipality apply management by results practices at the level of the Technical Coordination of Pharmaceutical Assistance?	X	
Does the municipality apply strategic planning practices at the level of the Technical Coordination of Pharmaceutical Assistance?	X	
Does the municipal manager have legal counsel to respond to judicial demands for the supply of medicines?	X	
Does the municipal manager have technical pharmaceutical counseling to respond to judicial demands for the supply of medicines?	X	
What is the highest incidence of judicial demand? A = Drugs from the specialized component	X	
What are the technical-managerial actions (logistics) performed by the pharmacist in the municipality? A = Management of pharmaceutical logistics, permanent education and health education	X	
What are the technical-assistance actions (Pharmaceutical Services) offered by the pharmacist in the municipality? A = Pharmaceutical intervention and/or case management	X	
Does the municipality fulfill the actions and/or services foreseen in the General Program of Actions and Health Services (PGASS)?		X
Sectoral policies		
Does the municipality offer Integrative and Complementary Health Practices?		X
Are there phytotherapic medicines (medicinal plants) offered by the municipality in the public health network?		X
According to Rename-Fito, which phytotherapies (medicinal plants) are offered? A = None of the alternatives		X
Are there homeopathic medicines offered by the municipality in the public network?		X
In general, is the notification of complaints and/or adverse drug events to the Health Surveillance Notification System - Notivisa/Anvisa?		X
Please indicate three themes (subjects) for courses in the field of pharmaceutical assistance - via remote teaching - that you believe COSEMS-PA should offer to the municipalities. A = Course on PGASS, PRI and PDR.	X	

Source: Institutionalization of pharmaceutical assistance in the municipality of Augusto Corrêa (2021).

As for sectoral policies, it is observed that the municipality does not adopt Integrative and Complementary Practices (IPC), such as medicinal plants and homeopathic medicines, among others. PIC's are medical systems and complex therapeutic resources employed to promote broad health care, valuing the autonomy, culture, and environment of individuals (Reis et al., 2018). These Practices, by privileging the therapeutic activity and being based on theories focused on environmental and behavioral aspects of the health-disease process, are characterized as potentially interesting strategies for facing the new challenges in health care (Habimorad et al., 2020).

Governance practices at the pharmaceutical assistance technical coordination level

The governance practices at the level of the Technical Coordination of Pharmaceutical Assistance (CTAF), in particular regarding people and competencies, principles and behaviors, organizational leadership, relationship with stakeholders, organizational strategy, trans-organizational alignment,

governance structure, risk management and internal control, internal audit, accountability, and transparency (Chart 5).

With regard to people and competencies, the Technical Coordination of Pharmaceutical Assistance (CTAF) did not present satisfactory results (Chart 5). It is known that an organization, in order to have satisfactory results, depends on the Human Resources that work there. Thus, the CTAF must invest in professionals with appropriate competencies. In this dimension of governance, it is essential to mobilize the knowledge, skills, and attitudes of workers to optimize results (Soler et al., 2017). Thus, it is necessary, for the good performance of human resources available within the organization, the periodic qualification, aiming at the achievement of results.

Table 5 - Governance practices at the pharmaceutical assistance technical coordination level.

CATEGORIES/INDICATORS	YES	NO
Practices regarding People and competencies		
Practice L1.1 Uses a transparent and formalized process that guides the nomination, selection, and appointment of members of top management and operational management.		X
Practice L1.2 Ensures the appropriate training of the members of the senior management and operational management, so that the competencies required to perform their activities are developed. The training process must be carried out when they are appointed to new positions or when it becomes necessary.		X
Practice L1.3 Establishes a performance evaluation system for the members of top management and operational management.		X
Practice L1.4 Ensure that the set of benefits from top management is transparent and adequate to attract good professionals and encourage them to stay focused on organizational results.	X	
Practices regarding Principles and behaviors		
Practice L2.1 Adopts a code of ethics and conduct formally instituted and sufficiently detailed and clear that defines standards of behavior applicable to the members of the boards, the senior management and the managers of organization.	X	
Practice L2.2 Establish appropriate control mechanisms to prevent biases, biases or conflicts of interest from influencing the decisions and actions of board members, senior management and managers.	X	
Practice L2.3 Acts according to behavioral standards, based on the constitutional, legal and institutional values and principles and on the code of ethics and conduct adopted, serving as an example to all.	X	
Practice L2.4 Contributes to the good reputation of the organization through good relations with citizens and other institutions.	X	
Organizational leadership practices		
Practice L3.1 Evaluates, directs, and monitors the organization's management, especially the achievement of institutional goals and the behavior of senior management and managers.	X	
Practice L3.2 Define the roles and distribute the responsibilities among board members, top management, and managers to ensure power balance and segregation of critical functions.	X	
Practice L3.3 It is accountable to the governance structures (internal and external) for establishing policies and guidelines for managing the organization and achieving the expected results.	X	
Practice L3.4 Evaluate the results of control activities and audit work and ensure that appropriate actions are taken.	X	
Stakeholder Relationship Practices		
Practice E1.1 Establish a social participation model, in which the involvement of society, users and other stakeholders in the definition of priorities is promoted.		X
Practice E1.2 Establish and disseminate communication and consultation channels with the different stakeholders and ensure their effectiveness, considering the characteristics and access possibilities of each target audience.	X	

Source: Institutionalization of pharmaceutical assistance in the municipality of Augusto Corrêa (2021).

The training or qualification of professionals does not occur in the governance practices in the organization within the CTAF. The work of Barros et al., (2017) states that the training of professionals is a relevant aspect in the consolidation of public policies. The organizational strategy should be defined in a way that allows the identification, development, and use of individuals' competencies for organizational success (Chouhan & Shivastana, 2014; Montezano, et al., 2019). In public organizations, management by

competencies is one of the elements that provides flexible forms of management, being entrepreneurial and innovative, once used to promote more quality and efficient public service (Guimarães, 2000; Montezano et al., 2019).

It is recognized, the premise that the domain of certain resources has a direct impact on the superior performance of an organization, the management by competencies has its core the management of competency gaps, seeking to reduce disparities between the available competencies and the competencies considered necessary for the achievement of organizational objectives and has shown itself as an important strategic management tool for organizations (Mello & Amâncio-Filho, 2010; Brandão & Bahry, 2015; Cavalcante & Renault, 2018). Professional competence can be considered the mobilization in a particular way by the professional in his productive action through a set of knowledge of differentiated nature, which form the intellectual, technical-functional, behavioral, ethical and political competencies, which generate results recognized individually, collectively, economically and socially (Paiva & Mageste, 2018).

Regarding principles and behaviors, the Technical Coordination of Pharmaceutical Assistance (CTAF) did not present satisfactory results (Chart 5). It is necessary to have in its staff, professionals with skills and abilities that demonstrate high standards of ethical conduct. One of the principles of good governance consists in the commitment of the team members with ethical values, with integrity, with observance and compliance with the legislation (Soler et al., 2107). Obeying this line of thought, the work developed within the organization provides efficient and effective results.

As for leadership, the Technical Coordination of Pharmaceutical Assistance (CTAF) did not show satisfactory results (Table 5). Leadership emerges as a process of social construction (Neto & Moura, 2019). In this sense, an act of leading can imply multiple simultaneous references to hierarchy, identity, individual or shared power, mission, and organizational responsibility (Neto & Moura, 2019). Leadership stands out as a resource to generate knowledge, behavior, and improve the results of organizations (Junior et al., 2016).

As for the relationship with stakeholders, the Technical Pharmaceutical Assistance Coordination (CTAF) did not present satisfactory results (Chart 5). It needs to relate to the other sectors of the organization, with social participation in a transparent way, and to promote communication channels between the parties. The focus of the CTAF should be the provision of services efficiently, the alignment of its actions with the expectations of stakeholders, whether direct and indirect, is fundamental to optimize results (Soler et al., 2017). Then in the dimension in relation to stakeholders, the participation of representatives of the social segment is fundamental, especially in municipal health councils, since it counts as a space for monitoring the implementation of public policies (Barros et al., 2017).

As for organizational strategy, the Technical Coordination of Pharmaceutical Assistance (CTAF) did not present satisfactory results (Chart 5). It should be interconnected with the key stakeholders in the governance process. The organization's objectives need the commitment of stakeholders, with a focus on results.

As for the trans-organizational alignment, the Technical Coordination of Pharmaceutical Assistance (CTAF) did not present satisfactory results (Chart 5). This practice identifies how institutions need to have trans-organizational relationships, with objectives and purposes that can drive and strengthen them, using mechanisms that provide the performance and cooperation so that the actors can collaborate with the mission of the organization (Federal Audit Court, 2014; Costa et al., 2018). For this reason, it is worth emphasizing the need for horizontal integration with public policies, especially of a cross-cutting nature as is the case of Pharmaceutical Assistance, so that there is an institutionalized mechanism in order to develop conditions for joint and synergistic action in those involved in the organization (Soler, 2017). The results in the municipality were positive.

As for the governance structure, it did not present satisfactory results (Table 5). However, it is known that governance structures are responsible for defining, implementing, and keeping in operation the organization's governance system (Soler et al., 2017).

As for risk management and internal control, the Technical Coordination for Pharmaceutical Assistance (CTAF) did not present satisfactory results (Chart 5). Risk management considers uncertainties and works with this in light of the organization's objectives. In this sense, risk management would aim at the delivery of quality services (Souza, 2016; Braga, 2017). In this sense, risk management becomes important in what concerns, the choice, selection of the best prognoses for the organization. So to reach these objectives, that risk management is done, as well as an adequate internal control system in organizations (Braga, 2017).

As for Internal Audit, the Technical Coordination of Pharmaceutical Assistance (CTAF) did not present satisfactory results (Chart 5). Thus, the internal audit performs an activity with objectivity and independence, providing support within the organization, aiming at improving organizational processes, among which is risk management (Ribeiro, 2021).

Regarding accountability and transparency, the Technical Coordination of Pharmaceutical Assistance (CTAF) did not present satisfactory results (Chart 5). Periodic performance reports of the governance and management systems were published according to the legislation in force. On the other hand, there were irregularities in this type of management process. Thus, in the context of governance practices there is much to be improved.

Governance practices, management by results and situational strategic planning, are new concepts in the field of actions, activities and tasks of the Technical Coordination of Pharmaceutical Assistance (CTAF). In this sense, a global analysis allows us to infer that there is much to advance (Soler et al., 2017; Maschieto, 2018).

Governance refers to organizational structures, functions, processes, and traditions that aim to ensure that planned actions, programs, are executed in such a way that they achieve their objectives and results in a transparent manner. Governance refers to activities supported by common goals, which may or

may not derive from legal and formally prescribed responsibilities and do not necessarily depend on police power to be accepted and overcome resistance (Brazil, 2013; Dagnino, 2016; Pena, 2016; Bretas Junior & Shimizu, 2017; Casanova et al., 2017; Lima et al., 2019).

Management by Results is an organizational management model that is based on the commitment of employees; that is, it is not focused on the number of hours worked, but on the commitment to meet goals. It starts from the premise that there is already a superior direction and that public agents must ensure that it is executed in the best possible way in terms of efficiency (Gomes, 2009; Pará, 2012; Soler, 2017). Management by results emphasizes the objectives to be achieved, as well as the organization's values.

Strategic Situational Planning (SEP) is an important management tool for governments; a process that allows for the identification, prioritization, and explanation of problems, as well as the definition of objectives, design of operations, and actions to achieve the objectives (Darosi, 2015; Pereira & Tomasi, 2016). Planning should consider the integrality of actions and health services in the territories. It is a tool that seeks observation to diagnose reality and propose alternatives to transform it. In the context of Pharmaceutical Assistance, there are several steps that correspond to its logistics cycle, which must be executed in a harmonic way in order to achieve the main objective, which is to ensure access and rational use of medicines (Matus, 1993; Kleba et al., 2011; Pan American Health Organization, 2014; Limberger et. al., 2016; National Council of Health Secretaries, 2021).

Finally, it is recognized that governance, management by results and planning in health are essential for the development and sustainability of any area of the Unified Health System (SUS), especially in the field of Pharmaceutical Care (Feil & Schreiber, 2017; Soler et al., 2017). When it comes to sustainability in health, strategies for the Promotion of the Rational Use of Medicines or Use with Quality of Medicines, become indispensable, among them, those related to ensuring the effectiveness of drugs, the effectiveness of medicines and the efficiency of treatments.

Difficulty, limit and bias: Difficulty in accessing up-to-date data was noted. Unilateral vision of a single professional interviewed can be a limit. Potential bias regarding misunderstanding of terms used.

Application: To reflect on the process of governance, management, planning, and institutionalization of pharmaceutical assistance at the municipal level.

4 CONCLUSION

It was found that the components of technical pharmaceutical care management and clinical drug management were not fully complied with; as well as governance practices at the technical pharmaceutical care coordination level need to be improved; in particular, personnel and competencies, principles and behaviors, organizational leadership, stakeholder relations, organizational strategy, cross-organizational alignment, governance structure, risk management and internal control, internal audit, accountability and transparency.

It is recommended to implement the Pharmacy and Therapeutics Commission, the Computerized System for Pharmaceutical Care Management, Integrative and Complementary Health Practices, Pharmaceutical Services, and to use the Health Price Bank.

Further studies are proposed in the municipality of Augusto Correa, Pará, aiming to correlate the indicators of the governance process, management by results, and situational strategic planning with access, use of medicines with quality, and improvement in the quality of life of users.

Author contributions: Authors TLSF, TCMS, BWBC and GCL conceived the research design under the guidance of KCOCC and OS. TLSF, TCMS, BWBC, and GCL applied the research instruments and wrote the paper under the supervision of KCOCC and OS. The authors read and approved the final version of the paper. The content of the paper is the sole responsibility of the authors.

Conflict of interest statement: The authors declare that the research was conducted in the absence of any business or financial relationships that could be construed as a potential conflict of interest.

REFERENCES

AbouZahr, C., & Wardlaw, T. (2001). Maternal mortality at the end of a decade: signs of progress? Bulletin of the World Health Organization, 79(6), 561–568. Maternal mortality at the end of a decade: signs of progress? - PubMed (nih.gov)

Almeida, H. G. & Silva, G. B. C. (1998). Programa Informações para Gestão Territorial: Socioeconômica do Município de Augusto Corrêa. Belém.

Amorim, A. S. & Campos, R. I. R. De. (2019). Perspectiva de ecoturismo na ilha de Camará-Açu e a relação de pertencimento do pescador local com a APA da Costa do Urumajó. 9(1):4-26. https://www.seer.ufal.br/index.php/ritur/article/view/5539

Araújo, C. E. L., Guilherme, Q. G. & Machado, J. A. (2017). Os municípios brasileiros e os gastos próprios com saúde: algumas associações. Ciências e Saúde coletiva, 22(3), 953-963. https://doi.org/10.1590/1413-81232017223.15542016.

Araújo, G. R. F. (2012). Migração, territorialização e pesca em Augusto Correa, PA (1990-2010). Universidade Federal do Pará [Dissertação Mestrado, Universidade Federal do Pará]. RIUFPA

Araújo, S. Q., Costa, K. S., Luiza, V. L., Lavras, C., Santana, E. A. & Tavares, N. U. L. (2017). Organização dos serviços farmacêuticos no Sistema Único de Saúde em regiões de saúde. Ciência & Saúde Coletiva. 22(4):1181-1191. https://doi.org/10.1590/1413-81232017224.27042016

Barbosa, M. M., Garcia, M. M., Nascimento, R. C. R. M., Reis, E. A., Guerra Junior, A. A., Acurcio, F. A. & Álvares, J. (2017). Avaliação da Assistência Farmacêutica no Sistema Único de Saúde em Minas Gerais. Ciências e Saúde coletiva. 22(8):2475-2486. https://doi.org/10.1590/1413-81232017228.10952017

Barreto, J. L. & Guimarães, M. C. L. (2010). Avaliação da gestão descentralizada da assistência farmacêutica básica em municípios baianos, Brasil. Cad. Saúde Pública. 26(6), 1207-1220. https://doi.org/10.1590/S0102-311X2010000600014

Barros, R. D. et al. (2017). Acesso a medicamentos: relações com a institucionalização da assistência farmacêutica. Rev Saude Publica. 51(Supl 2):8s. https://doi.org/10.11606/S1518-8787.2017051007138.

Batista, I. M. S. (2012). Histórias e memórias Urumajoenses: novas perspectivas. Sobre o Município (augustocorrea.pa.gov.br)

Beojone, C., Santos,H., Maruyama, L. & Mariano, E. (2016). Expectativa de vida é suficiente para o IDH? https://www.researchgate.net/publication/311617491_Expectativa_de_vida_e_suficiente_para_o_IDH

Bermudez, J. A. Z., Esher, A., Osório-de-Castro, C. G. S. Vasconcelos, G. C. C., Oliveira, M. A., Silva, R. M. & Luiza, V. L. (2018). Assistência Farmacêutica nos 30 anos do SUS na perspectiva da integralidade. Ciência & Saúde Coletiva. 23(6): 1937-1949. https://doi.org/10.1590/1413-81232018236.09022018

Boing, A. F & Blatt, C. R. (2013). Gestão da Assistência Farmacêutica: O uso de ferramentas da epidemiologia na assistência farmacêutica. Universidade Federal de Santa Catarina. Modulo_4_unidade_1_revisado (1).pdf

Braga, M. V. A. (2017). Risco Bottom Up: Uma reflexão sobre o desafio da implementação da gestão de risco no setor público brasileiro. Revista da CGU.
9(15):682-699. https://doi.org/10.36428/revistadacgu.v9i15.103

Brasil. Ministério da Saúde. (1990). Lei nº 8080, de 19 de setembro de 1990. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. Diário Oficial da União.

Brasil. Ministério da Saúde. (1998). Portaria GM nº 3.916, de 30 de outubro de 1998. Política Nacional de Medicamentos. Brasília. Diário Oficial da União. Brasil. Conselho Nacional de Saúde. (2004). Resolução CNS nº 338 de 6 de maio de 2004. Aprova a Política Nacional de Assistência Farmacêutica. Brasília. Brasil. Ministério da Saúde. (2006). Portaria nº 971/GM/MS, de 3 de maio de 2006. Institui a Política Nacional de Práticas Integrativas e Complementares (PNPIC), instituída pela publicada no Diário Oficial da União (DOU) nº 84, de 4 de maio de 2006, Seção 1, página 20. Brasília. Distrito Federal.

Brasil. Ministério da Saúde. (2006). Planejar é preciso: uma proposta de método para aplicação à assistência farmacêutica / Ministério da Saúde, Secretaria de Ciência, Tecnologia e Insumos Estratégicos, Departamento de Assistência Farmacêutica e Insumos Estratégicos. Editora do Ministério da Saúde. 06_1143_miolo.indd (saude.gov.br)

Brasil. Conselho Nacional de Secretários de Saúde. (2007). Assistência Farmacêutica no SUS. Conselho Nacional de Secretários de Saúde. (1 ed.). Coleção Progestores: Para entender a gestão do SUS. 180p. Brasília.

Brasil. Conselho Nacional de Secretários de Saúde. (2011). Assistência Farmacêutica no SUS. Conselho Nacional de Secretários de Saúde. Coleção Para Entender a Gestão do SUS. 7, 186. Brasília.

Brasil. Presidência da República. (2011). Decreto nº 7.508, de 28 de junho de 2011. Regulamenta a Lei nº 8.080, de 19 de setembro de 1990, para dispor sobre a organização do Sistema Único de Saúde (SUS), o planejamento da saúde, a assistência à saúde e a articulação interfederativa, e dá outras providências. Diário Oficial da União, Brasília, DF, 29 jun. 2011.

Brasil. Conselho Nacional de Saúde. (2012) Resolução nº 466 de 12 de dezembro de 2012. Aprova as diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. Brasília. Distrito Federal. https://www.inca.gov.br/sites/ufu.sti.inca.local/files//media/document//resolucao-cns-466-12.pdf

Brasil. Congresso Nacional. (2012). Lei Complementar nº 141, de 13 de janeiro de 2012. Dispões sobre os valores mínimos a serem aplicados anualmente pela União, Estados, Distrito Federal e Municípios em ações e serviços públicos de saúde entre outras providências. Brasília. Distrito Federal.

Brasil. Ministério da Saúde. (2013). Portaria GM nº 2.135, de 25 de setembro de 2013. Estabelece diretrizes para o processo de planejamento no âmbito do Sistema Único de Saúde (SUS). Brasília. Distrito Federal.

Brasil. Tribunal de Contas da União. (2013). Referencial básico de governança/Tribunal de Contas da União. – Brasília: TCU, Secretaria de Planejamento, Governança e Gestão, Coordenação-Geral de Controle Externo dos Serviços Essenciais ao Estado e das Regiões Sul e Centro-Oeste. 57p.

Brasil. Ministério da Saúde. (2017). Portaria nº 849, de 27 de março de 2017. Inclui a Arteterapia, Ayurveda, Biodança, Dança Circular, Meditação, Musicoterapia, Naturopatia, Osteopatia, Quiropraxia, Reflexoterapia, Reiki, Shantala, Terapia Comunitária Integrativa e Yoga à Política Nacional de Práticas

Integrativas e Complementares. Publicado no Diário Oficial da União (DOU), 28 de março de 2017, seção 1, página 68. Brasília. Distrito Federal.

Brasil. Ministério da Saúde. (2019). Portaria nº 2.979, De 12 de Novembro de 2019. Institui o Programa Previne Brasil, que estabelece novo modelo de financiamento de custeio da Atenção Primária à Saúde no âmbito do Sistema Único de Saúde, por meio da alteração da Portaria de Consolidação nº 6/GM/MS, de 28 de setembro de 2017. Brasília. Distrito Federal.

Brasil. Ministério da Saúde. (2019). Portaria n° 2.979, 12 de novembro 2019. Institui o Programa Previne Brasil, que estabelece novo modelo de financiamento de custeio da Atenção Primária à Saúde no âmbito do Sistema Único de Saúde. Brasília. Distrito Federal.

Brasil. Ministério da Saúde. (2020). Secretaria de Ciência, Tecnologia, Inovação e Insumos Estratégicos em Saúde. Departamento de Assistência Farmacêutica e Insumos Estratégicos. Relação Nacional de Medicamentos Essenciais: Rename 2020. Brasília: Ministério da Saúde, 2020. 217p. ISBN 978-85-334-2748-8

Brasil. Ministério da Saúde. (2021). Banco de dados do Sistema Único de Saúde: DATASUS. http://www.datasus.gov.br

Brasil. Conselho Nacional de Secretários de Saúde. (2021). Planejamento e gestão. Organizadores: Santos, A. O., & Lopes, L. T. Brasília. Distrito Federal. covid-19-volume2.pdf

Brasil. Ministério da Saúde. (2021). Gestão do SUS: Banco de Preços em Saúde. http://antigo.saude.gov.br/gestao-do-sus/economia-da-saude/banco-de-precos- em-saude.

Bretas Junior, N., & Eri Shimizu, H. (2017). Reflexões teóricas sobre governança nas regiões de saúde. Ciência & Saúde Coletiva, 22(4),1085-1095. https://www.redalyc.org/articulo.oa?id=63050551007

Bueno, H. (2010). Histórico e avanços na utilização das Salas de Situação em Saúde no Brasil. Organização Pan-Americana da Saúde. Ministério da Saúde. Brasília. Organização Pan-Americana da Saúde; 62p. Título da apresentação do treinamento (paho.org)

Cavalcante, F. V. & Renault, T. B. (2018). Gestão por competência: Uma avaliação das práticas de pessoas em uma instituição pública de ciência e tecnologia em saúde. Revista de Administração Hospitalar e Inovação em Saúde. 15(2). https://doi.org/10.21450/rahis.v15i2.4541

Carvalho, A. L. B, Jesus, W. L. A, Senda, I. M. V. B. (2017). Regionalização no SUS: o processo de implementação, desafios e perspectiva na visão crítica de gestores do Sistema. Ciência e Saúde Coletiva. 22(4):1155-1164. 10.1590/1413-81232017224.30252016

Casanova., A. O. Cruz, M. M., Giovanella, L. Alves, G. dos R. & Cardoso, G. C. P. (2017). A implementação de redes de atenção e os desafios da governança regional em saúde na Amazônia Legal: uma análise do Projeto QualiSUS-Rede. Ciência & Saúde Coletiva. 22. 1209-1224. 10.1590/1413-81232017224.26562016.

Corrêa, E. R. P. & Miranda-Ribeiro, A. de. (2017). Ganhos em expectativa de vida ao nascer no Brasil nos anos 2000: impacto das variações da mortalidade por idade e causas de morte. Ciência & Saúde Coletiva. 22(3):1005-1015. https://doi.org/10.1590/1413-81232017223.26652016.

Correia, E. O. (2020). Análise da infraestrutura e condições de armazenamento dos medicamentos da central de abastecimento farmacêutico, de um município do Extremo Sul Baiano. Caderno Saúde e

Desenvolvimento. 9(16). https://cadernosuninter.com/index.php/saude-e-desenvolvimento/article/view/1480/1096

Costa, A. C. P., Leal, A. F. P., Nascimento, L. C. B. do, Mendonça, C. M. C. de, & Guerra, L. C. B. (2018). Alinhamento da gestão de processos com os mecanismos do modelo de governança pública do TCU: O estudo de caso em uma universidade federal da Amazônia Oriental. Revista Do Serviço Público. 69(3):741-772. https://doi.org/10.21874/rsp.v69i3.3183

Costa, J. S. D. & Morimoto, T. (2017). Internações por condições sensíveis à atenção primária, gastos com saúde e Estratégia Saúde da Família uma análise de tendência. Ciências e Saúde Coletiva. https://www.cienciaesaudecoletiva.com.br/artigos/internacoes-por-condicoes-sensiveis-a-atencao-primaria-gastos-com- saude-e-estrategia-saude-da-familia-uma-analise-de-tendencia/16013?id=16013

Dagnino, R. (2016). Gestão Estratégica Publica. Fundação Perseu Abramo.

Feil, A.A. & Schreiber, D. (2017). Sustentabilidade e desenvolvimento sustentável: desvendando as sobreposições e alcances de seus significados. Cad. EBAPE.BR. 14(3):667-681 http://dx.doi.org/10.1590/1679-395157473

Ferreira, J. E. De S. M. (2020). Sistema de Informação em Saúde no apoio da Atenção Primária à Saúde: revisão integrativa. Revista Eletrônica de Comunicação Informação e Inovação em saúde. 14(4):970-82. https://doi.org/10.29397/reciis.v14i4.1923

Ferreira, J., Celuppi, I. C., Baseggio, L., Geremia, D. S., Madureira, V. S. F. & Souza, J. B. de. (2018). Planejamento regional dos serviços de saúde: o que dizem os gestores? Saúde e Sociedade. 27(1):69-79. https://doi.org/10.1590/S0104-12902018170296

Ferreira, R. L. & Soler, O. (2021). Prática de governança e gestão técnica da assistência farmacêutica no Município de Xinguara, Pará. Research, Society and Development. 10(4). http://dx.doi.org/10.33448/rsd-v10i4.14416

Figueiredo, J. O., Prado, N. M. de B. L., Medina, M. G., Paim, J. S. (2018). Gastos públicos e privado com saúde no Brasil e países selecionados. Saúde debate.
42(spe2). 37-47. https://doi.org/10.1590/0103-11042018S203

França, E., Teixeira, R., Ishitani, L., Duncan, B. B., Cortez-Escalante, J. J., Morais, Neto O. L. & Szwarcwald, C. L. (2014). Causas mal definidas de óbito no Brasil: método de redistribuição baseado na investigação do óbito. Rev Saude Publica. 48(4):671-681. https://doi.org/10.1590/S0034-8910.2014048005146

Fuginami, C. N., Colussi, C. F. & Ortiga, A. M. B. (2020). Análise dos instrumentos de gestão elaborados pelas Secretarias Municipais de Saúde de Santa Catarina no período de 2014 a 2017. Saúde em Debate, 44(126), 857-870. https://doi.org/10.1590/0103-1104202012620

Garcia, P. T. & Reis, R. S. (2016). Gestão Pública em Saúde: O plano de saúde como ferramenta de gestão. EDUFMA.

Garnelo, L., Sousa, A. B. L. & Silva, C. de O. da. (2017). Regionalização em Saúde no Amazonas: avanços e desafios. Ciência & Saúde Coletiva. 22(4):1225- 1234. https://doi.org/10.1590/1413-81232017224.27082016

Gomes, E. G. M. (2009). Gestão por Resultados e eficiência na Administração Pública: uma análise à luz da experiência de Minas Gerais. EAESP/FGV.

Gonçalves, N. V. & Gasparetto, D. (2008). Modelo de análise espaço-temporal da prevalência da malária, no município de Bragança e Augusto Correa, PA, no período de 2001 a 2006. Revista Electrónica de Geografía y Ciencias Sociales. 12(270):1-7. Modelo de análise espaço-temporal da prevalência da malária, no município de Bragança e Augusto Correa – PA, no período de 2001 a 2006 (ub.edu)

Habimorad, P. H. L., Catarucci, F. M., Bruno, V. H. T., Beteto, I. S., Fernandes, V. C., Demarzo, M. M. P., Spagnuolo, R. S. & Patricio, K. P. Potencialidades e fragilidades de implantação da Política Nacional de Práticas Integrativas e Complementares: revisão narrativa. Cien Saude Colet. 25(2):395-405. https://doi.org/10.1590/1413-81232020252.11332018

Instituto Brasileiro de Geografia e estatística (IBGE). (2021). Município de Augusto Corrêa. https://cidades.ibge.gov.br/brasil/pa/augusto-correa/panorama

Kleba, M. E., Krauser, I. M. & Vendruscolo, C. (2011). O planejamento estratégico situacional no ensino da gestão em saúde da família. Texto & Contexto – Enfermagem. 20(1):184-193. https://doi.org/10.1590/S0104-07072011000100022

Kleinert, S. & Horton, R. (2011). Brasil: no caminho da sustentabilidade e da igualdade na saúde. Lancet. 1:1-3. 11.

Landmann-Szwarcwald, C. & Macinko, J. (2016). A panorama of health inequalities in Brazil. Int J Equity Health. 15(1):174. 10.1186/s12939-016-0462-1

Lima, L. D. et al. (2019). Arranjos regionais de governança do Sistema Único de Saúde: diversidade de prestadores e desigualdade espacial na provisão de serviços. Cadernos de Saúde Pública. 35(2). https://doi.org/10.1590/0102-311X00094618

Limberger, J. B., Carpes, A. D., Noal, C. B. & Werlang, M. C. Gestão da assistência farmacêutica em hospital de ensino: a contribuição do planejamento estratégico situacional. Revista de Administração Hospitalar e Inovação em Saúde. 13(2). https://doi.org/10.21450/rahis.v13i2.3114

Lucena, K.D.T., Deininger, L.S., Silva, E.A., Figueiredo, D.C.M., Pereira, A.J. & Vianna, R.P.T. (2014). Sala de situação em saúde como ferramenta de gestão: planejamento das ações no território. Rev enferm UFPE. 8(3):702-8. DOI: 10.5205/reuol.5149-42141-1-SM.0803201427

Macinko, J. & Mendonça, C. S. (2018). Estratégia Saúde da Família, um forte modelo de Atenção Primária à Saúde que traz resultados. Saúde debate. 42:18-37. https://www.scielo.br/j/sdeb/a/Kr7jdgRFHmdqnMcP3GG8JTB/?format=pdf

Mallmann, E. M. (2015). Pesquisa-ação educacional: preocupação temática, análise e interpretação crítico-reflexiva. Cadernos de Pesquisa, 45(155), 76-98. http://dx.doi.org/10.1590/198053143088

Malta, D. C. et al. (2016). A Cobertura da Estratégia de Saúde da Família (ESF) no Brasil, segundo a Pesquisa Nacional de Saúde, 2013. Ciência & Saúde Coletiva [online]. 21(2):327-338. https://doi.org/10.1590/1413-81232015212.23602015. ISSN 1678-4561. https://doi.org/10.1590/1413-81232015212.23602015.

Maschieto, F. (2018). Avaliação dos indicadores de estrutura, processo e resultado da assistência farmacêutica básica na região metropolitana de Campinas. Piracicaba. Dissertação (Mestrado

profissional). Guerra, L. M. (Orientador). Universidade Estadual de Campinas, Faculdade de Odontologia de Piracicaba. São Paulo. Ficha Catalográfica Online (core.ac.uk)

Mallmann, E. M. (2015). Pesquisa-ação educacional: preocupação temática, análise e interpretação crítico-reflexiva. Cadernos de Pesquisa, 45(155), 76-98. http://dx.doi.org/10.1590/198053143088

Matus, C. (1993). Política, planejamento e governo. Ipea. 1 & 2. Brasília. Brasília; IPEA; 1993. 591 p. ilus, graf.(IPEA, 143).

Minayo, M. C. S.; Costa, A. P. (2018). Fundamentos Teóricos das Técnicas de Investigação Qualitativa. Revista Lusófona de Educação, 40:139-153. ISSN 1645- 7250

Montezano, L., Medeiros, B. N., Pinheiro, A. O. & Oliveira, C. A. A. M. de. (2018). Percepção de Servidores de uma Organização Pública Federal Quanto à Implantação da Gestão por Competências. Gestão E Sociedade. 13(34). https://doi.org/10.21171/ges.v13i34.2563

Moraes, D. A. F. (2020). Qualificação da assistência farmacêutica no município de Paraúna, Goiás. Paraúna. Paraúna. Projeto de Intervenção (Especialização). Ferraz, S. F. (Orientador). Escola de Saúde de Goiás: Superintendência da Escola de Saúde de Goiás Escola de Saúde de Goiás. 33p. Goiás. Brasil.

Moya, J., Santos, E. & Mendonça, A.V. (2009). Gestão do Conhecimento em Saúde no Brasil: avanços e perspectivas. Organização Pan-Americana da Saúde. Brasília. 9788579670039_por.pdf (paho.org)

Mucci, C. B. M. R. & Mafra. R. M. (2016). Pesquisa-ação e mediação dialógica como práticas metodológicas para emergência da ação comunicativa em Conselhos Gestores de Políticas Públicas. Rev. Adm. 50(1):107-128. http://dx.doi.org/10.1590/0034-7612136991

Navegantes, C. B. & Reis, N. M. G. (2017). Educação ambiental: uma abordagem sócio educativa na localidade de Pirateua, Augusto Correa/PA. Graduação. Belém. (Trabalho de Conclusão de Curso). Cardoso, V. A. (Orientador). Universidade Federal Rural da Amazônia. Curso de Pedagogia. Pará.

Neto, V. L. C. & Moura, G. L. (2019). Liderança e Autonomia nas novas formas de organização do trabalho: comparando empresas do porto digital de Pernambuco. Revista Gestão Organizacional, 12(4):63-93. 10.22277/rgo.v12i4.4803

Nora, L. C. D. (2016). A Assistência Farmacêutica no planejamento: relação entre a participação dos profissionais e a qualificação da gestão. Brasília. Dissertação (Mestrado). Universidade de Brasília: Programa de Pós-Graduação em Ciências da Saúde. Tavares, N. U. L. (Orientadora). Distrito Federal. Brasil.

Nora, L. C. D., Costa, K. S. Araújo, S. Q. & Tavares, N. U. L. (2019). Análise da assistência farmacêutica no planejamento: participação dos profissionais e a qualificação da gestão. Cadernos Saúde Coletiva. 27(3):278-286. https://doi.org/10.1590/1414-462X201900030359.

Organização das Nações Unidas (ONU). (2021). Objetivo de Desenvolvimento Sustentável: 3 Saúde e Bem-Estar. https://brasil.un.org/pt-br/sdgs/3

Organização Pan-Americana da Saúde (OPAS) (2014). Manual de planejamento, execução e avaliação de projetos da Representação da OPAS/OMS no Brasil/Organização Pan-Americana da Saúde. Brasília: Organização Pan-Americana da Saúde. 62. manual de planejamento 2015_a.pdf (paho.org)

Organização Pan-Americana da Saúde (OPAS). (2010). Salas de Situação em Saúde: compartilhando as experiências do Brasil/Organização Pan-Americana da Saúde. Orgs. José Moya, et al. Organização Pan-Americana da Saúde, Ministério da Saúde. sala_situacao_saude_2010.pdf

Paim, J., Travassos, C., Almeida, C., Bahia, L. & Macinko, J. (2011). O sistema de saúde brasileiro: história, avanços e desafios. Lancet. 6736(11):60054-8. 925_brazil1.pdf (actbr.org.br)

Paiva, K. C. M. & Mageste, G. S. (2018). Gestão de competência profissionais: Estudo comparativo com Médicos e Enfermeiros de dois hospitais. Revisa de Administração e Inovação Hospitalar. 15(2). https://doi.org/10.21450/rahis.v15i2.4890

Pena, A.A. (2016). Boas Práticas de Governança e sua Aplicabilidade no Sistema Único de Saúde (SUS). Brasília. Monografia (Especialização). Universidade de Brasília: Curso de Especialização em Gestão Pública na Saúde. Menelau, S. (Orientadora). Distrito Federal. Brasil. https://bdm.unb.br/bitstream/10483/14307/2/2016_AlexandreAntunesPena_tcc.pdf

Pereira, B. dos S. & Tomasi, E. (2016). Instrumento de apoio à gestão regional de saúde para monitoramento de indicadores de saúde. Epidemiologia e Serviços de Saúde. 25(2):411-418. https://dx.doi.org/10.5123/S1679-49742016000200019

Pereira, C. M. S. & Fernandes, C. S. E. (2017). Avaliação do ciclo da Assistência Farmacêutica nas farmácias hospitalares de Mogi Guaçu e Mogi Mirim – SP. FOCO: Caderno de Estudos e Pesquisas. 12:73-91. avaliação do ciclo da assistência farmacêutica nas farmácias hospitalares de mogi guaçu e mogi mirim- sp | pereira | foco: caderno de estudos e pesquisas (revistafoco.inf.br)

Pereira, F. Z., Araújo, A. G., Santos, A. M., Naves Silva, L. M. N., Oliveira, L. P. L., Lopes, P. V., Souto, R. & Lima, H. (2021). Mortalidade Infantil e sua relação com as políticas públicas em saúde sob o olhar dos Objetivos de Desenvolvimento do Milênio e Objetivos de Desenvolvimento Sustentável no Estado de Goiás. Brazilian Journal of Health Review. 4(1):3331-3348. DOI:10.34119/bjhrv4n1-262

Pinto, V. B. (2016). Armazenamento e distribuição: o medicamento também merece cuidados. OPAS/OMS-Representação Brasil. 1(12). Fasciculo 012a.pdf (paho.org)

Prata, N., Passano, P., Rowen, T., Bell. S., Walsh, J., & Potts. M. (2011). Where there are (few) skilled birth attendants. J Health Popul Nutr. 29(2):81-91. 10.3329/jhpn.v29i2.7812

Preuss, L. T. (2011). O pacto pela saúde nas cidades-gêmeas da fronteira do Rio Grande do Sul com a Argentina e o Uruguai. Doutorado (Tese). Pontifícia Universidade Católica do Rio Grande do Sul. Fernandes, I. (Orientadora). Porto Alegre. Brasil.

Preuss, L. T. (2018). A gestão do Sistema Único de Saúde no Brasil e as regiões de fronteira em pauta. Rev. Katálysis. 21(2):324-335. https://doi.org/10.1590/1982-02592018v21n2p324

Ramos Junior, I. De O., Neto, M. T. R., Kilmnik, Z. M. & Souki, G. Q. (2016). Liderança organizacional: um levantamento bibliográfico. Universitas Gestão e TI. 6(2):87-95. 10.5102/un.gti.v6i2.4189

Reis, A. M. M. & Perini, E. (2008). Desabastecimento de medicamentos: determinantes, consequências e gerenciamento. Cien. Saúde Colet. 13 (suppl):603- 610. https://doi.org/10.1590/S1413-81232008000700009

Reis, B. O., Esteves, L. R. & Greco, R. M. (2018). Avanços e desafios para a implementação das práticas integrativas e complementares no Brasil. Rev. APS. 21(3):355 - 364. Vista do avanços e desafios para a implementação das práticas integrativas e complementares no brasil (ufjf.br)

Ribeiro, R. A. A. (2021). Atuação dos auditores internos em organizações de saúde do poder Executivo Federal Brasileiro. Pubsaúde. 5:a101. https://dx.doi.org/10.31533/pubsaude5.a101.

Rodrigues Martins, P. C., Jardim Cury Pontes, E. R., & Higa, L. T. (2018). Convergência entre as Taxas de Mortalidade Infantil e os Índices de Desenvolvimento Humano no Brasil no período de 2000 a 2010. Interações (Campo Grande): 19(2):291-303. https://doi.org/10.20435/inter.v19i2.1552

Roque, E. S. (2017). Assistência farmacêutica: um perfil da gestão municipal. Cuiabá. (Trabalho de Conclusão de Curso). Curso de Saúde Coletiva. Galvão, N.
D. (Orientador). Universidade Federal de Mato Grosso. Mato Grosso.

Santos Neto, J. A., Mendes, A. N., Pereira, A. C. & Paranhos, L. R. (2017). Análise do financiamento e gastos do Sistema Único dos municípios da região de saúde Rota dos Bandeirantes do estado de São Paulo. Ciências e Saúde coletiva. 22(4): 1269-1280. https://doi.org/10.1590/1413-81232017224.28452016

Santos, C. L., Santos, P. M., Pessali, H. F. & Rover, A. J. (2020). Os conselhos de saúde e a publicização dos instrumentos de gestão do SUS: uma análise dos portais das capitais brasileiras. Ciência & Saúde Coletiva. 25(11):4389-4399. https://doi.org/10.1590/1413-812320202511.00042019

Santos, L. (2017). Região de saúde e suas redes de atenção: modelo organizativo sistêmico do SUS. Ciência e Saúde Coletiva. 22(4):1281-1189. https://doi.org/10.1590/1413-81232017224.26392016

Silva, C. R., Souza, T. C. de, Lima, C. M. B. L., & Silva Filho, L. B. e. (2018). Fatores associados à eficiência na Atenção Básica em saúde, nos municípios brasileiros. Saúde Em Debate. 42(117):382–391. https://saudeemdebate.org.br/sed/article/view/205

Silva, I. C. M., Restarepo-Mendez, M. C., Costa, J. C., Ewerling, F., Hellwig, F., Ferreira, L. Z., Ruas, L. P. V., Joseph, G. & Barros, A. J. D. (2018). Mensuração de desigualdades sociais em saúde: conceitos e abordagens metodológicas no contexto brasileiro. Epidemiologia e Serviços de Saúde. 27(1):e000100017. https://dx.doi.org/10.5123/s1679-49742018000100017

Silva, R. M. da., Pereira, N. C., Mendes, L. V. P. & Luiza, V. L. (2016). Assistência farmacêutica no município do Rio de Janeiro, Brasil: evolução em aspectos selecionados de 2008 a 2014. Ciência & Saúde Coletiva. 21(5):1421-1432. 10.1590/1413-81232015215.27692015

Soler, O., Sinimbu, A. V., Figueiredo, D. C., Vieira, H. K. S., Galucio, N. C. R., Pinheiro, P. N. Q., Sena, S. S. I., Silva, V. G., Vieira, V. M. B., & Ledo, Y. (2017). A reorientação da assistência farmacêutica na secretaria municipal de saúde de Belém (PA): Relato de experiência. Revista Eletrônica de Farmácia.14(4):41-55. https://doi.org/10.5216/ref.v14i4.45427.

Souza, G. S., Costa, E. A., Barros, R. D., Pereira, M. T., Barreto, J. L., Guerra-Junior, A. A., Acurcio, F.cA., Guibu, I. A., Álvares, J., Costa, K. S., Karnikowski,
M. G. O., Soeiro, O. M., & Leite, S. N. (2017). Caracterização da institucionalização da assistência farmacêutica na atenção básica no Brasil. Revista de Saúde Pública. 51(supl. 2):7s. https://dx.doi.org/10.11606/s1518-8787.2017051007135

Teixeira, S. R., Teles, M. & Moreira, P. (2017). Avaliação do Perfil da Assistência Farmacêutica dos Munícipios do Sudoeste da Bahia. Id online. Revista de Psicologia. 11(38):454. 10.14295/idonline.v11i38.912.

Trevisan, L. & Junqueira, L. A. P. (2007). Construindo o "pacto de gestão" no SUS: da descentralização tutelada à gestão em rede. Ciênc. Saúde Colet. 12(4):893- 902. 9.4 leonardo.pmd (scielo.br)

Uchimura, L. Y. T., Felisberto, E., Fusaro, E. R., Ferreira, M. P., & Viana, A. L. A. (2017). Evaluation performance in health regions in Brazil. Revista brasileira de saúde materno infantil. 17(suppl 1):S259-S270. 10.1590/1806-9304201700s100012

Venancio, S. I., Rosa, T. E. C., Sanches, M. T. C., Shigeno, E. Y. & Souza, J. M. P. (2016). Efetividade da Estratégia Saúde da Família sobre indicadores de saúde da criança no Estado de São Paulo. Rev. Bras. Saúde Matern. Infant. 16(3): 283-293. https://doi.org/10.1590/1806-93042016000300004

Vicentine F. B., Delatorre, T. & Feltrin, A. F. S et al. (2018). Aspectos da gestão que influenciam o processo de planejamento municipal e regional do Sistema Único de Saúde. Medicina. 51(1):1-11. http://www.revistas.usp. br/rmrp/article/view/150073

Vieira, F. S. (2018). Evolução do gasto com medicamentos do Sistema Único no período de 2010 a 2016. Texto para Discussão, 2356, Instituto de Pesquisa Econômica Aplicada (IPEA). Brasília. Distrito Federal. TD_2356.pdf (ipea.gov.br)

Wopereis, A. B. (2015). Avaliação da Assistência Farmacêutica de um município catarinense. Sete Lagoas. Graduação (Trabalho de Conclusão de Curso). (Orientador) Colussi, C. F. Universidade Federal de Santa Catarina. Curso de Farmácia. Santa Catarina.

Yin, R. K. (2015). Estudo de caso: planejamento e métodos. (5a ed.), Bookman.